

NATIONAL HEALTH PROGRAM

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE EIGHTIETH CONGRESS

FIRST SESSION

ON

S. 545

A BILL TO COORDINATE THE HEALTH FUNCTIONS OF THE FEDERAL GOVERNMENT IN A SINGLE AGENCY; TO AMEND THE PUBLIC HEALTH SERVICE ACT FOR THE FOLLOWING PURPOSES: TO EXPAND THE ACTIVITIES OF THE PUBLIC HEALTH SERVICE; TO PROMOTE AND ENCOURAGE MEDICAL AND DENTAL RESEARCH IN THE NATIONAL INSTITUTE OF HEALTH AND THROUGH GRANTS-IN-AID TO THE STATES; TO CONSTRUCT IN THE NATIONAL INSTITUTE OF HEALTH A DENTAL RESEARCH INSTITUTE; AND FOR OTHER PURPOSES

AND

S. 1320

A BILL TO PROVIDE A NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH PROGRAM

PART 3

JULY 9, 10, AND 11, 1947

Printed for the use of the Committee on Labor and Public Welfare



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CONTENTS

I. ALPHABETICAL LIST OF WITNESSES

	Page
Carey, James B., secretary-treasurer, Congress of Industrial Organizations	1351
Cruikshank, Nelson H., director, social insurance activities, American Federation of Labor	1319
Davis, Michael M., Ph. D., chairman, Committee for the Nation's Health, Inc., New York, N. Y.	1548
Hansen, Horace R., general counsel, Cooperative Health Federation of America, St. Paul, Minn.	1384
Lasker, Albert D., president, Albert and Mary Lasker Foundation, New York, N. Y.	1437
Lenroot, Katharine, Chief, Children's Bureau, Social Security Administration	1286, 1306, 1317
Louchheim, Joseph H., executive director, Committee for the Nation's Health, Inc., New York, N. Y.	1543
Miller, Hon. Watson B., Administrator, Federal Security Agency	1130
Mitchell, William L., Acting Commissioner for Social Security, Social Security Administration	1286, 1310, 1317
Parran, Dr. Thomas, Surgeon General, United States Public Health Service	1241
Poss, Edward F., chairman, board of grand trustees, and past grand worthy president, Fraternal Order of Eagles, Springfield, Ohio	1123

II. CHRONOLOGICAL LIST OF WITNESSES

Wednesday, July 9, 1947:

Edward F. Poss, chairman, board of grand trustees, and past grand worthy president, Fraternal Order of Eagles, Springfield, Ohio	1123
Hon. Watson B. Miller, Administrator, Federal Security Agency	1130
Dr. Thomas Parran, Surgeon General, United States Public Health Service	1241
William L. Mitchell, Acting Commissioner for Social Security, Social Security Administration	1286, 1310, 1317
Katharine Lenroot, Chief, Children's Bureau, Social Security Administration	1286, 1306, 1317

Thursday, July 10, 1947:

Nelson H. Cruikshank, director social insurance activities, American Federation of Labor	1319
James B. Carey, secretary-treasurer, Congress of Industrial Organizations	1351
Horace R. Hansen, general counsel, Cooperative Health Federation of America, St. Paul, Minn.	1384

Friday, July 11, 1947:

Albert D. Lasker, president, Albert and Mary Lasker Foundation, New York, N. Y.	1437
Joseph H. Louchheim, executive director, Committee for the Nation's Health, Inc., New York, N. Y.	1543, 1670
Michael M. Davis, Ph. D., chairman, Committee for the Nation's Health, Inc., New York, N. Y.	1548

III. LIST OF STATEMENTS AND COMMUNICATIONS

Cruikshank, Nelson H., director, AFL social insurance activities, declaration of American Federation of Labor in re social insurance at its sixty-fifth convention	1322
--	------

	Page
Carey, James B., secretary-treasurer, Congress of Industrial Organizations, letter of, to Philip R. Rodgers, committee clerk, enclosing list of names of foreign officials with whom he discussed compulsory insurance-----	1372
Davis, Michael M., Ph. D., chairman, Committee for the Nation's Health, Inc., New York, N. Y., insertions of:	
Chart entitled "Medical Expenditures in Relation to Family Income"__	1609
Chart entitled "And as a Percentage of Total Family Income"-----	1609
Public Health Reports, vol. 62, No. 11, March 14, 1947, Health Insurance Programs and Plans of Western Europe-----	1584
Donnell, Hon. Forrest C., a United States Senator from the State of Missouri, insertions of:	
American Historical Association, booklet prepared by, for United States armed forces, entitled, "Is Your Health the Nations' Business?"-----	1629
Association of American Physicians and Surgeons, resolution of, in opposition to S. 1320, adopted at meeting in Chicago, Ill., on June 27-28, 1947-----	1547
Committee for the Nation's Health, Inc.:	
Press release of, dated July 10, 1947, entitled, "Thurman Arnold Charges AMA With Monopolistic Practices"-----	1486
Statement prepared by, entitled, "Brief History of Health Insurance in United States"-----	1673
Eiseman, Robert, and Goldman:	
Data on, derived from report of the Special Committee on Un-American Activities of the House of Representatives, Seventy-eighth Congress-----	1661
Film strip by, entitled, "Medical Insurance—a Pathway to Health"-----	1662
House Report No. 786, Eightieth Congress, First Intermediate Report of the Subcommittee of the Committee on Expenditures in the Executive Departments Authorized To Investigate Publicity and Propaganda of Federal Officials in Formation and Operation of Health Workshops-----	1196
Mitchell, William L., Acting Commissioner for Social Security, Social Security Administration, statement of experience-----	1316
Newspaper clippings as follows:	
Christian Science Monitor, Boston, Mass.:	
April 12, 1947, Compulsory Health Insurance Costs Soar in New Zealand-----	1578
January 4, 1947, Hiatus in Sickness Insurance—Favorable Evidence or Praise Found Lacking in Areas Where System Is Adopted-----	1582
Daily Worker, New York, N. Y., June 2, 1947, New Film Strip Dramatizes Need for Health Insurance-----	1668
Shearon, Marjorie, Ph. D., letter to, from J. P. S. Jamieson, M. D., Nelson, New Zealand, in re New Zealand social-security medical services-----	1580
Hansen, Horace R., general counsel, Cooperative Health Federation of America, St. Paul, Minn., insertion of:	
Cooperative Health Federation of America:	
Board of directors, statement of, entitled, "Specific Provisions That Must Be Incorporated in National Health Legislation If Supported By Consumer-Sponsored Voluntary-Prepayment Organizations * * *"--	1386
Articles of incorporation and bylaws-----	1408
Cooperative League of the United States of America:	
Resolutions adopted by, at cooperative congress, Columbus, Ohio, September 9-11, 1946, in re health legislation-----	1385
Resolution Unanimously Adopted by Fifteenth Biennial Congress, Cooperative League of the United States of America, Columbus, Ohio, September 9-11, 1946-----	1388
Cooperative Health Federation of America, George W. Jacobson, secretary-treasurer, letter of, to Dr. Morris Fishbein, editor, Journal of the AMA, Chicago, Ill., setting forth statement of principles and aims of the federation-----	1390

	Page
Hansen, Horace R., general counsel—Continued	
Cooperative League of the United States of America, and Cooperative Health Federation of America, H. Jerry Voorhis, executive secretary, letter of, to the committee, authorizing Mr. Hansen to speak for the league before the committee-----	1388
Miller, Hon. Watson B., Administrator, Federal Security Agency, insertions of:	
Letter of, to Senator Taft, reporting on S. 545-----	1144
Letter of, to Senator Taft, reporting on S. 1320-----	1152
Office memo from Zilpha C. Franklin, director of information, Federal Security Agency, to Mr. Watson B. Miller, Administrator, in re request for participation in health workshop-----	1204
Murray, Hon. James E., a United States Senator from the State of Montana, insertions of:	
Chavez, Hon. Dennis, a United States Senator from the State of New Mexico, statement of, in re health legislation-----	1538
Committee for the Nation's Health, Inc., letter to, from Samuel Robert, ERG Productions, New York, N. Y., requesting information in re annual income of physicians-----	1692
Cruikshank, Nelson H., director, AFL social insurance activities, article of, Playing Politics With Health-----	1214
Fact sheet 1, Health Insurance, compiled by office of Senator Murray--	1270
Fact sheet 2, Health Insurance, compiled by office of Senator Murray---	1272
Louchheim, Joseph H., executive director, Committee for the Nation's Health, Inc., letter of, to—	
Senator Murray, amplifying Louchheim's testimony-----	1690
Samuel, Robert, ERG Productions, New York, N. Y., in re annual income of physicians-----	1690
McGrath, Hon. J. Howard, a United States Senator from the State of Rhode Island, statement of, in re health legislation-----	1516
Medical Annals, November 1946, excerpt from, The Lady Who Knows--	1213
Newspaper clipping from the Post-Dispatch, St. Louis, Mo., Jan. 19, 1947, Lobbyists Offer of Research Aid Against Health Bill Disclosed—	
GOP Employee Working on Measure for Senators Says She Rejected Proposal of Physicians' Agent-----	1210
Raymond Rich Associates:	
Letter of, to Dr. R. L. Sensenich, South Bend, Ind., in re public relations of the American Medical Association-----	1525
Note of, with regard to the National Physicians Committee-----	1534
Report on Public Relations to the Trustees of the American Medical Association, May 24, 1947, by Raymond Rich Associates----	1526
Telegram of, to the speaker of the house of delegates of the American Medical Association in re resignation of firm from public relations work for the association-----	1524
Rocky Mountain Medical Journal, October 1946, article of, Dr. Shearon Addresses Colorado Society-----	1213
Shearon, Marjorie, Ph. D.:	
Letter of, to members of health and medical professions and to others interested in defeating plans for establishment of State socialism in the United States-----	1207
Statement of, Announcing Establishment of the Shearon Medical Legislative Service, Washington, D. C., July 1, 1947-----	1208
Subcommittee Report No. 5 of Senate Committee on Education and Labor, Seventy-ninth Congress, pursuant to Senate Resolution 62 in re health insurance-----	1487
Taylor, Hon. Glen H., a United States Senator from the State of Idaho, statement of, in re health legislation-----	1535
Wagner, Hon. Robert F., a United States Senator from the State of New York, statement of, in re health legislation-----	1514
Pepper, Hon. Claude, a United States Senator from the State of Florida, insertions of:	
Arnold, Thurman, Washington, D. C., letter from, to Dr. Channing Frothingham, chairman, Committee for the Nation's Health, Inc., New York, N. Y., in re S. 545-----	1428
Kiplinger's Magazine of April 1947, article entitled "Health Means Plans and Dollars—We Must Find a Way To Meet Our Challenging National Medical Problem-----	1431

	Page
Pepper, Hon. Claude, a United States Senator, insertions of—Continued	
Shearon, Marjorie, Ph. D., Chevy Chase, Md., letter of, addressed to her readers, in re discontinuance of her news releases-----	1285
Supreme Court of the United States, decision of, in re the cases of <i>American Medical Association v. The United States of America</i> , and <i>The Medical Society of the District of Columbia v. The United States of America</i> -----	1222
United States Court of Appeals for the District of Columbia, decision of, in re the <i>American Medical Association v. United States of America</i> , and <i>Medical Society of the District of Columbia v. United States of America</i> -----	1227
Vessels, Alma, R. N., executive secretary, National Association of Colored Graduate Nurses, Inc., New York, N. Y., letter of, to Senator Murray in favor of S. 1320-----	1429
Parran, Dr. Thomas, Surgeon General, United States Public Health Service, statement of, The Need For and the Costs of Additional Medical Personnel and Facilities-----	1279
Potofsky, Jacob S., general president, Amalgamated Clothing Workers of America, and member of the executive board, Congress of Industrial Organizations, statement of, in re health legislation-----	1381
Smith, Hon. H. Alexander, a United States Senator from the State of New Jersey, insertions of:	
Lull, George F., American Medical Association, Chicago, Ill., letter of, to Senator Smith, in re Thurman Arnold's letter to Dr. Frothingham-----	1430
Robins, R. B., M. D., national committeeman, Democratic National Committee, Camden, Ark., letter to Gael Sullivan, executive director, Democratic National Committee, Washington, D. C., in re compulsory health legislation-----	1434
Woll, Matthew, second vice president, American Federation of Labor, telegram of, addressed to Philip R. Rodgers, committee clerk, authorizing Nelson H. Cruikshank to testify before the committee in behalf of the American Federation of Labor-----	1320

IV. LIST OF CHARTS AND GRAPHS

Agency participation in "health workshop" program-----	Faces 1202
The costs of medical care are unevenly distributed-----	1488
The lower the income, the more sickness and the less care-----	1489
Present coverage of voluntary plans-----	1491
The twenty-five percent:	
Type of services received-----	1493
Type of plan-----	1493
All Blue Cross members get hospitalization-----	1495
Medical services received-----	1498
Medical society plans, 1945-----	1498
Services offered by medical care prepayment plans-----	Faces 1500
Who buys prepayment-----	1503
Hospital insurance poll, Rochester, N. Y.-----	1505
American family incomes-----	1505
Turn-over in a voluntary medical care plan, rural Ohio-----	1506
Those who used the plan most remained members-----	1506
How tax-subsidized voluntary health insurance worked in six rural counties-----	1508
United States opinion on costs of medical care:	
I-----	1510
II-----	1511
III-----	1511
Medical expenditures in relation to family income-----	1609
Medical expenditures as a percentage of total family income-----	1609

NATIONAL HEALTH PROGRAM

WEDNESDAY, JULY 9, 1947

UNITED STATES SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 9:30 a. m., in the committee room in the Capitol Building, Senator H. Alexander Smith, presiding.

Present: Senators Smith (presiding), Donnell, Murray, and Pepper.

Senator SMITH. The committee will please come to order. Our first witness this morning is Mr. E. F. Poss, representing the Fraternal Order of Eagles, Springfield, Ohio. We will be glad to hear you, Mr. Poss.

STATEMENT OF EDWARD F. POSS, TOLEDO, OHIO, CHAIRMAN, BOARD OF GRAND TRUSTEES, AND PAST GRAND WORTHY PRESIDENT, FRATERNAL ORDER OF EAGLES

Mr. Poss. Mr. Chairman and gentlemen, I should like to say as a representative of the Fraternal Order of Eagles, that I appear here not for the purpose of directing or endorsing any particular movement, but rather for an expression of the 1,250,000 Eagles. As chairman of the board of grand trustees and former national president of the Fraternal Order of Eagles, I am appearing before your committee on behalf of an organization which has a membership of 1,250,000 representative Americans, a cross section of our population. Our order has aeries or lodges in approximately 1,400 communities. It is the largest benefit paying organization in the world.

In the 49 years of its existence, the Fraternal Order of Eagles has campaigned for measures that contributed to human welfare. Perhaps some of you gentlemen are familiar with its record. Back in 1921 the Eagles launched a crusade for State old-age pension laws. We regarded the poorhouse as an institution not in keeping with the dignity of Americans who had reached an advanced age without the proper means to maintain themselves. We felt that the American way was to provide cash payments so that our senior citizens could look after their own needs and retain their self-respect. The State old-age pension movement was started in Montana by an Eagle legislator, who received the full support of our order, with the result that the first State old-age pension bill was enacted into law. Practically every State old-age pension law can be traced to Eagle initiative and support.

Even in those early days, the Eagles felt that State old-age pensions were not the complete answer. Old-age pensions removed the stigma of the poorhouse, but they still left the recipients as wards of the State. The Eagles foresaw the time when American workers would contribute to their own security and participate in a retirement plan in which they would earn their benefits. That kind of program was in keeping with the pride and desire of the individual American. Thus the Eagles joined the movement for the national Social Security Act back in 1921. Our order spent more than a million dollars on an educational campaign in behalf of such legislation. Two national leaders of our order served on the advisory committee that drafted the Social Security Act. Senator Robert Wagner, a member of our order, introduced the bill in the Senate, and Representative David Lawrence, also a member of the order, sponsored it in the House. In acknowledgment of the services of the Eagles in behalf of this legislation, the late President Roosevelt, a life member of the order, invited Eagle representatives to witness the signing of the act, and presented them with a pen. A member of our order served on the first Social Security Board. We believe that our early faith in the sound principles of social security and the workability of a Government system of social insurance, based on a contributory plan, has been well justified. We are proud of the part our order has had in the enactment of this act, and we are campaigning for extension of social security to include the 20,000,000 Americans not now eligible to participate in benefits.

The Eagles campaigned for other worthy social legislation. The order was a leader in the fight for legislation to bring some degree of happiness into the lives of dependent mothers and provide them with assistance in the task of rearing their children when their husbands were taken by death. The first mothers' pension law in the United States was drafted by a Kansas City Eagle and passed in Missouri with the support of our order.

Senator DONNELLY. Was that Mr. Conrad Mayham?

Mr. POSS. No; that was Judge Porterfield.

Senator DONNELLY. The man who was at the head of it was Conrad Mayham, president of the chamber of commerce in Kansas City?

Mr. POSS. That is right. Our order was a leader, too, in the early movement for workmen's compensation. It fought for the first workmen's compensation law in America, the Wisconsin law, which was drafted by an Eagle and backed by his fraternity. Economic misfortune has been responsible for a great share of human misery and unhappiness, often due to no fault of the victims. As a fraternity we have tried to ease the burdens and impress upon our fellow citizens the common obligation we all have to lighten the misfortune which may come to any of us in the course of our daily living.

The Fraternal Order of Eagles is sponsoring programs that promote the general welfare. It has established national commissions to further these programs. The order is actively engaged in combating juvenile delinquency, in advancing child health and child welfare, in stimulating full employment, in rehabilitating our veterans, and aiding our handicapped and elderly citizens.

One of our primary concerns is child health. One of the important program slogans of the Eagles is "A chance at a real childhood for every child." Our order has given more than lip service to such an

objective. It established a National Youth Guidance Commission, which has aided aeries in many communities to promote wholesome undertakings for the young-youth centers, local youth guidance institutes, community youth councils, athletics and the like. In 1941 the Eagles at a cost of \$160,000 erected a dormitory for Father Flanagan's Boys Town.

About 2 years ago the Eagles set up a National Child Health Commission, and some of the results of this work are already apparent. Some of our aeries have set up well-baby clinics in cooperation with local health authorities, and have made available medical facilities to examine children and advise mothers on diet and the healthful upbringing of their children.

The Fraternal Order of Eagles has wholeheartedly supported health legislation which it believes will contribute materially to an improvement in the health of our Nation. Our fraternity endorsed the Federal school-lunch appropriations to the States, and scores of our aeries passed resolutions advocating such aid. Our order, too, endorsed the maternal and child welfare bill, sponsored by Senator Pepper, because it feels that the services proposed, medical and hospital care when children are sick, school-health services and dental care and child-guidance clinics, are essential for the well-being of our future citizens.

The Fraternal Order of Eagles favors certain provisions of the National Health Act of 1947, S. 545, sponsored by Senators Taft, Smith, Donnell and Ball. It regards the proposed legislation as a forward stride in solving some of the health problems that challenge solution. Certainly, the proposed expenditure of \$200,000,000 a year to provide general health, hospital and medical services for families and individuals with low incomes is a real approach to aiding the welfare of the underprivileged. Our order endorses the proposed establishment of a national health agency and the program this agency would administer. We are glad to see two objectives included among the proposed work of the agency, because they are objectives which our order has gone on record with its support. I refer to "the promotion of maternal, prenatal and child care, and the study and dissemination of information on child growth, development, and nutrition" and to "the training and rehabilitation of persons vocationally handicapped because of permanent disability with the objective of placing such persons in remunerative employment."

Our order, at its 1946 national convention, pointed to this need for vocational training both for our disabled war veterans and the victims of industrial accidents. The Eagles National Commission on Stimulation of Employment, in its report to the convention stated:

Too often have the various State agencies, charged with the responsibility of caring for injured workers, failed to properly discharge their trust. Too often have crippled workers been relegated to the human scrap heap and the conscience of legislatures and public officials salved by the payment of a pittance in money. The injured industrial worker often needs to be retrained and rehabilitated so that he may return to work and earn his own livelihood by the best utilization of his personal talents.

I have just quoted in part from the report of the Eagles' National Commission on Stimulation of Employment.

Other provisions of S. 545 are formidable assaults upon ill health. The distribution of funds for dental care, cancer control, a National

Institute of Dental Research, a survey of health and medical care resources, a dental care survey, are appropriations which our order believes will appreciably advance the public health services.

The means by which these funds would be allotted to the States—the grants-in-aid principle—is the guiding principle of the Social Security Act. Our order indorses such use of Federal funds. In fact, in our support of the Social Security Act, we stressed the soundness of Federal grants to States to provide for the public assistance of needy persons.

The Fraternal Order of Eagles wholeheartedly subscribes to the statement in the National Health Act of 1947 which would establish as the policy of the United States Government—

to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public health services to every individual regardless of race or economic status.

Our order further believes that a Federal health program to be adequate to meet the needs of all economic groups in our population should take into account the necessity for establishment of a system of national health contributions to the Social Security System on the part of employers and employees to pay for cash disability benefits and medical cost reimbursements.

We must recognize the fact that even if adequate provisions are made for medical services for low-income families and the needy, there will still remain millions of Americans upon whom illness will fall as a crushing economic disaster. The Census Bureau recently published figures which revealed that the median income for American families living under one roof was \$2,378 in 1945. Presumably these are families which cannot be classified as low-income groups, but it is very evident that they must struggle to maintain even a fair standard of living. Such families have no income to tide them over to meet medical expenses and ordinary family requirements when the wage-earner takes sick. Our order believes that a system of national health insurance is necessary to provide protection for vast numbers of American families.

When the Fraternal Order of Eagles held its 1945 national convention, it went on record for endorsement of "the general aim and objects" of the then pending Wagner-Murray-Dingell bill which provided for cash benefits for temporary and permanent disability. When I appeared before your committee last year relative to the national health bill, S. 1606, I stated that certain provisions of the Wagner-Murray-Dingell bill were in line with the long time fundamental policies and program of the Eagles, and that the same could be said for certain provisions of Senate bill 1606. This also holds true for Senate bill 545 or the national health bill of 1947. The Fraternal Order of Eagles endorses its general objectives and provisions. It conforms with many of the objectives of the Eagles in the national health field. But our order feels now, as it has in the past, that a system of national health insurance should be included in any approach to solution of our national health problem.

Last year before your committee, I made a statement on the Eagle position that was incorporated in the report of our order's National Old Age and Social Security Commission and unanimously adopted by the 1946 annual convention. I should like to restate this position.

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 sickness.

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.

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 that all of us will help foot the Nation's doctor bills instead of letting the unlucky or sickly one 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 expense provided—but not necessarily the medical care itself provided.

In conclusion, I should like to summarize the principal provisions advocated by the Fraternal Order of Eagles in a national health insurance plan.

1. Cash benefits covering wage loss during periods of temporary or permanent disability, identical with those now provided for wage loss during periods of unemployment.

2. Cash reimbursements to workers for major hospital, surgical, and medical expenses for themselves and their families.

3. Increased contributions from employer and employee to the social-security system, on the part of employers and employees, to pay for such cash disability benefits and medical cost reimbursements.

4. A guaranty of the independence of the medical profession, with no limitation on the average American's right to choose and pay his own family doctor or dentist, using social insurance only to guarantee his ability to do so.

5. Continued reliance on the fundamental principles of the original Social Security Act—Federal Government's grants-in-aid to States for the public assistance of the needy, and social insurance to give all Americans protection against the major economic hazards of life.

This program is a contributory system of protection against the economic hazards of illness, and provides for the dignity of the patient and the independence of the medical profession. It is practical and economically sound. The Fraternal Order of Eagles believes that such a program will eliminate a major fear in the daily life of the average family, the haunting fear of sickness-induced poverty. We believe that such a program will be a distinct contribution on the part of Government to the welfare and happiness of millions of our citizens. Thank you very much, gentlemen.

Senator SMITH. We very much appreciate your statement, Mr. Poss. I have just one question I would like to ask.

I think you have made it very clear in your statement, but your whole theory of the plan that you advocate contemplates an over-all tax, you might say, on everybody for contributions to the fund, the same kind of tax we have for Social Security today?

Mr. Poss. Yes.

Senator SMITH. You add this to that tax, but instead of giving service for the money paid in the way of medical service, you simply give compensation in dollars to the person, who could buy their own medical service? Is that the theory? You say here:

I venture the opinion that he wants insurance against medical expenses but not necessarily the medical care itself provided.

Mr. Poss. Here is what we mean by that: We mean that the insurance be set in such a way that the recipient of the service will be free to call the doctor of his choice. The compensation will be paid to him and he in turn compensates the doctor, rather than to have a list of doctors or a group of doctors who will be paid by the Surgeon General of the United States or by the Government. It will be given to the individual, and the individual receiving the aid will have the right to choose any doctor. Mrs. Brown may have an affection for Dr. Jones, who can best administer to her baby. Well, she will call Dr. Jones. Then the check will be sent to Mrs. Brown and she will pay the doctor. That will eliminate the stigma of socialized medicine. It is, we believe, the real democratic way of operation—operating exactly the same as an insurance company.

Senator SMITH. You probably have in mind what is called the fee for service system, their paying the doctor. We have had some discussion here to the effect that there are three ways to pay doctors' fees for services: The so-called "capitation" method, wherein the doctor is paid so much per patient taken care of; the over-all fixed salary method paid by the State or Federal Government. Your plan will leave the doctors where they are now, and you simply give dollar benefits to people who are insured under this system, so they can go and employ their own doctor and pay whatever fee the doctor charges?

Mr. Poss. Yes; the insurance plan will be a guaranty of medical service to them, and likewise pay for the doctor, but will not confine them to the selection of a Government-proposed doctor. They would have freedom of choice of the doctor whom they wanted to administer to them. I am of the opinion that the application of the law will bring out a plan and a program of how eventually the doctor will be paid. I suspect that over a period of years there might be a general plan of a certain sum for such service. I am just guessing at that. I don't know, but it would appear to me that eventually that would happen.

Senator SMITH. I have in mind such plans as the Blue Cross service plan for hospitalization by insurance, and the Blue Shield, and so on, those different plans that are being developed by the medical profession itself to try to help people to get proper insurance of medical care.

Mr. Poss. I have absolutely no argument with them, except we feel that there are too many who do not come within the scope of those plans.

Senator SMITH. Of course, that is one of the things we are discussing, how we can get over-all coverage in some adequate way. In S. 545,

which I am glad to see you support the principles of, we are thinking in terms of something like that where each State will be challenged to come out with its own plan and give us the benefit of 48 experiments going on continuously, and get the best plans from the States to meet the problem. I think we are all in sympathy with what you are driving at here, to take care of the needy. It is just a question of the best way to do it.

Mr. Poss. I want to leave this impression with you gentlemen, that by no stretch of the imagination do I appear here as trying to set up a plan or program. We are here to advocate the principles of health insurance; 1,250,000 Eagles are definitely interested in this program, and we are willing and anxious to go along with any program that will get the job done. We have no political axes to grind, as you understand, Senator.

Senator SMITH. I understand that. Senator Donnell, have you any questions?

Senator DONNELL. Mr. Poss, you mentioned in your statement that you appeared before the Committee on Education and Labor last year?

Mr. Poss. That is right.

Senator DONNELL. And I think this is your second trip to Washington?

Mr. Poss. Yes.

Senator DONNELL. At your own expense or that of your order?

Mr. Poss. The order pays it.

Senator DONNELL. But you have come here because of your interest in this great subject matter, and have endeavored to give us the views of your organization?

Mr. Poss. That is right.

Senator DONNELL. And your organization has been very active in this matter for some years?

Mr. Poss. That is right.

Senator DONNELL. That is all.

Senator SMITH. Do you have any questions, Senator Murray?

Senator MURRAY. I have only a very few questions. I would join with Senator Donnell in expressing my appreciation of your appearance here this morning, and I am very sorry that I was not able to be present when you were here a short time ago. I aided in every way to make it possible for you to come here this morning.

Senator DONNELL. I did not mean in my questions the slightest criticism. I was simply endeavoring to bring out the fact that the witness was very much interested in the matter and I am sure we all appreciate his being here.

Senator MURRAY. Yes; I appreciate what the Senator says. I merely wish to reiterate what he has said, because I know this gentleman has taken a very deep interest in the problem, and has come here at a great deal of inconvenience for the second time.

I understand, Mr. Poss, that you do not regard this bill, S. 545, as a substitute for a national health insurance?

Mr. Poss. No, sir.

Senator MURRAY. It is merely a stopgap? Isn't that it?

Mr. Poss. That is right. I think we have set forth plainly in our program what we stand for, and we are here to assist, in any way we can, this program.

Senator MURRAY. You say your order feels now, as it has in the past, that national health insurance should be included in any approach to the solution of our national health program?

Mr. Poss. That is right.

Senator MURRAY. S. 545 only provides \$200,000,000, which would be absolutely insufficient to provide any relief for the millions of people who are in need of health care and are not able to have it at this time.

Mr. Poss. I think that is true. I think I have indicated that in my discussion. I said the Fraternal Order of Eagles favors certain provisions, and further on I think I said that these are steps in the right direction, but we are far removed from the ultimate solution.

Senator MURRAY. But you would not recommend the extension of that system provided in S. 545 for the taking care of total needs of the people?

Mr. Poss. Definitely not.

Senator MURRAY. That would be socialized medicine in an extreme way?

Mr. Poss. Yes, I think so.

Senator MURRAY. Because the Government there would be paying the entire cost of the medical care, and it would avoid entirely the program that we are suggesting with reference to an insurance system?

Mr. Poss. Yes, sir.

Senator MURRAY. I think that is all.

Senator SMITH. Thank you very much, Mr. Poss. We are very glad to have you with us.

Mr. Poss. Thank you, gentlemen.

Senator SMITH. Next on our list this morning is Mr. Watson B. Miller, Administrator of the Federal Security Agency. We are glad to see you this morning, Mr. Miller.

STATEMENT OF HON. WATSON B. MILLER, FEDERAL SECURITY ADMINISTRATOR, WASHINGTON, D. C.

Mr. MILLER. I am glad to be here, Senator.

Senator SMITH. I think we know who you are, Mr. Miller. I think you are well enough known that we do not need to ask you for a biographical sketch of the witness.

I have here a statement marked, "Statement before the Senate Labor and Public Welfare Committee," and also I have here a letter which is addressed by you, apparently, to Senator Taft, and I am interested to know are they both relative to the same subject?

Mr. MILLER. One, Mr. Chairman, is the customary report upon one of the two measures under examination here, and I have no doubt that the second one constitutes my own statement before the subcommittee, rather than the formal comment upon the bill.

Senator SMITH. You may proceed in your own way, Mr. Miller.

Mr. MILLER. Mr. Chairman and gentlemen; we in the Federal Security Agency deeply appreciate your invitation to participate in these hearings on S. 545 and S. 1320. The importance of such hearings cannot be overestimated. They help us all to see the basic issues more clearly. And through indicating the gap between what can be done and what is being done to provide our people with the truly wonderful kind of medical care we have in our country, such hearings stimulate public discussion and study of the problems.

Whether or not any major health legislation be enacted in this session, very substantial progress has been made as a result of these and last year's hearings. I say this quite earnestly, because I feel that these public exchanges have disclosed substantial and important areas of agreement, which I like to think of in the light of the following five considerations.

FUNDAMENTAL AREAS OF AGREEMENT

The people as a whole have:

1. Recognized a Federal interest, to be backed by a Federal financial concern, in the health of each person in our country.
2. Agreed upon the necessity for broadening the availability of medical care and health services through new means and approaches.
3. Accepted the wisdom of overcoming shortages of personnel and facilities as rapidly as may be practicable.
4. Asserted the wisdom and necessity of adopting some prepayment method of meeting the costs of medical care.
5. Agreed upon the wisdom and necessity of decentralizing the administration of any national-health program.

FURTHER FUNDAMENTAL PROPOSITIONS

In addition to these fundamental areas of agreement, certain other propositions are, I believe, equally valid: That large numbers of otherwise self-supporting people are unable to secure all the medical care and health services which they need both to prevent and to alleviate illness; that this inability is in large measure due to the fact that a great many people cannot afford essential medical care, in terms of their general expenses for just living; that Abraham Lincoln's reflection is applicable:

* * * the legitimate object of Government [is] the doing for a community of people whatever they need to have done, but cannot do at all or cannot do so well for themselves in their separate and individual capacities—

and therefore that the Federal Government must devise a system through which medical and health care may be conveniently and effectively financed.

On the basis of these observations, we believe that health insurance is the most effective means by which our people can meet their health needs.

Senator SMITH. When you say "health insurance" there do you mean compulsory health insurance?

Mr. MILLER. Yes, Senator, so far as it is possible to develop such a plan. That conviction is based upon a growing and increasingly successful experience in the field of social insurance during the last 10 years.

Senator DONNELL. You mean in other countries?

Mr. MILLER. In this country, in the segments of social insurance. I do not have the competence to offer reflections upon the systems involved in other countries.

Senator DONNELL. We do not have any compulsory health insurance in this country, do we, Mr. Miller?

Mr. MILLER. So far as I know, we have not—at least, there may be some in some municipalities, but if there are, I am not aware of them.

Senator DONNELL. There are some statutes up in one of the New England States, Rhode Island, are there not, on a cash sickness benefit basis?

Mr. MILLER. I am not advised of that, Senator. It is quite likely that there may be.

Senator SMITH. Let me just develop that a little further. Your thought of a compulsory health insurance plan would be a compulsory health insurance tax like the social-security tax, added to the present percentage, whatever it may be, for social security?

Mr. MILLER. I think the national lawmaking body should develop the manner in which the money should be raised, but I favor an individual prepayment system which would bring about payment within the capacity of most people against the contingency of illness and necessity for medical care. I have made a good deal of inquiry around in the States as to the difference in the attitude of people toward receiving the monthly benefits under old age and survivors' insurance, and those who receive public assistance benefits because of advancing years, and so on, to which they contribute nothing, and I am told generally that the former group seems to have more self-respect and self-reliance and less feeling of dependency on the community at large.

Senator SMITH. Then whether your sick fund is to be raised by pay-roll deductions or any other scheme that might be devised, however the fund is raised, do you contemplate that that would be distributed in cash to the individuals receiving the benefit, in which instance he would be required to attend to his health needs with that many dollars, so that the obligation of the State would be satisfied by that route? Or would you have some form of organization of your medical profession in order to meet the responsibility assumed by the Government in asking individuals to make that deduction from his pay roll?

Mr. MILLER. I think the most convenient and effective plan would be disclosed by experimentation, Senator Smith. I am myself a member of one of the health groups, and I value my membership in it very highly.

(Discussion off the record.)

Senator SMITH. But you have in mind that possibly we might have to have some regulation to provide that the person rendering the service would be compensated from the funds dedicated to this purpose?

Mr. MILLER. Yes; the system would have to provide for payment for hospitals and doctors and nurses and others. Many millions of American men, women, and children have gone down into the shadow of the valley of death with our fine physicians. We have confidence in them. I myself am very proud of American medicine, and I would not consciously do it any harm. Conversely, confidence ought to flow the other way. Our fine physicians should have some confidence in their people and their Government to protect the fine physicians and the developments, the astonishing developments of medicine and their application, particularly in the last decade.

Senator SMITH. I would like to get more thoroughly just what your position is. As I get it, you start with the compulsory plan rather than the theory of S. 545, which aims to start in a slower way. I have never had any objection to the compulsory plan. I am told that California is interested in that idea, and I say let them try it. I am not prepared to say yet that we should adopt the compulsory

plan before we determine how we are going to have that fund applicable.

Mr. MILLER. No plan can emerge from a cloud on top of the mountain full-fledged and effective to maximum possibilities overnight. Of course, we are going to make a trial run and benefit by experience as we do in our other programs in the Federal Security Agency, and profit by experiences of success or failure.

Senator SMITH. You think we are ready to put this program under over-all social security and increase the pay roll deductions and say we are going to add to the benefits now given by Social Security a complete health coverage?

Mr. MILLER. I do, Senator, and I believe that as fundamentally and soundly as any conviction that I have can be. A 100 percent try may justify a lack of 100 percent success at the initiation of any program of this kind. That is true of other laws you have passed.

Senator SMITH. You prefer that rather than the slower trial and error method of giving the States the opportunity to work out their problems and give us the benefit of their experience?

Mr. MILLER. I shall make some reference to S. 545 as I go along.

Senator SMITH. Proceed, Mr. Miller. I shall not interrupt you any more.

Mr. MILLER. I do not mind interruption. I think this is wonderful. We learn in this way, and possibly we can give you the benefit of some of our experiences. I am one of those administrators who feel that the national legislature should have the time, as it can afford, to examine the processes of Government, and I would like to say—and it is rather in a vernacular, I think—that none of us in my Agency—and I think that is probably true of the Government generally—none of us desires to come up here and view with alarm all the time. We like to point with pride, and that I hope is what this sort of discussion will lead to.

PRESIDENT'S LONG-RANGE HEALTH PROGRAM

On November 19, 1945, and again on May 19, 1947, the President recommended to the Congress a 5-point health program as necessary to the national welfare and security. His proposals include:

1. Adequate public health services, including an expanded maternal and child-health program.
2. Additional medical research and medical education.
3. More hospitals and more doctors, in all areas of the country where they are needed.
4. Insurance against the costs of medical care.
5. Protection against loss of earnings during illness.

"We are a rich Nation and can afford many things," the President has said. "But ill health which can be prevented or cured is one thing we cannot afford." He has set our goal: "Everyone should have ready access to all necessary medical, hospital, and related services." The principal reason why people do not receive the care they need is that they cannot afford to pay for it when they need it. This is true not only of needy persons but also of a large proportion of normally self-supporting persons. Instead of segregating those who can pay for needed care from those who cannot, the President's program adopts the American formula of saving together, to meet such costs through expanding our existing compulsory social insurance system.

The two bills: The essential health needs of the Nation are of such scope and character that they can be met with reasonable adequacy only by the development of a broad and comprehensive health program. We feel that our health needs cannot be met adequately through a program of the size contemplated by S. 545, or through any program operated on a means-test basis. While I believe that a program of the dimensions proposed by S. 545 could contribute substantially toward meeting some of the most pressing health needs of the Nation, I am convinced that the bill would have to be modified in several very important respects which I have outlined more fully in my report on S. 545, which the committee has before it now, and which will be discussed at greater length by my colleagues, the Surgeon General, the Acting Commissioner for Social Security, and the Chief of the Children's Bureau.

Senator SMITH. The report to which you refer on S. 545 is the letter dated July 3, 1947, which is addressed to Hon. Robert A. Taft, chairman of this Committee on Labor and Public Welfare?

Mr. MILLER. That is correct.

Senator SMITH. That is just to identify it.

Mr. MILLER. No alternative program to the President's health program has yet been advanced which gives comparable promise of achieving, now or in the future, the goal of adequate medical care for all our people. Therefore, the Federal Security Agency endorses the basic approach of S. 1320, as it did last year with respect to S. 1606. The current bill contains a number of new or amended provisions, which in our judgment, are definite improvements. Since our testimony last year on S. 1606 stated our general position, I shall not consume your time in restating it. But I would like to call your attention to some of the major changes between S. 1320 and S. 1606, which, in my belief, make it even more desirable for enactment by the Congress as a foundation health program.

I. DECENTRALIZATION OF ADMINISTRATION

S. 1320 very clearly establishes a system of local administration, under State-wide plans. Since the Federal Government undertakes an obligation to the persons eligible under the bill, and finances the program, it reserves the right to administer the program in States where benefits would not otherwise be available. S. 1320 definitely provides for local administration within local health-service areas, by local officials or committees appointed under State plans. Many functions, placed by S. 1606 on the Surgeon General, are now placed by S. 1320 on local or State officers.

People living within the local health-service areas required to be set up by the bill are given a direct responsibility in the program's operation, through membership on local area committees and on special professional committees, which advise with the local administrative officers or committees. These committees are entrusted with substantial and important responsibilities.

Gentlemen, it has been said that S. 1320 does not really decentralize administration, since certain rule-making powers still remain by law with Federal authorities. Two observations occur to me:

1. The State health authorities who, it might be expected, would most violently react against such imputed breach of States' rights,

do not seem to find retention of Federal rule-making powers quite the bug-a-boo it appears to others. For example, at these very hearings Dr. Vlado Getting, secretary of the Association of State and Territorial Health Officers, although testifying in favor of S. 545, said:

We believe that the Federal agency should have authority to set minimum standards in the technical aspects of the program. * * * We, therefore, recommend that the United States Public Health Service be authorized to set minimum standards as to content of program * * *.

While his remarks were directed toward a grant-in-aid proposal, they apply with even greater force to a program where the Federal Government collects the funds and establishes entitlement to benefits.

A similar view was expressed at these hearings by Dr. Reginald M. Atwater, executive secretary of the American Public Health Association, who said:

It should be noted that S. 545 explicitly prevents Federal standards of any sort * * *. To prohibit Federal standards would set a precedent which could only result in administrative confusion and deterioration of quality of service. We believe that this provision of S. 545 is opposed to the best interests of local and State agencies and the health of the public they serve.

Still another State official expressed the same view at these hearings. Mr. Patrick Tompkins, chairman of the committee on medical care of the American Public Welfare Association, said that on the basis of their experience in administering State programs involving Federal grants-in-aid:

* * * We are obliged to conclude that S. 545 lacks the necessary minimum provisions to protect either the taxpayer or the recipient and would place the administering State agency in an extremely difficult position * * *. The specific difficulties which we would foresee in the administration of S. 545 arises from a confusion of the roles of administrator and practitioner and an apparent fear that any standards or minimum requirements would constitute interference with the rights of the latter. The bill itself sets no standards and specifically prohibits the Federal director from doing so. This is virtually unprecedented in Federal grants-in-aid program. * * *

Apparently State authorities most intimately concerned with, and who know most about, the problem, do not share fears over retention of rule-making authority, on minimum standards, in the Federal agency. And I think no Federal administrator could very long, under the proper scrutiny of the Congress and of the people, "get away" with unduly circumscribing procedural rules. And, of course, he should not.

With all States participating in the administration of benefits under S. 1320 the role of the Federal administrative agency would be mainly to collect and allocate the funds, determine insured status of individuals, and assure that the guaranties and basic standards are complied with. Thus, responsibility for the operation of the program is decentralized to the States and to local authorities.

2. Objection to such retained rule-making power is generally voiced by supporters of S. 545. I do not believe it an ad hominem argument to point out that S. 545 also retains Federal restrictions and limitations over the States as to determination of eligibility for its benefits. Although S. 545 is espoused on the principle of States' rights, it does exactly what S. 1320 does; it sets standards of eligibility which are binding on the State. S. 545 limits the States to using the Federal funds for the needy. It is a different standard from that in S. 1320,

but it is clearly a Federal limitation on the States in the most important of all aspects of the program, the scope of coverage.

II. FEDERAL AGENCY

S. 1320 also differs from S. 1606 by providing for administration through a National Health Insurance Board of five members rather than through the Surgeon General. In a program of this scope, this is a desirable change, and is in keeping with past experience in similar programs. The relationship between this Board and the Federal Security Administrator precisely follows that which prevailed between the Social Security Board and the Federal Security Administrator, which was sanctioned by the Congress in its approval of Reorganization Plan No. 1 of 1939, creating the Federal Security Agency, and which was particularly suitable during the early development and establishment of the program.

The National Health Insurance Board, which would not be made up wholly of professional people, would be under the direction and supervision of the Federal Security Administrator, who need not be a doctor of medicine. That is completely in the American tradition. We just vanquished hard and ruthless enemies, and we did this under a system whereby the Army and Navy were under the direction and supervision of people who were civilians, some of whom in fact were required by law to be civilians.

Senator SMITH. I would like to ask there, Mr. Miller, would you make an analogy, then, between the medical profession and the Army, that the profession be run by this Board as the Army is run? Is that the point?

Mr. MILLER. I am stating historical facts here.

Senator SMITH. You refer to the Army and Navy. That is the reason I asked the question.

Mr. MILLER. Not only has it applied to the Army and Navy, but to other important Federal establishments.

Senator SMITH. Then the medical profession would be more or less drafted into the Army that would be controlled by this Board that you contemplate under social security?

Mr. MILLER. Would you repeat the question, Senator?

Senator SMITH. I say you contemplate that the medical profession will be looked upon as members of the armed forces, to be directed by this Board which you advocate?

Mr. MILLER. No; we advocate the wider flexibility, the recognition of liberalities in the partnership proposed to be set up between the Federal Government and State governments, local establishments, and the world of physicians and dentists and nurses. I certainly reject a notion of drafting the medical profession.

Senator SMITH. I assumed you would, but I wanted to bring that out to see where you draw the line, if you are setting a program of this kind for over-all coverage into the Social Security Administration.

Mr. MILLER. The analogy is in relation to what has been frequently discussed before this committee and in the Senate, and that is whether the hands of the Administrator or even of the President of the United States should be tied by the circumscription of this, that, or the other provision in setting up an establishment of such great import and

proposed value to the people. For example, the provisions in the Fulbright-Taft bill formerly required that the head of the Bureau of Health had to be a physician qualified to practice in one or more of the political jurisdictions. We felt conscientiously that such requirement completely departed—aside from any notion of personal aggrandizement, of course—from the established traditions through undue restriction. So, we are attempting to point out here that much of the vital business of the Government is conducted by people who have the wide interest and understanding of the 140,000,000 American citizens in their hearts and minds and experiences and is not under the supervision of somebody whose qualifications are circumscribed by the terms of the law in education and narrowed in very important lines.

Senator SMITH. You concede, Mr. Miller, that your proposal here would be a drastic change in the present situation and asks for quite a revolutionary turn-over. You are making it part of the over-all social-security protection for the people?

Mr. MILLER. That is right.

Senator SMITH. That is your proposal?

Mr. MILLER. Yes, sir.

Senator MURRAY. My understanding, Mr. Miller, is that you do not feel that the administration of the medical-care program of the States should be under the exclusive control and direction of the medical profession merely because the subject deals with medical care?

Mr. MILLER. No. As a matter of fact, I do not want to get myself into the position here whereby, unconsciously or by lack of facility in use of the English language, I may depart from my deep respect for a profession which is so important to us from the time we come into this world till the time when we go out, but I still think that this sort of activity should be directed in or prominently supported by and concurred in by people who have a broad outlook, not only as to the value of medical service. These considerations are for Congress to determine, and I take it that what I am saying here will never be construed as truculence on my part, because I simply state our honest experiences and observations as best I can when we come before you.

Senator SMITH. Certainly you do. I am just trying to get the theory that you are approving. I take it you feel that this is a social problem rather than a health problem; that the health is secondary to the social problem?

Mr. MILLER. There isn't any one phase of American life and experience which is not involved either in the periphery or deeply centered in the business of health and medical care, and I don't believe you can operate any one of these programs without integration with the other. It has to do with welfare, public assistance, care of children, the social values involved in a contented and worth-while life, your health, medicine, education, and economic security.

Senator MURRAY. I think, Mr. Miller, we all have those sentiments that you have expressed with reference to our admiration and regard for the medical profession, but you do not feel that they should be placed in the exclusive control and management of the administration of an act dealing with medical care?

Mr. MILLER. That is true, Senator Murray.

Senator MURRAY. For instance, you would not feel that the members of the stock exchange or the security dealers of the country should

be in exclusive control of the Security Exchange Commission which we have in this country to regulate the sale of securities and control the operation of stock exchanges?

Mr. MILLER. I think I would not, Senator Murray. If I may say off the record, since 1929 my interest in the New York Stock Exchange has greatly decreased. [Laughter.]

Senator MURRAY. We all had some experiences in those days, and as a result of those experiences we determined that some regulation and control should be exercised by the Federal Government.

Mr. MILLER. Senator Donnell has asked if the administrator of the Federal Security Agency was a doctor; and the honest answer had to be, of course, "no," but for just a layman I have been for 25 years pretty close to medicine, and I have learned as much about it as any layman should be trusted with. I have never had any temptation to invade the medical profession or prescribe for myself or others.

Senator MURRAY. Among the members of the medical profession, is there a feeling that they should not be placed in exclusive control and direction of any program such as we are contemplating here?

Mr. MILLER. I have no quarrel with that, but I have taken the trouble, Senator, to make an examination of the State requirements with relation to the management of their own public health activities. I find that 24 States do not require a majority on their State boards of health to be doctors; and of the 24, 12 States do not by law require even a single doctor on their State boards of health. Two States have no statutory health boards. Ten States require doctors on their State board but not in the majority.

Senator DONNELL. Mr. Miller, I take it that since 24 of the States do not require that their State boards of health be composed of a majority of doctors, it would follow that under the provisions of S. 545, which is grants-in-aid to the States, there would be no danger, in your opinion, of the medical profession monopolizing the manipulation of these funds in those 24 States?

Mr. MILLER. I yield to your conclusion, Senator.

Senator DONNELL. You agree with that statement?

Mr. MILLER. Yes. I do not fear doctors. Too many of them have taken me up into the room upstairs.

Senator DONNELL. Mr. Chairman, Mr. Miller referred a little while ago to some questioning by myself previously. I want to say about that that by silence at this point I am not assenting to all of his views, and I expect to cross-examine him a little later on, with the permission of the committee.

Senator SMITH. I think we might continue, then, with Mr. Miller's statement.

Senator PEPPER. Mr. Chairman, before Mr. Miller leaves that, I would like to ask him if what you say would paraphrase something that has been attributed to Pompey, that "war is too important a matter to be left entirely to the generals"? I think probably health is far too important a matter in the over-all picture to be left exclusively to the doctors.

Mr. MILLER. In my modest participation in one war and a half, I had to leave a good deal to the generals.

We have entrusted the most powerful force on earth, atomic energy, to a board not even one member of which is required by law to be

an atomic scientist. There is no statutory requirement that our Department of Agriculture be under the direction of a farmer or that our Department of Commerce be headed by a businessman. In fact, no cabinet officer is required by statute to be a professional representative. Americans have always insisted that their major governmental establishments be headed by persons representing the public interest rather than by representatives of professional or vested interests.

Senator DONNELL. Of course, the Attorney General is an exception to that, is he not?

Mr. MILLER. I think not.

Senator DONNELL. Is he required to be a lawyer?

Mr. MILLER. I think not. I believe that at least the Solicitor General and the Assistant Attorneys General must be skilled in the law by the terms of the law itself, because much of the work before the Supreme Court, at any rate, is conducted by the Solicitor General and the Assistant Attorneys General.

Senator DONNELL. That may be. I am not familiar with the statutory provisions stating the requirements of the Attorney General, and you may be quite right. I take it, though, the custom certainly has been to choose a lawyer for Attorney General of the United States.

Mr. MILLER. I think that is obvious.

Senator DONNELL. I don't think, Mr. Miller, that you or I can recall any instance in which a person other than a lawyer has been selected as Attorney General of the United States. Is that correct?

Mr. MILLER. I think that is true. Certainly it is within your lifetime and in my longer chronological experience.

Senator DONNELL. Of course, you are much older than I am. I appreciate that.

Senator PEPPER. Before we get away from that, unless I am in error and unless the rule has been changed, there was a time when members of the supreme court of the State of the chairman did not have to be lawyers.

Senator DONNELL. That error has been cured, however, and they are required to be now.

Senator PEPPER. How long has it been since that occurred?

Senator DONNELL. About a hundred years, I think.

Senator PEPPER. Oh, no, no.

Senator SMITH. I am not certain when it was, Senator. I don't recall the history of it. In fact, I am not certain whether you are correct in your contention or not.

Senator PEPPER. Is the requirement now that they be lawyers?

Senator SMITH. The present constitutional convention is contemplating that now. Our present court of errors and appeals can have some lay members, but the majority are lawyers.

Senator MURRAY. The lay members on there are to keep the lawyer members of the court straight.

Senator SMITH. That is probably true. I am a lawyer, and I admit that lawyers might make mistakes.

Senator MURRAY. That same principle might be applied to other professions.

Senator SMITH. It might be applied to Senators, too.

Senator MURRAY. Yes; I think so.

Senator PEPPER. The people will keep watch of the Senators all right.

Senator MURRAY. It might be a good idea to have some commission sitting in the Senate to query what is going on there every day and report to the people periodically.

Senator SMITH. I think we have some voices that report to the people what is going on in the Senate. All right, Mr. Miller, will you proceed?

Mr. MILLER. It seems to me that no Cabinet officer is required by statute to be a professional representative.

It is hardly necessary to remind the members of this committee that the Surgeon General of the Public Health Service has reported for over 140 years to the Secretary of the Treasury and for the last 9 years to the Federal Security Administrator—

Senator DONNELL. It still remains true, however, Mr. Miller, that the Surgeon General of the Public Health Service himself is required to be a doctor?

Mr. MILLER. I am not sure about that.

Senator DONNELL. He is a doctor, at any rate.

Mr. MILLER. Yes.

Senator DONNELL. You cannot recall any instance in which he has not been a doctor?

Mr. MILLER. Not within my experience, Senator Donnell.

I wanted to complete the sentence—and this is not an offensive interjection, Senator—it is hardly necessary to remind the members of this committee that the Surgeon General of the Public Health Service has reported for over 140 years to the Secretary of the Treasury, and for the last 9 years to the Federal Security Administrator, neither of whom are required by law to be doctors of medicine.

It is very significant that the statutes of half of our States do not require that our State boards of health be composed of a majority of doctors, and that in a substantial proportion of these States there is not even a statutory requirement for one doctor on the State board of health (Distribution of Health Services in the Structure of Government, ch. 10; State Health Department Organizations, Public Health Reports, vol. 58, No. 14, April 2, 1943, pp. 541-577). In passing, may I note that at least five States do not by law require even their chief health officials—that is, their chief operating officials—to be doctors of medicine. I would gather from these State practices a realistic recognition that the problems of health and medical care administration involve considerations in addition to the skills required for expertness in the medical arts.

Physicians and other professional people who have criticized these similar provisions of S. 1820 seem to have forgotten that practically all of our voluntary hospitals are governed at the top by lay boards who know how to manage the institutions in the public interest while relying on their professional staffs for advice and guidance on professional matters.

This very view was adopted by one of the sponsors of S. 545, Senator Taft, in the opening day of testimony on that bill. In commenting on the relationship of S. 545 to another bill he is sponsoring, S. 140, a bill to create a Department of Health, Education, and Security, he specifically rejected the proposal that the statute require

the head of the agency discharging health functions to be a doctor. He said:

I do not think the health people should object to a health agency reporting direct to a Cabinet officer, a man of Cabinet rank, because I see no reason why such a man would not feel equally obliged to take care of health, as he does of welfare.

I agree with Senator Taft that it is not necessary to adopt arrangements which fly in the face of our whole national tradition in the Federal establishment.

III. UTILIZATION OF VOLUNTARY ORGANIZATION

In our testimony on S. 1606, last year, we discussed the role of voluntary agencies in the program. S. 1320 spells out more fully than did S. 1606 the assurances that voluntary agencies will be utilized to the fullest in the provision of services. Sections 216 and 217 guarantee broad opportunities for their participation in providing services, under circumstances which assure that they contribute to efficient and economical administration of the program.

IV. RURAL AREAS

Rural America is the most medically disadvantaged part of our country. Special attention is paid by S. 1320 to the medical and health needs of rural people. It contains many general provisions which are of special importance to rural areas. For example: (1) The establishment of local area committees, which by their nature will assure fair representation for rural people (sec. 233), and the requirement of rural representation on the State advisory committees (sec. 242 (a) (2)) and on the National Advisory Medical Policy Council (sec. 252); (2) the specific mention of consumer cooperatives in the definition of "person" (sec. 281 (e)) by whom services may be provided; (3) specific authorization in section 218 (a) (4) for the payment of mileage fees, in addition to payment for professional services, an item of great importance in rural areas; (4) clarification of the definition of "self-employed" in section 281 (a) (2), so that there will be no doubt that it includes farm operators; (5) inclusion of essential and exceptionally expensive prescription drugs in auxiliary benefits under section 201 (f), an item of considerable importance to the low-income rural population because of the current high cost of some essential drugs; and (6) flexibility in allocation of funds to States, section 272, which among other provisions would permit adequate planning for population changes due to the migration of seasonal farm labor.

In addition, you will note the inclusion of an extensive special section on rural areas, section 256, which includes important provisions designed to attract doctors to such areas, and other provisions for professional education in rural areas, for ambulance services and—in exceptional circumstances—necessary transportation of rural beneficiaries, and for special rural health information activities. This special section also requires the Board, in its annual reports, to make recommendations on measures to assure rural people equal health opportunities under the bill.

V. COVERAGE

S. 1320 follows the principle inherent in S. 1606 that, apart from beneficiaries under the old-age and survivors' insurance program and the annuitants under the Federal civil-service system, eligibility for benefits is limited to wage earners and the self-employed, and their dependents. The needy can be provided for, under sections 205 and 282, through State action in procuring voluntary coverage under the health-insurance program. While I still believe that we should not be satisfied with anything less than 100 percent coverage, I am pleased to note that S. 1320 extends eligibility to civilian Federal employees, including retired employees, and their dependents; and explicitly states the availability of eligibility to State and local government employees and their dependents, in groups, through voluntary coverage.

VI. PARTICIPATION OF PROFESSIONAL PRACTITIONERS

An important consideration in any medical-care program is its effect on the rights and prerogatives of both providers and recipients of care. On this point, I believe that S. 1320 is particularly praiseworthy. For example, I refer you to the sections relating to "Professional rights and responsibilities" (sec. 220), "Amounts of payments for services" (sec. 219), and "Local professional committees" (sec. 234), which, among others, seek to provide every possible legislative assurance that health services will be administered with democratic concern for all affected rights and interests.

Provisions in S. 1606, authorizing limitations on the number of patients a doctor may treat, were clarified in section 219 (c) of S. 1320. The committee will remember that was a provision in S. 1606. These provisions offer protection not only to the patients but even more so to the practitioners in the community against some few of their number who might abuse the system.

VII. PROTECTION OF PATIENTS

Legislative assurances are provided for patients in the program in a variety of manners: free-choice of doctors (sec. 203); nondisclosure of confidential information (sec. 254); prohibition against discrimination (sec. 255); national guaranty of benefits (sec. 202 (a)); removal of limitations on comprehensive service as rapidly as possible (sec. 202 (b)); assistance in developing personnel and other resources where deficient (secs. 202 (a), 242 (a) (5), 256, 272 (b), 273); and appeals procedures (secs. 261 and 262).

VIII. DEVELOPMENT APPROACH

While S. 1320 inaugurates a comprehensive program for making health-service benefits available throughout the Nation as rapidly and as completely as the availability of medical-care personnel and facilities will permit profiting by the hearings on S. 1606, the bill more realistically recognizes the problems posed by inequalities and inadequacies in the distribution of such facilities and personnel, and provides (sec. 202 (a) and sec. 242 (a) (5)) for surveys of the resources and needs of each State and for the development in each State of a

program designed to assure maximum use of such resources as are found to be available and to overcome the inadequacies disclosed. Not only does the formula for allocation of funds among the several States in section 272 (b) require that account be taken of need for increasing the adequacy of services where the personnel and facilities are below the national average, but section 256 provides for special assistance to rural areas, and particularly those with disproportionate shortages of personnel and facilities. In addition, subsequent provision for the support of medical education in section 273 and for the liberalization and extension of the Hospital Survey and Construction Act (title III, pt. B, sec. 321) will also contribute to correction of present inequities in the distribution of the Nation's medical resources. I am much impressed by what can be done if funds are effectively channeled into medical education. Recent discussions in various parts of the country with State and other officials lead me to stress very strongly the value of vigorous financial support for medical education.

IX. PUBLIC HEALTH SERVICES

Title III complements the prepaid personal-health-services provisions of title II by provisions directed toward the development and expansion of community health services. Part A amends present statutory provisions relating to Federal grants to States for public health services (including maternal and child health and crippled children's services) so as to permit the further extension of such services and their provision on a full-time basis in every community. A substantial increase in Federal appropriations and a more effective distribution of such Federal funds to the States through a variable matching formula are among the several specific devices utilized in title III which should yield satisfying results in the form of reductions in preventable deaths and disabilities.

There are other changes between S. 1606 and S. 1320, but they are generally in the nature of details and I shall not take your time to state them.

Gentlemen, I have faith in the democratic process. These and the preceding hearings on health legislation have, in our characteristic American way, resulted in some important forward steps despite our disagreements.

S. 545 will be a start if it be amended along the lines suggested by our report. Dr. Parran will discuss this matter in more detail. I repeat, if so amended, S. 545 could contribute substantially toward meeting some of the most pressing health needs of the Nation. But the really effective way to protect our most valuable national asset, the health of our people, is through legislation of the character of S. 1320.

Senator SMITH. Are you substituting S. 545 with the changes contained in the letter of July 3, 1947, addressed to Senator Taft, referred to a few moments ago?

Mr. MILLER. Yes, sir. S. 1320 is a much improved bill over S. 1606 of the Seventy-ninth Congress. It is a bill which proceeds upon the principle that the health of each American is a concern of all Americans. It accepts the premise that a matter which so intimately affects our national security and defense is a concern of the Government of all our people, the Federal Government. It proceeds on the fundamental tenet of our national life, that in union there is strength, and

it applies that principle in a characteristically American way, through insurance.

Democracy is not static. That our people are not satisfied with our present system of financing medical care is amply demonstrated by all opinion polls. We in the Federal Security Agency welcome the opportunity to work together with the Congress in devising better ways of doing what our people want done. I believe history will regard the development of universal medical care and health services of the highest American standards as inescapably part of the American scene.

Senator SMITH. I notice on the next page of your statement you say that you would like to file for the record your report on S. 545 and S. 1320.

Mr. MILLER. That does not apply now, Senator Smith, because the reports are before you.

Senator SMITH. I am very glad to have them included with your testimony here in the record, so we will visibly have your detailed conclusions on both these bills for our study in developing our legislation.

(The reports on S. 545 and S. 1320 follow:)

FEDERAL SECURITY AGENCY,
Washington, July 3, 1947.

HON. ROBERT A. TAFT,
*Chairman, Committee on Labor and Public Welfare,
United States Senate, Washington 25, D. C.*

DEAR MR. CHAIRMAN: This is in reply to your letters to this Agency and the Public Health Service requesting that we submit a report on S. 545, a bill to coordinate the health functions of the Federal Government in a single agency; to amend the Public Health Service Act for the following purposes: To expand the activities of the Public Health Service; to promote and encourage medical and dental research in the National Institute of Health and through grants-in-aid to the States; to construct in the National Institute of Health a dental research institute; and for other purposes.

Title I of S. 545 would establish a National Health Agency to administer the health services of the Federal Government. Several units now in the Federal Security Agency, including the Public Health Service, the Food and Drug Administration, and the maternal and child health, and crippled children activities of the Children's Bureau, would be transferred to the new Health Agency. Seven separate offices and services in the new agency are specifically provided for, together with the functions they would perform and, in certain cases, the qualifications of their directors. Studies are to be made as to the advisability of transferring additional agencies or organizations to the National Health Agency, and as to the improvement of its internal organization.

In a series of amendments to the Public Health Service Act, title II of the bill provides for four new programs of grants-in-aid to the States in the health field. These grants-in-aid would be available on a matching basis to States submitting approved State plans (1) for making medical care inventories and surveys in each State; (2) for periodic physical examination for school children and for medical-care services for families and individuals of low incomes unable to pay the whole cost of medical and hospital services; (3) for making dental-care inventories and surveys in each State; and (4) for dental examinations for all school children, for dental care to needy school children, and, at the option of the State, for dental care to other needy persons unable to bear the entire cost of such care. At the Federal level, the medical programs would be administered by the Director of the new Office of Medical and Hospital Care Services, with the assistance of a National Medical Care Advisory Council, and the dental programs would be in charge of the Director of the Office of Dental Care Services, assisted by a National Dental Health Council.

In addition, title II of the bill would authorize appropriations for cancer research and for grants-in-aid to the States for programs of cancer prevention and control. It would also establish a National Institute of Dental Research in the National Institute of Health which, in cooperation with a National Dental Health Council, would conduct, promote, and aid research into the cause, treatment, prevention, and control of dental diseases and impairments; the construction and equipment of buildings to house this new institute are also authorized.

The last title of the bill, title III, makes certain technical amendments occasioned by the reorganization of Government health agencies already mentioned, and authorizes deductions from the salaries of Federal employees, upon their request, for payments to voluntary nonprofit health-insurance funds. A special fund would be established in the Treasury to receive proceeds from taxes and other sources of revenue in amounts equal to those authorized to be appropriated by the bill, and to meet expenditures under the bill.

GENERAL DISCUSSION

It is the opinion of the Federal Security Agency that the measures proposed in S. 545 fall far short of meeting the essential health needs of the Nation. Those needs are of such scope, character, and immediacy that they can be met with reasonable adequacy only by the development under Federal auspices of a comprehensive health program such as that recommended by the President in his messages of November 19, 1945, and May 19, 1947—a program which would include measures whereby the costs of medical, dental, hospital, and nursing care can be distributed broadly by application of the insurance principle to all or most of the population, and measures for construction of needed health facilities, for expanding and improving State and local public health services, and for fostering and supporting medical education and general research in health and related fields.

We are convinced that our health needs can and should be met now on the broad front envisaged in the President's messages. We are likewise convinced that our health needs can never be met in any substantial degree of adequacy through a grant-in-aid program of the size contemplated by S. 545, or through any program operated on a "means test" basis. Experience has shown, we think, that such a test limits the availability of medical care by making people reluctant to apply for services they need until forced to do so.

If the Congress is not prepared to enact more comprehensive legislation at this time, however, we believe that a grant program of the size proposed by S. 545 could accomplish a substantial amount toward meeting some of the most pressing health needs of the Nation; but only if the bill were modified in important respects:

We believe that the Federal administrative structure proposed in title I of the bill would seriously interfere with the effective discharge of both the present health functions of the Federal Government and the new functions which would be established by the bill. Both in separating health functions from the security, education, and other related activities of the Government, and in splitting up the health functions themselves among a number of partially autonomous offices within the proposed National Health Agency, the bill would make much more difficult the coordination of Federal activities which is essential to efficient operation and would confuse and complicate Federal-State relationships in these fields. We therefore recommend the elimination of title I of the bill.

The grant-in-aid provisions of title II of the bill, by being limited to a needs-test program, appear to us to restrict the freedom of State action at the point where such restriction is the least desirable, but at the same time to omit important and desirable safeguards found in many existing grant-in-aid statutes. With financial implementation on the scale proposed the bill could not, in our judgment, even approach attainment of the objectives variously stated in section 2 (c) (to make services available "to every individual regardless of race or economic status") and in title II. Despite this obvious fact, the bill imposes a rigid structure on the States in meeting even so much of this stated goal as appears possible by requiring State health agencies to expand their programs of medical and dental care wholly on the basis of a means test, and precludes them from using these funds to strengthen and expand whatever parts of their medical- and dental-care programs they may think it most useful to enlarge. In its lack of

any Federal standards relating to the quality of care to be furnished, the methods of administration, and the safeguarding of individual rights of either providers or consumers of services, on the other hand, title II seems to us to discard much that is most useful in our experience of Federal-State cooperation. We therefore recommend that title II be revised in the several respects suggested in more detail below.

TITLE I. NATIONAL HEALTH AGENCY

A. The administrative arrangements proposed in title I of the bill would, in our judgment, be a definite backward step. All of the units of Government proposed to be transferred to the National Health Agency are at present within the Federal Security Agency. The essential question of policy posed by title I of the bill, therefore, is not the consolidation within one agency of civilian health functions of the Government, which (to the extent contemplated by S. 545) is now an accomplished fact, but rather the divorcement of those functions from the educational and social security and other related functions with which they are now associated in this Agency. We do not believe that such divorcement is wise. Even the authors of the bill have apparently recognized that complete separation of health from related functions is impracticable, since they have proposed to include in the National Health Agency the entire Food and Drug Administration and to exclude the entire Office of Vocational Rehabilitation, each of which has large areas of responsibility both within and outside the field of health.

The experience of the Federal Security Agency in the 8 years of its existence has, we think, borne out the wisdom of its creation. Our reasons for this view are stated at length in our report to the Committee on Expenditures in the Executive departments, and in my testimony before that committee, on S. 140, a bill introduced by Senator Fulbright and you "To create an executive department of Government to be known as the Department of Health, Education, and Security. I will not here repeat those reasons at length, but will merely point out that the substantive program proposed in S. 545 would afford an excellent illustration of the need to continue within a single agency of the Federal Government its responsibilities in the fields of health, education, and security. Just as the creation of an independent health agency would make it practically impossible to administer effectively a school-health grant-in-aid program such as that proposed in the bill introduced in this Congress by Senators Saltonstall and Smith (the successful administration of which requires the closest coordination between health and education authorities, both Federal and State), so the separation of Federal health authorities from Federal welfare authorities proposed in S. 545 would render it extremely difficult to administer successfully a medical-care-for-the-needy program.

In terms of practical administration the truth of this seems to me self-evident. S. 545 proposes to grant funds to provide health services to people of low income, a group that would include the group already receiving or eligible to receive public assistance or general relief. The common practice among welfare authorities of considering inability to pay the costs of medical care along with other factors in determining eligibility for cash assistance or relief, and of purchasing medical services or including medical-care items in the budget on the basis of which cash payments to the needy are calculated, makes it manifest that there must be the closest correlation between cash-assistance programs and any medical-care-for-the-needy programs—correlation both in the determination of need and in the avoidance of gaps or duplications in the payments made or the services furnished. In medical and dental programs for school children, again, there would be need for close and continuing relationships with the educational authorities. The fact that these programs are for the most part operated separately in the States, far from weakening the case for a unified Federal administration, we think, makes it all the more conclusive. By its actions in plan approval, and still more in its advisory role, a single Federal agency can do much to encourage or preserve consistency among the many State plans and agencies concerned and to assure a common approach to their common problems in the fields of health, education, and security.

B. Even if the creation of a separate health agency were advisable, the internal structure of the agency proposed in S. 545 is in our opinion not well adapted to efficient administration. Not only would the bill divorce health functions from social security, education, vocational rehabilitation, and other interrelated functions, but by setting up within the new Health Agency several largely autonomous offices with functions spelled out and frozen by law, the bill would also divorce

preventive from curative health services, medical services from dental services, and the compilation of statistics on health from the operating programs from which and for which the statistics are compiled. In addition, the provisions of section 108 would seem to contemplate the ultimate divorcement of research activities from all other activities in the new Agency.

Experience has amply shown that all these functions are but closely related segments of what should be a single program to meet a single problem—the betterment of the health of individuals. Their separate and independent administration within the new Agency would greatly impede efficient and economical administration, and complicate relationships between the States and the Federal Government, and between Government and the producers and consumers of health services. Yet the bill distributes the various programs among the several independent offices without giving the Administrator of the new Agency sufficient authority to effect the necessary coordination and integration of the programs, activities, policies, and procedures involved; the Administrator is not even given the usual power to supervise and direct his supposed subordinates and their activities except as he inherits it from the Federal Security Administrator with respect to the organizations now in the Federal Security Agency. Even the “general supervision” referred to in section 102 (b) (5) is vested in “the agency” rather than in the Administrator, and relates only to existing units transferred to the Agency, not to those newly created by the bill.

C. While the title of S. 545 states that one of its purposes is “to expand the activities of the Public Health Service,” the bill instead proceeds to bar that Service from several important areas in the health field in which it now exercises leadership, and to give to other newly created offices in the new Agency responsibility for administering all the new programs established by the bill with the exception of the cancer- and dental-research programs.

Over a period of many years the Congress has seen fit to charge the Public Health Service with ever-increasing responsibilities in the health field, and the Service has discharged these responsibilities in a manner which we believe has earned it the full confidence of the Congress, the States, the professions concerned, and the public. It would seem to us poor policy, and not calculated to promote economical or efficient administration, to break up this going concern and replace it with a cumbersome and unwieldy superstructure, consisting of three or four new offices to deal separately with closely related activities which would duplicate in substantial part the administrative facilities which already exist.

In dismantling and subordinating the Public Health Service as proposed in S. 545, the substantial progress which has been made in developing a Federal health program through the coordination of the several elements in this program in one Federal health organization—the Public Health Service—would be lost. Traditional relationships built up over the years between the States and the Public Health Service—relationships of which this Agency is proud and which have been commended repeatedly by the States—would be jeopardized. The vast and varied experience of the Public Health Service in the administration of health services would be wasted, or utilized to only a very limited degree in organizing and administering the new programs. The steady progress toward simplified and economical administration of health programs, to which the Public Health Service has contributed so substantially, would be stopped.

D. The provision for study of the desirability of retaining or modifying the Commissioned Corps of the Public Health Service is appropriate. As the bill recognizes, such a study should approach the problem from the viewpoint of the entire organization of which the Commissioned Corps is a part, and should be directed toward means for attracting and retaining in the Federal Service well trained and competent physicians, dentists, and other professional personnel. An undertaking of such scope, however, would require considerably more time than the 6 months' period stipulated in the bill, probably 2 years or more.

E. Section 103 (b) would transfer to the proposed National Health Agency the Division of Health Studies (sic) in the Bureau of Research and Statistics of the Social Security Administration. That Bureau contains a Division of Health and Disability Studies, concerned wholly with social-security problems and in large part with disability insurance. These are necessary research equipment for the Social Security Administration. It should not be deprived of them by any disposal to establish a separate health agency.

F. The bill would also transfer the maternal and child health and crippled children's services from the Children's Bureau. The close relation of these health services to the welfare programs administered by the Children's Bureau

affords another illustration of the necessity that all such interrelated functions be kept under a single room. The advantages of having the health and welfare services for children in the same Bureau are great. It not only facilitates coordinated administrative planning in the interest of children in these closely related fields, but also serves as a basis for more realistic and integrated planning in relation to other services needed by children provided elsewhere.

TITLE II. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

A. The provision for the establishment of cancer-control program, substantially along the lines of the venereal disease and tuberculosis programs, is under present circumstances sound and desirable. This section, however, should be clarified or broadened to make certain that aid for treatment as well as for research, diagnosis, and case finding would be authorized; determination of the presence of cancer would be of doubtful value without assurance of treatment. Similarly, the ceiling on the amount of funds should be raised or eliminated to enable the carrying on of an adequate cancer-control program.

B. The proposed new title VII of the Public Health Service Act, to be entitled "General Medical Service for Families and Individuals with Low Incomes," cannot be considered a suitable substitute for a comprehensive medical- and hospital-care program based on the principles of social insurance. A program of the size and kind proposed in S. 545 would inevitably fall far short of accomplishing even the lesser and very different objective (as stated in sec. 711 and 712 of the bill) of making available medical and hospital services to all those whose economic status is such as to render them unable to pay the full cost of such services. Except in the case of a few of the more wealthy States, the sums made available by S. 545, together with sums contributed by States and their governmental subdivisions, would probably do no more than enable the States during the 5 years of Federal grants to make adequate provision for the medical and hospital care of those individuals whose income is so low as to render them eligible for public assistance or other Government relief.

We believe that it would be preferable to leave a wider latitude to the States in utilizing for medical care such Federal funds as the bill would make available for that purpose. Instead of using these funds exclusively for services to persons of low income, some States might reasonably conclude that they could better advance their over-all health objectives by applying some portion of this new money to the expansion or improvement of existing programs, or the establishment of new ones, not bounded wholly in economic terms—programs for the chronically ill, for example; programs for persons suffering from particular diseases, such as tuberculosis, cancer, or heart disease, which have a high morbidity or mortality incidence, or which require extensive care or specialized therapy, or programs for the development of diagnostic or other specialized services. As you know, many such programs have traditionally been operated without a means test, and we think the Federal Government should not discourage their continuance or expansion on the traditional basis.

There is much evidence that when there are two systems of medical care, one for the poor and the other for those who can afford to make payment out of their own resources, it is very difficult if not impossible to avoid having different standards of care. This is not to say that physicians as a whole have different attitudes toward people on the basis of their economic status. A doctor who is motivated solely by the best interests of his patient may hesitate to ask for an X-ray if his patient is financially pressed, even though the X-ray may make the difference between accurate diagnosis and empirical judgment.

Finally, it is surprising that nowhere in the bill is there any provisions for coordination between health, welfare, and education authorities or programs of the States. It should also be pointed out that the provisions for "collection of proper charges of less than the total cost of such services" rendered to individuals and families "unable to pay in whole, but able to pay in part therefor" would require the States to set up complicated and costly overhead administration. Unless a simple affirmation of income were to be accepted, the investigation of family finances entailed, and indeed the entire means-test philosophy, would be administratively unwieldy to an extreme degree.

We believe that this bill, with the objectives of its medical, hospital, and dental care programs modified, and with the methods for attaining these objectives correspondingly changed and improved, in the respects noted below, could accomplish much by way of meeting some of our most pressing health needs:

1. *State initiative and determination.*—In its provision that the Federal funds may be used only for medical care of families and individuals of "low income," the bill departs from what otherwise appears to be one of its basic principles—that of affording maximum opportunity for State initiative and determination. S. 545 very soundly requires that each State plan must be based on a survey of existing medical and hospital services within the State and that the plan must be fashioned to meet first needs first. The stipulation that Federal funds can be used only to provide care for persons and individuals of low income, however, would deter States from establishing programs designed to meet their particular health needs as disclosed by the survey. In addition, State plans should be permitted to provide for such widespread problems as adequate care of children and mothers during maternity and of the chronic sick, improved quality of medical care through availability of diagnostic facilities, and more widespread use of hospital facilities, particularly for acute illness. These problems affect all groups within the population and are not confined to persons with low income. In requiring the States to impose a means test, the bill is far more restrictive upon the States than are existing Federal laws in the health field and than are health bills now pending in Congress such as S. 678 (as its sponsor, Senator Lodge, has proposed to amend it) or S. 1290 introduced by Senators Saltonstall and Smith.

It is our view that whatever sums the Congress may determine to authorize for this purpose in a general grant-in-aid medical-care program should be available to meet such part of the existing need for medical care in each State as that State may think the most urgent, and that there should be no Federal restriction to persons of low income.

2. *Plan conditions.*—In general, the conditions imposed on State plans are not such as to assure reasonably adequate and well coordinated medical care to those that would be aided under the bill. The bill fails to provide the minimum standards and safeguards—Federal, State, and local—necessary to assure that the Federal funds are used efficiently and effectively for the intended purposes, that services are adequate and comprehensive, and that the rights of the public, the professions, and the hospitals are safeguarded. In the light of our experience in administering Federal grants to the States in the health and welfare fields, the omission of such standards and safeguards must be regarded as a serious impediment to the success of the health programs provided for and to the maintenance of a balanced Federal-State partnership and responsibility of effort. At the minimum the bill should include prohibitions against excessive residence or citizenship requirements, prohibitions against discrimination for race, creed, or color, assurances that the non-Federal share includes State funds, assurances that eligibility determinations will be made by responsible Government officials and not left to persons or agencies which the Government cannot hold responsible for carrying out a declared public policy, assurances that fair hearings will be provided and that information will be regarded as confidential, and requirements for efficient administration including a merit system for administrative employees. Finally, in order to safeguard the quality of services to be given—particularly when such services are to be made available only to those persons who are not able to pay for care from their own resources—it is necessary that the State agency be required to establish State standards governing the kind of care which is to be made available as part of the State plan, and be responsible for their being observed throughout the State.

3. *Voluntary agencies.*—Furthermore, there is no provision for the establishment of standards governing arrangements with voluntary health plans through which the States would be permitted to provide services. The policy of entrusting to nongovernmental organizations the administration, at public expense, of health services to large groups of the population, seems to us unsound.

It is difficult enough at best to assure that services secured in this fashion will be of high quality and will be obtained at reasonable cost. The vulnerability of such a system to abuses renders it especially important, if the Congress determines to make Federal funds available for the purpose, that it should do so only when a State agency has proposed administrative techniques calculated to minimize these dangers.

The bill might be construed not to permit use of Federal funds to buy services from a compulsory health insurance system. Should any State establish such a system, it seems to us manifest that the funds granted under S. 545 should be available for the purchase of services from the insurance system, at least for needy persons not otherwise entitled to the benefits of that system, and preferably for any other groups which the State might select.

4. *Scope of services.*—Provision of comprehensive medical care would not be assured even to persons covered under the program, since the States are given the option to restrict the services which they provide to institutional care, home care, and/or office care. For example, how may the mandatory provision for hospital care be met if the State elects to provide services only in the physicians' offices? In leaving the provision of home, office, and institutional services to the needy entirely optional with the State, the bill may well reverse the growing trend toward continuity of medical services in all stages.

5. *Allotment and matching.*—The allotment and matching provisions, taken together, are seriously faulty. At best, they are likely to require that the wealthiest States would have to put up the smallest proportions of their aggregate incomes in order to receive the allotments of Federal funds and that the poorest States would have to put up the largest proportions. At worst, since it would appear that States could use present expenditures to match the Federal allotments, the proposals could operate so that the wealthiest States could qualify for their allotments with little or no new expenditures, while the poorest States might have to increase their present expenditures. In this connection it should be noted that at least a considerable part of State and local expenditures for community-wide preventive or other health services could apparently not be counted for matching purposes.

While the allotment formula takes account of the varying financial capacity of the several States, the purpose of equalization would be far better served if instead of a uniform 1:1 matching ratio a variable matching ratio should be used, so that proportionately less financial participation would be required from the poorer than from the more prosperous States.

It may nevertheless be anticipated that the total outlay for medical and hospital care would be increased mainly by the amounts of the Federal grants-in-aid. Under these circumstances it is very likely that there would be little, if any, redistribution of existing personnel and facilities to conform better to the needs of the population.

6. *Authorized ceiling.*—As we have already pointed out, the funds authorized to be appropriated, even if matched by as much State money, would be sufficient to assist only a small fraction of the population requiring assistance to meet the costs of medical, hospital, and related services. In 1939, in the course of the Senate hearings on S. 1620, the American Medical Association stated, in connection with its testimony, that persons with a family income of less than \$1,500 require assistance to pay medical bills for minor or for major illness; that persons in families with incomes of \$1,500 to \$3,000 would require assistance for medical care when confronted with major illness. In 1939, about 90 percent of our population were in families with incomes of less than \$3,000 per annum. Allowing for price changes as well as for increased income, it would not be unreasonable to assume that at least 70 to 75 percent of our population will need assistance when confronted with serious illness. A succession of minor illnesses, moreover, or a single major illness, may deplete the resources of families who are relatively well off. A chronic illness may wipe out the savings of years. While in any given year, only a small percentage of the population may have large medical costs, in a generation the great majority of families will have been affected. Yet under S. 545 persons who do not fall within the definition of low income would be denied care until their resources are depleted. This seems poor economy in terms of public planning.

Even though it may be true that in any given year only 20 or 25 percent of the population may require aid under such a program as is proposed in S. 545 the medical bills incurred by this particular 20 or 25 percent would account annually for 50 to 60 percent, or more, of the total national expenditures for medical care. To fulfill the stated objectives of the bill, the amounts would have to be raised to many times the \$200,000,000 authorized in the bill, as this amount would not go much beyond providing adequate medical care to those in receipt of public aid.

7. *Advisory Councils.*—To assure democratic operation of the program at the local level, provision should be made for local participation as through advisory councils, and representatives of the public should be required as members of such councils, both State and local.

8. *National Council.*—Finally, we believe it is unwise to confer upon a part-time council such administrative functions as are proposed in this title for the National Medical Care Council. Also, the provision relating to the composition of this council is so worded that it would be possible for all members to be individuals with a professional interest in health and medical care. It is important to clarify that representatives of the users of the services and of the

general public interest must be included on all councils advising on health and medical care. Since technical committees can be utilized for professional advice, and since this council will be concerned primarily with public policy, it would seem that at least a majority of the members of the council should be representatives primarily of the public interest.

C. Most of the above criticisms are applicable to the proposed title VIII of the Public Health Service Act, "Dental health services for school children and families and individuals with low income." The amounts of money authorized in relation to the size of the problem are particularly inadequate. In addition, this amendment appears undesirable because provision for the periodic inspection of the teeth of all children enrolled in the elementary and secondary grades of the public and private schools, with stringent limitations on eligibility for preventive or reparative service, would constitute a serious waste of dental manpower. Since almost all children are afflicted with dental disease, the periodic examination of children merely to find the same dental defects and diseases year after year is not justifiable. For the vast majority of our children, it is not a question of parents being unwilling to carry out the recommendations which are made, but much more of their economic difficulty in doing so. In 1941 three out of five of the children in this country were living in families with incomes less than \$2,100 per year, and four out of five in families with annual incomes of less than \$3,000. Moreover, 80 percent of children live in families of four or more persons.

Again, on the theory of giving maximum leeway to the States, the performance of orthodontia should not be ruled out by Federal statute.

The National Dental Health Council has too great a weighting of dentists. At the most, the legislation should require that three (instead of four) of the six members of the council be doctors of dental surgery.

D. Amendments to the Public Health Service Act that would add "Title IX—Further research and training, part A—dental research," for the establishment of a National Institute of Dental Research, are sound in principle; though the proposed section 902 of the Public Health Service Act would be redundant, in view of the broad authority already contained in section 301. However, the funds authorized for grants-in-aid for dental research and training and for research and scholarships within the institute (ranging up to \$300,000 annually for each purpose for fiscal year 1949 and thereafter) are too small for the important purposes to be accomplished. No legislative limit has hitherto been placed upon the funds which may be appropriated for research within the National Institute of Health, and it is suggested that this provision of the bill should authorize whatever appropriations may be necessary.

The problems of research with which the National Institute of Dental Research will be occupied are sufficiently different from those relating to provision of dental services to children and others as to suggest the desirability of a separate dental advisory council to be established in connection with the institute.

TITLE III. MISCELLANEOUS

The major substantive provision of this title, and the only one on which we shall comment, would be authorization for the deduction from the salaries of Government employees, upon their request, of payments to any public or private nonprofit health insurance fund. In principle we favor such a provision, but we see several serious objections to section 306 of the bill in its present form. In the first place, the section contains no authorization to set or to enforce standards to assure either that the services will be of good quality or that the charges will be reasonably related to the service offered; yet governmental assistance in the collection of premiums would involve governmental expenditure to perform this function and would be bound to imply to many persons governmental indorsement of the organizations to which the payments are made. The term "voluntary nonprofit health insurance fund," moreover, is so broadly defined as to embrace many organizations and purposes that would hardly fall within the ordinary concept of "health insurance." Finally, with no limitations upon the number of such organizations for which deductions might be required and no uniformity in the sums or percentages to be deducted, with complete freedom to each officer or employee to choose whatever organization or organizations he likes and to change his choice whenever he wishes, the administrative burden upon the several Government agencies would appear to be excessive. If a provision could be drawn which would meet these objections, we should be in favor of its enactment.

We shall make no comment on section 307, which would direct that certain tax proceeds be set aside to finance expenditures under the bill. This section raises questions which appear to concern the Treasury Department and the Bureau of the Budget more than this Agency.

Sincerely yours,

WATSON B. MILLER, *Administrator.*

FEDERAL SECURITY AGENCY,
Washington, July 3, 1947.

HON. ROBERT A. TAFT,

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

DEAR MR. CHAIRMAN: This is in response to your letter of May 25, 1947, requesting that we submit a report on S. 1320, a bill "To provide a national health insurance and public health program."

The provisions of S. 1320 are made under three titles.

Title I contains a statement of findings and declarations relating to the essentiality of good health to the security and progress of the Nation and the inadequacies in the present availability of health services to the people.

Title II outlines and establishes a Nation-wide program of prepaid personal health service benefits to be administered through State and local authorities in accordance with Federal standards. In addition, provisions are made for grants-in-aid for medical research and education. The provisions of this title are similar in scope and objectives to those of the health insurance provisions contained in S. 1606, extensive hearings on which were held during the Seventy-ninth Congress, but a number of significant changes have been incorporated in the current bill. Some of these changes will be identified and discussed later in this report.

Title III augments the prepaid personal health services provisions of title II by provisions directed toward the development and expansion of public health services. Part A of this title amends present statutory provisions relating to Federal grants to States for public health services (including maternal and child health and crippled children's services) so as to permit the further extension of such services and their provision on a full-time basis in every community. Part B contains amendments to the Hospital Survey and Construction Act designed to increase the total authorized Federal appropriations for the construction of hospital facilities and to liberalize the matching ratio between Federal and State funds.

TITLE I. DECLARATION OF PURPOSE

Entirely apart from the specific provisions contained in titles II and III, the statement of policy in title I is of major importance. If this title should be enacted into law it would represent a landmark in legislative recognition of the obligation of the Federal Government, in cooperation with the States and their subdivisions, to take all necessary and feasible steps toward the achievement of the goal of a healthy Nation. It would reject all artificial distinctions between public health and individual health. Such a statement of policy would provide the only foundation upon which a completely adequate national health program can be inaugurated.

TITLE II. PREPAID PERSONAL HEALTH SERVICE BENEFITS

In our testimony on S. 1606 (79th Cong.) we called attention to the present inadequacies in the medical care received by or available to large percentages of our people and expressed our conviction that a Nation-wide health insurance program designed to provide comprehensive health services to all, or virtually all, of our people appeared to be the most effective means of overcoming our present inadequacies. We therefore endorsed the basic approach of S. 1606, although a number of specific amendments or modifications were recommended. Nothing has happened in the past year to alter this basic position. The need for more medical care more equitably distributed is still acute. The economic barrier between doctors and patients is still widespread. And no alternative program has yet been advanced which gives comparable promise of achieving—now or in the future—the goal of adequate medical care for all our people. The Federal Security Agency has therefore only to reiterate its general endorsement of the basic features common to S. 1320 and its predecessor, S. 1606 (79th Cong.). In addition, however, the current bill (S. 1320) contains a number of new or amended

provisions which, in our judgment, make it a much more desirable bill than its predecessor. It is to these new or modified provisions that the following comments are directed.

1. S. 1320 inaugurates a comprehensive program for making health service benefits available throughout the Nation as rapidly and as completely as the availability of medical care personnel and facilities will permit. Profiting by the hearings on S. 1606, the bill more realistically recognizes the problems posed by inequalities and inadequacies in the distribution of such facilities and personnel, and provides (section 202 (a)) and section 242 (a) (5)) for surveys of the resources and needs of each State and for the development in each State of a program designed to assure maximum use of such resources as are found to be available and to overcome the inadequacies disclosed. Not only does the formula for allocation of funds among the several States in section 272 (b) require that account be taken of need for increasing the adequacy of services where the personnel and facilities are below the national average, but section 256 makes special provision for rural areas, and particularly those with disproportionate shortages of personnel and facilities. In addition, subsequent provisions for the support of medical education in section 273 and for the liberalization and extension of the Hospital Construction Act (title III, part B, section 321) will measurably contribute to an early correction of present inequities in the distribution of the Nation's medical resources.

2. Perhaps the most prominent revisions incorporated in S. 1320, as compared with its predecessor, are those relating to the allocation of administrative responsibilities. We heartily support the bill's plan to carry out its benefit provisions through State administration. With all States participating in the administration of benefits, the role of the Federal administrative agencies would be mainly to collect and allocate the funds, determine insured status of individuals and assure that the guarantees and basic standards are complied with. Thus, responsibility for the operation of the program is decentralized to the States and to local authorities.

3. In view of the emphasis which has so often been given to the need for flexibility and experimentation in the development of health program of national scope, it is gratifying to note the wide area of administrative discretion that is assured to State and local authorities in the administration of the program. This flexibility, together with such provisions as those relating to studies and reports (sections 253, 256 (b), etc.) and to State-wide meetings of local administrative personnel, offer assurance that the administrative pattern will not be static but will be adjusted and improved in each State in the light of actual administrative experience.

4. S. 1320 clarifies the role of voluntary agencies in the provision of services under the proposed program (sections 216 and 217). These provisions offer broad opportunities for participation by such voluntary agencies in providing services, while at the same time they vest in Federal and State administrative agencies the necessary responsibility and authority for assuring that voluntary agencies must conform to prescribed standards, so as to assure that their participation will contribute to efficient and economical administration of the program. Such assurance is a necessary and desirable safeguard, since experience in other countries provides a warning that an administrative structure which is complex and diffused in its distribution of responsibility may undermine the effectiveness of the entire program.

5. The bill is also commendable for its recognition of the need for close coordination and interlocking of preventive, diagnostic, and therapeutic health programs. At the State and local level, as well as in the provisions relating to Federal administration, the bill repeatedly encourages administration of all health programs under the direction or supervision of a single agency. This approach meets with our wholehearted approval. It would be a serious and costly error indeed if, in attempting to provide for one of the essential elements of a comprehensive national-health program, we should undermine the very unity and comprehensiveness of the program which we are seeking to establish.

6. S. 1320 differs from S. 1606 by providing for a National Health Insurance Board instead of the Surgeon General of the Public Health Service as the Federal administrative agency. We recognize and sympathize with the desire of the sponsors of this bill to dispel any public apprehension lest a single administrator be tempted to abuse his authority in a field in which so many interests are at stake. This is certainly a proper concern, particularly during the initial stages of a national health-insurance program.

We do have some reservations with regard to the provisions of the bill (section 232) permitting administrative authority to be vested in local administrative committees, but here the optional form of local organization permits a degree of local discretion which is consistent with the general policy of decentralized administration provided by the bill.

7. An important consideration in any medical-care program is its effect on the rights and prerogatives of both providers and recipients of care. On this point, we believe that the revised bill is particularly praiseworthy. In the sections relating to Professional Rights and Responsibilities (sec. 220; see also secs. 219 and 234), Non-Disclosure of Information (sec. 254), Prohibition Against Discrimination (sec. 255), and Complaints of Eligible Individuals and of Persons Furnishing Benefits (sec. 262), every possible legislative assurance has been given that health services will be administered with democratic concern for all affected rights and interests.

8. With respect to the eligibility provisions of S. 1320, it is gratifying to note that the bill now includes protection for Federal employees, who were not covered under the predecessor bill. While we still believe that we should not be satisfied with anything less than 100-percent coverage, we recognize the reasons which led to the coverage limitations in this bill. Since persons who are financially needy constitute a group most in need of coverage, we are in accord with the provisions of sections 205 and 282, which authorize a State to use its public assistance grants under titles I, IV, and X of the Social Security Act for payments of premiums to the personal-health-services account on behalf of needy persons.

9. Brief reference was made earlier in this report to the provision in S. 1320 (sec. 273) with respect to grants for medical research and education. In concluding our comments on title II, however, we should like to reiterate and reemphasize our endorsement of this provision, which we consider to be of outstanding importance. We should particularly like to emphasize the need for grants to assist in the training of medical personnel. While other legislation enacted by Congress, or now under consideration, has focused public attention on the need for medical research, no direct attack upon our acute shortage of medical personnel has yet been authorized by Congress. Even if a comprehensive medical-care program, such as provided by S. 1320, is not adopted by the Congress, we are faced with current personnel shortages. But if title II of S. 1320 should become law, these shortages would become even more urgent, for the distinction between need for medical care, on the one hand, and effective economic demand, on the other hand, would be virtually obliterated. In fact, one of the fundamental objectives of S. 1320 is to equate medical services with medical care needs. This cannot be achieved with the personnel we now have. The provisions of section 273 of S. 1320 would go a long way toward the ultimate provision of adequate medical and related personnel for the Nation. If it is assumed that half of the funds authorized by this section (beginning with the third year, 2 percent of the amount expended for benefits) would be allocated to grants for education, this would yield a sum, roughly, as large as the total present budgets for the Nation's medical and dental schools. This is a large figure, but it is large primarily because it represents a realistic measure of the inadequacies in our current "production rate" for medical and other health personnel.

Section 273 states the objectives, which are of the first importance, and provides the financial means for their attainment. In considering the section for enactment the Congress will probably wish to consider the development of provisions prescribing the methods or criteria to be used in distributing the funds, the methods of administration, and other aspects of this important program; but because of its intimate relationship to other programs of research and education which are still in the formative stage, we are not prepared at this time to submit recommendations for the more specific development of section 273.

TITLE III. DEVELOPMENT AND EXPANSION OF HEALTH SERVICES

Part A. Grants to States for health services

S. 1320 advisedly does not concentrate on the provision of individual health services at the expense of the community health programs which have up to the present comprised the principal concern of public-health authorities. While the record of progress in this field over the past four or five decades has been one of remarkable achievement, we cannot afford to be complacent. Roughly a third of our counties are still without full-time public-health services, and the effectiveness of programs in all communities could be still further extended

and improved with the definite assurance that such progress would yield satisfying results in the form of reductions in preventable deaths and disabilities.

Part A of title III recognizes the need for strengthening community health services and provides several specific means for achieving this objective. First, section 301 provides a broad and flexible statement of the purpose and availability of Federal grants and thereby provides an adequate basis for a comprehensive and progressive community program. Second, section 302 authorizes a progressive and substantial increase in Federal appropriations for financial support to States and local public-health programs. Third, the bill provides (secs. 305, 306, and 307) for more effective distribution of Federal aid by establishing a definite objective grant formula on a varying matching basis, so that the less prosperous States would receive the greatest proportionate amount of financial assistance. Fourth, this title sets a definite goal of a Nation-wide coverage by specifying, in paragraph (4) of sec. 304 (a), that State plans must assure the coverage of every community in the State with an adequate public-health organization within 10 years of approval of the first plan.

Finally, title III contemplates, at the option of each State, a single grant to the State covering all public-health services, as opposed to the separate earmarked grants required under present laws. The committee and the Congress will, no doubt, want to give careful consideration to this approach, with its possible contribution to simplified administration and balanced programs, as well as to the traditional alternative approach of providing or earmarking separate grants for special programs.

Part B. Construction of health facilities

Part B of title III consists of a series of proposed amendments to the Hospital Survey and Construction Act of 1946, all of which meet with my complete approval. Section 321 increases the authorized annual appropriations provided in the original act and extends the life of the program from 5 to 10 years. Over the 10-year period, the Federal appropriations authorized by this section would total \$975,000,000, which, together with the State matching funds, provides a much more realistic fiscal estimate of the unmet hospital and health center needs of the Nation than that authorized in the present act. In addition to increasing the total amount of Federal funds available, this bill would enhance the effectiveness of the hospital construction program in correcting the present inequitable geographic distribution of hospital facilities by two other modifications of the original act. First, it would provide for State-by-State variation in the Federal contribution to the cost of construction projects as opposed to the present uniform matching requirements. This would be a distinct improvement, since it is somewhat inconsistent to make larger gross allotments to poorer States without allowing for any variation in the matching requirements for individual hospital construction projects. Second, it is proposed to amend the present act so as to eliminate the requirement that a local applicant must demonstrate ability to meet maintenance and operation costs as a prerequisite to a construction grant. Under a system of Nation-wide prepaid medical and hospital benefits, such as that outlined in title II of S. 1320, the problem of meeting maintenance costs for hospitals in low-income areas would, of course, be greatly simplified, and this amendment to the Hospital Survey and Construction Act would be a logical one.

In the light of these comments, we would, therefore, recommend that this bill be enacted by the Congress.

Sincerely yours,

WATSON B. MILLER, *Administrator.*

Senator DONNELL. Mr. Miller, as you have indicated, you are the Federal Security Administrator. How long have you occupied that position?

Mr. MILLER. Since the 12th of October 1945, Senator.

Senator DONNELL. I would like to ask just a little about your biographical data, Mr. Miller, if I may.

In the first place, where were you born?

Mr. MILLER. The Senator will find it not very important, but it is something I am very glad to give to you.

Senator DONNELL. I think it has a bearing, in view of certain provisions in the bill, and I shall point those provisions out later, and I trust the witness will not object at all to the inquiries that I shall make. I do not think any of them will be improper at all.

Will you tell us, Mr. Miller, where you were born?

Mr. MILLER. In Indiana.

Senator DONNELL. And when were you born?

Mr. MILLER. On April 1, 1879.

Senator DONNELL. You were educated where?

Senator PEPPER. Day of the week—we might get the day of the week.

Senator DONNELL. Just a minute—I suggest for the record that this is a serious examination and is being conducted in that way.

Senator PEPPER. That is merely a suggestion. I wanted to know whether it was in the full of the moon or what. It might be important.

Senator DONNELL. I observe the serious nature of the Senator's questions, and they are, of course, noted in the record.

Now, Mr. Miller, will you be kind enough to tell us where you received your preliminary education?

Mr. MILLER. In the public schools of the State of Illinois.

Senator DONNELL. And were you graduated there and from one of the high schools in Illinois?

Mr. MILLER. I was not.

Senator DONNELL. How far did you proceed in your work in school?

Mr. MILLER. To the seventh grade.

Senator DONNELL. Then what further educational work did you pursue in any educational institution?

Mr. MILLER. None in a school.

Senator DONNELL. When did you finish your work in the seventh grade in the Illinois schools?

Mr. MILLER. I think at the age of 16, Senator.

Senator DONNELL. That would be in 1895?

Mr. MILLER. About that.

Senator DONNELL. And what did you do then, say, for the next 10 years?

Mr. MILLER. I had to go to work to support a rather large family of younger brothers because of a long-continued chronic illness of my father, who was the breadwinner.

Senator DONNELL. And what line of work did you follow?

Mr. MILLER. I swept out drygoods stores, washed windows, carried papers, milked cows, drove cattle and sheep. I did take some courses in the International Correspondence School, of Scranton, Pa.

Senator DONNELL. And what was your first major job that you had after you left school?

Mr. MILLER. Well, those activities that I have just mentioned were affairs requiring my full time and some evening time and for the purpose of scratching up a little money to buy food.

Senator DONNELL. Well, Mr. Miller, there is no intimation of any lack of respect for those activities. They are honorable and proper, and I honor you for them, but what I am trying to get at is your experience.

Mr. MILLER. It almost broke my parents' hearts. I remember that.

Senator DONNELL. I don't mean any reflection in the slightest, directly or indirectly or inferentially. I am simply asking about your experience.

What I wanted to find out is as to the work you have detailed—what was your first employment along your ultimate line of employment.

Mr. MILLER. Full-time job?

Senator DONNELL. Yes.

Mr. MILLER. I think perhaps the first thing is not important. My father was an engineer; and, partially recovering his health, he came to Washington and went to work for the General Land Office in a quasi engineering capacity. He had a good deal of field work in the Rocky Mountains; and as he could, at times, as my brothers came out of high school, he took us out on field work, and I learned to couple with my studies in mathematics and arithmetic and plane and spherical trigonometry—I learned the rudiments of engineering and was paid for it.

At one time I was employed for several years, while the boys were going through school, in a large Washington mercantile establishment as a salesman.

Senator DONNELL. Shall we count that as, in your opinion, the first full-time job, or had you had some other full-time job prior to that? I don't want to go into the greatest details.

Mr. MILLER. My earliest job in a Bloomington, Ill., department store was a full-time job.

Senator DONNELL. Then you came on to Washington, as you have detailed, and you were employed here in one of the large mercantile establishments in Washington?

Mr. MILLER. That is right.

Senator DONNELL. By the time you were 21, where were you located?

Mr. MILLER. I was located in the mercantile establishment in Washington.

Senator DONNELL. How long did you continue in that line of work?

Mr. MILLER. From the age of about 21 to 28, as I best remember, Senator Donnell, and at that time I helped to organize a brick-manufacturing concern in Baltimore, to which I gave my full time.

Senator DONNELL. For how long were you with the brick-manufacturing company, at the age of 28, which I understand was in 1903?

Mr. MILLER. There is something wrong with my chronology there. It is difficult for me to get those dates established with accuracy at this moment.

Senator DONNELL. Just approximately, how long were you with the brick company and in about what year?

Mr. MILLER. Well, in 1908 I spent 4 or 5 years in Baltimore in the brick-manufacturing business, and then the next definite date that I can remember is that I helped organize a small business contracting establishment here in Washington. I remember that date because of the—

Senator DONNELL. What was the date?

Mr. MILLER. 1921, the year in which the corporation was effectuated.

Senator DONNELL. What type of contracting was that?

Mr. MILLER. Designing and manufacturing of bank equipment, permanent fixtures for banks, and some fixtures to go in public buildings, such as State capitol buildings, and that involved allegorical

paintings and massive bronze decorative things. Among other things we helped to design and manufacture all of the furniture in the New House Office Building.

Senator DONNELL. For how long a period, approximately, after 1921 did you continue in that line of work?

Mr. MILLER. The war came along, and I enlisted, and that was about 1917. I continued my ownership of minority stock until the business was dissolved by the death of the other principal incorporator in 1943, but for many years I had no time to pay any attention to the business, and for 5 or 6 years I was not even in the office.

Senator PEPPER. Let him state his war experience.

Senator DONNELL. Yes; I will be glad to have you state your service in the war. That is the First World War?

Mr. MILLER. That is right.

Senator DONNELL. Will you state your service?

Mr. MILLER. I was commissioned a first lieutenant in the Motor Transport Corps, which was a staff corps organized for the purpose of that war, which does not now exist, I believe, and for the most part I trained troops in Camp Johnson, Fla., and Camp Sheridan, Ala., near Montgomery, and commanded motor transport of all descriptions and collected the overseas material. I was in Hoboken, N. J., ready to embark when the armistice was signed.

Senator DONNELL. Then have you finished now the military work?

Mr. MILLER. Yes.

Senator DONNELL. Then, after your war experience, did you then return here in this contracting work, or had it yet been started?

Mr. MILLER. Just before I went into the service there was a little of that work done under kind of a partnership between a gentleman who is now dead and myself, but the corporation was after I returned from the service in 1921. I returned from the service, however, in 1919.

Senator DONNELL. But the company was incorporated in 1921?

Mr. MILLER. That is right. And I was also owner of one-third of a bus transportation company.

Senator DONNELL. For how many years, approximately, did you continue active in that company, devoting substantially all of your time to it?

Mr. MILLER. Just about until December 1923.

Senator DONNELL. Was it 1923, about two years?

Mr. MILLER. Full time; yes, sir.

Senator DONNELL. From that time on, say for the next 10 years, what did you then do?

Mr. MILLER. In December of 1923 I was appointed chairman of the national rehabilitation committee of the American Legion, which, of course, has to do with the things we are talking about now.

Senator DONNELL. That was 1923?

Mr. MILLER. Yes, sir.

Senator DONNELL. How long did you serve in that capacity?

Mr. MILLER. Eighteen years.

Senator DONNELL. That brings us up to 1941?

Mr. MILLER. Yes, sir.

Senator DONNELL. Did you devote practically all your time to the American Legion work in that period?

Mr. MILLER. All of it practically. I did visit and conferred in the offices of the corporation, however.

Senator DONNELL. Then in 1941 did you discontinue that work?

Mr. MILLER. I was called by the Government to enter the Federal Security Agency.

Senator DONNELL. That was in 1941? In what capacity?

Mr. MILLER. Assistant Administrator.

Senator DONNELL. Did you succeed Mr. McNutt in that capacity, or was it in some other capacity you succeeded him?

Mr. MILLER. I succeeded Mr. McNutt in October 1945, as Administrator.

Senator DONNELL. So from 1941 until 1945 you were with the Federal Security Agency?

Mr. MILLER. As Assistant Administrator.

Senator DONNELL. From 1941 to 1945 as Assistant Administrator. Then you succeeded Governor Paul V. McNutt in 1945 as Federal Security Administrator, and you have been that ever since?

Mr. MILLER. That is right.

Senator DONNELL. Now, Mr. Miller, in the course of your work you have, of course, come frequently in contact with the medical profession, both in your Legion work and as Federal Security Administrator, have you not?

Mr. MILLER. Continuously.

Senator DONNELL. And I noted right in the opening paragraph of your statement you have given us this morning you referred to the "truly wonderful kind of medical care we have in our country." That represents your observation on the medical care that has been available in this country, at least to some of the people? Is that correct?

Mr. MILLER. Emphatically.

Senator DONNELL. I am not saying everybody has had this medical care, but your observation on the whole is that the quality of such medical care as has been rendered in this country is excellent? That is correct, is it not?

Mr. MILLER. That is my observation.

Senator DONNELL. Now, Mr. Miller, I referred to the Rhode Island matter. I have before me here the statutes of Rhode Island, namely, chapter 1200, enacted at the January session of the 1942 legislature, 5 years ago, the Rhode Island Cash Sickness Compensation Act. In your work have you had occasion to see that section, that statute itself?

Mr. MILLER. No, sir.

Senator DONNELL. Did you know of its existence?

Mr. MILLER. No, sir.

Senator DONNELL. It has been in existence since some time in 1942, having been enacted, as I say, at the January session of the Rhode Island Legislature.

Mr. MILLER. I have a recollection of having heard from—I think more or less casually—from our associates that such a system was in vogue in Rhode Island, and I think it was suggested in one other State, but I am not sure of that.

Senator DONNELL. This act in Rhode Island was approved April 29, 1942, which is over 5 years ago, and you are not familiar with the operation of that Cash Sickness Compensation Act?

Mr. MILLER. That is correct.

Senator DONNELL. Now, Mr. Miller, you referred to some other States that you have heard—

Senator PEPPER. To save time, will you allow me to interrupt right there? Would you state what the act is, what the purpose of it is, what it actually provides?

Senator DONNELL. I would not undertake, Senator, to give a complete synopsis of the act. I am not myself able to do that.

Senator PEPPER. I understand that, but what does it provide? I understand that it simply provides compensation to people during the time of their illness. My understanding is it does not have any relationship to the amount of medical care they require during that period, but it just pays their wages or their salaries during the time of their illness. I get my information from the statement of Senator McGrath, one of the authors of S. 1320, who was Governor at the time the act was adopted.

Senator DONNELL. The Senator may well be correct. I have not read the act myself. I observe in section 3 of the act this sentence right at the outset:

There is hereby created a Rhode Island cash sickness-compensation fund to be administered by the board, without liability on the part of the State beyond the amounts paid into and earned by the fund.

I observe also in section 4 there is an obligation on each employee to contribute—well, it doesn't say there is an obligation. The language is: "Each employee shall contribute."

Senator PEPPER. I understand that is a contributory system.

Senator DONNELL. So Rhode Island has had a cash-sickness-compensation fund with respect to employment after June 1, 1942. The act is quite an extensive act. I observe it is set forth in the Session Act of Public Laws of Rhode Island, 1941-42, pages 564 and following, approved April 29, 1942.

Now, Mr. Miller, you spoke of some other State to the effect that you have heard there is some legislation along similar lines. Do you have in mind what that other State is?

Mr. MILLER. I do not recall, and I did not present that as an assertion, but merely as something that remains in my memory.

Senator DONNELL. You have not studied the legislation of the States of the Union to ascertain whether or not there are any acts comparable to the Rhode Island act?

Mr. MILLER. I have studied some State statutes with particular relation to welfare and public assistance.

Senator DONNELL. But the point I am getting at is that you have not studied the statutes of the various States to see what approaches they have made with respect to insurance, if they have made any such approaches?

Mr. MILLER. That is an accurate statement.

Senator DONNELL. Now, Mr. Miller, in the course of your statement you said that on the basis of these observations; that is, observations that you have set forth on the first page and the early portion of the second page of your statement—"we believe that health

insurance is a most effective means by which our people can meet all health needs." I understood that you, in response to one of the questions asked you earlier in your testimony by Senator Smith, by the term "health insurance" are referring to compulsory health insurance?

Mr. MILLER. Yes, sir.

Senator DONNELL. Now, Mr. Miller, have you studied at all the experience of other nations in compulsory health insurance?

Mr. MILLER. I have relied upon the studies made by the specialists in the Social Security Administration and in the Public Health Service, and they have been extensive ones.

Senator DONNELL. But I mean you personally, have you studied the history of compulsory health insurance in any nation of the world?

Mr. MILLER. I would not call it "study." I have read some of the experiences in both England and Germany.

Senator DONNELL. Do you recall what book or books, if any, you have read on those subjects?

Mr. MILLER. They have been pamphlets and other documentary historical material supplied to me by the Social Security Administration and by the Public Health Service.

Senator DONNELL. Do you recall who the author of any of those pamphlets was?

Mr. MILLER. No, sir. They were home reading.

Senator DONNELL. You have not read any books, as distinguished from pamphlets, on the subject of compulsory health insurance, either in England or in Germany?

Mr. MILLER. No extensive documents.

Senator DONNELL. How about New Zealand? Have you read the experience of New Zealand with compulsory health insurance?

Mr. MILLER. I have not.

Senator DONNELL. Have you read anything on the New Zealand compulsory health insurance, pamphlet or otherwise?

Mr. MILLER. Only discussions with my associates on the New Zealand developments.

Senator DONNELL. But I say, though, have you read anything on the New Zealand development at all?

Mr. MILLER. I have not.

Senator DONNELL. You mean by "developments" the developments in health insurance, and I take it you understood that to be my meaning? Is that right?

Mr. MILLER. I have not.

Senator DONNELL. All right. Now, you spoke about the expert advice on which you have relied. On whose expert advice do you rely, Mr. Miller, in formulating this opinion that you express here that health insurance means compulsory health insurance is the most effective means by which our people can meet their health needs?

Mr. MILLER. The Commissioner for Social Security.

Senator DONNELL. Who is that?

Mr. MILLER. Dr. Arthur J. Altmeyer and his immediate associates, and the Surgeon General.

Senator DONNELL. That is Dr. Parran? Is that right?

Mr. MILLER. The Surgeon General and his research advisers.

Senator DONNELL. Mr. Altmeyer has been in Geneva for some time, has he not?

Mr. MILLER. He has been in Geneva for a little better than 2 months.

Senator DONNELL. In addition to Dr. Parran and Mr. Altmeyer, have you relied on the expert advice of anyone else?

Mr. MILLER. Dr. George St. John Perrott.

Senator DONNELL. He is in the Public Health Department, is he not?

Mr. MILLER. Yes. And we get information from Dr. Martha Eliot.

Senator DONNELL. Is Dr. Eliot in the room?

Mr. MILLER. Associate Chief of the Children's Bureau, and others, who, because of our association with the State Department in enterprises germane to our duties in the international field, as a result of the setting up of the United Nations and of prior experiences, conducted researches to find out where the world was going in this field.

Senator DONNELL. Have you conferred with Dr. Isidore Falk at all in formulating your opinion?

Mr. MILLER. I have conferred with Dr. Falk perhaps briefly six times or more in the course of several years that I have been with the Agency.

Senator DONNELL. Six times or more?

Mr. MILLER. Commonly the conversations would be group discussions of these matters in which the talent and experience we had available would all be assembled.

Senator DONNELL. And have you seen any of Dr. Falk's productions or suggestions or his writings on subjects of this general nature?

Mr. MILLER. I have read them in pamphlet form, and particularly his statistical studies, as a part of home reading.

Senator DONNELL. Dr. Falk is in the room this morning, is he not?

Mr. MILLER. Yes.

Senator DONNELL. He, as you know, has been quite active in connection with these health insurance matters? You know that, generally speaking?

Mr. MILLER. I do not know the extent of his activities. If the Senator refers to the studies he has produced, I am sure he has been active.

Senator DONNELL. What is the official connection of Dr. Falk with the Federal Security Agency?

Mr. MILLER. He has been director of the Bureau of Research and Statistics of the Social Security Administration, formerly the Social Security Board.

Senator DONNELL. Now, I have before me a chart issued under date of August 8, 1946, over the facsimile of yourself, Administrator, and I fail to find in here any reference to the Bureau of Research and Statistics. [Producing a chart.]

Senator PEPPER. Is that a Government publication?

Senator DONNELL. This is a chart issued by Watson B. Miller, Administrator.

Senator MURRAY. That is not the one in which Senator Pepper and I are referred to as "Fellow Travelers?"

Senator DONNELL. No; that is not. I don't find any reference here to Dr. Falk's position that you have mentioned. If I have overlooked it, I would like for you to call it to my attention, and tell me, if you don't find it, where it should be.

Mr. MILLER. Senator, this is an over-all chart devised as a study just before adoption by the Congress of the President's Reorganization

Plan No. 2 of 1946, although it is dated a month subsequent to the action by Congress. It is an over-all chart which does not carry with it the bureaus and sections which are pertinent to every one of these major agencies in the Agency.

Senator DONNELL. Mr. Miller, I call to your attention the fact that the date of this is August 8, 1946. Does it not reflect the condition brought about by Reorganization Plan No. 2?

Mr. MILLER. Yes, sir, in an over-all way, Senator.

Senator DONNELL. But there is not any mention on this chart to which I refer to the position occupied by Dr. Falk? That is correct, is it not?

Mr. MILLER. Let me look. I think that is correct, but I can check it here. [Examining the chart.] It does not, apparently, and I am not sure whether it has existed as a separate bureau or whether it is a bureau within one of these bureaus. I think maybe Mr. Mitchell might enlighten me on that.

Senator DONNELL. Mr. Mitchell is to testify, I think, a little later. We will ask him about that. If you are not familiar with that, Mr. Miller—

Mr. MILLER. I would suppose that it should be here as a bureau by itself. I cannot explain the absence of it, except that this is a general over-all chart which shows only the major constituent units of the Federal Security Agency.

Senator DONNELL. The chart does, so far as you observe, generally speaking, set forth the various important bureaus and divisions of the Federal Security Agency?

Mr. MILLER. Oh yes, it sets out in a general way the responsibilities.

Senator DONNELL. And the Bureau of Research and Statistics, headed by Dr. Falk, is considered by you, even though it is not upon this chart, as one of the exceedingly important bureaus in the Federal Security Agency? That is correct?

Mr. MILLER. It would be to any activity of that nature, yes.

Senator DONNELL. Now, Mr. Miller, you have given us your statement this morning, and again I want to say that my question is not intended to be in the slightest degree offensive—but for my information, did anyone collaborate with you in the preparation of this statement which you have given us this morning?

Mr. MILLER. It was roughed out for me and presented to me on a Sunday, and I went over it in detail and made changes which I regarded necessary to be made—Sunday a week ago.

Senator DONNELL. Who roughed it out for you in the first instance?

Mr. MILLER. I think it was Mr. Harry N. Rosenfield, one of my two staff assistants, who is not connected with any bureau of any of the constituent groups or agencies.

Senator DONNELL. Do you know where Mr. Rosenfield secured the information and views that are set forth in this statement that you have given us this morning?

Mr. MILLER. No; I cannot answer that specifically “yes” or “no,” but I should like the record to show that Mr. Rosenfield is quite experienced in matters of this nature.

Senator DONNELL. Is he widely experienced in the matter of compulsory health insurance?

Mr. MILLER. I would say that he is more widely experienced than I am, perhaps.

Senator DONNELL. I am asking whether he is widely experienced in matters of knowledge of compulsory health insurance, so far as you know?

Mr. MILLER. That is my opinion.

Senator DONNELL. Do you know yourself whether he has ever read any books on the history of it in any country?

Mr. MILLER. No, sir.

Senator DONNELL. Do you know whether he has ever gone to any country and made an examination there?

Mr. MILLER. No, sir.

Senator DONNELL. You don't know whether he has or has not?

Mr. MILLER. I do not.

Senator DONNELL. He is here in the room, also, is he not, this morning?

Mr. MILLER. He is.

Senator DONNELL. Now, Mr. Miller, some reference was made to S. 1606. That bill was in turn a descendant—child, grandchild, or great grandchild—of S. 1620, was it not, which was introduced by Senator Wagner in the Senate on February 26, 1939, entitled "An act to provide for the general welfare, make more adequate provision for the public health," and so forth?

Mr. MILLER. I believe so, Senator.

Senator DONNELL. Do you know, as a matter of fact, that S. 1620, introduced by Senator Wagner back in 1939, is itself an act which is based on grants to States—and I quote "grants to States for medical care," just as S. 545 is based on grants to States for medical care, quoting from title 13 of that act, S. 1620, and I ask you if you know that to be a fact?

Mr. MILLER. No, sir.

Senator DONNELL. You do not? Well, I call your attention to the fact that on page 2 of that act, title 5, there is entitled "Grants to States for maternal and child welfare," and that on page 16, title 6, "Public Health work and investigation," section 601 of which starts out:

For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas—

and so forth—

to extend and improve Public Health work * * * there is authorized to be appropriated—

certain amounts, and—

sums authorized under this section shall be used for making payments to States which have submitted and had approved by the Surgeon General of the Public Health Service State plans for extending and improving such services.

I assume you will agree that I am reading this accurately; at least, you have no reason to believe otherwise. I call your attention to page 34 of that bill, title 13, entitled "Grants to States for medical care," being a total of some \$35,000,000, which, in the language of the concluding sentence of 1301 is as follows:

The sums authorized under this section shall be used for making payments to States which have submitted and had approved by the Social Security Board hereinafter called the Board, State plans for extending and improving medical care.

So, Mr. Miller, the fact is, assuming the truthfulness of my reading here, which I assure you is correct—

Mr. MILLER. I know it is.

Senator DONNELL. The fact is that the Wagner bill, introduced back there in 1939, S. 1620, proceeds directly on the same theory that S. 545 today proceeds. That is correct, is it not?

Mr. MILLER. Without doubt. I hope the Senator will permit me mildly to remark—this is not argumentative at all—that since 1939 we have had a very lengthy and very increasingly grave experience with the business of compulsory prepaid benefits, which we believe could profitably be applied to the operation of a medical and health service.

Senator DONNELL. I appreciate that point, and also the fact that you undoubtedly believe, or you would not have testified, that the bill now before us, S. 1320, represents what you think are improvements over the predecessor bills, but the point I am making is that the Wagner bill started out in 1939 with the same theory that S. 545 today starts out with. Maybe his ideas have progressed. Maybe improvements have come into S. 1320.

Mr. MILLER. The Senator has made the only point respecting that possibility that I could possibly advance myself.

Senator DONNELL. But at any rate, Mr. Miller, the point I was making is, so that we may have it before the committee for its consideration, that the Wagner bill originally started out on the same basis as S. 545 stands today. I think that is correct.

Senator PEPPER. If you will allow me there, Senator, some people think that man started out as a monkey, but he didn't stay there.

Senator DONNELL. Well, I would hesitate to say that Senator Wagner or his bill started out as a monkey, but I will let the matter stand in the record with the Senator's statement.

Mr. MILLER. I heard it said on the floor of the Senate by a very distinguished member of the upper body, in response to a rather sharp interrogatory the other day that "we live and learn."

Senator DONNELL. Yes, that is true. Now, let us take up some of this bill S. 1320 that we now have before us.

In the first place, Mr. Miller, you made quite an extensive point in your statement—in fact, it is the first main point, I think—appearing on page 3, of decentralization of administration, and you say that S. 1320 very clearly establishes a system of local administration under State-wide plans. I take it by that statement you recognize the importance of local administration? That is correct, isn't it?

Mr. MILLER. We have only one considerable program which is not operated on that basis in partnership with the States and localities, and we espouse that method of operation between the central government and its constituents and the people.

Senator DONNELL. In other words, regardless of whether you favor Nation-wide compulsory health insurance or not, you and I agree, I believe, upon the fact that local administration is of great importance. We agree on that, do we not?

Mr. MILLER. We do, sir.

Senator DONNELL. And by your statement—

Mr. MILLER. The Senator believes that is true, and we so agree.

Senator DONNELL. And by your statement that S. 1320 very clearly establishes a system of local administration under State-wide plans, I take it you mean to express approbation with respect to S. 1320, by reason of its establishment of such system of local administration under State-wide plans?

Mr. MILLER. Quite right.

Senator DONNELL. So you are not censuring S. 1320 for that fact?

Mr. MILLER. Correct.

Senator DONNELL. I take it, however, by your statement about local administration, you do not deny that the Federal Government in S. 1320 is relinquishing the right of ultimate supervision over the entire program Nation-wide, do you?

Mr. MILLER. Not completely. Not more than the Federal Government should relinquish stimulative control and establishment of at least basic minimum standards of various kinds, the determination of complex issues of eligibility in any program as to which it produces plan for financing.

Senator DONNELL. Now, Mr. Miller, I would like to go into this bill even to the extent of being a little tedious, because I think it is very important to go into certain provisions of the bill to find out just what this bill does with respect to decentralization or the contrary, and I call your attention to title II—you have a copy of the bill before you, S. 1320?—entitled “Prepaid personal health insurance benefits.” That is the title that relates to the compulsory health insurance. That is correct, is it not?

Mr. MILLER. Benefits and eligibility; yes, sir.

Senator DONNELL. Title II is the title that covers all matters of compulsory health insurance here, does it not?

Mr. MILLER. That is true.

Senator DONNELL. The only remaining title after title II is title III, which is entitled “Development and Expansion of Health Services,” and that provides for certain grants to States, does it not?

Mr. MILLER. Title II is divided into several parts.

Senator DONNELL. Yes, title II is divided into a number of parts, beginning with section 201 and running down through section 283. It all relates to prepaid personal health insurance benefits, and that is the compulsory health insurance portion of S. 1320?

Mr. MILLER. That is right.

Senator DONNELL. Now, Mr. Miller, I would like for you to direct your attention, please, to page 38 of the bill, which is within that title, and I call your attention, at the bottom of page 38, section 251, to the language: “There is hereby established in the Federal Security Agency”—and I pause to ask, that is the agency of which you are the head; is it not?

Mr. MILLER. That is right.

Senator DONNELL. “There is hereby established in the Federal Security Agency a National Health Insurance Board.” You observe that?

Mr. MILLER. Yes, sir.

Senator DONNELL. Now, I want to ask you some questions a little later about the composition of that board, but we will pass that for the moment. I call your attention now, after the provisions here for the establishment in your agency of a National Health Insurance

Board, to this language over on page 39, beginning at the bottom, line 24 and following:

The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

I have correctly quoted it, have I not?

Mr. MILLER. Yes, sir.

Senator DONNELL. I take it, Mr. Miller, that the language which I have just read, which in part says the Board shall perform such functions as it finds necessary to carry out the provisions of this title, gives the Board a very important general control over everything in title II, does it not, because it is left to that Board to determine what functions it finds necessary to carry out the provisions of title II?

Mr. MILLER. That is right.

Senator DONNELL. And even though the State has certain functions, which of course States do under this bill, the ultimate determination as to what is necessary to carry out the provisions of the compulsory insurance portion of S. 1320 is left to the National Health Insurance Board, as I have read, is it not?

Mr. MILLER. That is right.

Senator DONNELL. Now let us see if it is right. Let us turn for a minute back to page 39 again and let us read just a sentence ahead of this which I have read, and which contradicts what I have just read to you.

Mr. MILLER. I know what you are going to read.

Senator DONNELL. Of course you do. It says:

All functions of the Board—

it doesn't say part of them, half of them, three-quarters of them—

All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

I have quoted it correctly?

Mr. MILLER. That is right, sir.

Senator DONNELL. So that when we find in the sentence which I first read that the Board shall perform such functions—remember the word “functions”—such functions as it finds necessary to carry out the provisions of the title, namely, the compulsory health insurance title, those functions “shall be administered by the Board under”—not above, not coordinate with, but “under the direction and supervision of the Federal Security Administrator.” That is right, isn't it? That is what it says? Is that right? Isn't that what it says?

Mr. MILLER. That is right.

Senator DONNELL. Now, go right ahead with your comments.

Mr. MILLER. I want to say, Senator, that if the Congress finds that there is a contradiction there, it would be easy for the law-making body to correct it. I will say to the Senator, following his own line—what I think is his own line of thought—when I examined this bill and came to the lines the Senator has just quoted, it seemed to set up a sort of a contradiction, and I placed a question mark in the margin for further discussion. I thought it was eligible for further discussion, but I did not go to the liberty of changing the script in this bill.

Senator DONNELL. Now, Mr. Miller, I want to remove what I just

called a contradiction, because I don't think that ultimately there is any contradiction. It is if you just stop with what I first read to you, namely, "The Board shall perform such functions as it finds necessary to carry out the provisions of this title." It would appear that the ultimate authority resides in the Board, but as I have indicated, that is contradicted by this other sentence which precedes it, which says that all those functions shall be administered under the direction and supervision of the Federal Security Administrator, but as I see it, the two sentences can be and should be and are properly read in conjunction and juxtaposition, and giving due effect to both sentences—in other words, what it means is that the Board shall perform such functions as it finds necessary to carry out the provisions of the title, to make all regulations, and so forth, but it is provided that all those functions shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

So I think, Mr. Miller, that under the theory of this bill, S. 1320, there is no occasion to change the language, and so far as I am personally concerned, on the matter of legal construction I see no necessity for the question mark on the border. I do, however, raise this point, and I think you will agree with me, that under the terms of this bill, particularly pages 39 and 40, from which I have read to you, the ultimate determination of what is to be done in the administration of the compulsory health insurance provided by that bill, comes back to the Board and then right up to one man, and his decision is the decision that counts, and that one man is the Federal Security Administrator. That is correct, is it not?

Mr. MILLER. I am not trying to fence with the Senator, of course. I am not given to trickery or evasion.

Senator DONNELL. I know you are not, and I do not imply that.

Mr. MILLER. I believe that this means—and I raise the question only for the purpose of discussion here, as you have raised it—that there must be vested some place the authority for developing standards and the necessary circumscription which should only go so far as to assure that the objects of the bill are carried out. I said in my presentation that no administrator could get along with arbitrary or capricious action, and I am one who thinks he should not be permitted to get along in a capricious manner with Congress looking at him, the people looking at him, and even if they were not, he ought not to do it.

Senator DONNELL. I agree with you there should not be any capricious action, but the point I am getting at is that while you make in your statement as your first main point, and you devote several pages of your statement to it—two pages anyway—to the decentralization of administration, the actual fact is that, regardless of all these provisions about State administration, the ultimate decision on everything comes back up to one man, the Federal Security Administrator. That is correct, is it not?

Mr. MILLER. It comes to the Congress through him.

Senator DONNELL. It comes to him under the provisions of this bill, so that if Congress passes this bill, the Federal Security Administrator is where the ultimate authority resides. That is correct, is it not?

Mr. MILLER. You cannot read into this part of the section or any place in this bill that the Administrator or the Board has the right

to go out and station policemen, or should go out and station policemen or enforcement people in these States or in these communities.

Senator DONNELL. That is not what I am talking about, Mr. Miller. What I am saying is, just as I said a moment ago, and I want to ask you if you do not agree with this, that the ultimate authority under this bill, under title II—which is the Compulsory Health Insurance Title—the ultimate authority resides in one man, the Federal Security Administrator?

Mr. MILLER. Certainly for the production of regulations and the development of standards.

Senator DONNELL. It is true, and I quote at line 22, page 39, again—and I am not laboring the point further except to read this—

All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

We agree that that is in the bill, is it not?

Mr. MILLER. That is right. Is there a feeling, sir—if I may ask—that somebody should be held responsible to this body under the people for the administration of a piece of legislation which is as important and complex as this?

Senator DONNELL. Certainly there should be some responsibility somewhere, but the point I am making is this: You have emphasized here very clearly and very excellently this point of decentralization of administration. The point I am making is that while there is all this language here over page after page, State administration, declaration of policies, State plan of operation, State this and State that, and so forth, that when you get right down to the meat in the coconut, page 39, line 22, to line 4 on page 40, the ultimate authority resides right in one man, and he is down here in Washington, D. C., and he is the Federal Security Administrator. That is true, is it not?

Mr. MILLER. I am glad to admit that.

Senator DONNELL. All right. Now, Mr. Miller, let us just consider a minute—and this is the reason I asked you what I hope you did not take any offense at, about your early experience, and I want to repeat that I have the utmost respect for your experience; I have no criticism whatever of it, but the point I am making is, and that I want to present for your consideration, just as it will be presented to this committee and to Congress—whether it is advisable to vest all the power in the first place in Washington, D. C., at all, whether that is advisable; and in the second place, is it advisable to vest it in an individual—not you particularly, any more than anybody else—but in some individual who is not required by law to possess particular, specific qualifications? That is the point I am leading up to, and with all due respect to you, Mr. Miller, I want to point out, and I ask you again for the record, as I have in the past, you are not a physician, are you?

Mr. MILLER. No, sir.

Senator DONNELL. And, of course, you make the point, and you make it clearly and concisely and excellently, that, in your opinion, a doctor should not be at the head of this. That is your judgment?

Mr. MILLER. That is right.

Senator DONNELL. That is your thought. Now, we may never agree on that, and I am not expecting that you will agree with everything

I say here this morning, nor ask you, but I would like to call your attention, if you will turn to page 14 for a moment—

Mr. MILLER. Senator, I think I have some truly extraordinary qualifications for handling this job, a job of this kind, and if the Senator will go into it with me sometime I will try modestly to recite those experiences.

Senator DONNELL. Now, Mr. Miller, I am not criticizing you in the slightest. I have every respect for Watson B. Miller. I know him and like him, and we have got along fine in the past, and I think will in the future.

Mr. MILLER. That goes both ways.

Senator PEPPER. And may I—I would like at this time to hear the statement of why you think you are qualified to administer the duties of the office you hold.

Senator DONNELL. I think that is very proper, and we would be very happy to have him do that.

Mr. MILLER. I have had somewhat larger administrative and business experience than I have attempted to expose here, a very varied experience not only in this country but in foreign countries. I have traveled a good deal, and for the 18 years that I was chairman of the American Legion's rehabilitation committee—

Senator DONNELL. Pardon me, Mr. Miller—this is not meant to interrupt you rudely at all, but I would like somewhere, before you proceed, I just want to mention, of course, that this bill in no place, of course, makes mention of any one individual, and there is no assurance in this bill as to the qualifications of your successor over a period of years, whether he will have the same qualifications as you have or not.

Mr. MILLER. I have conceded, Senator, the right of any member of this body to develop the point that he is working out with me, but which is evidently to reinforce his feelings that the head of an agency of this kind should be a physician. I have not that viewpoint.

Senator DONNELL. Proceed as Senator Pepper suggests. I think his suggestion is excellent.

Senator PEPPER. To start with, you were appointed by the President of the United States?

Mr. MILLER. Yes, sir.

Senator PEPPER. Who was chosen by the people of the United States to discharge the duties of his office?

Mr. MILLER. Yes, sir.

Senator PEPPER. And you were confirmed by the Senate of the United States?

Mr. MILLER. Yes, sir.

Senator PEPPER. And you have made reports from time to time to the President of the United States and to the American Congress relative to the discharge of your duties?

Mr. MILLER. Yes, sir; special and regular reports.

Senator PEPPER. Under the law and under S. 1320 your successor would be appointed by the President of the United States and confirmed by the Senate of the United States?

Mr. MILLER. I think he would be.

Senator DONNELL. Of course, Mr. Miller, when you were appointed, S. 1320 was not then in existence and is not yet the law of this land, so that when you were appointed by the President the functions of a

compulsory health insurance director were not in the office to which you were appointed? That is correct; is it not?

Mr. MILLER. That is right.

Senator DONNELL. Now proceed, Mr. Miller, with your qualifications.

Mr. MILLER. I will start by saying that I had, for just an average, very modest American citizen, a rather varied and sometimes colorful experience in this country and other countries. I have traveled somewhat widely. When I was appointed, somewhat against my own volition, to head up the very extensive medical, administrative, and claims section of the American Legion, with a budget of sometimes a quarter of a million dollars a year to do business with, I recognized that the further we departed from the First World War in terms of time, the more important position medicine would assume. I don't have to point out the reason for that, except maybe to say that the sources of evidence die out; you have to study closely considerations of etiology, causative factors in medicine, considerations which might effect an identity between something that occurs in a man's medical history 20 years after his departure from service with something that occurred in service, though lately called by quite a different name. Consequently, one of the first things I did was to surround myself with full-time medical men, and establish an advisory group, such as is set up in this bill, of the best physicians and specialists in the world. Thus for some 20 years I was led gradually, though a layman, through many medical experiences, divorcing myself from the notion, as I said a while ago, of invading the medical profession. I found it to have a very great interest for me, and I ventured into operating theaters and had personal observation of at least 2,000 major physical operations, and occasionally went to the autopsy table, which is something less pleasant. All this instruction was valuable to my work then and now.

I studied X-ray interpretation. I studied anatomy and physiology, and I did my best to acquaint myself with the job I had on hand. After leaving the Legion, I devoted myself to that very diligently as Assistant Administrator and as Administrator of the Federal Security Agency. That is a sketchy outline.

Senator PEPPER. Let me interrupt there. How were you chosen by the American Legion, Mr. Miller? I mean were you appointed by the commander or elected by a convention?

Mr. MILLER. I was appointed by John Quinn of California, in 1923.

Senator PEPPER. And how long did you remain in office; how long after that?

Mr. MILLER. Eighteen years.

Senator PEPPER. Were you appointed then by subsequent commanders?

Mr. MILLER. There was never any reappointment.

Senator PEPPER. You just remained?

Mr. MILLER. It was a career job.

Senator PEPPER. It was a career job, and you remained in that position under subsequent commanders of the American Legion?

Mr. MILLER. Yes; and in that job we were associated with many officials in Florida, Montana, New Jersey, Missouri, some of them physicians and dentists.

(Discussion off the record.)

Senator PEPPER. Did you, during the time you were chairman of the rehabilitation committee of the American Legion, have any action taken for any experience, conducted by either the commander of the Legion or by the Legion in convention, either in commendation or in condemnation of your services as chairman of the rehabilitation committee?

Mr. MILLER. Well, the national executive committee of the American Legion, which constitutes membership of something like 3,000,000 people, developed and approved the budget, and I think my career service was generally recognized as being diligent and sincere and effective. I think it was conceded that we did not do an apathetic job, but we established at that time a will to do, with far-reaching effect. We were recognized as the advisers to the Congress, and through these years I had the responsibility of perfecting and presenting what might be the technical phases of proposed legislation. I always tried to come to the Congress, not with the notion that we had a lot of votes in the American Legion, but with something based upon either historical or actual experience which would justify a presentation of such a piece of legislation.

Senator PEPPER. Will you allow me one other question, Senator? Since you were speaking about the rehabilitation of veterans, I want to refer to the fact that at the present time the man in charge of the Veterans' Administration is Gen. Omar Bradley, is he not, and the Veterans' Administration has a colossal health program under it embracing many hospitals, many nurses, many technicians in its employ, and one of its principal functions is to look after the physical rehabilitation of the veterans and furnish hospital and medical care to them?

Mr. MILLER. It is those hospitals in which I got my medical instruction.

Senator PEPPER. Yet Gen. Omar Bradley is not a doctor; is he? He is a professional soldier; is he not?

Mr. MILLER. I know he is a professional soldier, and I am sure he is also a very good one, but I suppose he is not a doctor, although I don't know. I have visited many hospitals in those countries in relation to the care of veterans in foreign countries, for the purpose of adding to my knowledge, just as I now occasionally sally out into the States and make inquiries as to how we are doing. That is true of many other types of clinical instruction with which I was not familiar. I have studied hospital administration from the time of their construction, including landscape gardening, drainage, utilities, laundry service, production of food, transmission, storage, and service to the bedside, laboratory facilities, nursing, and everything that has to do with the conduct of a clinical institution of which all Americans should be proud, providing an increasingly effective line of hospitals in the service of veterans.

Senator PEPPER. Your conclusion, then, Mr. Miller, is that you had a rather unique opportunity to see this whole subject in perspective, and that is what an administrator needs to have in the administration of a large activity of that sort?

Mr. MILLER. Well, since this matter has come under discussion, I don't want to be unduly modest about it, and I am sure Senator Don-

nell would not want me to be, but I have been a source of some wonder to the profession as to the things a layman could pick up and become acquainted with. I said laughingly to the Senator from Webster Groves one day that many doctors might have given me an M. D., but I am afraid some might add an A between the M and the D.

Senator DONNELL. Now, Mr. Miller, I take it you feel that your experience in regard to X-ray matters, attendance at autopsies, 2,000 cases that you had observed in your studies of hospitals, your studies of nursing—that all of that tends to make you more efficient than you otherwise would be?

Mr. MILLER. I think that is the reason for my being selected by the President for my job.

Senator DONNELL. But I say, you think that all those experiences tend to make you better qualified than you otherwise would be to perform the duties under S. 1320? Is that right?

Mr. MILLER. Without doubt.

Senator DONNELL. Now I call your attention to the fact, Mr. Miller, that there is no requirement in S. 1320 that the man who shall succeed you shall have any of these experiences or qualifications which you regard as particularly and peculiarly qualifying yourself, and that is the point I am making. I would say that you have had an extraordinary experience, Mr. Miller, in many respects, as you have indicated, but what we are discussing here is a bill that does not say that the authority herein shall be vested in Mr. Watson B. Miller. It says it shall be vested in the Federal Security Administrator, and my point is that there isn't anything in the statute, anything in the law of this country, which requires that the Federal Security Administrator shall have had any of those experiences. The next one may or may not have had them.

Mr. MILLER. The President appoints and the Senate ratifies, does it not?

Senator DONNELL. It is put up to the President to make the appointment, and it is confirmed by the Senate, that is true; but the point I am getting at is that there is no requirement in the statute that the Federal Security Administrator shall have had all this vast experience which you regard yourself as of great importance in your own case. That is true; is it not?

Mr. MILLER. That is right. I assume that any appointee would have or would acquire knowledge of all the phases of the job, medical and otherwise.

Senator DONNELL. Now, Mr. Miller, I want to call this to the attention of the committee, to have it in this record so we will not in any sense overlook it, one of the fundamental things that I want to bring up this morning, not particularly the question as to whether this man should or should not be a doctor—not that at all—but the point is that this bill vests ultimate authority where? Not in the States at all, but in Washington, D. C., and my point is that it is unwise to vest such vast authority in the National Government as distinguished from the States; that that thought was recognized in the first Wagner bill that I have referred to, and, furthermore, that it is not only unwise to so vest authority in Washington, but it is unwise to vest it in one individual, regardless of who he may be, a doctor or nondoctor, or whatever he may be.

Mr. MILLER. Is there unwisdom—may I ask a question?

Senator DONNELL. Certainly.

Mr. MILLER. With complete respect, of course—is there any wisdom in the selection of an individual whom the Congress and the people can particularly hold responsible for doing the job? Is there any unwisdom in the present interesting and somewhat complex mosaic of the Federal Security Agency to have one man who will carry those responsibilities, put everything he has, all his diligence and all his heart into them, and stand ready at all times to be responsible and responsive to the Congress? I think not.

Senator DONNELL. That is your judgment, and, of course, you have had wide experience, and your judgment is entitled to careful consideration; but the point I am making is that here is a vast new experiment, one that you have not personally studied at all. You are not familiar with the Rhode Island experience, which is not compulsory health insurance in the sense that this bill is at all, does not go anywhere near as far as this bill—you have not studied the Rhode Island situation, you have not studied the situation in foreign countries, and yet here is a bill behind which you have put your opinion—and you are entitled to it, of course—which vests the authority ultimately over the entire administration of a vast new compulsory health insurance plan in one individual in Washington, D. C., and an individual who, so far as I know, is not required by the statute to have any qualifications peculiarly qualifying him for that compellingly important position.

Mr. MILLER. I would do that, and I would like to add, if I may, that it is not within human comprehension or intellectually possible for a person with this kind of responsibility personally to study every detail, personally to determine the accuracy or the effective justice of every proposal that comes about. The Senator will concede that.

Senator DONNELL. I think you are correct.

Mr. MILLER. And in your very busy lives you have to have expert professional assistants—one whom you would dislike to lose sits here today, who worked with me for some years before he came to the Capitol, to Congress. I did not like to lose him.

Senator PEPPER. Will you allow me to interrupt to inquire who that is?

Mr. MILLER. Dr. Cornell.

Senator PEPPER. Senator, I respectfully submit that the inquiry made by the able Senator from Missouri is a matter addressed to argument rather than information, but I want to observe that in the Constitution of the United States, in section 5 of article I, there is no qualification whatever laid down for membership in the Congress of the United States, the two bodies of the Government intrusted with the enactment of the laws of this great land. It says each House shall be the judge of the election returns and qualifications of its own members. The Constitution saw the wisdom of the membership of each side deciding whether a man elected by the people was qualified or not.

Senator DONNELL. Will the Senator yield for just an observation? May I call attention to the fact, however, that Congress consists of 531 men, whereas, the bill centralizes authority in 1 man.

Senator PEPPER. But I suggest, if I may, along the line of the argument already made by the witness, that we have got the discretion of the President of the United States and the confirming power of the Senate, which I submit is an adequate test of Congress. Now, I want also to suggest that under article III of the Constitution there is a provision for the judges of the United States. I do not know whether the statute—I don't have the statutes here before me, and I don't recall whether the statutes prescribe the requirements as to whether Judges of the Supreme Court and judges of the inferior courts shall be lawyers or not, but it is interesting that the founders, the framers of our Constitution, provided for our whole judicial system, for our judges in the following language, article III, section 1 :

The judicial powers of the United States shall be vested in one Supreme Court and in such inferior courts as the Congress may from time to time ordain and establish. The judges, both of the Supreme Court and of the inferior courts, shall hold their offices during good behavior, and shall at stated times receive for their services compensation which shall not be diminished during their continuance in office.

The founders of the United States Constitution, apparently, so far as the Constitution is concerned, left it to the President and to the confirming power of the Senate to assure the country that the judges of the Supreme Court and all inferior courts would be competent to discharge their duties, but it did not require that they be lawyers.

Senator DONNELL. I direct the able Senator's attention to the fact that the fundamental point which I have been driving at this morning, earlier, this more detailed point is to the fact of the unwisdom of centralizing authority in any one individual, regardless of whatever statutory qualifications may be provided. There is a subsidiary point, though, to which I am now going to address myself, this matter of the peculiar type of individual who is to discharge the duties prescribed under the proposed S. 1320.

Senator PEPPER. There is nothing in this language to prevent the President from requiring that the incumbent of this office must be a doctor. That is left up to the President and to the Senate.

Senator DONNELL. However, the bill itself, which is the law which determines what shall be done under compulsory health insurance, does not contain a provision making it mandatory that any particular qualifications would be possessed by the Federal Security Administrator.

Senator SMITH. I might announce at this point that under the rules of the Senate we will recess at 12 o'clock until we obtain consent of the Senate to continue this hearing, so at 12 o'clock we will recess for 2 or 3 minutes until we get the consent which has been asked for.

Senator DONNELL. Now, Mr. Miller, referring to the particular duties that will devolve upon the Federal Security Administrator under this bill, I would like to call your attention, if you will turn to page 14—

Senator SMITH. We will recess for 3 or 4 minutes, until I am advised that consent has been given for us to continue.

(Whereupon, at 12 o'clock noon, a short recess was taken.)

Senator SMITH. The committee will come to order, and we will resume the testimony of Mr. Miller.

Senator DONNELL. Mr. Miller, when we recessed I was just about to direct your attention to lines 15 and following on page 14 of the bill. I call your attention that that particular language is contained in the section which is entitled "Physicians and Dentists; Specialists":

Any individual who is a physician or a dentist legally authorized in a State to render any services included as general medical services or general dental services shall be deemed qualified to render such services in that State as benefits under this title. Any such individual who is found to possess skill and experience of a degree and kind sufficient to meet standards established for a class of specialist services shall be deemed qualified to receive compensation for specialist services of such class as benefits under this title.

Then I call your attention to this:

The Board, after consultation with the Advisory Council, shall establish standards as to the special skills and the experience required to qualify an individual to render each such class of specialist services as benefits under this title, and to receive compensation for such special services.

Now, Mr. Miller, I ask you whether or not you regard it as of importance that a Board which is to establish standards as to special skills and experience required to qualify an individual to render specialist services as either a doctor or dentist, would be qualified better to establish those standards if that Board had doctors upon the Board?

Mr. MILLER. Yes, sir.

Senator DONNELL. Now I call your attention to this fact, however, that while this language that I have read provides that the Board shall establish these standards, again, to go back to page 39, line 22—

All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

I take it, therefore, that under this bill, S. 1320, as thus written, the ultimate determination of standards as to the special skills and experience required to qualify an individual to render these various physician and dental specialist services, the ultimate power goes back through the Board back into the hands of one man, the Federal Security Administrator, who is not required to be a doctor. You would agree to that statement of fact, would you not?

Mr. MILLER. That is right.

Senator DONNELL. Now, I would like to call your attention to a few other illustrations, if you will turn, please, to page 7 of the bill.

Mr. MILLER. But I remarked as to this type of authority, however, that Congress extended, for example, to the Veterans' Administration recognition of the specialist groups.

Senator DONNELL. Well, at any rate, the language reads as I have given it to you in my question?

Mr. MILLER. Yes. I would suppose, though, that what would happen, there, if I had anything to do with it, is that the recognition would be made with close reference to the 19 specialist boards that exist in this country for the particular purpose of recognizing specialists in one or another branch of medicine.

Senator DONNELL. However, Mr. Miller, there is nothing in this bill that requires anybody to recognize those 19 boards.

Mr. MILLER. I concede that.

Senator DONNELL. Now, Mr. Miller, before I call your attention to page 7, however, I should mention this: the Board after consultation with the Advisory Council—now, let us just take up this matter of

the Board for a minute. Will you turn, please, to page 38 and observe the composition of the Board, the National Health Insurance Board, to be composed of five members, three of whom shall be appointed by the President, by and with the advice and consent of the Senate, and the other two of whom shall be the Surgeon General of the Public Health Service and the Commissioner for Social Security? Now, it will be observed there that two are the Surgeon General and the Commissioner for Social Security. The Surgeon General of the Public Health Service is, of course, a doctor?

Mr. MILLER. That is correct.

Senator DONNELL. Who is the present Commissioner for Social Security?

Mr. MILLER. Arthur J. Altmeyer.

Senator DONNELL. Is he a physician?

Mr. MILLER. No, sir.

Senator DONNELL. He is not required by law to be a physician?

Mr. MILLER. No, sir.

Senator DONNELL. Now, as regards the appointive members of the Board, these three to be appointed by the President, I call your attention to lines 6 and following—

At least one of the appointed members shall be a doctor of medicine licensed to practice medicine or surgery in one of the States.

That is what it says, is it?

Mr. MILLER. Yes, sir.

Senator DONNELL. So, of the five members of the National Health Insurance Board, only two are, by this law and the existing law relative to the Surgeon General, required to be doctors? That is true, isn't it?

Mr. MILLER. That is right.

Senator DONNELL. And the other three do not have to be doctors?

Mr. MILLER. That is right.

Senator DONNELL. Now, when we were talking a little while ago about page 14, about the Board, of which only two out of five have to be doctors, the Board being required to establish standards as to special skills and experience required to qualify an individual to render each such class of specialist services, I read also something about an Advisory Council, after consultation with the Advisory Council.

Mr. MILLER. In line 15.

Senator DONNELL. Yes. In that connection I would like to direct your attention to page 42 of the bill, which tells us something about the Advisory Council. We start right at the top of that page—

There is hereby established a National Advisory Medical Policy Council (referred to in this title as the "Advisory Council").

Now, the Council consists of whom?

The Chairman of the Board, who shall serve as Chairman of the Advisory Council, ex officio, and 16 members, appointed by the Federal Security Administrator.

That will be 17 people on that Council. Who appoints the 16 members?

Mr. MILLER. The Federal Security Administrator.

Senator DONNELL. Yes, it says right there in lines 6 and 7—
appointed by the Federal Security Administrator.

So here we have this set-up: That we have a Board of five persons, only two of whom have to be doctors, and we have an Advisory Council

of 17 persons, 16 of whom are appointed by the Federal Security Administrator, and then the ultimate authority over the Board is vested in the same Federal Security Administrator, who appoints 16 of the 17 persons who advise him. That is the situation in this bill.

Mr. MILLER. That is right, but this will not be the only board that we have appointed, and full recognition has been given in the appointment of all of these Advisory Council members and boards to the interests which are particularly pertinent to the activity. I see little in the proposition there that are permissive elements in this bill. You certainly have got to place some reliance in the man doing the job. If he went far astray you would hear from the people.

Senator SMITH. Of course, you are giving extraordinary powers to him in this bill. I think that is the reason Senator Donnell is asking the questions.

Senator DONNELL. And for the further reason that under this bill, as I read it back here at the start, where it talks about the Advisory Council and talks about the Board after consultation with the Advisory Council, the casual reader of that bill would get the idea that there is an ample safeguard, that the Board can do these things only after consultation with the Advisory Council, but when you get down to pages 39 and 42, you find that in the first place the Board cannot do anything except under the direction and control of one man, the Federal Security Administrator, and that this Advisory Council, which would appear at first glance here to be such a protection and help, is an Advisory Council of 17 men, 17 persons, 16 of whom are appointed by the one man who has ultimate power of decision.

May I read a little further, beginning in line 7:

At least 8 of the 16 appointed members shall be individuals who are familiar with the need for personal health services in urban or rural areas, and who are representative of the interests of individuals eligible for benefits under this title, and at least 6 of the members shall be individuals who are outstanding in the medical or other professions concerned with the provision of services provided—and so forth.

Mr. MILLER. What would you do in the case of the Hill-Ball-Burton bill, Senator?

Senator DONNELL. I was coming to the Hill-Burton bill. You appointed the Advisory Council under that bill, didn't you?

Mr. MILLER. Exactly under the terms of the statute.

Senator DONNELL. Did you appoint Mr. Michael Davis one of the members of the Hospital Advisory Council?

Mr. MILLER. Yes, sir.

Senator DONNELL. Mr. Michael Davis is on the Committee for the Nation's Health, isn't he?

Mr. MILLER. Well, I don't know.

Senator DONNELL. Well, you know that Mr. Davis has been very active in a number of different organizations that have had representatives here appearing and giving testimony, that had close contact with Dr. Boas, Dr. Frothingham, Dr. Butler, and various other persons mentioned, participating in the testimony? You know that to be true, do you not?

Mr. MILLER. I believe it is true.

Senator DONNELL. And you know that Mr. Michael Davis is a registered lobbyist, do you not?

Mr. MILLER. No, sir.

Senator DONNELL. You would not say that is not true, but you don't know? Is that the situation?

Mr. MILLER. My answer was that I don't know.

Senator DONNELL. You don't know one way or the other?

Mr. MILLER. That is right.

Senator DONNELL. Now, Mr. Miller, going back here, if you will, please, to page 7 of the bill, let us take up another illustration of what type of ultimate authority rests in the Federal Security Administrator under this bill. At the bottom of page 6 it says "Hospital services." That is one of the personal health services to be made available as benefits as are medical services, dental services, home nursing services. Then come hospital services, which consist of hospitalization, including necessary nursing services—

and such physician, laboratory, ambulance, and other services in connection with hospitalization as the National Health Insurance Board (hereafter referred to as the "Board"), after consultation with the National Advisory Medical Policy Council (hereinafter referred to as the "Advisory Council"), by regulation designates as essential to good hospital care for a maximum of 60 days in any benefit year.

You observe that, do you not?

Mr. MILLER. I think the hospitalization can be extended beyond that in an emergency.

Senator DONNELL. Well, maybe it can. I don't recall, but at any rate—yes, it does, down at the bottom there, lines 12 to 16 on that same page, page 7—

Whenever the Board, after consultation with the Advisory Council, finds that moneys in the account (established by sec. 71) are adequate and that facilities are available, it may by regulation increase the maximum days of hospitalization in any benefit year.

Mr. MILLER. I don't remember exactly the reference.

Senator DONNELL. The point I was directing attention to is not the matter of 60 days, but the point I was directing your attention to is that this Board, this National Health Insurance Board, however, acting at all times under the direction and supervision of the Federal Security Administrator, can, by regulation—in fact, I think "shall" by regulation, or "may" by regulation—designate "as essential to good hospital care," such hospitalization, nursing services, physician, laboratory, ambulance, and other services as it, after consultation with the Council—which is again appointed, 16 out of the 17, by this one man—the top of a system—determines to be proper.

Mr. MILLER. That is right. That is exactly the system that prevails right now in our Agency with its medical responsibilities, including something like two score or more hospitals and such other vital health responsibility. The Administrator has the ultimate responsibility for this and the nonmedical phases.

Senator DONNELL. The point I am getting at—and of course, you have mentioned yourself, your great experience with hospitals, which I think you mentioned because you thought it had a bearing on your qualifications under this act.

Mr. MILLER. I did, with some reluctance.

Senator DONNELL. But you mentioned it, and properly so. But the point I am getting at is that there is vested ultimately under this bill, through the Board, with the assistance of a council of 17 members,

16 being appointed by the Federal Security Administrator, ultimate authority to determine by regulation what hospitalization, what nursing services, what physician services, what laboratory services, what ambulance, and what other services are proper and essential to hospital care. That ultimately goes back to one man, the Federal Security Administrator, who is not required to know anything about any of these matters, so far as the bill says or any other provision of law says. That is true, is it not?

Mr. MILLER. I think that is eminently proper, Senator, but he would not last long unless he acquainted himself with those things.

Senator DONNELL. Now, I call to your attention page 47 of the bill. This is a section which pertains to the very important subject of the administration of the title in rural areas. It is section 256 and reads like this, page 47, line 7:

Mr. MILLER. Let me see it, please. [After examining the bill.] Yes; that is right, the latter part of the important section 256.

Senator DONNELL. Yes; line 7. It is referring here to the administration of the title where special consideration shall be given to problems of rural areas and so forth.

The Board—

which, of course, again, as I have indicated at numerous times, is subject to the direction and supervision of the Federal Security Administrator—

is authorized to make such regulations, after consultation with the Advisory Council—

16 of the 17 members of whom are appointed by the Federal Security Administrator—

as may be necessary to promote and facilitate the accomplishment of the objectives of this section.

Mr. MILLER. Those set out particularly in section 256 (a), I take it.

Senator DONNELL. Yes; that is right, 256 (a). Now, Mr. Miller, that is another very vast power which is vested in the Federal Security Administrator ultimately, isn't it?

Mr. MILLER. Yes, sir.

Senator DONNELL. And in addition to that, at line 15 of page 47—

The Board—

and I supplement that by saying, which acts again under the direction and supervision of the Federal Security Administrator—

shall include in its annual reports to Congress recommendations concerning such further legislative measures as it considers desirable to assure to rural people an equality of opportunity to obtain the personal health service benefits available under this title.

That devolves a very important and far-reaching function ultimately on the Federal Security Administrator too?

Mr. MILLER. That is right.

Senator DONNELL. Now, I would like to ask you—direct your attention to just a very few further illustrations. Will you turn, please, to page 15 of the bill, under the subject "Nurses"? I will read to you this language, and I read it without comment, though you may have leave, of course, to comment upon it, but directing your attention to the point that here again, to the fact that ultimate direction

and supervision is in the one man, I call to your attention that vast power given to him by section 212:

Any individual shall be deemed qualified to render home nursing service in a State as benefits under this title if such individual is (a) a professional nurse registered in such State, or (b) a practical nurse (1) who is qualified as such under the State standards or requirements, or, in the absence of State standards or requirements, is found to be qualified under the standards established by the Board—

now, I interpolate a parenthesis (which acts under the direction and supervision of the Federal Security Administrator)

after consultation with the Advisory Council—

I would like to put in another parenthesis there (16 of 17 members of which are appointed by the Federal Security Administrator)

and with nursing agencies.

That is the language, is it not, of this portion of that section 212?

Mr. MILLER. Yes, sir.

Senator DONNELL. Now, I want to mention just a similar illustration. I will not go into detail, but with respect to what constitutes hospital care, there is also a provision over on page 16 in regard to agreement with individual practitioners, hospitals, and others, who may enter into an agreement—it says an individual may enter into an agreement with a State agency—

which, in accordance with part D, has assumed responsibility * * * to * * * furnish such class or classes of services as benefits to individuals.

That refers to the making of agreements with State agencies.

I think the section I had in mind, however, is not this section but is section 214, just ahead of it, and that is an auxiliary service where it says:

Any person (as defined in sec. 281 (1)) who is qualified under State standards or requirements to furnish a class of service included as auxiliary services, or, in the absence of State standards or requirements, is found to be qualified to furnish a class of such services under standards established for such class by the Board—

and I add a parenthesis (under the direction and supervision of the Federal Security Administrator)

after consultation with the Advisory Council—

another parenthesis (16 of the 17 members of which will be chosen by the Federal Security Administrator)

shall be deemed qualified to furnish such class of auxiliary services in that State as benefits under this title.

The language is as I have read, with the interpolations by myself.

Mr. MILLER. Auxiliary services are described in another part of the bill.

Senator DONNELL. I also call your attention, Mr. Miller, on page 36, that the Federal Government may, under certain circumstances, stipulate, in the event that a State fails to approve a plan of operation—again may I read to you this language, line 10, page 36:

If a State has not, prior to July 1, 1948, submitted and had approved a plan of operations, the Board—

parenthesis again, I will insert: (Under the direction and supervision of the Federal Security Administrator)

shall notify the governor of the State that the Board—

I insert the parenthesis: (under the direction and supervision of the Federal Security Administrator)

will be required to administer this title in the State.

Then "The Board," and so forth—

If within 60 days after such notification to the governor the State has not submitted an approvable plan, the Board—

with the same parenthesis—

shall undertake the administration of this title in the State—

the parenthesis put in again by myself.

Now, I will not go further in the illustration.

Senator MURRAY, For the purpose of shortening the proceedings I suggest that those interpolations be considered as being inserted in all the questions asked by the distinguished Senator.

Senator DONNELL. Only where I insert them.

Senator MURRAY. Wherever they have been inserted, that they be considered as reinserted in each recurring question.

Senator DONNELL. No; I would prefer to frame the question as each question arises.

Now, Mr. Miller, did you give any special consideration in this bill to whether or not free choice is given to the patient, under this bill, of selection of a doctor?

Mr. MILLER. Yes, sir.

Senator DONNELL. And did you make a statement on that in what you gave to us here this morning?

Mr. MILLER. I think perhaps in a very brief way.

Senator DONNELL. I don't recall. Perhaps I didn't hear that.

Mr. MILLER. The benefit of free selection and maximum independence of physicians; their right to reject or accept.

Senator DONNELL. Where is that in your statement? I didn't get that.

Mr. MILLER. It might not be here. The Senator would have noted it, I expect. Senator Smith, do you remember it?

Senator SMITH. I remember it in the statement of a previous witness with reference to page 7, "Participation of professional practitioners." Is that what you have reference to?

Mr. MILLER. "Professional rights and responsibilities, amount of payment for services, local professional committees." An important consideration in any medical-care program is the effect on the right and prerogative of both the provider and the recipient of care. I think that statement is headed toward the right of free selection, free acceptance or rejection.

Senator DONNELL. Did you find anything in your statement there that is specific on the point of free choice of doctors by the patient?

Mr. MILLER. I will look a little more carefully.

I find here on page 7 under "Protection of patients" the statement:

Legislative assurances are provided for patients in the program in a variety of manners: free choice of doctors (sec. 203).

Senator DONNELL. I am glad that you made that point, and I want to call your attention to section 203, and I think this a very important point. Section 203 reads, the relevant part of it—there may be some

other part that some may think relevant, but I will read only the part that at the moment I see has relevancy :

Every individual eligible for personal health service available under this title may freely select the physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection.

You observe that?

Mr. MILLER. Provided that the practitioner—

Senator DONNELL. Yes—

Provided, That the practitioner, medical group, hospital, or other person has agreed under part B to furnish the class of services required and consents to furnish such services to the individual.

Now, I call your attention, first, to the fact that this outright statement in your prepared statement, which you read here this morning—

Legislative assurances are provided for patients in the program in a variety of manners: Free choice of doctors (sec. 203)—

is provided by the proviso in section 203, namely—

Provided, That the practitioner, medical group, hospital, or other person has agreed under part B to furnish the class of services required and consents to furnish such services to the individual?

Mr. MILLER. Of course, it is.

Senator DONNELL. Now, Mr. Miller, I take it therefore that there is no mandatory provision requiring every doctor in the United States or in the District of Columbia to consent to furnish the class of services or to furnish any service under this bill? That is correct, is it not?

Mr. MILLER. That is right.

Senator DONNELL. Therefore, if this taxation plan of paying for a vast health-insurance measure goes into effect, and if you want to get Dr. Jones, who lives over here at Seventeenth and S Streets, to prescribe for you and have it paid for out of the tax money, but Dr. Jones had not consented to enter into one of these agreements, you don't have any liberty under this bill to get him to render these services which have been paid for by taxation, do you?

Mr. MILLER. I will answer that by agreement with what the Senator has said.

Senator DONNELL. I want to call your attention further to page 20, if you will just turn to page 20 of the bill. Page 20 says, in referring to methods of payment for services that—

Agreements for the furnishing of medical or dental services (other than specialist services) as benefits under this title shall provide for payment—

by four different methods, and I will just read the first two. I have no objection to reading the other two, but I don't think they are relevant—

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

(2) on a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list.

Now I ask you, Mr. Miller, doesn't that contemplate as you read it, a per capita method, providing the doctors in the particular area involved decide on a per capita basis?

Mr. MILLER. If that is adopted by the practitioners themselves by agreement with the State and local authorities, it does.

Senator DONNELL. Well, Dr. Boas, I get from him—you know Dr. Boas, do you not?

Mr. MILLER. I do not.

Senator DONNELL. Have you ever heard of him, chairman of the Physicians Forum?

Mr. MILLER. Yes, sir.

Senator DONNELL. Well, I get just this language, and I assure you it is my understanding he has said this:

Insurance guaranteeing complete medical coverage cannot be set up except at prohibitive costs if the fee-for-services principle is retained.

I take it that if we agree with Dr. Boas it would appear reasonable to assume that, at least in many areas of the country, this per capita basis will have to be adopted in order to make this scheme work. That is true, isn't it?

Mr. MILLER. I don't know whether it will have to be adopted or not. Personally I prefer the fee-for-service plan if it can be adjusted, the right kind of plan.

Senator DONNELL. This bill, however, permits this per capita basis if the doctors want to install it in any particular locality?

Mr. MILLER. That is true; yes.

Senator DONNELL. Now, Mr. Miller, suppose we say that in Sedalia, Mo., the doctors there decide that they want a per capita basis. That means, does it not, as you understand it, that a certain number of persons will be allotted to Dr. Jones, a certain number of persons will be allotted to Dr. Smith, and a certain number of persons to Dr. Williams. That is right, isn't it? That is the way that a per capita plan operates, isn't it?

Mr. MILLER. Yes; but you can't read into this proposition that Dr. Jones and Dr. Smith and Dr. Williams will have to accept an undue number of special risks, an undue number of individuals. It lies within their capacity to refuse to do that.

Senator DONNELL. I agree with you, and that leads right up to the point I am leading up to. There is this practitioners' list that is mentioned here, a list of, we will say, in the case of Dr. Jones, 200 patients; Dr. Smith, 200 patients; Dr. Williams, 200 patients. We will take that as an illustration.

Now, suppose, for instance, that it is determined that in Sedalia, Mo., the per capita basis is adopted, and it is decided that there are 200 patients to Dr. Jones, 200 to Dr. Smith, 200 to Dr. Williams. We will say that Dr. Jones is considered the best doctor in that country around, and there is an immediate rush down to the courthouse, to the Federal building, where they have the register of practitioners, the list; and instead of 200 people coming down, 400 come down to get on Dr. Jones' list, and the first 200 that get there get on his list. That is right, isn't it?

Mr. MILLER. I would not think so.

Senator DONNELL. How is that list made up, as you understand the actual operation?

Mr. MILLER. I think it would have to be done by trial and error. I think that even if you have no list in Sedalia, some of these people are going to have to accept Dr. Williams rather than Dr. Jones,

even if there is no system of this kind at all, because they are the medical purveyors in that community, and that is all there is.

I think there should be an equitable distribution of services, and I presume there can be provisions in emergencies, where surgery is required or in a childbearing case.

Senator DONNELL. But now let us follow through. We will take that phase up in a moment. Let us follow through the illustration I have used. Suppose that the practitioners' list for Dr. Jones is made up and consists of 200 names, all set down on the list, and then Mr. Miller, Mr. Watson B. Miller, who lives there, we will say, concludes that he wants to go to Dr. Jones, and there has been a tax paid in behalf of Mr. Miller, and he feels that he is entitled to his free choice of a physician, which is what you say in your statement, free choice of doctors—he is entitled to that, and he comes down and he says: "I am entitled under this bill, I am guaranteed the right, to get Dr. Jones."

Mr. MILLER. Dr. Jones won't have to take him. Dr. Jones can reject him.

Senator DONNELL. Dr. Jones can reject him. There are 300 people on his list, and Mr. Miller comes along, knowing that his taxes have been paid, and he wants Dr. Jones, and he is entitled, as I get from your statement, to free choice of doctors, and that choice is Dr. Jones, but there is nothing in this bill that permits you to select Dr. Jones and compel him to give you his services, is there?

Mr. MILLER. Under the capitation plan, that is right.

Senator DONNELL. And if you go to Dr. Jones and he has more patients than he wants, more than he can take care of, there is no law to compel him to take you?

Mr. MILLER. I agree with that.

Senator MURRAY. I beg pardon, but isn't there another system of elimination by just raising the fees?

Senator DONNELL. Yes; and I am glad you mentioned that, because I want to come to that in just a minute, about raising the fees.

However, Mr. Miller, if you go to Dr. Jones in Sedalia, and he looks you over and you look like you are a pretty sick man, and he wants to take you, and he says: "Well, my list—I really have as many patients as I can take care of, but I believe I can arrange to take Watson Miller. He is a good fellow, and he needs me right away"; and if he will take you, you can get his services. That is right; isn't it?

That is correct under a voluntary system, isn't it?

Mr. MILLER. That is right.

Senator DONNELL. But under the compulsory health insurance, when your taxes are paid, the only way you can get Dr. Jones then is to rely on the payment of taxes and get your free choice of doctors that is guaranteed here by the language of this bill? That is true, isn't it, under this bill?

Mr. MILLER. I don't know whether I think that would have to be true, whether it is authorized or not, but the law——

Senator DONNELL. Well, it is true under this bill, isn't it? You would agree to that?

Mr. MILLER. Yes.

Senator PEPPER. Right on that point, that particular point, I don't think there is anything in the bill that fixes a mathematical limit to the number of patients, the per capita amount, that a doctor may serve.

Mr. MILLER. It is done by negotiation within the State or community.

Senator PEPPER. That is right. Then that is up to the judgment, up to the discretion, of the governing agency as to what the limit shall be. It is not even required that it shall be the same limit for all doctors. In other words, in the case put by the Senator from Missouri, if Dr. Jones wanted to attend Mr. Miller, and he could make any kind of showing to the governing board that he was able to do it, or if he wanted to reject some patient that he previously had on his capitation list and make a place for him, that would be possible, wouldn't it?

Senator DONNELL. May I ask the Senator where there is in the bill any such provision?

Senator PEPPER. I don't have it before me here at the moment, but there isn't any limit at all in there to the supervisory authority. But the Senator is assuming—I will ask him where he gets the authority in the bill to assume that there is a per capita basis limit.

Senator DONNELL. I will call your attention to page 20, lines 7 to 9.

Senator PEPPER. All that says is that benefits under this title shall provide for payment—

(1) On the basis of fees for services rendered as benefits, according to a fee schedule.

That doesn't limit the number of patients. Then the next line:

(2) On a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list.

That doesn't say how many can be put on the list.

Senator DONNELL. No; I didn't say that the bill says how many are to be on the list, but there must be a limit somewhere. The Senator asked where I found in the bill anything about—I have forgotten the exact language—but limitation of the number on the list, but it seems to me that in lines 7, 8, and 9, where it says—

on a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list—

it seemed to me perfectly clear that that means a list containing a certain number. Somebody determines the number, it is true.

Senator PEPPER. But the Senator is going on the complete assumption that somebody other than Dr. Jones would determine the number of people that he can care for on his list, and where does the Senator find anything in this law, or any authority for any public official to say to Dr. Jones in the case put by the Senator that he cannot attend Mr. Miller if he wants to attend Mr. Miller?

Senator DONNELL. I may say to the Senator that I think it is perfectly clear from what I have read that this bill contemplates a practitioner's list with a certain number of individuals on the list. I am not saying whether it shall be the same in every community, but there is to be a list, and somebody determines the list; regulations will be set down here under the bill, and, as a matter of fact, as a practical illustration, in England I understand there have been lists fixed at 2,500 persons to a given doctor.

Senator PEPPER. That may be true in England, but we are talking about the specific bill here before us, and I understand that what the bill is saying in that subsection (2), to which the Senator refers, is just as any insurance company can send a certain number of people to a doctor with whom they have an agreement, or a hospital, that the doctor or the hospital would care for a certain number of patients; and then if they have an agreed schedule of fees, that they should pay as much for the number of people they care for that came in that category. But it was the Senator who was assuming that when the list got to 200 it was a hard and fast rule that there is an absolute prohibition against Dr. Jones attending Mr. Miller, if he wants to go there. I say that that is not justified.

Mr. MILLER. I see that section 219, beginning on page 22, gives us some additional information and flexibility. I think maybe section (c), at the bottom of page 23—

In order to maintain high standards in the quality of medical or dental services furnished as benefits, a State agency may fix maximum limits for the State or for classes of health-service areas, upon the number of eligible individuals with respect to whom any person may undertake to furnish such services as benefits.

Senator PEPPER. And it goes on:

The State agency may reduce such limits for a health-service area on the basis of the recommendations of the persons furnishing such service in the area:

—the recommendation of the doctor—

Any such limits shall take account of professional needs and practices, shall provide suitable exceptions for emergency and temporary situations, and shall not exceed maximum limits fixed by regulations made by the Board after consultation with the Advisory Council, which regulations may provide for nationally uniform limits or for limits varied to take account of relevant factors.

Senator DONNELL. The Senator has very clearly read the language which obviously gives the Board—which, again, is under the direction and supervision of the Security Administrator—the right to prescribe maximum limits for these lists.

Senator PEPPER. I started off on the assumption that the Senator was right in assuming that there was a discretionary authority there to fix such limits, but it is very clear from reading this language that it is the outside limit that may be fixed by regulation, and I am assuming that these intelligent people are going to be advised by competent people, that they are going to take an outside limit which is a limit of reason and capacity. Now then, within that outside limit they are given discretion to determine how many people should be on this list. The Senator can put a hard case, like the one he put, that comes under emergency provisions, but the Senator surely would not want a doctor to profit here on the patient. Suppose the doctor should say "I will take 5,000" when 2,000 is the maximum number that any doctor can reasonably take care of; suppose he says, "I want to make more money, and I will take 5,000, I will take 10,000." Now, surely the Senator from Missouri would not allow a doctor to be paid from the common insurance fund for a number of people whom he could not possibly take care of, and it is a protection thrown around the people, it seems to me, and not undue interference on the part of the State authority.

Senator DONNELL. With reference to the point made by the distinguished Senator from Florida, who has given much thought and study

to these problems over many years, I would like to make this statement, that the bill purports to provide free choice by the patient, as set forth in section 203, and was so understood by the person who prepared his statement in rough draft, and was relied on, obviously, by Mr. Miller in approving the rough draft, after changing it last Sunday, I believe he said, but I say that the provision in section 203, which he understood to provide free choice of doctors—and it says that in section 203—

every individual eligible for personal health services available under this title may freely select a physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection—

with the proviso right after it, however, which does limit it, and my point is that although there is a glowing statement of the right of free choice of doctors, when you get right down to it this bill has exactly the same point that was emphasized repeatedly in the testimony on S. 1606, namely, that in a community in which the per capita plan shall be agreed upon, there shall be limits placed upon the number of persons, and that those limits shall not exceed certain maxima fixed by regulation made by the Board, which again is subject to the direction and control of the Federal Security Administrator, after consultation with the 17-member Advisory Council—16 of whom are appointed by the Federal Security Administrator—and that these limits, when once they are made, the doctors cannot exceed. Thus, if Mr. Jones had a limit of 200, and Mr. Watson Miller walks up there and wants to become a patient, leaving out for the moment the emergency situation to which the Senator referred—and I will refer to that in a moment—leaving that aside for the moment, if he just wants to be a steady patient of Dr. Jones right along, he cannot choose Dr. Jones.

Senator PEPPER. But, Senator, the language of the act is intended to be synonymous with the competent capacity of the doctor. Now, the Senator surely would not suggest that a doctor today can attend more people than he can attend physically. There is a limit somewhere. He has got to have a little sleep. He can only attend a certain number of people. The Senator is imagining a case which is held to be beyond the capacity of the doctor. Today there are lots of people that do not have free choice of doctors, because, first, they cannot pay for it, secondly, because the doctor has got all he can do. A lot of times you call a doctor and he cannot come. If he has every patient he can possibly take care of, yes, you are then excluded because he can't take care of any more, but I don't think the Senator can substantiate that such is an effective denial of free choice of the people among you to select a doctor.

Senator DONNELL. May I make the further point that today the doctor himself determines what is his capacity, and if Mr. Watson Miller goes to Dr. Jones in Sedalia, Mo., and Dr. Jones has 200 patients, the doctor himself can decide whether or not he is to take on 200 or 201; whereas, under the bill, Mr. Watson Miller or his successor in Washington, D. C., has it within his power to say how many patients Dr. Jones may take. I think that is perfectly clear.

Mr. MILLER. But you have to read that with the context, Senator Donnell.

Senator DONNELL. Is there anything in the context that would disturb that conclusion?

Mr. MILLER. I think so. If the Senator will look at page 24, under the heading "Professional rights and responsibilities," termination of agreements, for example, in (a) and in (b) :

Every physician, dentist, or nurse agreeing to render services as benefits under this title shall be free to practice his profession in the locality of his own choosing, consistent with the requirements of the laws of the States.

I take it that would apply, irrespective of what they call a "panel" in England, and what you might call a "list" in this country. And in connection with the latter part of (c) under 219, which takes cognizance of relevant factors—emergencies, without doubt, among other things such as temporary situations—that matter takes care of itself. I don't think it is perfect, and I don't think, as I said this morning, that this law can spring full-fledged at the moment it is signed, in maximum usefulness and effectiveness, but I say it is a start.

Senator DONNELL. Referring to Mr. Miller's comment, reading from section 220, I don't think that deserves the conclusion that you suggest, because, while certain provisions are set forth therein with respect to professional rights and responsibilities, obviously the statute would be read in the light of well-established statutory rules of interpretation, so as to make effective every provision of the statute, and while it is true that the physician may be—

free to the extent consistent with applicable State law and customary professional ethics to accept or reject as a patient any individual requesting his services—

he could keep him off the panel under that language, I take it, yet when the Board down here in Washington, under the supervision and direction of one man, fixes a panel, those limits—and I quote again from page 24—

shall not exceed maximum limits fixed by regulations made by the Board, after consultation with the Advisory Council, which regulations may provide for a nationally uniform limit or for a limit varied to take account of relevant factors.

The very fact that in that sentence the only exception that is provided therein is this matter of emergency, to which I stated I would refer in a moment—emergency, a temporary situation—quoting lines 5 and 6—

shall provide suitable exceptions for emergency and temporary situations—indicating, obviously, that the Board, subject to the direction and supervision of the Federal Security Administrator, may make limits, maximum limits not to be exceeded.

Mr. MILLER. That is what you want to serve, is it, the emergency?

Senator DONNELL. Yes.

Mr. MILLER. Obviously, you and I would be running a job in a very captious manner if we did not make provision for Dr. Jones, if Dr. Jones is the only man in Sedalia, Mo., who could do laparotomy, and for his payment and for treatment by Dr. Jones. I don't think we have an insuperable situation here.

Senator SMITH. Just a minute there. I want to get the judgment of my colleague here. It is 10 minutes of 1. Another subcommittee meets at 1:30 this afternoon, that Senator Donnell and I both have to attend. When we recess now we must recess, I think, until 2:30. Dr. Parran is the next witness, and I asked him if he could come at 2:30 and he told me he could, so the question arises,

Senator Donnell, Senator Murray, and Senator Pepper, can you estimate how much longer you would like to question Mr. Miller, and whether I should tell Dr. Parran we will not get to him today, and possibly put some of these witnesses over till tomorrow?

Senator DONNELL. In regard to Mr. Miller, I will say that in my judgment I will be finished with my interrogation of him in not to exceed 10 minutes.

Mr. Miller, I would like to ask you which of the following agencies are under the Federal Security Agency of which you are the head: United States Public Health Service?

Mr. MILLER. Under my supervision.

Senator DONNELL. Children's Bureau?

Mr. MILLER. Under my supervision.

Senator DONNELL. Office of Education?

Mr. MILLER. Under my supervision.

Senator DONNELL. United States Employment Service?

Mr. MILLER. Not under my supervision.

Senator DONNELL. That is temporarily in the Labor Department?

Mr. MILLER. Department of Labor—I heard the able Senator argue that point on the floor of the Senate.

Senator DONNELL. It is referred to your Department under the provisions of the War Powers Act?

Mr. MILLER. Yes; I believe so.

Senator DONNELL. The Department of Agriculture, of course, is not under you. Your research and statistics, Social Security Board. That is in your Department?

Mr. MILLER. Yes, sir.

Senator DONNELL. That is the Bureau of which Mr. Isidore Falk is the head?

Mr. MILLER. Yes, sir.

Senator DONNELL. Did you appear as a witness before the Committee on Expenditures in the Executive Departments in the House of Representatives recently?

Mr. MILLER. No.

Senator DONNELL. Have you seen the report of that committee?

Mr. MILLER. I saw it for the first time yesterday afternoon.

Senator DONNELL. I am going to offer at this time—

Mr. MILLER. I should like to say, to make myself perfectly clear, I did confer with Representative Harness of Indiana, in company with Mr. William Mitchell, but it was only in the sense of proffering him all of the facilities we had in the way of giving information or records, and to express the hope that the proceeding would be not an ex parte one, and that I would have an opportunity to enter such material as seemed pertinent. That did not come about. I am finding no fault, of course.

Senator DONNELL. Mr. Isidore Falk's administrative assistant is Miss Margaret Klem, is she not?

Mr. MILLER. I think so.

Senator DONNELL. Do you know as a fact that she was a witness before the Committee on Expenditures in the Executive Departments in the House?

Mr. MILLER. I don't know it as a fact, unless it is so set out in the report.

Senator DONNELL. It is set out in the report, and I have a copy of her testimony here. She was a witness on June 18, and she is Chief of the Medical Economics section of Mr. Falk's division?

Mr. MILLER. Yes, sir.

Senator DONNELL. She was one of the group of Federal employees that charted, arranged and conducted the Jamestown, N. Dak., Health Workshop?

Mr. MILLER. That is not within my knowledge at the moment. It is possible.

Senator DONNELL. There was testimony the other day here by a lady from North Dakota, Mrs. Evanson, who appeared here for a farm organization, that she herself had been present at Jamestown, and that there were some 20 representatives of Federal departments here at that so-called Jamestown Health Workshop, and it was that Health Workshop at which some expression of opposition to S. 545, I believe, was drawn up, and possible some commendatory expressions with respect to S. 1320.

Mr. MILLER. That I do not know.

Senator DONNELL. I call your attention to the fact that in this report of this Committee on Expenditures in the Executive Departments, which was filed on June 2, 1947, and in Report No. 786 of the Eightieth Congress, first session, appears this language:

Mr. Isidore Falk is Director of the Division of Research and Statistics in the Social Security Board.

That is page 5—

His principal assistant, Miss Margaret Klem, was a witness before your committee on June 18. Miss Klem was identified as Chief of the Medical and Economics Section of Mr. Falk's Division, that she is one of the group of Federal employees who charted, arranged and conducted the Jamestown Health Workshop. The testimony also discloses that she helped draft the Wagner-Murray-Dingell bill.

I would like the record to show at this point, if I may, Mr. Chairman, a few of these questions and answers here from the transcript of the hearing, page 265 of the typewritten testimony of Miss Klem:

Miss KLEM. I wonder if I might make one statement about the statement made this morning?

The CHAIRMAN. By whom?

Miss KLEM. It was by Mr. Engebretson. If I remember correctly, he said that I had influenced the drafting of the Wagner-Murray-Dingell bill, or something of that sort. I did not know whether I should let it go into the record like that, because although we do give information and help when we are requested, I do not believe that I could say that I influenced the drafting of that bill.

The CHAIRMAN. Did you have anything to do with the drafting of the bill?

Miss KLEM. Yes; I attended meetings when the bill was discussed.

The CHAIRMAN. When provisions were being put together in the bill?

Miss KLEM. That is right.

I offer that in the record. Is there more to come? Then I would like to offer in the record—I would like to ask you, Mr. Miller, first, did you know anything about Miss Klem attending these meetings at which the Wagner-Murray-Dingell bill was drafted?

Mr. MILLER. I not only knew nothing about her attending, but I did not know of her attending any conference where the bill was drafted. It could be, however.

Senator PEPPER. Senator, did you understand that the conference referred to was an interdepartmental conference or does it say? I got the impression that it might have been a conference within the department.

Senator DONNELL. I think, Senator, this is the workshop in St. Paul. I find that at page 264 she refers to the St. Paul workshop.

Senator PEPPER. But I am talking about the drafting of the bill.

Senator DONNELL. I don't know that that was an interdepartmental conference. I think it was a workshop conference.

Senator PEPPER. But the bill was not drafted in a workshop by any means. I just wanted to see if there was anything that excluded the idea that when the lady refers to sitting in in consultation, it might have been in consultation with other departments.

Senator DONNELL. I see your point. I think you are quite correct. I think the workshops were the workshops at which were considered these various matters of legislation, and at which expressions of opinion were drawn up, and in the case of the Jamestown workshop that was attended by many Federal employees, and I observe at page 264 of her testimony, referring to the St. Paul workshop, the question is:

You met there with representatives of these organizations, CIO, A. F. of L., and Farmers Union?

Miss KLEM. And the railroad brotherhoods.

and that she participated in the forum panels, and so forth, that were held at those workshops, as a consultant. That appears at pages 264 and 265. Where those meetings took place at which the drafting of the bill occurred, I am unable to state, but the inference I draw is that it was not in those workshops.

Senator PEPPER. Now, the Senator does not suggest that the participants in those workshops, the railroad brotherhoods, the A. F. of L., the CIO, were un-American, or were citizens other than citizens of the United States?

Senator DONNELL. No; I have no such inference to draw, but I am presenting the thought that governmental employees in Mr. Miller's department, certainly Miss Klem, were participating in these workshops, and the purpose of the point that I am presenting now will be noted by citing, in addition to the full report which I now ask—it is only seven pages—may be set forth in the record—signed by the chairman, Mr. Harness, James W. Wadsworth, Henry J. Latham, Carter Manasco, and J. Frank Wilson; a report of Mr. Hoffman from the Committee on Expenditures in Executive Departments, authorized to investigate publicity and propaganda of Federal officials in the formation and operation of health workshops. I offer this entire document.

Senator SMITH. You say that it is a report of the House committee?

Senator DONNELL. The report of the House Committee on Expenditures in the Executive Departments.

Senator PEPPER. Before the Chair rules on that, may I be permitted to make an observation?

Senator DONNELL. Certainly.

Senator PEPPER. I will ask the clerk to bring me a copy of the report, or will the Senator lend me his, or do you have a copy there? [The clerk handed the report to Senator Pepper.]

Mr. Chairman, I don't know any rules of evidence, of course, that govern what goes into the record in a committee hearing of this character that would apply if it were a court proceeding of some sort, but I do submit that there are certain fundamentals in our whole American concept of inquiry—I think Daniel Webster defined inquiry as defying due process of law, as a procedure of condemnation before the court has rendered judgment. Now, the House of Representatives, I respectfully submit, has not observed this fundamental American concept of due process of law or, in terms of lay language, fairness.

While Miss Klem may have been invited as a witness, Mr. Miller, who is the head of the Federal Security Agency and the man legally responsible for the administration of most of these bureaus which are mentioned here, was not permitted to be heard before he was condemned, and his Agency condemned, for improper action, although he proffered, according to his testimony, his testimony and his services to the committee, and in making the inquiry, so far as I know, so far as the record has disclosed here this morning, none of the other people that are mentioned and condemned in this report were heard by the House committee when it formed the basis of this report.

Mr. MILLER. May I make an inquiry of one of my associates? I want to be sure that the statement of the Senator from Florida is accurate. Was I called before the committee myself?

Mr. HARRY N. ROSENFELD. Not to my knowledge.

Mr. MILLER. Do you recall before what committee I was called when I was out on the west coast?

Mr. WILLIAM MITCHELL. I can answer that. You were called before the over-all Committee on Executive Expenditures when they were considering the President's reorganization plan.

Mr. MILLER. Then my statement that I did not appear would be supported by the proposition that I was not called.

Senator DONNELL. May I ask, Mr. Miller, did you discuss any of these matters with Mr. Harness, the chairman of this subcommittee, Forest A. Harness?

Mr. MILLER. I went there for the purpose of finding out the nature of the inquiry, in order that I could make available, without any reservation whatever, any records or any information that lies within our power, in addition to the written record. And I expressed the hope at that time that if there were to be further proceedings, we would have an opportunity to be heard, and some of us were, I have no doubt.

There was one further thing discussed with Mr. Harness and Mr. Mitchell and myself, and that was the proposition that Mr. Harness has stated on the floor of the House, that we proposed sending Mr. Jacob Fisher of our staff to New Zealand for the purpose of giving us a first-hand report on the operation of their general social-security system, which did include some services in the health field.

I will add that in view of our deep respect for the American Congress and its Members, and apprehending that there might be further inquiry, we deferred the proposed visit of Mr. Fisher to New Zealand until some time that the Congress would consider more appropriate.

Senator PEPPER. If the Senator will allow me to proceed with my objection—in the second place, Mr. Chairman, I don't know of any-

thing that distinguishes activities of these agencies from the general activities of the agencies of the United States Government. I know I have been to many public meetings, agricultural meetings, livestock meetings, and others, where representatives of the Government whose duties had to do with the purposes of that meeting were represented.

In the next place, on page 6 of this report we see the attitude of this committee toward the Department of Justice of the United States and toward the Supreme Court of the United States. I will read two paragraphs:

In this connection, your committee recalls that it was the activities of the Group Health Association of Washington, D. C., which led to the filing, in 1937, of the antitrust proceeding against the Medical Society of the District of Columbia and the American Medical Association under the Sherman Antitrust Act.

This legal action by the Department of Justice was carried to the Supreme Court of the United States on the basis of the original complaint and accusations of Group Health Association of Washington, D. C., serving effectively to intimidate and restrain the activities of the American Medical Association in resisting the Federal propaganda.

Now, Mr. Chairman, it is a serious thing for a committee of the United States Congress to condemn a group of citizens for calling attention to the violation of a Congressional enactment, and then condemn them for initiating a prosecution which resulted in a conviction in the courts of the country, and affirmance of that conviction by the Supreme Court of the United States.

In the last instance, on page 7, here is a concluding paragraph which shows the nature of this inquiry, and effectively establishes that it does not meet, it seems to me, the standards that should be applied to documents and inquiries of this sort. Here is a conclusion arrived at, although these people never had a chance to be heard. I read from page 7, the concluding paragraph—this is talking about the health program that we Senators have introduced here as colleagues of these gentlemen in the elective body of the people of the United States—

Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American communism hold this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard.

Now, that is a base calumny and a damnable lie, and I speak for myself as one citizen of the United States, and any Member of Congress or of that committee that imputes communistic motives to the author of this bill, they are damnable liars, and some of us here have heard it till we are getting a little tired of it, and yet they come along, and it is part of the same thing that we heard a little about awhile ago, when Mrs. Shearon, who was originally attached to the staff of this committee, and who sits in this committee today as the adviser of the Senator from Missouri, although her services with this committee have been terminated by the committee, has published a pamphlet entitled "Blue Print for the Nationalization of Medicine," in which there appears a chart headed "Administration plan for nationalization of medicine. Spheres of influence and interlocking directorates, collaborationists, fellow travelers, appeasers, satellites, and gullible accepters." Then she has got this chart which includes the President of the United States, the Washington Post, and over here Members of Congress,

Representative Biemiller, Senators Wagner, Murray, and Pepper, Congressional committees, House Ways and Means Committee, Social Security technical staff included John J. Corson; Senate Finance Committee, Senate Education and Labor Committee, Senators Murray and Pepper, Democratic National Committee. Then Wilbur J. Cohen, adviser to Altmeyer, assistant to Falk; Margaret C. Klem, liaison with SSB field staff; Committee on Economic Security, American Association for Labor Legislation; ILO Special Committee on Seafarers' Insurance.

Then over here is Michael M. Davis, lobbyist, organizer, consultant to Falk; Barkev S. Sanders, health and disability studies chief; American Public Welfare Association; American Public Health Association.

Then up here under "Lobbying groups" are listed the Physicians Forum; Committee for the Nation's Health; Committee of Physicians for the Improvement of Medical Care; Committee on Research in Medical Economics; Federal Security Agency, Watson B. Miller, Administrator; United States Public Health Service, naming Dr. Parran, Dr. Mountin, George St. J. Perrott, W. P. Dearing, Louis R. Reed; United States Department of Agriculture; United States Department of Labor. Then under "Committees on Executive Agencies": Committee on Adequacy Studies, Subcommittee on Medical Care, United States Public Health Service Legislative Committee, and so on.

So I submit, Mr. Chairman, that while there is no rule that applies to the admission of evidence here, here is an ex parte statement that is made by this committee of the House, and purports to have an authenticity which it does not possess, and I think the whole character of it and the manner in which it was put together indicates that it is not deserving of being included in the records of this committee. If this committee wishes to ascertain anything it should make its own inquiry, as it is doing now. These people are here before us. This man is head of the Agency, and it would be better for us to be governed by our own inquiry—at least when these people would have an opportunity to present themselves. I respectfully object to the submission of the report.

Senator SMITH. The objection will be noted, of course, as the Senator requests, but I want to call attention to the fact that this committee is not sitting in judgment on anybody. The committee is not trying anybody. This committee is endeavoring to find out ways and means to pass legislation to meet an important objective, and I can see no objection to anything that is brought before the committee being used by the committee itself, when they are considering the framing of legislation, and I am very happy to note—I am not happy, but I am sorry—that the Senator from Florida feels offended by the offering of this document, but the Senator's comments will be included also in the record, and if Senator Murray wishes to make any comments they will be included in the record, so we will have the views of everyone when we come to consider the legislation. I think that is the proper way to handle it. I dislike to rule some evidence out and admit other evidence. There is a difference of opinion, of course. Many people feel that propaganda has been carried on both ways in regard to this legislation, and as chairman of the subcommittee I am trying my best to separate

the so-called chaff from the wheat and see if we can get at the facts that will get the bill that we all desire.

(H. Rept. No. 786, 80th Cong., 1st sess., follows:)

FIRST INTERMEDIATE REPORT OF THE SUBCOMMITTEE OF THE COMMITTEE ON EXPENDITURES IN THE EXECUTIVE DEPARTMENTS AUTHORIZED TO INVESTIGATE PUBLICITY AND PROPAGANDA OF FEDERAL OFFICIALS IN FORMATION AND OPERATION OF HEALTH WORKSHOPS

FOREWORD

The committee, after full consideration of the report as submitted by the subcommittee, upon motion duly made and seconded, unanimously approved and adopted the report as the report of the full Committee on Expenditures in the Executive Departments. The chairman was directed to transmit a copy of the report to the Speaker of the House of Representatives.

Your committee reports to the House that, on the basis of hearings held on May 28 and June 18, 1947, it finds that at least six agencies in the executive branch are using Government funds in an improper manner for propaganda activities supporting compulsory national health insurance, or what certain witnesses and authors of propaganda refer to as socialized medicine, in the United States.

This report summarizes our hearings on this phase of the inquiry to date and presents the conclusions arrived at, following careful evaluation of the testimony and documentary evidence presented by, and relating to, the several Federal agencies involved.

The departments, bureaus, and agencies known to have participated in this campaign are:

1. The United States Public Health Service;
2. The Children's Bureau;
3. The Office of Education;
4. The United States Employment Service;
5. The Department of Agriculture; and
6. Bureau of Research and Statistics, Social Security Board.

Your committee finds that the use of Federal funds for the purpose of influencing legislation before Congress is unlawful under section 201, title 18, of the United States Code. We have, therefore, brought these matters to the attention of the Department of Justice, with a request that the Attorney General at once initiate proceedings to stop this unauthorized and illegal expenditure of public moneys. A copy of the chairman's letter to the Attorney General is made a part of this interim report (exhibit 1).¹

Our exhibit 2,² in this report, is a chart prepared by the committee staff, showing the number of Federal agencies and the number of Federal pay-roll personnel participating in the so-called health workshops arranged throughout the country during the last 2 years, to mobilize pressure groups in behalf of a national program for what certain witnesses and authors of propaganda refer to as socialized medicine.

The first meeting in furtherance of these health workshops was held in Washington, D. C., on November 2, 1945. At that meeting only 10 persons were present, all of them full-time employees of the Federal Government. George Perrott, of the United States Public Health Service, presided as chairman of the meeting. The Federal agencies represented in this meeting—and the representatives of these agencies were the only persons present—were United States Public Health Service, Department of Agriculture, and the Federal Security Agency.

The latest figures available from the Budget Bureau show that for the fiscal year 1946 total expenditures in the executive branch for publicity and propaganda activities were \$75,000,000. During that fiscal year 45,000 Federal employees were engaged, full or part time, in such activities. The most recent prior compilation by the Budget Bureau covering the fiscal year 1941 showed total publicity expenditures amounting to \$27,770,000. An increase of approximately 300 percent in Federal expenditures for publicity and propaganda in a period of 5 years is deemed by your committee to be a proper subject for inquiry by the Congress.

It will be the purpose of your committee, in future interim reports, to examine this expenditure in detail by departments and agencies, with particular refer-

¹ See appendix, p. 7.

² See appendix, p. 8.

ance to illuminating those activities which are directed primarily to influencing the decisions of Congress on pending legislation.

Our first report deals exclusively with activities calculated to build up an artificial, federally stimulated public demand upon Congress for enactment of legislation for compulsory health insurance referred to by witnesses and publications as the Murray-Wagner-Dingell bill.

The extraordinary executive pressure exerted upon the staff of the United States Public Health Service to further the campaign for what certain witnesses and authors of propaganda refer to as socialized medicine is indicated by a letter sent under date of December 10, 1945, by Thomas Parran, Surgeon General of the United States Public Health Service, to all field men and staff operatives throughout the country. This letter referred to the message sent to Congress on November 19, 1945, by President Truman, urging enactment of a national health program. The Surgeon General's letter referred to the President's message as "a subject of the highest importance to every citizen." His letter continues (transcript of hearing, May 28, 1947, p. 88) :

"The appropriate executive agencies of the Government have been specifically instructed by the President to assist in carrying out this legislative program as presented to Congress on September 6, 1945."

The Surgeon General then listed the several health bills pending before Congress, continuing :

"Every officer of the Public Health Service will wish to familiarize himself with the President's message and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the Public Health Service."

Pursuant to this policy, the Public Health Service launched its national program of health workshops.

Following the Washington conference of November 2, 1945, a broader planning conference was arranged at the University of Chicago, November 26-27, 1945. At this meeting 20 persons were present, 9 of whom were full-time employees of the Federal Government. The 11 non-Government persons in this meeting were representatives of the CIO, A. F. of L., and the Farmers Union.

Next the planning committee met in Washington, D. C., on December 10, 1945, to evaluate the Chicago meeting and plan for the health workshops. The first health workshop was held in St. Paul, Minn., February 6-10, 1946, with 80 persons participating, 15 of whom were Government employees, representing 7 different agencies in the Federal establishment.

The second health workshop was held in Jamestown, N. Dak., September 27-30, 1946, with 98 persons participating, 18 of whom were Federal employees, representing 7 Federal agencies. The chairman of this meeting was Dr. Mayhew Derryberry, Ph. D., of the United States Public Health Service. Apart from Federal personnel, there were no doctors of medicine in attendance at this meeting as delegates. The testimony before your committee indicates that no registered doctor of medicine was invited to participate.

All the evidence before your committee indicates that these health workshops were planned, conducted, and largely financed with Federal funds, by a key group on the Government pay roll, who used the workshop method of discussion subtly to generate public sentiment in behalf of what certain witnesses and authors of propaganda refer to as socialized medicine. It is evident from the record that most of the planning was done by the Federal officials in Washington prior to each workshop conference and that each meeting was devoted to their own purposes—that of organizing pressure groups to agitate for compulsory health insurance as then pending in Congress.

In preparation for the Jamestown Health Workshop, the Public Health Service distributed in advance to all invited delegates a packet of pamphlets published by the CIO, AFL, the Physicians' Forum (a propaganda agency for the Wagner-Murray-Dingell bill), and the Government bureaus, in support of what certain witnesses and authors of propaganda refer to as socialized medicine. These packets were mailed to the delegates in advance of the conference, at Federal expense. They urged that letters be written to Senators and Representatives advocating immediate action on the Wagner-Murray-Dingell bill.

After the propaganda packets had been delivered, well in advance to the invited delegates, the Jamestown Health Workshop assembled on September 27.

Your committee received a detailed account of this health workshop from Mr. E. F. Engebretson, executive secretary of the North Dakota State Medical Association, who attended as an uninvited observer. On June 18, 1947, Mr. Engebretson testified :

"The meeting began on Friday, September 27. Friday was spent in its entirety in a so-called training program. The sponsoring organizations had invited various Federal and State officials to attend the conference as so-called consultants. Twenty-one of these consultants were in attendance, of which 19 were Federal employees and 2 were employees of the State of North Dakota.

"The training session the first day was not open to the general membership of the Farmers Union or other groups sponsoring the program. Rather, a hand-picked group of leaders from the various local societies were brought in for the purpose of being trained in workshop procedure. This training program was handled entirely by the employees of the Federal Government. In charge of the program in a general way was Dr. Mayhew Derryberry, Chief of the Office of Health Education, United States Public Health Service. In charge of the training instructions was a Dr. Hubert Stanley Coffey, Chief of Training, Federal Security Agency. The hand-picked group from the local societies were designated as delegates, and in training them they were seated around a conference table with the 21 consultants lined up behind them."

After the training program the indoctrinated delegates were given 30-minute tests to measure their leadership ability by setting forth the immediate health needs of North Dakota. At this point Witness Engebretson testified:

"It was very interesting to note that when left to themselves the delegates seemed unable to think of any particular health problems in the State."

Your committee then obtained from the Federal Security Agency a full copy of the instruction sheets used by the training officers at these health workshops. Among the topics listed are:

Techniques for the organization of citizen groups.

Formation of pressure groups.

Methods of bringing about group action.

Testimony demonstrating the efficacy of this indoctrination of delegates by the Federal officials was found in the formal summary of the Jamestown Workshop, as presented by the United States Public Health Service.

One section of the "action program," approved by the conference, urged "that congressional candidates and incumbents be polled by the committee, on their stand on the national health program, and that their opinions be sent to the State organizations for publication."

In the opinion of your committee, this recital presents the complete picture of Government propaganda in action. The Federal employees arrange the meeting, invite the delegates, train the delegates, preside at the meetings, and then frame the formal summary of resolutions and actions.

And all of this is paid for with public moneys never authorized or approved by Congress for these or any like purposes.

Testimony before the committee indicates also that the staff and resources of the Bureau of Research Statistics in the Social Security Board were devoted freely, from time to time, to the preparation of pamphlets and propaganda literature for the CIO, the AFL, and the Physicians' Forum. Much of this material prepared for the CIO and other groups, by the Social Security Board at Government expense, supported what certain witnesses and authors of propaganda refer to as socialized medicine in every approach and dismissed contemptuously all arguments controverting the fixed position of the Social Security Board (transcript of hearing, June 18, 1947, p. 170).

Your committee concludes from the testimony that most, if not all, of this literature, as distributed by the CIO, the AFL, the Farmers' Union, and the Physicians' Forum originates in, and emanates from, the Bureau of Research and Statistics in the Social Security Board. Mr. Isadore Falk is Director of the Division of Research and Statistics in the Social Security Board. His principal assistant, Miss Margaret Klem, was a witness before your committee on June 18. Miss Klem was identified as Chief of the Medical Economics Section of Mr. Falk's Division. She was one of the group of Federal employees who charted, arranged, and concluded the Jamestown Health Workshop. The testimony discloses also that she helped draft the Wagner-Murray-Dingell bill.

At a later date, your committee will submit a separate detailed report on the activities of the Social Security Board during the last 10 years in behalf of what certain witnesses and authors of propaganda refer to as socialized medicine.

Other evidence before the committee reveals that the Bureau of Research Statistics of the Social Security Board also prepared pamphlets and propaganda material to be distributed under the imprint of the CIO. Similar pamphlets were prepared in the same office for distribution as Government literature through the Department of Agriculture's Interbureau Committee on Postwar Programs. All

this material, as presented in our hearings, is similar in tone, content, and objective. It all originates in one spot, in the Social Security Board. It is all paid for, save the actual printing, by a process which your committee deems an improper use of Federal appropriations.

Samples of all these pamphlets and propaganda leaflets are available in your committee's files for examination by the public. Photostatic copies of some of them have been transmitted to the Attorney General, with our request for action in defense of the American taxpayers, who are paying the bill.

The spirit and purpose which dominates the officials of the United States Public Health Service in their campaign to high-pressure this legislation through Congress is reflected faithfully in the testimony of Dr. Herman Hilleboe, Assistant Surgeon General, who appeared before the committee on May 28, 1947. He was asked by our committee chairman if the literature prepared by the Federal agencies offered all sides of the discussion or was limited merely to supporting material to carry out the President's order. To this question, Dr. Hilleboe answered: "We would naturally give emphasis to that, because that is why we are in government. Otherwise, we should get out of government."

The same attitude of intolerance toward honest discussion or debate of the issue was indicated in the testimony of Mr. Harry J. Becker, health consultant in the United States Children's Bureau, Federal Security Agency.

Questioned as to the number of speeches he had made throughout the country in advocacy of the subject, the witness recalled several such appearances. Committee counsel, Frank T. Bow, pressed the inquiry (transcript of hearings, June 18, 1947, p. 228) :

"Mr. Bow. Did you give both sides of the question of compulsory national health insurance when you gave your discussions?"

"Mr. BECKER. I don't know what you mean by 'both sides.'"

The Children's Bureau, Federal Security Agency, was represented in the health workshops movement by Mr. Harry J. Becker, a full-time employee of the Federal Security Agency, in the capacity of health consultant. Mr. Becker, while engaged in his Federal position, also was one of the principal organizers of the Group Health Association of Washington, D. C., of which he later became president. He is also vice president of Cooperative Health Federation of America, which he helped organize in meetings at Two Harbors, Minn., and Columbus, Ohio, while on the full-time pay roll of the Children's Bureau.

In this connection, your committee recalls that it was the activities of the Group Health Association of Washington, D. C., which led to the filing, in 1937, of the antitrust proceeding against the Medical Society of the District of Columbia and the American Medical Association under the Sherman Antitrust Act.

This legal action by the Department of Justice was carried to the Supreme Court of the United States on the basis of the original complaint and accusations of Group Health Association of Washington, D. C., serving effectively to intimidate and restrain the activities of the American Medical Association in resisting the Federal propaganda.

Mr. Becker was a witness before your committee on June 18. His testimony delineates in some detail the historical development of the movement within the Federal Government to set up, at Federal expense, a Nation-wide campaign in support of pending legislation. Your committee invites particular attention to the testimony and cross-examination of Mr. Becker, because we feel that the devices and arrangements of Federal employment in this instance provide a typical example of how funds appropriated by Congress for the legitimate expenses of Federal agencies are diverted within the bureaus to full-time propaganda for what certain witnesses and authors of propaganda refer to as socialized medicine.

Not only are men and women paid substantial salaries in their Federal positions for their full-time activities in other fields, but in many instances traveling expenses and incidental costs of these pressure-group meetings are paid out of funds of the same Federal agencies.

Your committee has, for example, a report from the General Accounting Office, showing that various Federal agencies paid out a total of \$1,950 in traveling expenses of Federal employees to and from the Jamestown Health Workshop. This conference took 18 Federal officials away from their desks for a total of 126 man-days.

Another report from the General Accounting Office shows that the Federal Government paid almost \$5,000 in traveling expenses of Federal employees for

the series of five health workshop conferences and planning meetings held throughout the country before our investigation began.

Certain documentary evidence also has come to the attention of your committee, that the Bureau of Research and Statistics in the Social Security Board also maintains close contact with movements for compulsory health insurance in other countries.

Under date of May 14, 1947, Mr. Isadore Falk, Director of the Bureau of Research and Statistics, sent a memorandum to the Acting Commissioner for Social Security, urging that one Jacob Fisher, a member of Mr. Falk's staff, be sent to New Zealand at Government expense, to study compulsory health-insurance programs and activities in that nation.

We find that this same Jacob Fisher has been documented by the House Committee on Un-American Activities for almost uninterrupted association, since 1939, with various Communist-front and fellow-traveler organizations in the United States. At various times, according to his record, Jacob Fisher has been identified with seven different groups or organizations avowedly sponsoring the Moscow party line in the United States. He has published at least one report on health insurance in New Zealand, in the Social Security Bulletin—a report which has been criticized by some reputable medical authorities as extremely biased.

In a later interim report on the propaganda activities within the Social Security Board, we shall present to the Congress the detailed record of Jacob Fisher's activities, as certified to us by the Committee on Un-American Activities, together with additional material bearing upon organized Communist agitation for what certain witnesses and authors of propaganda refer to as socialized medicine, through such agencies as the Southern Conference for Human Welfare.

Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American communism holds this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow-travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard.

Approved:

FOREST A. HARNES, *Chairman.*
 JAMES W. WADSWORTH.
 HENRY J. LATHAM.
 CARTER MANASCO.
 J. FRANK WILSON.

EXHIBIT 1

CONGRESS OF THE UNITED STATES.
 HOUSE OF REPRESENTATIVES,
 SUBCOMMITTEE ON PUBLICITY AND PROPAGANDA OF THE
 COMMITTEE ON EXPENDITURES IN THE EXECUTIVE DEPARTMENTS.,
 Washington, D. C., June 30, 1947.

HON. TOM C. CLARK,
Attorney General of the United States,
Department of Justice, Washington, D. C.

SIR: There is transmitted to you, herewith, a copy of the Interim Report of the Subcommittee on Publicity and Propaganda of the Committee on Expenditures in the Executive Departments, for your consideration and appropriate action.

It is the opinion of the subcommittee, from the evidence considered by it at public hearings, that there have been violations of section 201 of title 18 of the United States Code, by employees of the departments and agencies specifically mentioned in the report. It is suggested and recommended that action be taken by the Attorney General of the United States to prosecute these violations and to prevent further disregard by Federal employees and agencies of the law cited.

The hearings and evidence adduced by the subcommittee are available and will be supplied to the Department of Justice upon request.

I have the honor to remain,
 Yours very truly,

FOREST A. HARNES, *Chairman.*

EXHIBIT 2.—Federal employee participation in health-workshop program

	Washington, D. C., Nov. 2, 1945	Chicago, Ill., Nov. 26-27, 1945	Washington, D. C., Dec. 10, 1945	Minneapolis, Minn., Dec. 28-29, 1945	Minneapolis, Minn., Jan. 9, 1946	St. Paul, Minn., Feb. 6-10, 1946	Washington, D. C., May 13, 1946	Fargo, N. Dak., July 13, 1946	Great Falls, Mont., July 15, 1946	Denver, Colo., July 17, 1946	Jamestown, N. Dak., Sept. 27-30, 1946	Washington, D. C., Oct. 29, 1946	Aberdeen, S. Dak., Nov. 22, 1946
*Kenneth Pohlmann, Agriculture Department.	X	Ch.	X			X	X	X	X		X	X	
*Dr. Mayhew Derryberry, U. S. Public Health Service.	X	X	X			X	Ch.	X	X		Ch.	Ch.	
*Harry Becker, Federal Security Agency.	X	X	X			X		X	X		X	X	
*Eleanor Finger, Federal Security Agency.	X							X	X	X	X	X	
*C. L. Williams, U. S. Public Health Service.	X						X	X	X	X	X	X	
*George Perrott, U. S. Public Health Service.	Ch.						X						
*Dr. W. P. Dearing, U. S. Public Health Service.	X	X	Ch.			X							
*Dr. George H. Hunt, U. S. Public Health Service.	X					X							
*Frank Stafford, Federal Security Agency.	X	X	X			X	X						
*Barkev Sanders, Federal Security Agency.	X												
*Margaret Klem, Federal Security Agency.		X	X			X					X	X	
*Helen Manley, Federal Security Agency.											X	X	
*Dr. Mark Zeigler, Agriculture Department.							X				X	X	
*Elliott Pennell, U. S. Public Health Service.								X			X	X	
*Miss Thorne, Federal Security Agency.											X	X	
*Ralph Nanderworker, Federal Security Agency, housing.							X				X	X	
*Dr. Hubert Coffey, Federal Security Agency.											X	X	
Evelyn Rahm, U. S. Public Health Service.											X	X	
Dr. Arthur B. Price, U. S. Public Health Service.											X	X	
Edith Foster, Federal Security Agency.											X	X	
Richard Cole, Agriculture Department.											X	X	X
R. L. Pritchard, Federal Security Agency.											X	X	
J. A. McElligott, Agriculture Department.		X		X	X						X	X	
A. H. Hedges, Federal Security Agency.		X									X	X	
Dr. Joseph Mountin, U. S. Public Health Service.						X							
Louise Eskridge, U. S. Public Health Service.					X	X							
Mr. Lamb, U. S. Public Health Service.						X							
Dr. Estella Warner, U. S. Public Health Service.						X							
Esther Huseman, Federal Security Agency.						X							
Dr. Ronald Lippitt, Federal Security Agency.						X							
Tom G. Rathbone, Federal Security Agency.						X					X		
Chester B. Lund, Federal Security Agency.								X					
Dr. Fred Foard, U. S. Public Health Service.									X				
Chester E. Hazard, Agriculture Department.									X				
John E. Gross, U. S. Employment Service.									X				
Miss McIntosh, Federal Security Agency.									X				

Footnote at end of table.

EXHIBIT 2.—Federal employee participation in health-workshop program—Con.

	Washington, D. C., Nov. 2, 1945	Chicago, Ill., Nov. 25-27, 1945	Washington, D. C., Dec. 10, 1945	Minneapolis, Minn., Dec. 28-29, 1945	Minneapolis, Minn., Jan. 9, 1946	St. Paul, Minn., Feb. 6-10, 1946	Washington, D. C., May 13, 1946	Fargo, N. Dak., July 13, 1946	Great Falls, Mont., July 15, 1946	Denver, Colo., July 17, 1946	Jamestown, N. Dak., Sept. 27-30, 1946	Washington, D. C., Oct. 29, 1946	Aberdeen, S. Dak., Nov. 22, 1946
C. D. Head, Jr., U. S. Public Health Service						X							
*Miss Hollingsworth, Federal Security Agency							X						
Dr. McKneeley, Federal Security Agency							X						
Claire Rosen, Federal Security Agency		X											
Marie Keller, Federal Security Agency		X											
*Statistical clerk, U. S. Public Health Service						X							
*Dr. L. Falk, Pepper committee						X							
Dr. L. Hoyle, Agriculture Department											X		X
Wallace Murdock, Agriculture Department											X		
Walter Murdock, Agriculture Department											X		
Total	10	10	5	1	2	15	9	4	3	5	18	9	2

*Indicates employees from Washington.

Although U. S. Public Health Service is under Federal Security Agency, its employees are listed separately here to show widespread participation of this agency.

Other Federal Security Agency divisions participating included Children's Bureau, Office of Education, Social Security Administration, Office of Vocational Education.

Total number of meetings, 13.

Total number of Federal employees attending, 46.

Total number appearances of Federal personnel, 93.

Total number Washington personnel participating, 20.

Notes on personnel: Becker is with Children's Bureau; Stafford and Klem, Office of Education; Finger was information specialist; Williams and Mountin, Assistant Surgeon General.

Federal agencies participating: Department of Agriculture; U. S. Public Health Service; and the following, under Federal Security Agency—Children's Bureau, Office of Education, U. S. Employment Service, Federal Housing.

Mr. MILLER. Then, Mr. Chairman, may I ask permission to read into the record, immediately following the document—and I, of course, have no objection, could properly have no objection to it being entered in the record—

Senator DONNELL. I wonder if Mr. Miller would have any objection if I would complete the record in that regard at this point. I would like to put in a little further information that I have here.

Mr. MILLER. I will yield to the Senator from Missouri.

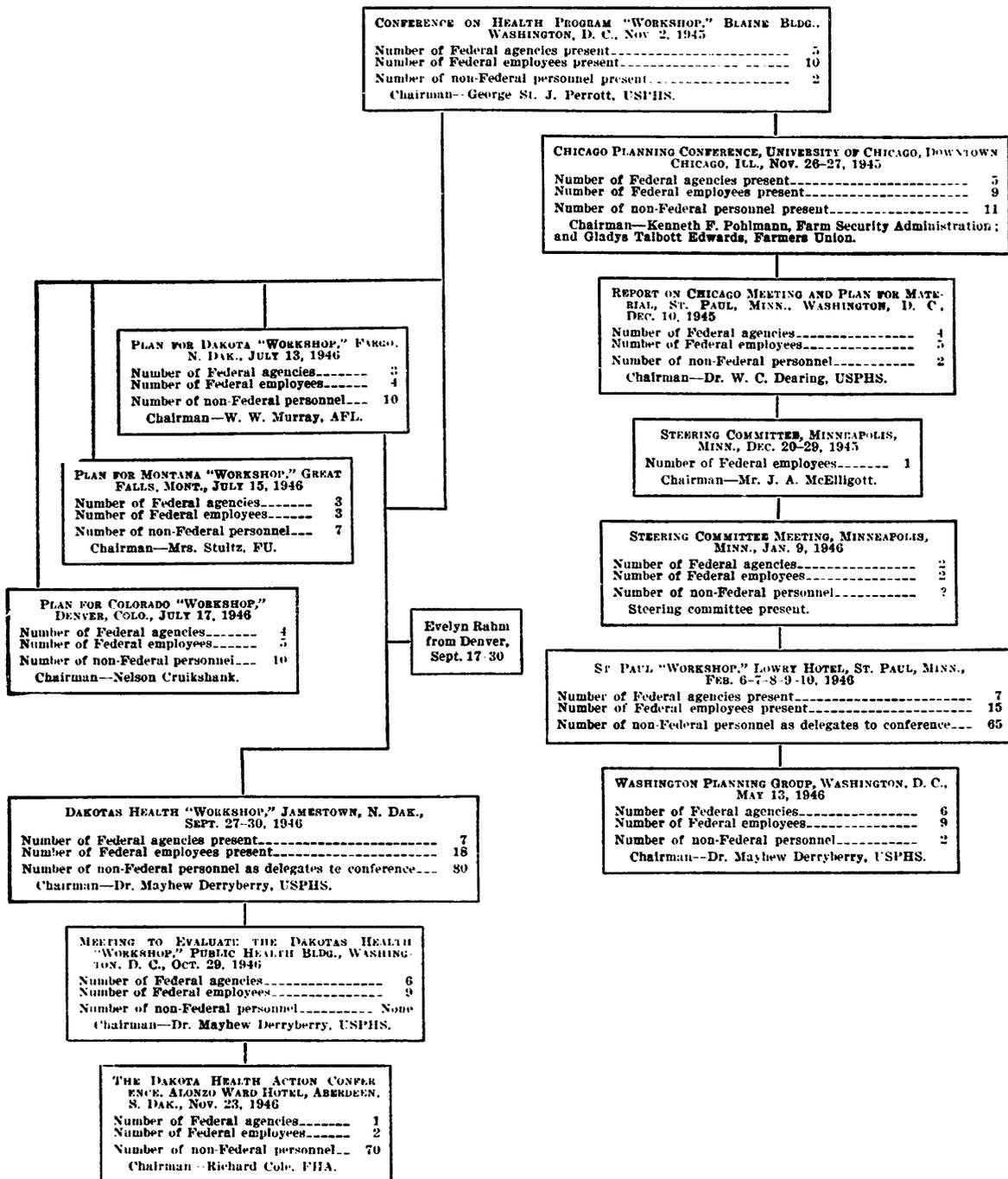
Senator DONNELL. I will call attention to the fact, Mr. Chairman, that in the typewritten copy of the testimony before the Committee on Expenditures of the House of Representatives, among the witnesses is Dr. Derryberry. I will ask Mr. Miller if he is health educator in the Public Health Service under the Federal Security Agency?

Mr. MILLER. Yes, sir.

Senator DONNELL. And Mr.—“Doctor” I presume it is—Herman Hilleboe, he is Assistant Surgeon General in the Public Health Service, in charge of hospital construction and tuberculosis control activities?

Mr. MILLER. He is just now on leave of absence as State Commissioner of Health in the State of New York.

EXHIBIT 2.—Agency participation in "health workshop" program



Senator DONNELL. And Mr. Harry J. Becker, is he of the United States Children's Bureau, Social Security Administration?

Mr. MILLER. I don't know Mr. Becker. I made an inquiry as to him, and I believe he is in the Children's Bureau.

Senator DONNELL. At any rate, the United States Children's Bureau is under the Federal Security Agency?

Mr. MILLER. That is right.

Senator DONNELL. And Mr. Becker is with that Bureau?

Mr. MILLER. I think that must be right.

Senator DONNELL. I also call attention to the fact that this document which I have offered, and which I understand has been admitted to the record—

Senator SMITH. Yes.

Senator DONNELL. Purports to be, and so states at the outset—I will just read the opening sentence:

The committee, after full consideration of the report as submitted by the subcommittee, upon motion duly made and seconded, unanimously approved and adopted the report as the report of the full Committee on Expenditures in the Executive Departments.

And that committee report purports to be signed by the five members, the gentlemen whose names I have already read into the record.

Now, Mr. Miller, if you will proceed.

Mr. MILLER. Mr. Chairman, the word "workshop," I have it in a notation here, is a term coined, I believe, in recent years, which has come to mean a convention for the exchange of experience in technical or not fully developed fields and for the projection of experiments as in a laboratory.

These devices have been employed in and out of Government to develop understanding, cooperation, promote sales, and the like.

Our agency has stimulated, and participated in, many such conferences. It has been more than intimated by a committee of the House that we have crossed into the realm of legislative propaganda. I believe this has not been done by my associates in conscious defiance of propriety or the law. I have great confidence in a very fine staff. I feel that the Congress should not give us too rigid a definition, but should permit us to use our best judgment and mature discretion. This, because under legislative fiat we confer with advisory bodies and in recognition of our public responsibilities cooperate with a vast array of voluntary groups pertinent to our wide range of duties.

I believe it is to be within our competence to explain the program which Congress has decreed to the people calculated to be served by them through proper channels and thus to aid in understanding and acceptance.

I realize that the dividing line is somewhat tenuous which might be unconsciously crossed. We shall do our best not to do so. I have lately conferred with public officials in four States who effectuate the operating ends of our partnership programs. This was done in order that I might learn of their problems and in general "how we are doing." I have discussed health and medical care programs, as before the Congress, with three great medical associations and by radio with Senator Taft. On occasion some unsought small press interviews have taken place and I have explained our programs, the current legislative situations, and even proposals for the Congress, current or hoped for.

In no instance have I felt that I failed in the amenities or in my respect for the Congress. Perhaps a workshop can be likened to what we are doing here this morning.

This document I have here, Mr. Chairman, is dated January 22, 1947, months, of course, before any of us had any indication, any intimation that the activities of workshops would be under examination by the Congress, and I would like to submit it in its entirety for the record, and I think it has something that will even in that period make graphic our feeling about things of this sort. It is a memo to me from the Director of Information, Mr. Zilpha C. Franklin, and says, under date of January 22, 1947:

The Public Health Service has recently had a request from the Grange and the Farmers' Union, acting jointly, to participate in a forthcoming health workshop for organization and community leaders in the States of Washington and Oregon. This project, which would substantially parallel the workshops previously held in Minneapolis and Jamestown, N. Dak., again brings up the question of agency participation in such conferences. In a meeting held in my office on January 7, the questions raised by the Farmers Union letter of October, asking you to set up a workshop-unit in the Agency, were again discussed in the light of this new request.

The group agreed that the outstanding asset of such workshops is the two-way opportunity to provide wanted information to alert community and organization leaders and to get from them a first-hand view of public attitudes and interests in the programs with which we are officially concerned. On the debit side must be weighed the expense of sending Agency staff members to such meetings, and the possibility that such participation may be misinterpreted as propagandizing—in spite of the fact that the Government consultants are meticulous in carrying out their instructions to operate solely as sources of factual information. One important question remains unanswered—the extent and effectiveness of what the workshop participants can carry back to their own localities and can communicate to others. Though these end results are not very tangible, the Agency people who took part in the earlier workshops feel that the carry-over to the community is probably substantial. One significant gain seems to have been the demonstration, to State and local health officers, of active and constructive citizen-interest.

The balance of it is subject to my approval that under these circumstances certain individuals be permitted to attend these workshops. I would like to have the whole statement placed in the record.

Senator SMITH. It will be admitted.

(The memorandum dated January 22, 1947, follows:)

OFFICE MEMORANDUM, UNITED STATES GOVERNMENT

Date: January 22, 1947.

To: Mr. Watson B. Miller, Administrator.
From: Zilpha C. Franklin, Director of Information.
Subject: Request for Participation in Health Workshop.

The Public Health Service has recently had a request from the Grange and the Farmers Union, acting jointly, to participate in a forthcoming health workshop for organization and community leaders in the States of Washington and Oregon. This project, which would substantially parallel the workshops previously held in Minneapolis and Jamestown, N. Dak., again brings up the question of Agency participation in such conferences. In a meeting held in my office on January 7, the questions raised by the Farmers Union letter of October, asking you to set up a workshop unit in the Agency, were again discussed in the light of this new request.

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gandizing—in spite of the fact that the Government consultants are meticulous in carrying out their instructions to operate solely as sources of factual information. One important question remains unanswered—the extent and effectiveness of what the workshop participants can carry back to their own localities and can communicate to others. Though these end-results are not very tangible, the Agency people who took part in the earlier workshops feel that the carry-over to the community is probably substantial. One significant gain seems to have been the demonstration, to State and local health officers, of active and constructive citizen interest.

Subject to your approval, we agreed to proceed along the following lines:

1. The Federal Security Agency should continue its interest in workshops on health, or other subjects in the Agency's fields, and should make available, on request, whatever consultant services it can. But at the present time, for both policy and practical reasons, our participation should continue on an informal basis, and no special unit for this purpose should be set up in the Administrator's Office or elsewhere in the Agency.

2. The Agency should participate in the Washington-Oregon Workshop. The consultants should be selected from Washington and regional staff to cover all programs. But, as indicated below, their number should be held within reasonable limits.

3. The Administrator's Office can assist in making Agency participation effective by (a) pulling together the potential contributions of all interested constituents; (b) taking over-all responsibility for authorizing participation; and (c) designating the individual to head up the Agency participants and to be responsible for organizing its consultative services.

4. Along with its responsibility to see that all pertinent aspects of the Agency's work are covered, the Administrator's Office should take steps to forestall too large an Agency "delegation." (At the two previous workshops interest was so general among both Washington and regional personnel that some 30 Agency people were present for all or part of the meeting.) As outlined by Dr. Derryberry, the Agency representatives at the Washington-Oregon Workshop might include:

(1) Miss Evelyn Rahm, of the Denver Public Health Service office, to assist in the preliminary planning and in arranging the details for the conference about a week in advance.

(2) Dr. Hubert Coffey, on WAE employment, to direct the workshop.

(3) Dr. Butterworth, to assist Dr. Coffey.

(4) Miss Klem, of the Medical Economic Section, Social Security Administration, or Mr. Becker, of the Children's Bureau, to serve as consultant on payment for medical care.

(5) Mr. Ralph Vanderwerker, sanitary engineer consultant to the Federal Public Housing Authority, or someone he may designate, to cover housing and sanitation.

(6) Dr. Rose, to cover medical facilities and personnel.

(7) Dr. Gregg, to cover public health.

(8) Miss Eleanor Finger, Labor Information Division, Social Security Administration, conference reporting.

(9) Representative of the Office of Vocational Rehabilitation (?)

(10) Representative of the Children's Bureau (?)

(11) An FSA information specialist to study and report to the Agency on informational needs, etc.

(12) The Farmers Home Administration should be asked to take part if this has not already been arranged.

The Social Security Administration's Labor Information Service can be called on if needed, as well as the Social Security Regional Office and the Public Health Service District Office.

Dr. Butterworth—in Dr. Derryberry's absence on detail to the Red Cross—will take responsibility for advance planning, etc.

5. The possibility of bringing into the workshop such interested voluntary organizations as the Red Cross and the Cancer Council should be explored with the workshop sponsors. Such organizations have facilities for community follow-up which could be very helpful.

6. The Agency will try to take advantage of this workshop to get additional data, particularly an accounting of the cost of Agency participation. Some method of post-workshop follow-up should also be developed, if possible, in order to get a better picture of the end results in terms of carry-over to individuals and community leaders.

Senator DONNELL. Mr. Chairman, I am practically finished with Mr. Miller.

Senator MURRAY. Before you proceed, Mr. Chairman, I wish to join with my colleague here in objecting to this line of evidence going into the record. Heretofore I have objected to the presence on this committee of Mrs. Shearon, who has been engaged for some time in spreading this propaganda which was referred to by my colleague, Senator Pepper, a few moments ago. A short time ago, upon our objection, she was discharged from this committee, but she still serves here, and she maintains an office in the Senate Office Building with a large sign on the door advertising herself as a consultant.

Senator SMITH. Let me just correct you, if I may, Senator Murray. When Dr. Shearon was discharged, it was understood she was to continue until the hearings were concluded, her services would be discontinued. I think that was the understanding; otherwise, it would appear as though she were here in an unauthorized way.

Senator DONNELL. May I interrupt you there, Senator? She is not any longer on the pay roll of this committee.

Senator MURRAY. But she is disseminating propaganda. She is engaged in sending out propaganda against Members of the Senate who are sponsoring this legislation. As Senator Pepper has called to our attention, she has already spread this propaganda throughout the country by means of this chart which she has prepared, and in which she refers to the Senators who are sponsoring this legislation as collaborationists and fellow travelers. I resent that. I consider her personally obnoxious, and I don't think we should be subjected to these insults. We are Members of this Senate just the same as the chairman and other Members of the Senate are, and I don't think we should be required to sit here and be insulted from day to day by a propagandist who was brought here in the first instance, I understand, by the Republican National Committee, and was on the pay roll of the Republican National Committee. We have investigated her, and we find that she is not a proper or suitable person to be serving on this committee or acting here at all. Because of her unjustified attitude toward us, we resent her presence here, and we think she should be immediately discharged from this room and not permitted to sit at this table along with the Members, in view of her willful misconduct and of the insults she has heaped upon us.

Now, Mr. Chairman, I want to call attention to her record. Dr. Shearon's record since 1934 is a succession of employment with various important Government agencies, each terminated because of her inability to maintain responsible and workable relations with other people. These positions include the New York Department of Social Welfare, New York City Department of Welfare, WPA, Social Security Board, United States Public Health Service. She was also employed for a time by the Senate minority conference group in 1946, and later by the Republican National Committee. During this latter period she indulged verbally, in writing, and through her influence on Members of Congress, in a smear campaign against other Members of Congress, against prominent citizens, and against responsible Government officials. Now, as an employee of the Senate Committee on Labor and Public Welfare, she is continuing to carry on a biased and vindictive lobby. Even though she has been separated from the pay

roll, she is still permitted to use an office in the Senate Office Building, and I suppose use other facilities.

Senator SMITH. Senator Murray, may I just say this at this point: To my knowledge Dr. Shearon has not sent out any material of that nature since she has been working with this committee. I have instructed her not to, and I have no evidence that she has done so. Furthermore, it seems to me the material that you are presenting was brought before our committee and not made part of the record. I think what you say is relevant, and if you want to put it in, you have got the right to, because this other material has gone in. I don't see that it has any relation to this investigation, however.

Senator MURRAY. I think it ought to go in, because it is entirely relevant to what is already in the record.

Senator SMITH. Unfortunately we are getting into something here—if that is going to be done we are getting off the trail of what we are trying to do, and I will have to make my investigations of some others that have been working on the other side of this.

Senator MURRAY. That is perfectly all right with me.

Senator SMITH. I don't want to be put in that position. I don't feel it is the right thing to do from the standpoint of trying to get constructive legislation here, to get into personalities and differences. I have asked Dr. Shearon not to participate in them, and so far as I know she has not.

Senator MURRAY. She has engaged in propoganda ever since she was taken off the pay roll. Here is a letter dated June 9, after she had been removed from the pay roll, in which she addresses "To Members of Health and Medical Professions and to Others Interested in Defeating Plans for Establishment of State Socialism in the United States."

It reads:

In February 1945 I was appointed research analyst to serve Senator Taft and other Republicans in the fields of health, education, social security, and welfare. Last year I worked with Senator Donnell in cross-examining witnesses at hearings on S. 1606.

On March 21, 1947, I was appointed consultant to the Senate Committee on Labor and Public Welfare. On May 22 I was fired at the instance of Senators Pepper and Murray after I had aided Senator Donnell in cross-examining witnesses at the current hearings on S. 544 and S. 1320. Objection was taken to my views as expressed in the Blueprint for the Nationalization of Medicine—

This is the blueprint that we have just been referring to, and in which she refers to the President and to the Members, certain Members of the Senate, as being collaborationists and fellow travelers, and engaged in establishing socialism and communism in the United States. Continuing with this letter:

Objection was taken to my views as expressed in the Blueprint for the Nationalization of Medicine—Plans To Enchain Medicine by Regulative Interference and in my speech on bureaucratic control of medicine. Senator Taft was unable to obtain a majority vote to retain my services since Senators Morse and Aiken voted with the Democrats for my removal.

That did not occur at all. She was removed with the consent of all members of the committee, and no vote was taken on it whatever. So that is a false statement with reference to the action of this committee. She was removed by Senator Taft, who stated at the time that he thought she was unstable, that he would not feel satisfied to

have her continue on the committee, and he therefore agreed that she should be removed from the pay roll. She further says:

Senator Taft was unable to obtain a majority vote to retain my services since Senators Morse and Aiken voted with the Democrats for my removal. I am to continue with the committee until the hearings on S. 545 and S. 1320 have been completed and am then to be dismissed.

The day after I cease to be a Senate employee (either July 1 or July 16) I shall resume publication of my weekly releases, *American Medicine* and the Political Scene, and shall start the other activities described in the announcement herewith. Your support in the fight against state socialism is earnestly solicited.

My professional qualifications include: Ph. D. in pure science, Columbia; Phi Beta Kappa; Sigma Xi; 10 years in scientific research; 12 years in financial management and publicity; 13 years in public administration and research, local, State, and Federal, including 5 years at Social Security Administration, 4 years at Public Health Service, and 2½ years with Senate committees.

MARJORIE SHEARON, Ph. D.,
P. O. Box 4034, Chevy Chase, Md.

JUNE 9, 1947.

Now, I offer this entire chart in evidence and this statement, and also the additional material which she has sent out with this letter to the people that she addressed this communication to. I also wish to have this statement included in the record.

(The chart referred to appears hereafter in pt. 4.)

Senator DONNELL. Have you finished, Senator Murray?

Senator MURRAY. I also ask to have these clippings put into the record at this point, one from the *St. Louis Post Dispatch*, by Edward A. Harris, Washington correspondent of the *Post Dispatch*, discussing this situation.

Senator DONNELL. What is the date of that?

Senator MURRAY. January 18.

Senator DONNELL. This year?

Senator MURRAY. It is dated Washington, January 18, this year, 1947.

I want to call attention also to the fact that the American medical profession objects to Mrs. Shearon, and points out that she is unstable, and that they have written in some of their medical journals criticisms of her. I have two here, one an excerpt from the *Rocky Mountain Medical Journal* of October 1946, volume 43, No. 10, page 798, which I will put into the record at this point; also an excerpt from *Medical Annals* for November 1946, pages 558-559, entitled "The Lady Who Knows"; also an article by Nelson H. Cruikshank entitled "Playing Politics With Health," in the *American Federationist*, page 24, the entire article.

(The material submitted by Senator Murray follows:)

ANNOUNCING ESTABLISHMENT OF THE SHEARON MEDICAL LEGISLATIVE SERVICE,
WASHINGTON, D. C., JULY 1, 1947

OBJECTIVES

1. To furnish concise, timely, analytical information about current Federal legislative proposals in the fields of health and medicine, with special emphasis on compulsory sickness insurance legislation;
2. To issue weekly releases entitled "*American Medicine and the Political Scene*" while Congress is in session;
3. To conduct research in the social, economic, and legislative aspects of medicine and to make available to subscribers the results of such research;

4. To write informative reports, leaflets, and research documents for the benefit of subscribers and of Members of Congress and for wide distribution to the press and to the public;

5. To provide consultative services in connection with preparation of testimony for congressional hearings and of speeches and radio talks, such services to be available to physicians, dentists, nurses, and other health personnel, to insurance companies, actuaries, industrial organizations, and to other groups and individuals interested in preserving the system of free enterprise, including a free medical profession;

6. To aid in mobilizing opposition to establishment of state socialism in the United States via enactment of Federal compulsory sickness insurance as part of an over-all plan for national social insurance for the entire population patterned on the proposals of the International Labour Organization.

PRINCIPLES

Intellectual freedom and integrity are the sine qua non for conducting such a service as I would offer. I must present facts as I find them, letting the chips fall where they may. Politically, I am an independent. I would avoid a party label, especially since social legislation must be judged by its content and implications rather than by the political alinement of its sponsors. I will not be controlled by any political, business, or professional organization.

My subscribers must at all times be certain that I cannot be bought, intimidated, or cajoled. A research analyst must be above suspicion. My views are not shaped to please any partisan, pressure, or bureaucratic group. It must be patent that a person who can be bought by one faction, could as easily be bought by an opposing one with more money.

I believe that what we need more than all else at the present time in the fight against compulsion and state socialism are alertness and plenty of that good, old-fashioned American quality best described by the virile Anglo-Saxon word "guts."

PROPOSALS

I intend to set up an office near the Capitol so that my organization may be a going concern as soon as I cease to be consultant to the Senate Committee on Labor and Public Welfare. On July 2, I will resume publication of American Medicine and the Political Scene.

If I find it impossible to terminate my committee connections before July 15, because hearings on S. 545 and S. 1320 have been extended to July 11, I shall hold up mailing of releases until July 11, but they will begin with the July 2 number. I will present the story behind the story regarding the moves during the past 2 months with respect to Federal compulsory sickness insurance legislation.

SUMMER PLANS

In the summer months, when Congress is not in session, time is available for research, writing, and speaking. My activities will be as follows:

1. I shall analyze the hearings on S. 545 and S. 1320 and shall prepare an annotated report, including a day-by-day account of the lobbying activities employed throughout the hearings. In the report I shall include data on the individuals and organizations which have been sponsoring compulsory sickness insurance legislation during the past decade, their tie-in with Communist-front organizations, the operations of governmental lobbies and nongovernmental lobbies, and other facts regarding the movement for nationalization of medicine as one step toward establishment of the socialist state in the United States.

2. I shall prepare leaflets suitable for wide circulation through doctors' offices, business organizations, women's clubs, chambers of commerce, etc. This material should be ready for distribution in the fall. Remember, creation of a comprehensive system of national social insurance will be a major political issue in the 1948 Presidential campaign.

3. I expect to push the distribution of the Blueprint for the Nationalization of Medicine—Plans to Enchain Medicine by Regulation Interference. Some organizations have been discussing purchases of from 75,000 to 200,000 copies.

4. I am now accepting speaking engagements for the next 6 months. Arrangements are being made to have me speak before mixed audiences, including not only members of the medical and allied professions, but also representatives of social-work agencies, parent-teacher associations, Kiwanis, Rotary clubs, etc.

FINANCES

I seek immediate financial support to enable me to carry out these objectives and plans. I desire support on a wide base, rather than large subsidies from a few organizations or individuals. I require funds at once for office furniture and equipment. A lease must be signed. A small staff, including an executive secretary, research assistant, news gatherer, secretary, and mimeograph operator, must be employed. Sustaining funds are needed to pay for office upkeep and to cover cost of material distributed free of charge to Members of Congress, to the press, and to civic leaders for educational purposes.

SUBSCRIPTION RATES

Support for the objectives listed above is sought on the following bases:

	<i>Annual rate</i>
Sustaining subscriptions, including right to all material published.....	\$500
Organization subscriptions:	
Large organizations requiring diversified services.....	200
Small organizations with limited needs.....	100
Individual subscriptions entitling to at least 35 releases a year.....	15
Consultative services on a fee-for-service basis.....	--

MARJORIE SHEARON, Ph. D.,
P. O. Box 4034, Chevy Chase 15, Md.

JUNE 9, 1947.

SUBSCRIPTION BLANK

MARJORIE SHEARON, Ph.D.

P. O. Box 4034, Chevy Chase 15, Md.

I hereby subscribe for 1 year beginning July 1, 1947, to the Shearon Medical Legislative Service, to be established in Washington, D. C., between July 1, and July 15, 1947.

I enclose my check for \$ _____ for the subscription indicated below:
Check () *Annual rate*

— Sustaining subscription, entitling subscriber to 10 copies of each weekly news release and to 1 copy of all material published.....	\$500
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Organization subscription:

- | | |
|---|-----|
| — For large organizations requiring diversified services and 10 copies of weekly news release for officers..... | 200 |
| — For smaller organizations with limited needs and requiring only 5 copies of weekly news release..... | 100 |
| — Individual subscriptions entitling individuals to 1 copy of weekly news release and to minor services..... | 15 |

NOTE.—American Medicine and the Political Scene, the weekly news release referred to, will be published not less than 35 times a year—throughout regular sessions of Congress and for about 2 weeks before and after Congress convenes. Sustaining and organization subscriptions may be paid on a semiannual basis if desired. Special services will be billed on a fee-for-service basis. Prices on quantity lots of publications will be quoted as material is printed.

Name _____
Address: _____

[From the Post-Dispatch, St. Louis, Mo., January 19, 1947]

LOBBYISTS OFFER OF RESEARCH AID AGAINST HEALTH BILL DISCLOSED—GOP EMPLOYEE WORKING ON MEASURE FOR SENATORS SAYS SHE REJECTED PROPOSAL OF PHYSICIANS AGENT

(By Edward A. Harris, a Washington Correspondent of the Post-Dispatch)

WASHINGTON, January 18.—A letter that has been circulating around Washington for some time discloses that a lobbyist of the physicians' group fighting the Wagner-Murray-Dingell health insurance bill made an offer of free research

and clerical help to a Senate committee or, alternatively, a substantial contribution to the Republican National Committee.

The offer was made last April.

The letter was written by the person to whom the offer was made, Mrs. Marjorie Shearon, a research employee of the Republican National Committee currently assigned to work on the health insurance bill for the Senate committee of the majority. She has an office in room 8B in the Senate Office Building.

The offer was made by Edward F. Stegen, a registered lobbyist who is an associate director of the National Physicians' Committee.

AUTHOR OF THE LETTER

Mrs. Shearon, a volatile, quick-tempered individual of advanced years, is an implacable foe of national prepaid medical insurance. She devoted much of her letter to an attack on proponents of the Wagner-Murray-Dingell bill. She also assailed the propaganda methods of the National Physicians' Committee's Washington representatives.

She has worked closely with Senator Robert A. Taft, Republican, Ohio, new chairman of the Senate Labor Committee, and Senator Forrest C. Donnell, Republican, Missouri, in their opposition to the bill. She broke into the news last year when the Post-Dispatch described her feverish activities in supplying Senator Donnell with stacks of "research" at open hearings on the insurance bill held by the Senate Labor Committee. Senator Taft has introduced an alternative measure which excludes the prepaid insurance feature of the Wagner-Murray-Dingell program.

As Mrs. Shearon made clear in her personal letter—copies of which were sent to the National Physicians' Committee directors and a small influential group of physicians—the NPC is the propaganda arm of organized medicine mobilized to defeat the Wagner-Murray-Dingell bill. Its ties with the American Medical Association are intimate, although it maintains it is merely an educational body dissociated from AMA.

CRITICISM OF TACTICS

Mrs. Shearon asserted that the lobbying and propaganda tactics of NPC's paid staff in the capital have brought discredit to the entire medical profession, adding that the NPC directors themselves doubtless were not aware of the nature of its representatives' activities.

Stegen, she related, came to her office in the Senate Office Building and "offered to furnish clerical workers and research assistants gratis to help me in preparing research material for the Senators in connection with my work on the hearings" on the Wagner-Murray-Dingell bill.

"I explained," she went on, "it would be improper for me to accept financial aid from any lobbying group, because there would be implicit in such an arrangement the thought or expectation that I would use my real or fancied influence with the Senators to favor the NPC at hearings, and that I would color my research findings in a way agreeable to that particular lobbying group."

"Stegen," she continued, "countered by proposing that the NPC would make a substantial contribution to the Republican National Committee to be earmarked for my use. He assured me it could all be quietly arranged—or words to that effect—so that no one, not even the donor of the gift, would be the wiser".

Mrs. Shearon said she "turned the proposition down cold."

To clinch the matter, she declared, she telephoned the Republican National Committee while Stegen was still in her office and asked if headquarters wanted political contributions on such terms. They did not, she said.

LOBBYIST STEGEN'S VERSION

Stegen, asked about Mrs. Shearon's assertions, told the writer at the Willard Hotel that he was reluctant to add to the dissension, but her version was not quite correct, and he thought the true version ought to be known.

"I went to see Mrs. Shearon about the various medical bills pending in Congress, including Senator Taft's proposal," he said. "She seemed very busy, and kept telling me how little clerical help she had, and how difficult it was to get things done on the small overhead allowed her.

"Perhaps I was guileless, or just thoughtless, but, in the face of her complaints and with the best of intentions, I said perhaps I could provide her with some clerical help. When she brushed over this, I said maybe I could get an individual

donor, not the NPC, to make a contribution to the Republican National Committee so that she would have more funds for clerical aid in carrying on her fine work in the interest of progressive medical legislation.

"She telephoned her research superior in the national committee, while I was sitting there, and he agreed with her that it could not be done. That ended the matter so far as I was concerned."

MRS. SHEARON INDIGNANT

Mrs. Shearon said in her letter that she felt considerable indignation that Stegen had dared to make his suggestion.

"I believe," she wrote, "there is not a single reputable physician who would thus have proposed, none too subtly, to purchase a lien on my professional services to Republican Senators."

She said she "could not but wonder" if Stegen thought she was naive, or devious, or "downright crooked," and secondly, "whether he was expanding the influence of the NPC by making similar propositions to other persons who, in his estimation, might prove useful. Surely he knew exactly what he was doing and what was implicit in his offer."

Mrs. Shearon told the Post-Dispatch that the letter, sent last August 9, stirred up a hornet's nest within the NPC and efforts were made to have her relieved of her job. The proposition had been made to her by Stegen last April, she said.

"PURELY LOBBYING GROUP"

"Senator Taft told me we should not get involved in medical politics," said Mrs. Shearon, "and I shouldn't be talking about it now. But the NPC tactics make me so furious. For one thing it's ridiculous for the NPC to pretend that it isn't associated with the American Medical Association, and for another, to pretend it's an educational instead of a purely lobbying group. Their men here just don't have the facts in their fight on the Wagner-Murray-Dingell bill, and they resort to distortions, misstatements, and downright falsifications."

Her vitriolic letter was mailed, she said, without prior consultation with Senators Taft or Donnell or anyone else. She said she used official envelopes of Senator Taft in mailing them, but bought her own stamps.

Other highlights of her letter included the statement that she is completing a booklet on the proposed "nationalization" of medicine to be mailed by the Republican National Committee to every doctor and dentist in the Nation; the assertion that NPC has supplied the medical profession and the public with "sheer buncombe" in its propaganda; sharp criticism of the NPC for having "its legislative lobbying activities financed in considerable measure" by the drug industry; and the statement that the NPC's "paid staff of promoters" has done many things that would "horrify" the group's board of directors if it knew what went on.

The tone of the entire seven-page, single-spaced letter reflected the researcher's firm opinion that the NPC might do well to abandon its own methods of working against the Wagner-Murray-Dingell bill in favor of open, above-board techniques.

She made it clear that she considered herself the most fully qualified person to expose the "dangers" of the measure. She offered her services as a speaker before medical groups, saying that while the Republican National Committee would pay her traveling expenses in whole or in part, she preferred to have the sponsoring group do so.

Senator Taft, at whose instance she said she was first employed by the GOP, has approved her acceptance also of "honorarium for speeches and fees for articles." While at no time is such payment required or expected, she went on, on the other hand, "no group should think my speech will be influenced in any way by an honorarium."

Mrs. Shearon, who told recipients of her letter there was "nothing official" in her remarks, is a doctor of philosophy in science, and formerly worked for 5 years with the Social Security Board and 4 years with the Public Health Service.

NONPOLITICAL, NONPROFIT

The full name of the NPC is the National Physicians' Committee for the Extension of Medical Service, with main offices at 75 East Wacker Drive, Chicago.

Its letterhead states that it is a "nonpolitical, nonprofit organization for maintaining ethical and scientific standards and extending medical service to all the people."

In recent years it has sent out tons of literature assailing the Wagner-Murray-Dingell bill as "communistic." Much of this propoganda has been distributed to drug stores.

In a telegraphic message to "all American physicians," dispatched January 5, the NPC urgently solicited contributions, saying in part:

"November elections have provided a better climate in which to work out solutions. Lines of activity are clearly indicated. Estimated that Federal regulation of Lobbying Act may deprive us of approximately \$200,000 revenue annually."

Last year the Treasury Department ruled that the NPC was a "business league" and contributions to it were not deductible from taxes.

[Excerpt from Rocky Mountain Medical Journal, October 1946, vol. 43, No. 10, p. 798]

DR. SHEARON ADDRESSES COLORADO SOCIETY

Doctors in the Rocky Mountain area have had several opportunities to hear talks by Marjorie Shearon, doctor of philosophy, research analyst for the Conference of the Minority, United States Senate. The last occasion of this sort occurred during the recent annual session of the Colorado State Medical Society at Estes Park. This meeting, incidentally, registered a total of 545 persons; among them were 35 individuals from 14 other States. Thus the audience represented a territory much larger than these Mountain States.

Dr. Shearon addressed doctors and their wives at one of the evening meetings. Unfortunately, the majority of her listeners were disappointed. She spent what seemed to be a disproportionate amount of time reviewing her own personal history and responsibilities. Among her introductory comments were also several remarks and implications which the ladies interpreted as a direct disparagement of their intelligence, general knowledge, and ability to interpret the significance of the current political threat to American medicine. She seemed to overlook, for a few moments, the great part that doctors' wives have always taken in enabling and inspiring their husbands to carry on a humanitarian toil. Several comments, also, could not be interpreted as complimentary by representatives of the AMA. Our parent organization, we grant, has been on the receiving end of some adverse criticism and publicity, particularly in reference to a personality or two and some financial and political considerations. However, the AMA is still our parent organization. To it we owe more than many of us realize, and it is taking material steps to mend those ways and to dethrone a personality or two which have unfortunately harmed the institution's national respect and influence. It still deserves the loyalty of our profession and its representatives.

Admirers of Dr. Shearon and the very sincere and conscientious work she has done on behalf of our profession are not likely to misjudge any palaver which falls short of her well-known standards. We are willing and anxious to blame it upon an unpredictable audience, an unruly microphone, or the altitude. But we hope that she will work on in her usual quiet and effective way, will speak to small groups guided by her keen intelligence rather than emotion, and will spare the women and the AMA. For in them we have faith—the women forever, and the AMA at least since certain airings at the San Francisco meeting and subsequent evidence of reparations.

[Excerpt from November 1946 Medical Annals, pp. 558-559]

THE LADY WHO KNOWS

Those who attended the hearings of the Senate Committee on Education and Labor last winter and spring will recall an alert, rather intense, graying woman always seated next to Senator Forrest C. Donnell, of Missouri. She was Mrs. Marjorie Shearon, research analyst, Conference of the Minority of the United States Senate, who had been assigned the task of supplying the Senator with data and prompting him when questioning witnesses.

Mrs. Shearon was not always on organized medicine's side. For a number of years she was employed by the Social Security Board. She says that 3½ out of the 5 years with the Board she served under Isidore S. Falk Director of the Bureau of Research and Statistics. In the course of this association she developed a bitter antipathy for Mr. Falk's views on medical care. Since leaving

the Government, she has made her opinions known whenever the occasion offered.

Along in the early summer of 1946, Mrs. Shearon issued bulletins devoted to health legislation. These were more than factual reports. They indicated how deeply Mrs. Shearon felt about opponents of organized medicine. Medicine's cause became hers, and she had stronger convictions about what should be done than most doctors. Critical of the representatives of organized medicine, and especially those who she said were paid for the purpose of "guarding its interests," she warned that the medical profession is in "an extremely weak position in combating the forces now working for the destruction of the private practice of medicine."

What she called the House of Falk, however, was the principal object of her attack. Here she laid down her heaviest verbal barrage. Unfortunately, the length to which Mrs. Shearon went to discredit Mr. Falk invalidated some of her otherwise sound arguments.

Under date of August 9 she issued a bulletin in which she set forth at length her qualifications for the role in which she had been cast. These were impressive enough, and several medical societies invited her to speak to them. One of these was the Michigan Medical Society.

Albert Deutsch of the loud leftist newspaper PM who baits organized medicine whenever the opportunity offers, covered the meeting addressed by Mrs. Shearon in Michigan. As usual, he went at his assignment without gloves. Mrs. Shearon, he cried, "put the finger on Fishbein and other alleged participants in this international plot," the plot being to turn the world over to "Joe" Stalin. Mr. Falk came in for special attention. "Now this fellow Falk," Mrs. Shearon is quoted as saying, "is the most dangerous man in America. He is very, very clever, and a master of intrigue." Michael M. Davis and others she considered "nearly as dangerous." Finally, according to Mr. Deutsch, she got around to Dr. Fishbein, who, she is said to have related, is often seen in Washington in company of known advocates of compulsory sickness insurance. "I don't trust Fishbein," she is reported as saying. In fact, she is said have added that Dr. Fishbein and Mr. Falk are "like two peas in a pod. I would like to see them both dumped into the river."

Mr. Deutsch chided doctors present for applauding Mrs. Shearon's "flights into fantasy."

As these lines are being written, an announcement of Mrs. Shearon's appearance before another medical society came to your observer's attention. She is listed on the program as "The Lady Who Knows the Sinister Implications of Socialistic Medicine."

PLAYING POLITICS WITH HEALTH

(By Nelson H. Cruikshank, director, A. F. of L. social insurance activities)

"When I think how every labor bill was suppressed during those years in which your party maintained control and you were chairman, and when I think of the general procedure of this committee to put across that general plan, I certainly am surprised at the attitude you have taken this morning when we take the opportunity, when we have control of the committee, to present our case first."

The speaker is Senator Robert A. Taft, chairman of the Senate Committee on Labor and Public Welfare. The scene is the big committee room in the Capitol where hearings have just opened on Senator Taft's charity health bill before a subcommittee. The time is the morning of May 21, 1947.

Senator James A. Murray, of Montana, former chairman of the committee, has just raised an objection to the manner in which the hearings are being conducted, charging that more than nine-tenths of the scheduled time of the hearings has been assigned to organizations opposed to health insurance of the kind envisaged in the bill which he and Senators Wagner, McGrath, Chavez, and Pepper have just introduced. He has pointed out that less than 2 hours of time have been allowed organizations representing millions of people who are expected to be opposed to the proposals embodied in Senator Taft's bill.

In order fully to appreciate the significance of this little drama one needs to know what has been going on behind the scenes in this subcommittee for the past several months. It is because the implications of this story have a significance that goes beyond the treatment of the health proposals that I believe the readers of the Federationist will be interested in the whole story.

It started last year during the hearings on S. 1606, the National health-insurance bill. At those hearings Senator Donnell, of Missouri, submitted every

witness in favor of health insurance to a rigorous cross-examination. At his elbow sat Dr. Marjorie Shearon, a former employee of the United States Public Health Service and a former employee of the Social Security Board, who constantly passed him little notes on which his sharpest questions were obviously based. Investigation at that time revealed that Dr. Shearon was then in the employ of the Republican National Committee and remained with the committee until sometime early this year.

After the conclusion of the Senate hearings on the health-insurance bill of last year Dr. Shearon, while still on the pay roll of the Republican National Committee, moved over into Senator Taft's office and began to issue a series of pamphlets and news letters attacking not only the principle of national health insurance but the motives and patriotism of practically every person and agency that had ever indicated support of such a measure. This included the Social Security Board, the United States Public Health Service, and the International Labor Organization as well as the American Federation of Labor and other organizations that had supported the Wagner-Murray-Dingell bill. Although carefully disavowing official endorsement of her position by the Senate committee, these releases unmistakably implied that their author was on the inside track.

The periodic news releases which Dr. Shearon sent out apparently went to a select list of doctors and hospital administrators who she felt sure were opposed to health insurance. Doctors have to be careful because of the tight control that the American Medical Association holds on their professional activity, but there are many of them whose sympathies definitely lie with the people whom they serve. Some of these have the courage to keep us informed as to the kind of material that is coming from such sources, and we regularly received copies of the propaganda that was being sent out, if not by Senator Taft's office at least from Senator Taft's office.

Apparently some of Dr. Shearon's activities proved embarrassing to the Republican National Committee, just as they had in years past to the Public Health Service and the Social Security Board. But her friend, Senator Taft, evidently did not share the embarrassment as we find her next, at his insistence, employed as a consultant on health matters to the Senate Committee on Labor and Public Welfare. The bulletins and newsletters, entitled "American Medicine and the Political Scene," continued to come out over her signature; and we continued to get copies from friendly doctors.

This signature, by the way, is interesting. It is always "Marjorie Shearon, Ph. D." The learned doctor, who is now the health expert of the majority members of the committee, has established her qualifications in the field by authorship of such treatises as the *Habitat of the Eurypeterida*, which, according to Webster's Dictionary, is "an order of aquatic, exclusively Paleozoic arthropods, related to the arachnids and especially to the kind crabs." Other special studies which she has authored include the Schrammen Collection of Cretaceous Siliceous Sponges and the Jurassic of Cuba.

In case any of the readers of the *Federationist* are in the same state of ignorance about matters of such vital public concern as the writer, Jurassic, according to Webster's, is the geological period in which "ichthyosaurs, plesiosaurs, and other reptiles abounded in the sea."

I have no desire to ridicule the good doctor (Ph. D.), for no doubt her studies represent important and valuable contributions to that field of learning relating to prehistoric crabs, sponges, and reptiles. But I do seem to recall that last November there was a lot of talk about getting rid of long hairs and brain trusters in Government.

On May 2, News Letter No. 19 was sent out which contained full particulars of the schedule of hearings on Senator Taft's bill. It indicated also that efforts would be made by the proponents of health insurance to obtain hearings on the bill about to be introduced by Senators Wagner and Murray. It went on to indicate how this effort could be forestalled.

Perhaps the most significant thing about this issue of the Shearon letter is the date—May 2. For at this same time representatives of the American Federation of Labor, on calling the office of the chairman of the Subcommittee on Health—Senator H. Alexander Smith, of New Jersey—were being referred to Dr. Shearon, who advised us that the subcommittee had not met and that the schedule of hearings had not been determined. She explicitly informed us that the day of the hearings had not definitely been determined and that it was not known whether the hearings would include a study of the health-insurance bill. Yet at the same time, in her news letter, she was giving her American Medical Association friends precise information to the contrary.

Thus it was that when Senator Murray pointed out at the opening sessions of the hearings that almost all the time was being given to advocates of Senator Taft's public charity health bill, Senator Smith could accurately respond that time was being given to those who had requested to be heard on the Taft bill. Of course, many opponents of health insurance and supporters of a medical poor law of the kind proposed by Senator Taft had asked to be heard, as they were directed to do so by Dr. Shearon. The result is that practically all the time during the first 4 weeks of the hearings is now being given to supporters of the Taft bill, with no time allotted to the opponents, whereas all the supporters of genuine health insurance, including the American Federation of Labor, are to be crowded into 3 days after the hearings on the Taft bill are completed.

There are other implications of Senator Taft's statement which need to be examined. What are the facts with respect to his charge that the hearings last year were stacked against his bill?

In the first place, he charges that supporters of his bill last year were not heard until the end of the hearings. But the hearings last year began on April 2, and it was more than a month later when Senator Taft introduced his bill. He could hardly expect that time would be given the proponents of a bill which had not yet been introduced. This year both bills were introduced prior to the opening hearings.

Looking at the schedule of last year's hearings, we find that supporters and opponents of health insurance were heard regularly throughout the hearings. Although supporters outnumbered the opponents, the opponents were not put off until the end of the hearings. Representatives of the American Medical Association, of so-called voluntary health plans, and of State medical societies were heard during the second week of the hearings, which lasted 6 weeks.

Incidentally, in connection with last year's bill, Senator Taft indicated to representatives of the American Federation of Labor that he was planning to introduce such a bill and said that he would like to discuss its contents with them prior to its introduction. This, however, he failed to do, and no representative of the American Federation of Labor was consulted prior to the introduction of the bill, either this year or last.

Last January I personally talked with Senator Taft about the possibility of health legislation this year. He stated at that time that he was discussing a new bill with "interested persons." I suggested that the 7,500,000 members of the American Federation of Labor and their families who would be affected by any health legislation might properly be included among the interested persons. He brushed this off by saying:

"Your organization represents some of the interested persons."

To what does Senator Taft refer when he says: "We have control of the committee"? He could have meant and probably meant only to imply that a majority of the Subcommittee on Health is now composed of members of his party; namely, Senators Smith, of New Jersey; Ball, of Minnesota; and Donnell, of Missouri. But in the hearings there were indications that his statement meant more than he intended to imply, for on the opening day Dr. Ross Sensenich, chairman of the board of trustees of the American Medical Association, stated that his organization had been consulted in drafting the final form of the bill and indicated that many of the suggestions made by the AMA had been incorporated. So, in health as in labor legislation, Senator Taft listens to the reactionary forces that have a direct stake in denying the progress the people are demanding. The NAM writes his labor bills and the AMA his health bills.

Or perhaps Senator Taft is listening to the National Physicians Committee, the propaganda arm of organized medicine, which, according to the records of registration required by the Lobbying Act, spent \$306,000 during the last 5 months of 1946 in smearing and attacking national health insurance.

The issues between the two bills now before the committee are clearly drawn and the stakes are high. The stakes are more than financial. They involve the opportunity for working people over the Nation to obtain adequate medical care of high quality as a right and in a manner consistent with the dignity and self-respect of free workers in a democracy, as opposed to the proposal to provide through State machines dominated by medical politicians a minimum of medical care doled out as a public charity.

The health-insurance bill (S. 1320) would provide to all employed and self-employed persons and the members of their families as soon as personnel and facilities are available all needed preventive, diagnostic, and curative

services by a family physician of the patient's choice; services of specialists when required; hospital care, laboratory, and X-ray services; and special services, including the unusually expensive medicines, special appliances, and eyeglasses. Dental, home nursing, and auxiliary services would be limited in terms of available facilities and funds, with priority given to services for children.

The bill provides free choice of doctor, hospital, group clinic, dentist, or nurse, and guarantees like freedom on the part of professional persons to accept or refuse a patient. It provides a democratic method of administration through the maximum use of State and local agencies, assisted by representative advisory councils on which the recipients of medical care are fully represented. It provides for the continued operation of voluntary group-health agencies, including those established under collective-bargaining agreements.

It is anticipated that the cost of these services would be borne by contributions by both employer and employees, based on pay rolls in amounts somewhat less than is now paid by wage earners, on the average, for medical services over a period of years, to be supplemented by funds from the general revenues of Government.

In short, the bill makes possible a pooling of the amounts personally spent for medical care by wage earners and their families and a spreading of the risks.

Recognizing that the problem of paying for medical care on the part of individuals is not the whole problem—though a very important one—the health-insurance bill makes provision for expanding public-health services and for developing the necessary facilities, such as hospitals and health centers, through a system of grants-in-aid to the States. It also provides additional grants for expanded maternal and child-health services and services for crippled children and to pay the insurance premiums for those who are eligible for public assistance.

In direct contrast to this approach, Senator Taft's bill (S. 545) proposes to solve the national health problem by offering medical charity. It authorizes a Federal appropriation of \$200,000,000 a year, to be apportioned among the States to help care for those whom the States determine, without the aid of any Federal standards, to be unable to pay for all or part of the cost for medical services. This bill also proposes that aid shall be given from public funds to the so-called voluntary health-insurance plans to enable them to enroll medically needy persons by paying all or part of their insurance charges. To be eligible for such assistance persons would have to prove their need to a relief agency, as determined by each State.

The fine hand of the AMA can clearly be seen in the administrative provisions of the Taft bill. Doctors and hospital administrators are to be in control at all levels of administration. Professional control is also assured on the advisory bodies at both the Federal and State levels. No provision is made to assure representation of the point of view of the general public, nor of the recipients of the care contemplated in the bill.

These two bills present a clear-cut choice as between comprehensive medical care through a public-insurance program under consumer control and inadequate charity service under monopoly control. It is a choice that deserves full consideration and careful study. But the hearings as now scheduled give little promise of the kind of fair and impartial analysis upon which a sound decision of far-reaching importance to the American people can be made by Congress.

Senator MURRAY. Now, Mr. Chairman, I renew my objection to this party being permitted to remain at this table and to participate in these further proceedings. I also object to her being permitted to maintain an office in this building and to call herself "consultant" while at the same time she is engaged in spreading this sort of propaganda against Members of the Senate.

Senator SMITH. The Chair will take the matter up with the committee.

Senator DONNELL. Mr. Chairman, I don't want to prolong this unduly. I want to make only this statement: The Blueprint, which I think is perfectly proper, should be offered for the record. It is admitted?

Senator SMITH. Yes.

(The document referred to will appear in pt. 4.)

Senator DONNELL. The Blueprint does contain the language at the top of the chart:

Administration plans for nationalization of medicine, emanating from the House of Falk. Spheres of influence and interlocking directorates, collaborationists, fellow travelers, appeasers, satellites, and gullible accepters.

I am informed by Dr. Shearon that by the term "collaborationists" and "fellow travelers" she was referring to collaboration and traveling along with Mr. Falk, Isidore Falk.

I may call attention to the fact that the left-hand lower portion of this Blueprint is this legend "Direct line of control." That shows a black line from direct lines of control on staff of or consultant to I. S. Falk, i. e., on Federal pay roll. Then a broken line and—

Indirect lines of control: Collaborationists, fellow travelers, appeasers, satellites, and gullible accepters.

I call attention to the further fact that it is my information from Dr. Shearon that approximately only 10 of these Blueprints were printed, that she does not know how this particular one came into the possession of either Senator Murray or Senator Pepper; but I offer it in the record at this time, Mr. Chairman, a copy taken from the booklet marked "Blueprint for the Nationalization of Medicine," by Marjorie Shearon, Ph. D., research analyst.

I offer for the record a similar print entitled "Administration Plans for Nationalization of Medicine, emanating from the House of Falk," in which I call attention that immediately under "the House of Falk" instead of the words "Spheres of influence and interlocking directorates, collaborationists, fellow travelers, appeasers, satellites, and gullible accepters," the words on this are: "Spheres of influence and interlocking directorates," and all reference to collaborationists and fellow travelers, appeasers, satellites, and gullible accepters has been omitted from this print that appears in this Blueprint issued in Washington in 1947.

Senator SMITH. You are offering that in connection with matter referred to by Senator Murray?

Senator DONNELL. That is correct.

(The paper referred to will appear in pt. 4.)

Senator DONNELL. I also would like at this time to ask the reporter—I want this to go into the record—if he will be kind enough at his earliest convenience to look at page 1647 of the record of these hearings, at which page appears this question and answer:

Senator MURRAY. Then what right has she to be here?

I may interrupt there to say that "she" is Dr. Shearon. Then this appears by myself:

Senator DONNELL. She is here.

My recollection is, Mr. Chairman, and my best judgment is that there is an error in the report of my statement "She is here." I think that what I said was substantially "She is assisting me," or perhaps "She is here assisting me." I am not asking the reporter to change the record. If he doesn't find that in his notes I want it to stay as it is, but nevertheless I will ask him if he will be kind enough to examine the record and let me know whether or not there should be

any correction at page 1647 of the transcript. If he finds that the record is correctly transcribed, namely, "She is here," I desire to state that there was no intention whatsoever on my part of being curt or abrupt or anything of the sort, and that what I should have said, and what I meant to say, is that Dr. Shearon is here assisting me.

(The reporter having searched his notes subsequently supplied the language which appears in the colloquy on p. 1111.)

Senator MURRAY. I recall that is exactly what the Senator said, not that "She is here" but that "She is here assisting me." I have examined the transcript of this testimony, and I find very few pages in it that are correct. The testimony in the transcript the other day was so completely garbled that you can't understand it in some places. Some parts of the questions that I asked and questions that Senator Pepper asked are not in the record. I called attention to the fact the reporter was not getting all the testimony when you were cross-examining the witness a day or two ago, I believe it was the representative of the Lawyers Guild. You both were talking at the same time and I objected because I wanted to have it all in the record, but the stenographer at the time claimed she was getting it. She was not getting it, could not get it; no one could get it. We could not understand it ourselves, because the interruptions were so rapid and the witness was not permitted to complete his statement half the time, and therefore I think that some regulations should be made or some effort should be made to permit us to get a complete record here, so we may have all of the questions and all of the answers, and not have it garbled and emasculated as it has been in the last few copies of the record that I have examined.

Senator DONNELL. Mr. Chairman, I want to say this, that I quite agree with Senator Murray as to the importance of having this record complete and correct and accurate, and I may say that I recall myself the other day having interrupted Mr. Silberstein, and I should not have interrupted him. I did not have any intention to shut him off, and the Senator will recall I requested him to proceed, and I want to say at this point that I became quite irritated and regret exceedingly the irritation. Senator Murray has always been so courteous to me. Likewise Senator Pepper, and I intended no discourtesy.

Senator MURRAY. I wish to say to the Senator from Missouri that I have always regarded him as being absolutely fair, and he has always treated me with the greatest of courtesy. I have no criticism whatever to make of the Senator, but I do think that it is unfair to us, sitting here as coequals, to be insulted from time to time by a woman who has no business being here sitting at this table. I think she ought to be removed immediately. She ought to be told right now to step aside, in view of the facts that we have brought to the attention of this committee. I don't think I want to sit in this committee any longer if she is going to continue to remain here. If she is not removed, I may have to remove myself from this committee and be absent from now on, because I think it is absolutely unfair and unjust to us.

Senator DONNELL. May I state for the record that my information is from Dr. Shearon—and I believe it to be correct—that she is on the staff of Senator Taft, and I think she has the right to be here at the request of a Member of the Senate. She has been of tremendous assistance to me. She is highly informed on this subject, and I know of no

discourtesy that she has intended in the course of these hearings at any time to any member of the committee. She has been extremely helpful, and it appears to me it would be decidedly improper for her to be removed. I ask very respectfully that she be permitted to remain and assist. She is on the staff, so I am informed by her, and I believe it to be true, of Senator Taft, and I think she has a right to be of any assistance to Senator Murray or Senator Pepper or Senator Smith or any other member of this committee. No discourtesy is intended to either of these gentlemen. They have been so courteous and very gentlemanly at all times to me, and I assure them of my appreciation of it.

Senator SMITH. I would like to say at this point, I was not present when this difficulty came up the other day so I am not familiar with it, but as far as I am concerned, I have heard nothing done in the presence of the committee or in the hearings by Dr. Shearon along the line of these accusations. As to these documents here, I have not had time to examine them, but I can say to the Senator that had anything discourteous happened at these hearings, I should have protected the Senator from Montana and from Florida, as well as anybody else. Senators are entitled to the greatest respect, and nothing has been done that I have seen in the presence of the committee, and I requested Dr. Shearon not to send out these statements after they were called to the attention of the committee, and I understand that that request has been carried out. I certainly agree that we should keep away from propaganda in this matter. What we are after is facts, and we must have facts before we can get results in the way of legislation, and it is very distressing to me to have an issue of this kind come up, especially when I think there is only one more day of hearings, maybe two more, and we are about through, and it seems to me that we can work this out without attendant publicity and difficulty. I am perfectly willing to take the matter up before the whole committee, and I think that is where it belongs, and I want to respectfully say to the Senators from Montana and Florida that I have had nothing presented to me that would justify me in saying that Dr. Shearon at this moment should leave the room. I think that is utterly unfair for the Senators to ask me to do that, and I would have to very respectfully decline to do it, but I assure you I am going to do everything in my power to see that matters of this nature do not come up when we are trying to get at the facts.

Senator MURRAY. I sympathize with the Senator, and I appreciate his expressions here, but the Senator will recall that when we had the matter up before the executive meeting of the committee it was conceded then that her actions were improper, and that she would not be permitted to continue on the committee, but at the special request of Senator Donnell, I believe, she was permitted to remain.

Senator SMITH. I made the request that Dr. Shearon assist us in getting information.

Senator MURRAY. But with the understanding that she was to desist in these propaganda activities that she has been engaged in. But she did not desist. I have seen statements that she has sent out subsequent to that time, and I suspect she is sending out material every day.

Senator PEPPER. It may be that the Senator would prefer to make a decision about this matter in executive session.

Senator SMITH. I would prefer it.

Senator PEPPER. I would suggest, if it is agreeable to the Senator from Montana, as it will be to me, that this matter be taken up and disposed of in executive session.

Senator SMITH. I think that is where it belongs.

Senator PEPPER. Mr. Chairman, in view of the fact that the House report, the so-called House Report No. 786, which was introduced in evidence, refers critically on page 6 to the actions of the Department of Justice and to the Supreme Court of the United States in respect to:

This legal action by the Department of Justice was carried to the Supreme Court of the United States on the basis of the original complaint and accusations of Group Health Association of Washington, D. C., serving effectively to intimidate and restrain the activities of the American Medical Association in resisting the Federal propaganda.

I say, in view of that paragraph and the preceding paragraph, I agree to submit to the clerk for inclusion in the record, following the introduction of this House Report No. 786, the decisions of the United States Supreme Court and the Court of Appeals in the Group Health medical case referred to in that report, because it is only fair that the record of the case, the official record of the case, be included in this record.

Senator DONNELL. Mr. Chairman, there is no objection on my part to that being done.

May I ask this one question. Perhaps I misunderstood the Senator from Florida. I understood he did not intend to indicate that this report contains anything disrespectful to the Supreme Court or the Department of Justice.

Senator PEPPER. Yes; I thought so, Mr. Chairman.

Senator DONNELL. I don't think there is anything disrespectful in it.

Senator PEPPER. In view of those two paragraphs.

In this connection, the committee will recall that it was the activities of the Group Health Association of Washington, D. C., which led to the filing in 1937 of the antitrust proceeding against the Medical Society of the District of Columbia and the American Medical Association under the Sherman Antitrust Act:

This legal action by the Department of Justice was carried to the Supreme Court of the United States on the basis of the original complaint and accusations of Group Health Association of Washington, D. C., serving effectively to intimidate and restrain the activities of the American Medical Association in resisting the Federal propagandists.

Now, surely, the decision of the United States Supreme Court and the pleadings upon which that decision was based, instituted by the Department of Justice, should speak for themselves.

Senator DONNELL. I think so. But, Mr. Chairman, I don't think the Senator from Florida understood my inquiry and I don't understand that his answer in any sense contradicts what I have said. I understood him in the earlier part of his reference to these paragraphs to indicate that he thought those paragraphs in the report constituted some accusation or charge against the Department of Justice or against the Supreme Court. As I see it, there is not a word said there against the Department of Justice or against the Supreme Court. It simply recites that the Department of Justice instituted an antitrust proceeding, and that legal action was carried to the Supreme Court of the United States, and the reflection, if any,

is not upon the Department of Justice or the Supreme Court, but is upon the American Medical Association or the Group Health Association of Washington, D. C., and I am sure the Senator did not mean to indicate that there was any reflection here against either the Department of Justice or the Supreme Court.

Senator PEPPER. The Senator from Florida may be misunderstood, but it was his intention to say that he cannot construe that language other than to conclude that it was the desire and intent on the part of that committee to include the action of the Department of Justice and the Supreme Court as *particeps criminis* with the action, which they denounce, of the Group Medical Association in Washington. The report, of course, will have to speak for itself, but the Senator did intend to say that the report was intended to bring the Supreme Court, the Department of Justice and the Group Health Association all together in condemnation, because it says this served effectively to intimidate and restrain the activities of the American Medical Association, not intimidation from violating the antitrust laws, but it says "in resisting the Federal propaganda"—that decision of the United States Supreme Court effectively prevented them from resisting the Federal propaganda.

Senator DONNELL. I have no objection to including it in the record.

Senator SMITH. You do not have them here?

Senator PEPPER. I will furnish them.

Senator DONNELL. May I make one further suggestion, that is, that all of these documents, House Report 786, and the other papers that have been introduced, be incorporated in the record at the places where presented, so that we do not have to look back at an appendix somewhere to find it.

Senator PEPPER. It should appear in the regular order.

Senator SMITH. Are there any further questions?

Senator DONNELL. I have no further questions.

Senator SMITH. The committee will recess until 2:30 this afternoon, and Dr. Parran will proceed at that time.

(Whereupon, at 1:15 p. m., the subcommittee recessed until 2:30 p. m. this day.)

(The decision of the United States Supreme Court in the action referred to follows:)

SUPREME COURT OF THE UNITED STATES.

Nos. 201-202.—OCTOBER TERM, 1942.

American Medical Association, a corporation, Petitioner, 201	vs.	The United States of America.
The Medical Society of the District of Columbia, a corporation, Petitioner, 202	vs.	The United States of America.

On Writs of Certiorari to the United States Court of Appeals for the District of Columbia.

[January 18, 1943.]

Mr. Justice ROBERTS delivered the opinion of the Court.

Petitioners have been indicted and convicted of conspiring to violate § 3 of the Sherman Act,¹ by restraining trade or commerce in the District of Columbia.

¹ Act of July 2, 1890, § 3, c. 647, 26 Stat. 209, 15 U. S. C. § 3.

They are respectively corporations of Illinois and of the District of Columbia. Joined with them as defendants were two unincorporated associations and twenty-one individuals, some of whom are officers or employes of one or other of the petitioners, the remainder being physicians practicing in the District of Columbia and members of the petitioners serving, as to some of them, on various committees of the petitioners having to do with professional ethics and with the practice of medicine by petitioners' members.

For the moment it is enough to say that the indictment charged a conspiracy to hinder and obstruct the operations of Group Health Association, Inc., a non-profit corporation organized by Government employes to provide medical care and hospitalization on a risk-sharing prepayment basis. Group Health employed physicians on a full time salary basis and sought hospital facilities for the treatment of members and their families. This plan was contrary to the code of ethics of the petitioners. The indictment charges that, to prevent Group Health from carrying out its objects, the defendants conspired to coerce practicing physicians, members of the petitioners, from accepting employment under Group Health, to restrain practicing physicians, members of the petitioners, from consulting with Group Health's doctors who might desire to consult with them, and to restrain hospitals in and about the City of Washington from affording facilities for the care of patients of Group Health's physicians.

The District Court sustained a demurrer to the indictment on the grounds, amongst others, that neither the practice of medicine nor the business of Group Health is trade as the term is used in the Sherman Act.² On appeal the Court of Appeals reversed, holding that the restraint of trade prohibited by the statute may extend both to medical practice and to the operations of Group Health.³

The case then went to trial in the District Court. Certain defendants were acquitted by direction of the judge. As to the others, the case was submitted to the jury which found the petitioners guilty, and all the other defendants not guilty. From judgments of conviction the petitioners appealed to the Court of Appeals, which reiterated its ruling as to the applicability of § 3 of the Sherman Act, considered alleged trial errors, and affirmed the judgments.⁴

We granted certiorari limited to three questions which we thought important: 1. Whether the practice of medicine and the rendering of medical services as described in the indictment are "trade" under § 3 of the Sherman Act. 2. Whether the indictment charged or the evidence proved "restraints of trade" under § 3 of the Sherman Act. 3. Whether a dispute concerning terms and conditions of employment under the Clayton and Norris-LaGuardia Acts was involved, and, if so, whether petitioners were interested therein, and therefore immune from prosecution under the Sherman Act.

First. Much argument has been addressed to the question whether a physician's practice of his profession constitutes trade under § 3 of the Sherman Act. In the light of what we shall say with respect to the charge laid in the indictment, we need not consider or decide this question.

Group Health is a membership corporation engaged in business or trade. Its corporate activity is the consummation of the cooperative effort of its members to obtain for themselves and their families medical service and hospitalization on a risk-sharing prepayment basis. The corporation collects its funds from members. With these funds physicians are employed and hospitalization procured on behalf of members and their dependents. The fact that it is cooperative, and procures service and facilities on behalf of its members only, does not remove its activities from the sphere of business.⁵

If, as we hold, the indictment charges a single conspiracy to restrain and obstruct this business it charges a conspiracy in restraint of trade or commerce within the statute. As the Court of Appeals properly remarked, the calling or occupation of the individual physicians charged as defendants is immaterial if the purpose and effect of their conspiracy was such obstruction and restraint of the business of Group Health. The court said:⁶ "And, of course, the fact that defendants are physicians and medical organizations is of no significance, for Sec. 3 prohibits 'any person' from imposing the proscribed restraints. . ." It is urged that this was said before this court decided *Apeæ Hosiery Co. v. Leader*,

² United States v. American Medical Association, 28 F. Supp. 752.

³ United States v. American Medical Association, 72 App. D. C. 12, 110 F. 2d 703, 710, 711.

⁴ American Medical Association v. United States. — App. D.C. —, 130 F. 2d 233.

⁵ Compare, Associated Press v. National Labor Relations Board, 301 U. S. 103, 128-9; In re Duty on Estate of Incorporated Council, 22 Q. B. 279, 293; Maryland and Virginia Milk Producers' Ass'n v. District of Columbia, 119 F. 2d 787, 790; La Belle v. Hennepin County Bar Ass'n, 206 Minn. 290, 294.

⁶ 110 F. 2d 711.

310 U. S. 469. But nothing in that decision contradicts the proposition stated. Whether the conspiracy was aimed at restraining or destroying competition, or had as its purpose a restraint of the free availability of medical or hospital services in the market, the *Apex* case places it within the scope of the statute.⁷

Second. This brings us to consider whether the indictment charged, or the evidence proved, such a conspiracy in restraint of trade. The allegations of the indictment are lengthy and detailed. After naming and describing the defendants and the Washington hospitals, it devotes many paragraphs to a recital of the plan adopted by Group Health and alleges that, principally for economic reasons, and because of fear of business competition, the defendants have opposed such projects.

The indictment then recites the size and importance of the petitioners, enumerates means by which they can prevent their members from serving Group Health plans, or consulting with physicians who work for Group Health, and can prevent hospitals from affording facilities to Group Health's doctors.

In charging the conspiracy, the indictment describes the organization and operation of Group Health and states that, from January 1937 to the date of the indictment, the defendants, the Washington hospitals, and others cognizant of the premised facts, "have combined and conspired together for the purpose of restraining trade in the District of Columbia, . . ." In five paragraphs the pleading states the purposes of the conspiracy. The first is the purpose of restraining Group Health from doing business; the second, that of restraining members of Group Health from obtaining adequate medical care according to Group Health's plan; the third, that of restraining doctors serving Group Health in the pursuit of their calling; the fourth, that of restraining doctors not on Group Health's staff from practicing in the District of Columbia in pursuance of their calling; and the fifth, that of restraining the Washington hospitals in the business of operating their hospitals.

After reciting certain of the proceedings and plans adopted to forward the conspiracy, the indictment alleges that the conspiracy, and the intended restraints which have resulted from it, have been effectuated "in the following manner and by the following means"; and alleges that the defendants have combined and conspired "with the plan and purpose to hinder and obstruct Group Health Association, Inc. in procuring and retaining on its medical staff qualified doctors and to hinder and obstruct the doctors serving on that staff from obtaining consultations with other doctors and specialists practicing in the District of Columbia." It states that, pursuant to this plan and purpose, the defendants have resorted to certain means to accomplish the end, and recounts them.

In another paragraph, the defendants are charged to have conspired with "the plan and purpose to hinder and obstruct Group Health Association, Inc. in obtaining access to hospital facilities for its members and to hinder and obstruct the doctors on the medical staff of Group Health from treating and operating on their patients in Washington hospitals." It is alleged that, pursuant to this plan and purpose, defendants have done certain acts to deter hospitals with which they were connected and over which they exercised influence, from affording hospital facilities to Group Health's doctors.

The petitioners' contention is, in effect, that the indictment charges five separate conspiracies defined by their separate and recited purposes, namely, conspiracy to obstruct the business of Group Health, to obstruct its members from obtaining the benefit of its activities, to obstruct its doctors from serving it, to obstruct other doctors in the practice of their calling, and to restrain the business of Washington hospitals. The petitioners say that they were entitled to have the trial court rule upon the sufficiency in law of each of these charges and, as this was not done, the general verdict of guilty cannot stand. They urge that even though some of the named purposes relate to the business of Group Health, and that business be held trade within the meaning of the statute, yet, as the practice of medicine by doctors not employed by Group Health is not trade, and the operations of Washington hospitals are not trade, the last two purposes specified cannot constitute violations of § 3 and the jury should have been so instructed. In this view they insist that the jury may have convicted them of restraining physicians unconnected with Group Health, or of restraining hospitals, and, if so, the verdict and judgment cannot stand.

If in fact the indictment charges a single conspiracy to obstruct and restrain the business of Group Health, and if the recited purposes are really only subsidiary to that main purpose or aim, or merely different steps toward the ac-

⁷ Compare *Fashion Originator's Guild v. Federal Trade Commission*, 312 U. S. 457, 465, 466, 467.

complishment of that single end, and if the cause was submitted to the jury on this theory, these contentions fail.

When the case first went to the Court of Appeals that tribunal construed the indictment as charging but a single conspiracy. It said:⁸ "The charge, stated in condensed form, is that the medical societies combined and conspired to prevent the successful operation of Group Health's plan, and the steps by which this was to be effectuated were as follows: (1) to impose restraints on physicians affiliated with Group Health by threat of expulsion or actual expulsion from the societies; (2) to deny them the essential professional contacts with other physicians; and (3) to use the coercive power of the societies to deprive them of hospital facilities for their patients."

In the trial, the District Court conformed its rulings to this decision and submitted the case to the jury on the theory that the indictment charged but one conspiracy.

We think the courts below correctly construed the indictment. It is true that, in describing the conspiracy, five purposes are stated which the conspiracy was intended to further, but, in a later paragraph, still in the charging part of the instrument, it is alleged that the purpose was to hinder and obstruct Group Health in various ways and by various coercive measures, which are identical with the "purposes" before stated. The trial judge, after calling the jury's attention to the juxtaposition of these two formulations of the charge, added:

"These purposes, it is alleged, were to be attained by certain coercive measures against the hospitals and doctors designed to interfere with employment of doctors by Group Health and use of the hospitals by members of its medical staff and their patients. . . ."

In immediate context the judge added:

"To sustain that charge the Government must prove beyond a reasonable doubt that a conspiracy did in fact exist to restrain trade in the District in at least one of the several ways alleged, and according to the particular purpose and plan set forth."

At another point the trial judge summarized the Government's claim that the evidence in the case showed opposition by the petitioners to Group Health and its plan; that they feared competition between the plan and the organized physicians and that, to obstruct and destroy such competition, the petitioners conspired with certain officers and members and hospitals to prevent successful operation of Group Health's plan by imposing restraints upon physicians affiliated with Group Health, by denying such physicians professional contact and consultation with other physicians, and by coercing the hospitals to deny facilities for the treatment of their patients. Again the judge charged: "Was there a conspiracy to restrain trade in one or more of the ways alleged?" And again: "If it be true . . . that the District Society, acting only to protect its organization, regulate fair dealing among its members, and maintain and advance the standards of medical practice, adopted reasonable rules and measures to those ends, not calculated to restrain Group Health, there would be no guilt, though the indirect effect may have been to cause some restraint against Group Health."

We need add but a word as to the sufficiency of the proof to sustain the charge. The petitioners in effect challenge the sufficiency, in law, of the indictment. They hardly suggest that if the pleading charges an offense there was no substantial evidence of the commission of the offense. But, however the argument is viewed, we agree with the courts below that the case was one for submission to a jury. No purpose would be served by detailed discussion of the proofs.

Third. We hold that the dispute between petitioners and their members, and Group Health and its members, was not one concerning terms and conditions of employment within the Clayton⁹ and the Norris-LaGuardia¹⁰ acts.

Section 20 of the Clayton Act, as expanded by § 13 of the Norris-LaGuardia Act, is the only legislation which can have any bearing on the case. Section 20 applies to cases between "an employer and employees, or between employers and employees, or between employees, or between persons employed and persons seeking employment, involving, or growing out of, a dispute concerning terms or conditions of employment . . ."; and provides that none of the acts specified in the section shall "be considered or held to be violations of any law of the United States."

⁸ 110 F. 2d 711.

⁹ 38 Stat. 730, §§ 6 and 20, 15 U. S. C. 17, 29 U. S. C. 52.

¹⁰ 47 Stat. 70, §§ 4, 5, 6, 8 and 13, 29 U. S. C. §§ 104, 105, 106, 108 and 113.

Section 13 of the Norris-LaGuardia Act defines a labor dispute as including "any controversy concerning terms or conditions of employment, or concerning the association or representation of persons in negotiating, fixing, maintaining, changing, or seeking to arrange terms or conditions of employment, regardless of whether or not the disputants stand in the proximate relation of employer and employee." It also provides that "A case shall be held to involve or to grow out of a labor dispute when the case involves persons who are engaged in the same industry, trade, craft, or occupation; or have direct or indirect interests therein; or who are employees of the same employer; or who are members of the same or an affiliated organization of employers or employees; whether such dispute is (1) between one or more employers or associations of employers and one or more employees or associations of employees; (2) between one or more employers or associations of employers and one or more employers or associations of employees; or (3) between one or more employees or associations of employees and one or more employees or associations of employees; or when the case involves any conflicting or competing interests in a 'labor dispute' (as defined in this section) of 'persons participating or interested' therein (as defined in this section)."

Citing these provisions the petitioners insist that their dispute with Group Health was as to terms and conditions of employment of the doctors employed by Group Health since the District Medical Society objected to its members, or other doctors, taking employment under Group Health on the terms offered by that corporation. They assert that § 20 of the Clayton Act, as expanded by § 13 of the Norris-LaGuardia Act, includes all persons and associations involved in a dispute over terms and conditions of employment who are engaged in the same industry, trade, craft, or occupation, or have direct or indirect interests therein. And they rely upon our decisions in *New Negro Alliance v. Sanitary Grocery Co.*, 303 U. S. 552, and *Drivers Union v. Lake Valley Co.*, 311 U. S. 91, as bringing within the coverage of the acts a third party, even though that party be a corporation not in trade, and employers and employees' associations even though they be only indirectly interested in the controversy. They insist that as the petitioners and Group Health, its members and doctors, other doctors and the hospitals, were either directly or indirectly interested in a controversy which concerned the terms of employment of doctors by Group Health, the case falls within the exemption of the statutes and they cannot be held criminally liable for a violation of the Sherman Act.

It seems plain enough that the Clayton and Norris-LaGuardia Acts were not intended to immunize such a dispute as is presented in this case. Nevertheless, it is not our province to define the purpose of Congress apart from what it has said in its enactments, and, if the petitioners' activities fall within the classes defined by the acts, we are bound to accord petitioners, especially in a criminal case, the benefit of the legislative provisions.

We think, however, that, upon analysis, it appears that petitioners' activities are not within the exemptions granted by the statutes. Although the Government asserts the contrary, we shall assume that the doctors having contracts with Group Health were employees of that corporation. The petitioners did not represent present or prospective employees. Their purpose was to prevent anyone from taking employment under Group Health. They were interested in the terms and conditions of the employment only in the sense that they desired wholly to prevent Group Health from functioning by having any employees. Their objection was to its method of doing business. Obviously there was no dispute between Group Health and the doctors it employed or might employ in which petitioners were either directly or indirectly interested.

In truth, the petitioners represented physicians who desired that they and all others should practice independently on a fee for service basis where whatever arrangement for payment each had was a matter that lay between him and his patient in each individual case of service or treatment. The petitioners were not an association of employees in any proper sense of the term. They were an association of individual practitioners each exercising his calling as an independent unit. These independent physicians, and the two petitioning associations which represent them, were interested solely in preventing the operation of a business conducted in corporate form by Group Health. In this aspect the case is very like *Columbia River Packers Association, Inc., v. Hinton*, 315 U. S. 143. What was there decided requires a holding that the petitioners' activities were not exempted by the Clayton and the Norris-LaGuardia Acts from the operation of the Sherman Act.

The judgments are affirmed.

Mr. Justice MURPHY and Mr. Justice JACKSON took no part in the consideration or the decision of this case.

A true copy.

Test:

Clerk, Supreme Court, U. S.

(The decision of the Court of Appeals for the District of Columbia in the action referred to follows:)

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

No. 7929

AMERICAN MEDICAL ASSOCIATION, A CORPORATION, APPELLANT

v.

UNITED STATES OF AMERICA

No. 7930

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA, A CORPORATION, APPELLANT

v.

UNITED STATES OF AMERICA

Appeal from the District Court of the United States for the District of Columbia

Decided June 15, 1942

Messrs. Seth W. Richardson and William E. Leahy, with whom Messrs. Edward M. Burke, Charles S. Baker and Warren E. Magee were on the brief, for appellant in each case.

Messrs. John Henry Lewin and Grant W. Kelleher, Special Assistants to the Attorney General, with whom Assistant Attorney General Arnold and Messrs. E. Compton Timberlake and Walton S. Allen were on the brief, for appellee in each case.

Mr. Edward M. Curran, United States Attorney, also entered an appearance for appellee in each case.

Before MILLER, RUTLEDGE and MARTIN, Associate Justices.

MILLER, *Associate Justice*: In *United States v. American Medical Association*,¹ we held that the term "in restraint of trade" as used in Section 3 of the Sherman Act had its genesis in the common law; that the practice of medicine was recognized by the English cases as constituting trade; that a restraint imposed upon the practice of medicine may constitute a restraint of trade; that restraints imposed upon the operation of hospitals and upon Group Health Association, designed to prevent it from making available to and financing medical services on behalf of its members may constitute restraint of trade; that the indictment under which appellants were charged stated a case under Section 3 of the Sherman Act. Accordingly, we held that the indictment was sufficient as against a demurrer; we reversed a judgment of the District Court, which had sustained a demurrer, and remanded the case for trial. Upon the trial which followed and at the close of the Government's case the court directed verdicts of acquittal for two unincorporated associations and two individual defendants. Thereafter the jury convicted the appellants and acquitted all other defendants. Appeals from the judgment of the District Court, based upon these convictions, were consolidated for hearing in this court.

On this appeal it is suggested that the Supreme Court, in *Apex Hosiery Co. v. Leader*,² repudiated the doctrine stated in our earlier decision; hence that we should reconsider and abandon the position which we there took. But we see no reason to adopt the suggestion which, apparently, grew out of appellants' failure to distinguish between *trade* and *restraint of trade*. Appellants' confusion is

¹ 72 App. D. C. 12, 110 F. (2d) 703, cert. denied, 310 U. S. 644.

² 310 U. S. 469.

evidenced by the following statement from their brief: "The *Apex* case held in substance and effect that no activity could be in 'trade' unless it was a commercial activity and exercised and used in such a way as to affect the market either by fixing prices or suppressing competition in the market to the injury of the public." Of course the Court did not so hold, nor has any court ever so held. Most activities which are in trade serve, rather than injure, the public.

In the *Apex* case,³ no question was involved as to whether the petitioner was engaged in trade or commerce. The opening sentence of the opinion states, as an undisputed fact: "Petitioner, a Pennsylvania corporation, is engaged in the manufacture, at its factory in Philadelphia, of hosiery, a substantial part of which is shipped in interstate commerce." Neither was the Court in doubt as to whether trade or commerce was affected by the actions complained of.⁴ The question which was presented for its decision was whether the conduct of the labor union and its members constituted *restraint* of trade, within the meaning of Section 1 of the Sherman Act.⁵

In answering this question, the Court, first, restated the familiar common law doctrines relating to contracts and combinations in restraint of trade and the equally familiar history of the taking over, by the Sherman Act, of the common law concept of illegal restraints.⁶ It then concluded that (1) the Sherman Act does not condemn all combinations and conspiracies which interrupt interstate transportation;⁷ (2) labor unions are to some extent and in some circumstances subject to the Act;⁸ but (3) it does not apply to all labor union activities affecting interstate commerce!⁹ (4) the evil at which the Sherman Act was aimed was the control of the market "by suppression of competition in the marketing of goods and services . . .";¹⁰ (5) the end sought was the prevention of "restraints to free competition in business and commercial transactions which tended to restrict production, raise prices or otherwise control the market to the detriment of purchasers or consumers of goods and services . . .";¹¹ and, finally (6) "Restraints on competition or on the course of trade in the merchandising of articles moving in interstate commerce is not enough, unless the restraint is shown to have or is intended to have an effect upon prices in the market or otherwise to deprive purchasers or consumers of the advantages which they derive from free competition."¹²

The trade or commerce which was involved in the present case was of three kinds: (1) The making available and financing of medical and hospital services; (2) medical service itself, *i. e.*, service rendered by medical doctors; (3) hospital service, *i. e.*, service rendered by hospital staffs and the use of hospital facilities. As we indicated in our earlier opinion the common law recognized the practice of medicine as being trade¹³ and there is nothing in the *Apex* case to suggest the contrary. It may be regrettable that Congress chose to take over in the Sherman Act the common law concept of trade, at least to the extent of including therein the practice of medicine. Developments which have taken place during recent decades in the building up of standards of professional education and licensure, together with self-imposed standards of discipline and professional ethics, have, in the belief of many persons, resulted in substantial

³ 310 U. S. 469, 480.

⁴ *Apex Hosiery Co. v. Leader*, 310 U. S. 469, 484; "Cessation of petitioner's manufacturing operations, which respondents compelled, indubitably meant the cessation of shipment interstate. The effect upon the commerce resulted naturally and inevitably from the cause. The occupancy of petitioner's factory by the strikers prevented the shipment of the substantial amount of merchandise on hand when the strike was called. In point of the immediacy of the effect of the strikers' acts upon the interstate transportation involved and of its volume, the case does not differ from many others in which we have sustained the Congressional exercise of the commerce power."

⁵ *Apex Hosiery Co. v. Leader*, 310 U. S. 469, 487, 490: ". . . the question to which we must address ourselves is whether a conspiracy of strikers in a labor dispute to stop the operation of the employer's factory in order to enforce their demands against the employer is the kind of *restraint of trade* or commerce at which the Act is aimed . . . Since in the present case, as we have seen, the natural and predictable consequence of the strike was the restraint of interstate transportation the precise question which we are called upon to decide is whether *that restraint* resulting from the strike maintained to enforce union demands by compelling a shutdown of petitioner's factory is the kind of *'restraint of trade or commerce'* which the Act condemns." [Italics supplied.]

⁶ *Apex Hosiery Co. v. Leader*, 310 U. S. 469, 497-498.

⁷ *Apex Hosiery Co. v. Leader*, 310 U. S. 469, 486, 491.

⁸ *Id.* at 489.

⁹ *Ibid.*

¹⁰ *Id.* at 493.

¹¹ *Ibid.* and see n. 15.

¹² *Apex Hosiery Co. v. Leader*, 310 U. S. 469, 500-501.

¹³ *United States v. American Medical Association*, 72 App. D. C. 12, 20, 110 F. (2d) 703, 711, *cert. denied*, 310 U. S. 644.

differences between professional practices and the generally accepted methods of trade and business. As we pointed out in our earlier decision,¹⁴ the American Medical Association and other local medical associations have undoubtedly made a profound contribution to this development. However, our task is not to legislate or declare policy in such matters but, rather, to interpret and apply standards and policies which have been declared by the legislature. That Congress did use the common law test there is no doubt. That Congress was not otherwise advised was perhaps because of the failure of the professional groups to insist upon the distinction and to secure its legislative recognition. In any event, there is no doubt that Group Health Association was engaged in trade or commerce, within the meaning of the applicable section of the statute.¹⁵ It is not necessary, in order to constitute trade or business, that it shall be carried on for profit.¹⁶ Appellants protest that the District Court has said in *Group Health Association v. Moor*:¹⁷ "The actions of the plaintiff [G.H.A.] in no way tend to commercialize the practice of medicine." They argue from this that the activities of Group Health Association were not commercial activities and hence not in trade within the meaning of the Sherman Act. But this argument misses the point. The activities of Group Health Association are commercial, but because the lay executives of Group Health Association do not in any way interfere with the professional work of the medical doctors, their commercial activities do not tend to commercialize the *practice* of medicine. Medical doctors have long conceded the propriety of medical services furnished by large industrial organizations, to their employees, by doctors also in their employ.¹⁸ There is no greater incongruity in the making available of medical services by a cooperative association or a non-profit mutual benefit association, in similar manner; nor any more reason for suggesting that such industrial organizations are not engaged in commercial activities. In each case the service is rendered in accordance with the standards of the profession and to that extent uncontrolled by the corporate employer.¹⁹ But, at the same time, the salaries of such professional employees may undoubtedly be paid by the corporation and charged as an ordinary and necessary expense of business.²⁰ Although there is authority for the proposition that for some pur-

¹⁴ *Id.* at 20-21, 110 F. (2d) at 711-712.

¹⁵ Nonprofit cooperative association have been held to be "doing business" in a variety of situations. For purposes of taxation: Maryland & Virginia Milk Producers' Ass'n., Inc., v. District of Columbia, 73 App. D. C. 399, 119 F. (2d) 787, *cert. denied*, 314 U. S. 646; Hazen v. National Rifle Ass'n., 69 App. D. C. 339, 347, 101 F. (2d) 432, 440; Memphis Chamber of Commerce v. Memphis, 144 Tenn. 291, 296-297, 232 S. W. 73, 74; Sears, Roebuck & Co. Employees' Savings & Profit-Sharing Pension Fund v. Commissioner of Internal Revenue, 7 Cir., 45 F. (2d) 506, 509. For purposes of qualifying to do business under the corporation laws of a foreign state: Ku Klux Klan v. Commonwealth ex rel. State Corporation Commission, 138 Va. 500, 509, 122 S. E. 122, 125; State ex rel. Griffith v. Ku Klux Klan, 117 Kan. 564, 572-573, 232 P. 254, 258; 17 FLETCHER CYC. CORP. (Perm. Ed.) § 8467. For purposes of compliance with legislation regulating corrupt political practices: La Belle v. Hennepin County Bar Ass'n., 206 Minn. 290, 294, 288 N. W. 788, 790. For purposes of service of process on agents: Pacific Typesetting Co. v. International Typographical Union, 125 Wash. 273, 277, 216 P. 358, 360. Cf. Roman Catholic Archbishop v. Industrial Accident Commission, 194 Cal. 660, 670-671, 230 P. 1, 5 (religious corporation sole held sufficiently engaged "in trade or business" to warrant application of Workmen's Compensation Law); Gardner v. Trustees of Main Street M. E. Church, 217 Iowa 1390, 1395, 250 N. W. 740, 745-746, superseding opinion in 244 N. W. 667, 668; Note, 18 Iowa L. Rev. 557.

¹⁶ Hazen v. National Rifle Ass'n., 69 App. D. C. 339, 345, 101 F. (2d) 432, 438, and authorities there cited.

¹⁷ D. C., 24 F. Supp. 445, 446.

¹⁸ Virginia Iron, Coal & Coke Co. v. Odle's Adm'r., 123 Va. 280, 305, 105 S. E. 107, 115; McCord, *The Economics of Industrial Medicine*, PROCEEDINGS OF THE ANNUAL CONGRESS ON MEDICAL EDUCATION, MEDICAL LICENSURE AND HOSPITALS (1932) 83; Leland, *Contract Practice*, *id.* at 75, 81: "That there are many conditions under which contract practice is not only legitimate and ethical, but in fact the only way in which competent medical service can be provided, becomes evident on analysis. For instance, when large numbers of workmen are employed remote from urban centers, as in some mining or logging camps, efficient medical service can be secured only by contracting with some competent physician to do the work. Certain industrial situations arise wherein large employers of labor are compelled by law to provide medical services for their employees under certain conditions, and this at times can be secured only by some form of contract." Laufer, *Ethical and Legal Restrictions on Contract and Corporate Practice of Medicine*, 6 LAW AND CONTEMP. PROB. 516, 524-527; Note, 48 YALE L. J. 346, 349.

Similar questions have arisen in connection with other professions. For a general discussion see Note, 44 HARV. L. REV. 1114. As applied to practice of law see Merrick v. American Security & Trust Co., 71 App. D. C. 72, 77, 107 F. (2d) 271, 276, *cert. denied*, 308 U. S. 625; 6 FLETCHER CYC. CORP. (Perm. Ed.) § 2524; 5 LAW AND CONTEMP. PROB. No. 1 (pp. 1-174).

¹⁹ Pearl v. West End St. Ry. Co., 176 Mass. 177, 179, 57 N. E. 350.

²⁰ 53 STAT. (Part I) 12, 26 U. S. C. A. § 23 (a) (1); Corning Glass Works v. Lucas, App. D. C. 168, 170-171, 37 F. (2d) 798, 800-801, *cert. denied*, 281 U. S. 742; Elm City Cotton Mills v. Commissioner of Internal Revenue, 5 B. T. A. 309, 312; 1 MONTGOMERY, FEDERAL TAX HANDBOOK (1940) 417.

poses charitable hospitals are not engaged in trade, business or industry,²¹ we have no doubt that the hospitals described in the indictment were engaged in trade and commerce within the meaning of the common law and of the Sherman Act.²²

So far as Group Health and the hospitals are concerned, therefore, their activities are properly described as business and commercial in character. There is also no question that commercial and business competition was not only the possible but the probable result of Group Health's activities. Consequently—entirely apart from any direct restraint upon the practice of medicine itself—if a conspiracy was shown, the purpose of which was to restrain competition, raise prices, or otherwise control the market to the detriment of purchasers or consumers of medical or hospital services, by destroying or injuring Group Health Association, it was sufficient to sustain the conviction.

The fact of commercial and business competition is the predominant note in the controversy which preceded the initiation of criminal prosecutions in this case.²³

²¹ Private hospitals, supported by appropriations and charity, held not an industry, and its employees not engaged in "industry, trade, craft or occupation" within the meaning of Anti-Injunction Act. *Western Pennsylvania Hospital v. Lichter*, 340 Pa. 382, 387, 17 A. (2d) 206, 209. A charitable home for girls held not a "business, trade or industry" within legitimate operation of power to make city zoning laws. *Rochester v. Rochester Girls' Home*, 194 N. Y. S. 236, 237. A charitable home for the aged not a business within the sense of a restrictive covenant. *Easterbrook v. Hebrew Ladies' Orphan Society*, 85 Conn. 289, 293, 82 A. 561, 564; Note, 41 L. R. A. (N. S.) 615. A municipal ordinance declaring hospitals for profit to be nuisances does not discriminate in favor of charitable hospitals, as the distinction is reasonable. The former are and the latter are not "businesses." *Lawrence v. Nissen*, 173 N. C. 359, 364, 91 S. E. 1036, 1038.

²² In *Jordan v. Bashiro*, 278 U. S. 123, 127-129, it was held that operation of a hospital was included within the meaning of the words "trade" and "commerce" as used in a treaty authorizing Japanese subjects in the United States "to carry on trade" and to "do anything incidental to or necessary for trade upon the same terms as native citizens or subjects." Cf. *Lawrence v. Nissen*, 173 N. C. 359, 364, 91 S. E. 1036, 1038: "The establishment and conduct of hospitals for pay is now a recognized and established business." In *Armendarez v. Hotel Dieu, Tex. Civ. App.*, 145 S. W. 1030, 1031, it was held that in so far as a hospital accepted paying patients for the purpose of obtaining revenue to carry on its charitable work, it was carrying on a business.

²³ The identification of "fair competition" with ethical principles is expressed in the Principles of Medical Ethics of the American Medical Association and in the Constitution of the District Medical Society.

Chapter III, Article VI of the Principles of Medical Ethics reads in part as follows: "Conditions of Medical Practice. Section 2. It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. . . ."

"Contract Practice. Section 3. . . . Contract practice per se is not unethical. However, certain features or conditions if present make a contract unethical, among which are: 2. When there is underbidding to secure the contract. 3. When the compensation is inadequate to assure good medical service. 4. When there is interference with reasonable competition in a community."

Chapter IX, Article III, Section 1 of the Constitution reads as follows: "It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community." [Italics supplied.]

These provisions were utilized for purposes of disciplinary action against members of the District Medical Society employed by Group Health. Thus, the expulsion of Dr. Scandiffo, a member of the Group Health staff, from the District Medical Society followed a finding of the Compensation, Contract and Industrial Medicine Committee that he was guilty of violating Sections 1 and 2, Article III, and Section 5, Article IV, all of Chapter IX of the Constitution of the Society. That this disciplinary action against members of the Society was intended to affect Group Health Association is shown by the letter of December 10, 1937, sent by the Chairman of the Compensation, Contract and Industrial Medicine Committee of the Society to its Executive Committee which reads as follows: "On November 22nd, 1937, our committee addressed a communication to you advising you of our investigation concerning Drs. Allan E. Lee and M. Scandiffo and recommended that they be expelled as members of the Society because of their violation of Section 1, Article III, Chapter 9, and Section 5, Article IV, Chapter 9, of the Constitution of the Medical Society of the District of Columbia. Our committee is today in receipt of a letter from Dr. Allan E. Lee, advising us that he has resigned from the staff of Group Health Association. Inasmuch as our recommendation respecting Dr. Lee was based upon the fact that he had entered into a contract with Group Health Association and that contract has now been terminated by him, we feel that no further action should be taken with respect to Dr. Lee. We therefore, respectfully request that the charges and recommendations against Dr. Lee, embodied in our communication of November 22, 1937, be withdrawn and that appropriate action be taken by your committee thereon."

It is shown, also, by the letter of the same Chairman to Dr. Lee under date of December 21, 1937: "In acknowledgement of your letter of December 10, in which you enclose a copy of your resignation as a member of the medical staff of Group Health Association, Inc., may I say that upon receipt of same the Compensation, Contract and Industrial Medicine Committee appeared before the Executive Committee and requested a withdrawal of its charges against you, which request was granted. Such action places your status as that of a member now in good standing."

The concern of the defendants Association and Society with the effect of Group Health on the economic status of the medical profession, and upon competition in financing and

One of the major purposes of Group Health Association was to provide *low-cost medical service*, on a prepayment basis.⁴⁴ Appellants, in fact, recognize the existence of a controversy concerning this question. They requested an instruction in which they asserted their right to disapprove the attitude of Group Health

making available medical and hospital services, is abundantly illustrated by articles and statements of officers and members thereof. An article, appearing in the Journal of the American Medical Association for October 2, 1937, reads in part as follows: "Out of a total population of 486,869 in the District of Columbia, 115,912 are civil employees of the United States government, and, of these, 2,517 are employees of the Federal Home Loan Bank Board and its affiliated agencies. If to these persons, all of whom are eligible for membership in Group Health Association, their dependents are added, allowing an average of two dependents for each employee, a total of 347,736 persons is reached, out of a total population of 486,869 that the promoters of Group Health Association, according to their certificate of incorporation, seek to withdraw from the ordinary practice of medicine and to cover into a group health insurance contract practice system and treat through physicians hired for that purpose. The effect of the withdrawal from private practice of even one-half that number of persons, all of whom are able to pay for medical services, will materially disturb medical practice in the District of Columbia and react against public interest. * * * The scheme is so planned that the richer and more liberally paid employees are to obtain medical service at rates based on the incomes of the poorest employees. The courts have repeatedly held that the value of medical services rendered to a patient may be properly appraised in relation to his wealth, just as the value of legal services are commonly appraised in relation to the value of the interests that the lawyer is called on to protect, whether interests involving the life of his client or his client's property. Under the present scheme, fees that are charged for medical services to the richer and more liberally paid employees are to be identical with those charged employees of the lowest grade, doing part-time work."

The author of this article, who was one of the individual defendants, was Director of the Bureau of Legal Medicine and Legislation of the American Medical Association from 1922 to 1939 when he retired. He holds degrees both of law and of medicine. He was called as a witness by appellants and developed the theme of the article further as follows:

"If GHA expanded its activities to a point where it took over a substantial part of the people of the District of Columbia—rich and poor alike—the United States Government subsidizing its services—it is quite obvious that the various doctors in the District of Columbia, with their plants, with their experience, and everything else, would not be able to compete on a fair, honest basis; and that is when medical practice would be broken down by the subsidized practice, tending to destroy the medical profession."

The record reveals other similar statements of which the following are examples: "I think it would be exceedingly unfortunate to stabilize the income of the medical profession, because there is just as much difference in the qualifications of doctors as there is in the qualifications of stenographers. Some of them can do it and some of them are rotten. * * * It would be unfortunate to stabilize the pay of doctors."

" . . . let us . . . consider what would happen in the District of Columbia provided you were able to obtain the maximum of enrollment in this corporation. . . . you see what it would do here as an economic thing. * * * It would simply result in the necessary exodus of a large part of the medical profession of the District of Columbia. . . ."

" . . . Quite naturally, however, the organized profession is insisting upon not being forced by misguided or unfair competition to give up any of its rightful prerogatives."

"The question has many implications. . . . About all the outside doctor would have to do would be to take care of the indigent and the riff-raff and the members who had been dropped by the club."

"Dr. McGovern said that he looked upon this Group Health Association movement as an organization coming in and *interfering with his business*. He added that he expected to be in practice for some 20 years and he did not propose, if it could be avoided at all, to have an organization such as was proposed to interfere with his work and income. 'Just what are you fellows going to do about it?' He cited the instance of the musicians who had succeeded in preventing the Marine Band from cutting in on their business in playing before assemblies without cost to the sponsors. . . . The lawyers as a group had prevented inroads in their business. 'It just doesn't seem that we are active in preventing the National Government from entering the practice of medicine and interfering with our business. It should be demanded from the American Medical Association that they send a man down here now and see just what could be done.'" [Italics supplied]

" . . . corporation practice of medicine . . . in the District of Columbia threatens to have a far reaching and deleterious effect on the private practice of medicine."

" . . . one is compelled to wonder what will become of the private practice of medicine in those centers if the government is to subsidize cut-rate medical schemes. . . ."

Maintenance of "free and fair competition" was the theme of defendants' request for instruction No. 31, refused by the trial court which read in part: ". . . the defendants were entitled, both collectively and individually, to adopt and carry out reasonable regulations in professional practice for the purpose of maintaining free and fair competition in the District of Columbia and . . . any restraints caused thereby upon Group Health Association, Inc., its doctors, members or operations, without more, would not violate the Sherman Act."

* Group Health Association is described in the indictment as follows: "33. Group Health Association, Inc. was incorporated on February 19, 1937, and authorized to do business under and by virtue of the laws of Congress for the District of Columbia. Said corporation is a non-profit, cooperative association of employees of certain departments in the executive branch of the United States Government employed in the District of Columbia. Most members of Group Health Association, Inc. are embraced within the low income group, over 80% of them earning annual incomes of not more than \$2,000. Said corporation is engaged in the District of Columbia in the business of arranging for the provision of medical care and hospitalization to its members and their dependents on a risk sharing prepayment basis. Said corporation collects monthly payments in the form of dues from its members. Medical care is provided by a medical staff consisting of salaried general

Association with respect to low-cost medicine plans.²⁵ That appellants' attack on Group Health Association was designed to restrain competition is revealed by the following statement in their Reply Brief: "Appellants insist that the origin of GHA is traceable directly to the Twentieth Century Fund, its subsidiary corporations, and others whose purpose was to destroy the private practice of medicine in the District . . . and to establish corporate practice of medicine." If, as appellants thus contend, they believed that the purpose of the Twentieth Century Fund and the purpose of GHA was to destroy the private practice of medicine in the District, by establishing corporate practice of medicine, obviously, the bitterest kind of competition in making available medical and hospital service was under way. If the purpose of appellants was to prevent such competition by the destruction of GHA, obviously that purpose was to restrain trade.²⁶

The important question is, therefore, whether the methods used constituted improper restraints of competition, within the meaning of the statute in the trade or commerce of financing and making available all or any of the three several services to which reference has been made. And, as the prosecution in the present case is under Section 3 of the Act no question of the interstate character of that trade or commerce is involved. Appellants urge a number of contentions to negate unlawful restraint. The first of these is that the controversy here involved is a labor dispute; hence that appellants are excluded from the operation of the Sherman Act, by virtue of provisions of the Clayton Act and of the Norris-LaGuardia Act.

Presumably appellants' contention casts medical doctors in the role of laborers; Group Health in the role of employer; and themselves in the role of labor organizations, or perhaps in a role comparable to that of the New Negro Alliance;²⁷ all this on the assumption that medical practice, the furnishing of medical services and the furnishing of hospital services, come within the common law definition of trade; with the consequence, they argue, that a controversy arising between these three groups, or any two of them, concerns "terms or conditions of employment, or * * * the association or representation of persons in negotiating, fixing, maintaining, changing, or seeking to arrange terms or conditions of employment, . . ."²⁸ That medical doctors, lawyers, teachers and other professional people can be and are employed there is no doubt. Some professional or pseudo-professional groups have organized themselves into unions. Medical societies and bar associations are sometimes referred to by laboring people as "doctors' unions" and "lawyers' unions." But after all it is a *labor dispute* which is the subject of definition and application in these Acts. Although, in the broader sense, all forms of mental and physical exertion may be called labor, even including attendance at a symphony concert or the labor of childbirth; and, although a dispute concerning any form of such labor might perhaps be called a labor dispute,

practitioners and specialists engaged in group practice under the sole direction of a medical director. Said corporation pays adequate salaries to the doctors on its medical staff and provides the medical staff with a modern, well equipped clinic, which was opened on November 1, 1937. Said corporation also defrays, within limits, the expenses of hospitalization of its members and their dependents. The personal relationship ordinarily existing between doctor and patient obtains between the doctors on the medical staff of Group Health Association, Inc. and their Group Health Association, Inc. patients."

²⁵ "Evidence has been permitted in this case with respect to the public need or lack of need of so-called low-cost medicine. I charge you that any need, or lack of need, for a low-cost medicine plan, has nothing to do with the right of the defendants to exercise their lawful powers and duties in connection with the practice of the medical profession. The rights of Group Health Association, Inc. are no greater because of an alleged need for low-cost medicine, than if no such need existed. Group Health Association, Inc. had a lawful right to disapprove of what it may have thought was the attitude of the defendants toward low-cost medicine plans, just as the defendants had an equal right to disapprove of what the defendants thought was the attitude of Group Health Association, Inc. with respect to low-cost medicine plans. Each party to the controversy had the right to further and advance its own opinion in the controversy by all methods of legitimate persuasion and reasoned argument whether applied to members of the medical profession, the Washington hospitals, or the public. Refused. J. M. P."

²⁶ That appellants' attack on Group Health was for the purpose of restraining competition is admitted, by implication, also in their opening brief: ". . . that a corporation known as the Twentieth Century Fund with assets of approximately \$3,500,000, and whose main objective was to actively promote the organization of group payment agencies, i. e., organizations through which groups of people might obtain all-around medical and hospital care in return for some fixed periodic payments, was subsidizing GHA and enabling it to sell medical services at less than cost for the purpose of destroying the private practice of medicine and to set up in its place or stead a theory of the distribution of medical services advocated by such Fund; that HOLC was diverting Government moneys to subsidize GHA and thereby enabling it to sell medical services at less than cost; . . ."²⁷

[Italics supplied]

²⁷ New Negro Alliance v. Sanitary Grocery Co., 303 U. S. 552.

²⁸ Norris-LaGuardia Act of March 23, 1932, 47 Stat. 73, 29 U. S. C. § 113 (c).

the purpose of Congress seems to have been to describe a more limited range of activity.³⁰

The Committee Reports on the Clayton and Norris-LaGuardia Acts indicate that the legislation was enacted in contemplation of disputes between workingmen,³⁰ or wage earners,³¹ or laborers,³² on the one hand, and aggregated capital, commonly in corporate form, on the other. A physician is not a workman³³ or a laborer,³⁴ as those words are known to the law, and his compensation is not wages.³⁵

The matrix of the controversy must be the employer-employee relationship,³⁶ although the disputants need not stand in the proximate relation of employer and employee.³⁷ If physicians employed on the contract basis in industrial medicine should form associations for collective bargaining they might, perhaps, fairly be said to come within the operation of the Norris-LaGuardia and Clayton Acts.³⁸ Or if the laity were so dominantly organized into consumer cooperatives that it might properly be said of the physician, as of the individual unorganized worker, that he is "commonly helpless . . . to obtain acceptable terms and conditions of employment, . . ." or protection "from the interference, restraint, or coercion of employers of labor. . . ." then possibly the two Acts would be applicable.⁴⁰ But, under the actual facts of the present case, even the contracting physicians occupy no such position. For a fixed sum they assumed to render services when needed.⁴¹ In the rendering of those services, when needed, they are not subject to supervision by the Association.⁴² Originally independent contractors, they do not lose that status by contracting to perform unsupervised services.⁴³

In our opinion, therefore, neither the Clayton Act nor the Norris-LaGuardia Act was intended to cover such a controversy as existed in the present case. The carefully chosen language of the *Hutcheson* case⁴⁴ seems particularly significant in this respect: "The Norris-LaGuardia Act reasserted the original pur-

³⁰ *Columbia River Packers Ass'n., Inc. v. Hinton*, 315 U. S. 143; Note, 51 *YALE L. J.* 1039, 1040-1041.

³¹ *H. R. REP. No. 612, 62d Cong., 2d Sess. (1912)* 10: "The consensus of judicial view . . . is that *workingmen* may lawfully combine to further their material interests without limit or constraint, and may for that purpose adopt any means or methods which are lawful. It is the enjoyment and exercise of that right and none other that this bill forbids the courts to interfere with." [Italics supplied.]

³² *SEN. REP. No. 163, 72d Cong., 1st Sess. (1932)* 9: "The right of *wage earners* to organize and to act jointly in questions affecting wages, conditions of labor, and the welfare of labor generally is conceded and recognized by all students of the subject." [Italics supplied.]

³³ *Ibid.*: "A single *laborer*, standing alone, confronted with such far-reaching overwhelming concentration of employer power, and compelled to labor for the support of himself and family, is absolutely helpless to negotiate or to exert any influence over the fixing of his wages or the hours and conditions of his labor." [Italics supplied.]

³⁴ *Harris v. Mayor and City Council*, 151 Md. 11, 17, 133 A. 888, 890; nor is a lawyer, *Gay v. Hudson River Elec. Power Co.*, N. D. N. Y., 178 F. 499, 502; nor a skilled chemist, *Gagnell v. Levinstein, Ltd.*, [1907] 1 K. B. 531, 540; Note, 129 A. L. R. 990.

³⁵ *Weymouth v. Sanborn*, 43 N. H. 171, 173; nor is a minister, *Holy Trinity Church v. United States*, 143 U. S. 457, 463; nor a lawyer, *Latta v. Lonsdale*, 8 Cir., 107 F. 585; nor a teacher, *School Dist. No. 94, v. Gautier*, 13 Okla. 194, 204, 73 P. 954, 957; nor an actor, *Universal Pictures Corp. v. Superior Court*, Cal. 50 P. (2d) 500, 501-502.

³⁶ *Magners v. Dunlap*, 39 Ill. App. 618, 619; *First Nat. Bank v. Barnum*, D. C. M. D. Pa., 160 F. 245, 248; *Gay v. Hudson River Elec. Power Co.*, N. D. N. Y., 178 F. 499, 503; nor the fees of lawyers, *First Natl. Bank v. Barnum*, *supra*. Cf. *Romans* 6:23.

³⁷ *Columbia River Packers Ass'n., Inc. v. Hinton*, 315 U. S. 143.

³⁸ *Ibid.*; *New Negro Alliance v. Sanitary Grocery Co.*, 303 U. S. 552.

³⁹ See *Associated Press v. National Labor Relations Board*, 301 U. S. 103. Cf. *Michigan Trust Co. v. Grand Rapids Democrat*, 113 Mich. 615, 617, 71 N. W. 1102, 1103.

⁴⁰ *Norris-LaGuardia Act of March 23, 1932*, 47 *STAT.* 70, 29 U. S. C. § 102.

⁴¹ *Columbia River Packers Ass'n., Inc. v. Hinton*, 315 U. S. 143.

⁴² *Jordan v. Group Health Ass'n.*, 71 App. D. C. 38, 45, 107 F. (2d) 239, 246.

⁴³ *Group Health Association By-Laws*.

⁴⁴ *Meigs I. United States*, D. Mass., 30 F. Supp. 68, 69-70. *aff'd*, 115 F. (2d) 13; *Virginia Iron, Coal & Coke Co. v. Odie's Adm'r.*, 128 Va. 280, 289, 105 S. E. 107, 109. See *Cardillo v. Mookabee*, 70 App. D. C. 16, 18, 102 F. (2d) 620, 622.

⁴⁵ *United States v. Hutcheson*, 312 U. S. 219, 227, 231: "Whether the use of conventional, peaceful activities by a union in controversy with a rival union over certain jobs is a violation of the Sherman Law, Act of July 2, 1890, 26 Stat. 209, as amended, 15 U. S. C. § 1, is the question. * * * The Norris-LaGuardia Act removed the fetters upon *trade union activities*, which according to judicial construction § 20 of the Clayton Act had left untouched, by still further narrowing the circumstances under which the federal courts could grant injunctions in labor disputes. More especially, the Act explicitly formulated the "public policy of the United States" in regard to the industrial conflict, and by its light established that the allowable area of *union activity* was not to be restricted, as it had been in the *Duplex* case, to an immediate employer-employee relation. Therefore, whether *trade union conduct* constitutes a violation of the Sherman Law is to be determined only by reading the Sherman Law and § 20 of the Clayton Act and the Norris-LaGuardia Act as a harmonizing text of outlawry of labor conduct." [Italics supplied.]

pose of the Clayton Act by infusing into it the *immunized trade union activities* as redefined by the later Act. In this light § 20 removes all *such allowable conduct* from the taint of being a 'violation of any law of the United States,' including the Sherman Law. * * * It was precisely in order to minimize the difficulties to which the general language of the Sherman Law in its application to *workers* had given rise, that Congress cut through all the tangled verbalisms and enumerated concretely the types of activities which had become *familiar incidents of union procedure*.⁴⁵ [Italics supplied] In the *Hutcheson* case the Court expressly distinguished the situation in which a union acts, not in its own self-interest, but in combination for other purposes, with nonlabor groups.⁴⁶ It cited as an example *United States v. Brims*.⁴⁷ In the latter case it was held that a conspiracy of manufacturers of millwork, building contractors and union carpenters, to check competition from nonunion made millwork was a violation of the Sherman Act; the conspiracy agreement being that the manufacturers and contractors would employ only union carpenters, who in turn would refuse to install the nonunion millwork. And, in contrast, the Court, in the *Hutcheson* case, also said: "Clearly, then, the facts here charged constitute lawful conduct under the Clayton Act unless the defendants cannot invoke that Act because *outsiders to the immediate dispute also shared in the conduct*."⁴⁸ [Italics supplied] This, it would seem, was also the situation in the *New Negro Alliance* case.⁴⁹ Assuming a *bona fide* labor dispute, the participation of a non-labor organization therein should not, without more, deprive it of its character as a labor dispute; give it the character of criminal conduct; or authorize judicial restraint except in compliance with the limitations of the Norris-LaGuardia Act.

But, under the circumstances of the present case, appellants cannot escape the proscriptions of the Sherman Act even if we assume that the controversy was a labor dispute. As we have already noticed, the Supreme Court plainly indicated in the *Apex* case⁵⁰ that some phases of labor disputes may come under the condemnation of the Sherman Act; if, for example, they involve a combination or conspiracy which has as its purpose restraint upon competition, or if the labor organization is used by combinations of those engaged in an industry as the means or instrument for suppressing competition or fixing prices.⁵¹ In the *Apex* case the Sherman Act was held to be inapplicable because it did not appear that the strikers' acts were intended to restrain competition or that they had any effect on market prices of goods or services.⁵² But that was not the situation of the present case.

Appellants reassert—in support of their contention that their conduct was not in restraint of trade—a proposition urged on the earlier appeal, that their conduct was no more than a reasonable regulation of the practice of medicine; and they rely upon the language of our earlier opinion: "If there is any justification for the restraint, so as to make it reasonable as a regulation of professional practice, it must be shown in evidence as a defense . . ."⁵³ But in that same opinion—after recognizing the large and beneficent part which appellants have played in raising the standards of medical practice, and in contributing to the relief of the unfortunate and destitute—we also said: "Notwithstanding these important considerations, it cannot be admitted that the medical profession may through its great medical societies, either by rule or disciplinary proceedings, legally effectuate restraints as far reaching as those now charged."⁵⁴ And we did not, by any means, declare the law to be—as appellants now assert—that a conspiracy "entered into with the object of properly and fairly regulating the practice of medicine, . . ." was not a violation of the Sherman Act. The prayer for instruction which appellants requested upon this point was contra-

⁴⁵ *Id.* at 236, 237.

⁴⁶ *United States v. Hutcheson*, 312 U. S. 219, 232.

⁴⁷ 272 U. S. 549.

⁴⁸ *United States v. Hutcheson*, 312 U. S. 219, 233.

⁴⁹ *New Negro Alliance v. Sanitary Grocery Co.*, 303 U. S. 552, 555-556; *Columbia River Packers Ass'n., Inc. v. Hinton*, 315 U. S. 143.

⁵⁰ *Apex Hosiery Co. v. Leader*, 310 U. S. 469, 487-489.

⁵¹ *Id.* at 501. See *New Negro Alliance v. Sanitary Grocery Co.*, 303 U. S. 552, 562-563: ". . . short of fraud, breach of the peace, violence, or conduct otherwise unlawful. . . ."; *United States v. Hutcheson*, 312 U. S. 219, 231: "Therefore, whether trade union conduct constitutes a violation of the Sherman Law is to be determined only by reading the Sherman Law and § 20 of the Clayton Act and the Norris-LaGuardia Act as a harmonizing text of outlawry of labor conduct."

⁵² *Apex Hosiery Co. v. Leader*, 310 U. S. 469, 501-502.

⁵³ *United States v. American Medical Ass'n.*, 72 App. D. C. 12, 21, 110 F. (2d) 703, 712, *cert. denied*, 310 U. S. 644.

⁵⁴ *Ibid.*

dictory on its face and was properly refused. Under no circumstances could the commission of crime be justified as a reasonable regulation of professional practice.⁶⁵

The wide scope of appellants' contention concerning their power to effect a reasonable regulation of the practice of medicine is revealed by proposed instructions and by their arguments on brief which seem to assume for them powers of a state legislature to enact and enforce laws to require improvement of standards of professional practice. Thus they rely upon such cases as *Semler v. Oregon State Board of Dental Examiners*⁶⁶ and *Graves v. Minnesota*,⁶⁷ which involved the constitutionality of state statutes and in each of which the statute was upheld on the ground that it constituted a reasonable exercise of the police power of the state. Needless to say, appellants have no such power.

The situation which confronts appellants, and which they have sought to control, is not confined to the medical profession alone. Profound changes in social and economic conditions have forced members of all professional groups to make readjustments. The fact that these changes may result even in depriving professional people of opportunities formerly open to them does not justify or excuse their use of criminal methods to prevent changes or to destroy new institutions. Lawyers, too, have seen, during recent decades, large-scale changes in their professional work.⁶⁸ There was a time when lawyers worked entirely on fee or retainer in particular cases and controversies; now many of them are salaried employees on the staffs of large corporate industrial and financial organizations. Many of the simpler functions of business which once required the assistance of lawyers are now the routine work of better educated and more highly skilled business men; some of them law school graduates. Recent legislation has had the effect of removing from the field of judicial controversy and determination, a large percentage of cases which at an earlier time constituted the mainstay of lawyers' practice.⁶⁹ A good example is found in connection with accidents occurring in industrial employment. In some of this new legislation representation by lawyers is expressly discouraged.⁷⁰ In some of it, formal rules of pleading, practice and evidence—the lawyers' tools—are dispensed with.⁷¹ There are some who regret and some who resent these changes. Over the years, as individuals and as members of professional associations they have labored to prevent or minimize them. But they would not suggest that criminal conduct, as individuals or as associations, would be proper for such a purpose.

⁶⁵ In *Anderson v. United States*, 171 U. S. 604, 615-616, upon which appellants rely, the law was stated in the following terms: "Where the subject-matter of the agreement does not directly relate to and act upon and embrace interstate commerce, and where the undisputed facts clearly show that the purpose of the agreement was not to regulate, obstruct, or restrain that commerce, but that it was entered into with the object of properly and fairly regulating the transaction of the business in which the parties to the agreement were engaged, such agreement will be upheld as not within the statute, where it can be seen that the character and terms of the agreement are well calculated to attain the purpose for which it was formed, and where the effect of its formation and enforcement upon interstate trade or commerce is in any event indirect and incidental, and not its purpose or object."

⁶⁶ 294 U. S. 608.

⁶⁷ 272 U. S. 425.

⁶⁸ Jackson, *An Organized American Bar*, 18 A. B. A. J. 383; Rutledge, *What Changed Conditions Must the Lawyer Face in the Practice of Law?*, 9 AM. L. SCHOOL REV. 1174.

⁶⁹ See Llewellyn, *The Bar's Troubles, and Poulitices—and Cures?*, 5 LAW AND CONTEMP. PROB. 104, 107.

⁷⁰ *E. g.*, the Longshoremen's and Harbor Workers' Compensation Act of March 4, 1927, 44 STAT. 1435. 33 U. S. C. § 919 (d): "At such hearing the claimant and the employer may each present evidence in respect of such claim and may be represented by any person authorized in writing for such purpose."

The legislation establishing a Small Claims and Conciliation Branch in the Municipal Court of the District of Columbia provides in part that "The clerk of said branch shall, at the request of any individual, prepare the statement of claim and other papers required to be filed in an action in this branch. . . ." 52 STAT. 103, § 5 (a); D. C. CODE (1940) § 11-805 (a).

See *Eagle Indemnity Co. v. Industrial Accident Commission*, 217 Cal. 244, 248, 18 P. (2d) 341, 343; Note, 22 CALIF. L. REV. 121; Robinson, *Appearances by Laymen in a Representative Capacity before Administrative Bodies*, 5 LAW AND CONTEMP. PROB. 89.

⁷¹ *E. g.*, the Longshoremen's and Harbor Workers' Compensation Act of March 4, 1927, 44 STAT. 1437. 33 U. S. C. § 923 (a): "In making an investigation or inquiry or conducting a hearing the deputy commissioner shall not be bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this Act; but may make such investigation or inquiry or conduct such hearing in such manner as to best ascertain the rights of the parties."

In proceedings in the Small Claims and Conciliation Branch of the Municipal Court, "The Judge shall conduct the trial in such manner as to do substantial justice between the parties according to the rules of substantive law, and shall not be bound by the statutory provisions or rules of practice, procedure, pleading, or evidence, except such provisions relating to privileged communications." 52 STAT. 105, § 8 (b); D. C. CODE (1940) § 11-808 (b).

Professions exist because the people believe they will be better served by licensing especially prepared experts to minister to their needs.⁶² The licensed monopolies which professions enjoy constitute, in themselves, severe restraints upon competition. But they are restraints which depend upon capacity and training, not special privilege. Neither do they justify concerted criminal action to prevent the people from developing new methods of serving their needs. There is sufficient historical evidence of professional inadequacy to justify occasional popular protests.⁶³ The better educated laity of today question the adequacy of present-day medicine.⁶⁴ Their challenge finds support, as indicated in the margin, from substantial portions of the medical profession itself.⁶⁵ The people give the privilege of professional monopoly and the people may take it away. A highly regimented military profession under strict governmental control; a ministerial or religious profession, without uniform standards or licensure; a large group of highly trained persons who serve the people as experts in news collection and dissemination but who have never had professional standing, licensure or monopoly; ⁶⁶ these are all examples of alternative methods which the people have used to develop and control their professional groups.

In some instances professional groups have been charged by legislative fiat with powers and duties concerning professional education, licensure, discipline, removal of licensees from practice, and other related subjects.⁶⁷ In such cases

⁶² *Alabama Power Co. v. Federal Power Commission*, (No. 7853, decided March 30, 1942) — App. D. C. —, — F. (2d) —: "The grant of a license, being a privilege from the sovereign can be justified only on the theory of resulting benefit to the public. . . ."

⁶³ SHRYOCK, *THE DEVELOPMENT OF MODERN MEDICINE* (1936) 2: "When Rush died, in 1813, he was widely acclaimed the greatest physician his country had known. Three short decades passed, and an outstanding American physician of the next generation found himself reevaluating Rush's medical essays. The results were rather startling. 'It may be safely said,' observed Elisha Bartlett in 1843, 'that in the whole vast compass of medical literature, there cannot be found an equal number of pages containing a greater amount and variety of utter nonsense and unqualified absurdity. A more sudden and extreme revision of scientific opinion could hardly be imagined. Here was Rush lauded by one generation and repudiated by the next.'"

⁶⁴ SHRYOCK, *id.* at 371-372: "Hence there gradually evolved, in educated minds, a syllogism of some such form as this: Medical science can now prevent or cure certain major diseases. Many people continue to suffer from these very diseases. Ergo, medical science does not serve the people as it should. The most obvious explanation was to be found in the mounting costs of service. Here, again, it is to be noted that it was the very progress which physicians had made in science, which involved them in new difficulties in the practice of their art. Technical improvement led to simultaneous increase in the demand for medical services and in the price that must be paid for them. And so the more that people trusted medical aid, the less they could afford it. Here was a serious and unexpected impasse in the public relations of the profession."

⁶⁵ SHRYOCK, *id.* at 399-400: "In 1926 some fifteen leaders in medicine, public health, and the social sciences had inaugurated a series of conferences which led to the creation of a national Committee on the Costs of Medical Care. This body consisted of fifty members drawn from various interested groups ranging from private practitioners to economists. Dr. Ray Lyman Wilbur, Secretary of the Interior in President Hoover's cabinet, served as Chairman. . . . The Committee carried out a nation-wide survey of sickness and medical service among nearly nine thousand white families. Their reports revealed, by 1932, a direct correlation between income and all types of medical service; and tended in general to substantiate the claims made by the advocates of health insurance more than a decade before. The lowest income group (under \$1,200 per year) received more of certain types of care—presumably due to charity services—than did the next two higher groups (\$1,200 to \$3,000); but in general these classes all received much less service than those whose incomes were above the last-named amount. Thus the group with the lowest amount of service received only 50 per cent as many days of hospitalization, and only 41 per cent as many medical calls as did the group with the highest amount of service. In every case, the latter was the highest income group. The highest group itself received less medical service than the standard which the majority of the Committee considered essential to good care."

The American Medical Association, it is true, disagrees with the conclusions of these eminent professionals. SHRYOCK, *id.* at 401: "Taking quite another view of the situation, the Bureau of Economics of the American Medical Association conducted an investigation which . . . revealed the fact that there are few, if any, people in the United States really suffering from lack of medical care. . . ."

⁶⁶ It is perhaps significant that in the latest professional development—radio broadcasting—increased emphasis has been placed on ruthless competition (Federal Communications Commission v. Sanders Brothers Radio Station, 309 U. S. 470) and governmental control. Federal Communications Act of 1934, 48 STAT. 1082-1087, 47 U. S. C. §§ 303(m), 304, 307(d), 309(b) (1), 311, 312(a) (b); *id.* 48 STAT. 1104, 47 U. S. C. §§ 606 (c) (d), as amended by the Act of January 26, 1942, Public No. 413, 77th Cong., 2d Sess.

⁶⁷ *E. g.*, the Integrated Bar in the legal profession. The State Bar Act of South Dakota provides in part (South Dakota Laws 1931, c. 84, §§ 11, 13, 14 J. AM. JUR. SOC. 188, 189): "Section 11. Unlawful Practice of Law. After the organization of the State Bar has been accomplished, as provided by this act, the Supreme Court shall fix a date after which no person shall practice law in the State of South Dakota unless such person be a member of the State Bar in good standing."

"Section 13. Violation of Rules May Be Punished. The by-laws, rules and regulations, when adopted by the Bar Board and when approved by the Supreme Court, shall be binding upon all members of the State Bar, and the wilful violation of any such rules and regulations by any member of the State Bar may be punished by suspension from the practice of

they act as agencies of government. Although some similar delegations of power have been made to the organized medical profession,⁶⁸ there is no evidence of delegation of power to appellants, sufficient to authorize the conduct for which they have been convicted. In the absence thereof professional groups must abide by the general laws just as scrupulously as any private citizen or private corporation. It is in this setting that appellants were permitted to organize, to establish standards of professional conduct, to effect agreements for *self-discipline and control*. There is a very real difference between the use of such self-disciplines and an effort upon the part of such associations to destroy competing professional or business groups or organizations. Again, to use the analogy of the legal profession, the activities of the American Medical Association in the present case more nearly resemble the situation which would exist if the American Bar Association or one of the state associations should undertake to destroy, by methods of criminal conspiracy, business organizations which employ lawyers, such as automobile associations, collection agencies, bankers' associations and title and trust companies. It is true that they have attempted, by means of actions to forbid unlawful practice of the law and by efforts to secure legislation, thus to prevent activities which they regarded as encroachments upon the practice of law. Such actions at law and such efforts to secure enactment of legislation are equally available here to appellants. But there is a clearly defined line of demarcation here which must be observed if the penalties of the Sherman Act are to be avoided. As we suggested in our earlier opinion, appellants have open to them always the safer and more kindly weapons of legitimate persuasion and reasoned argument,⁶⁹ as a means of preserving professional esprit de corps, winning public sentiment to their point of view or securing legislation.⁷⁰ But they have no license to commit crime. When they go so far as to impose unreasonable restraints, they become subject to the prohibition of the Sherman Act.⁷¹ This, then, represents a limit to professional group activities. If it is desired to extend them beyond this point, legislation is required for that purpose. It may be desirable that this professional group shall be given such enlarged powers, but if so it will be necessary for the legislature to speak upon the subject rather than for the courts to recognize a privilege based upon preemption or usurpation.

The same general misconception seems to underlie appellants' effort to show absence of restraint by contending that Group Health Association is an illegal organization or that it is engaged in illegal activities. It is elementary that a person is not privileged to kill another simply because the latter is a bad man.⁷² Neither can justification for the commission of a crime be found in the fact that its commission benefited the community; and evidence offered for such a pur-

law, for such period as may be determined by the Supreme Court under the same procedure as now provided by law for suspension of the right of attorneys to practice law in this state."

The State Bar Act of California provides in part (California Statutes 1927, c. 34, §§ 23, 24, 26): "Sec. 23. The board shall have power to aid in the advance of the science of jurisprudence and in the improvement of the administration of justice."

"Sec. 24. With the approval of the supreme court, and subject to the provisions of this act, the board shall have power to fix and determine the qualifications for admission to practice law in this state. . . ."

"Sec. 26. The board of governors shall have power, after a hearing for any of the causes set forth in the laws of the State of California warranting disbarment or suspension, to disbar members or to discipline them by reproof, public or private, or by suspension from practice, and the board shall have power to pass upon all petitions for reinstatement. . . ."

See Sayre, *Proposed Integration of the Bar in Iowa*, 17 IOWA L. REV. 50, 53, n. 5. For general discussion see *Report of the Special Committee on Incorporation of the Bar*, 11 MICH. STATE BAR JOURNAL 50*.

⁶⁸ *E. g.*, in Maryland the examination of applicants for licenses to practice is entrusted to a Board of Medical Examiners elected by the state medical society, the Medical and Chirurgical Faculty. MD. CODE (1939) art. 43, § 117. The Board is charged to establish its own standard of requirements for examinations (*id.*, § 120), and all licenses to practice are to have affixed the seal of the Medical and Chirurgical Faculty. *Id.* § 126.

The educational standards established by the American Medical Association for medical schools are sometimes given legislative recognition in statutes providing for the granting of certificates to practice to graduates of foreign schools which maintain such standards. VA. CODE (1936), c. 68, § 1615 (d).

The high standards adopted by the medical profession have also been recognized by state laws permitting the admission to practice of licentiates of the National Board of Medical Examiners. MD. CODE (1939) art. 43, § 121; GA. CODE (1933) § 84-914. See 119 A. M. A. J. 178 (May 9, 1942).

⁶⁹ *United States v. American Medical Ass'n.*, 72 App. D. C. 12, 21, 110 F. (2d) 703, 712, *cert. denied*, 310 U. S. 644.

⁷⁰ *Henderson v. Knoxville*, 57 Tenn. 477, 481, 9 S. W. (2d) 697, 698, 60 A. L. R. 652, 654.

⁷¹ *Sugar Institute, Inc. v. United States*, 297 U. S. 553, 597-600.

⁷² *State v. Morrison*, 121 S. C. 11, 113 S. E. 304.

pose is properly excluded.⁷⁵ Nor is the fact that a crime was committed with the intent to accomplish some ultimate good, an excuse for its commission;⁷⁶ even if it was for the purpose of enforcing the law.⁷⁵

The same rule applies in conspiracy cases as in criminal cases generally. Thus it was no defense to a charge of conspiracy to dynamite a man's house that the house was a disreputable resort, a place where moonshine whisky was sold and where lewd women congregated for unlawful purposes.⁷⁷ And the same rule applies in cases of conspiracy under the Sherman Act.⁷⁷ Neither the fact that the conspiracy may be intended to promote the public welfare,⁷⁸ or that of the industry,⁷⁹ nor the fact that it is designed to eliminate unfair, fraudulent and unlawful practices,⁸⁰ is sufficient to avoid the penalties of the Sherman Act.

Appellants are not law enforcement agencies; they are charged with no duties of investigating or prosecuting, to say nothing of convicting and punishing. They have been given no power to require their members, or Group Health Association, to reveal the intimate details of their affairs, as was attempted in the present case.⁸¹ Except for their size, their prestige and their otherwise commendable activities, their conduct in the present case differs not at all from that of any other extra-governmental agency which assumes power to challenge alleged wrongdoing by taking the law into its own hands.⁸² Although extreme situations may seem sometimes to have required vigilante action where effective law enforcement by duly constituted officers had broken down or never been established;⁸³ and although persons who reason superficially concerning such matters may find justification for extra-legal action to secure what seems to them desirable ends; this is not the American way of life.⁸⁴ If Group Health Association is illegal, or is engaged in illegal activities, there is a method provided by law to determine the facts and to secure appropriate action.⁸⁵ If further controls are needed in

⁷⁵ *Republica v. Caldwell*, 1 Dall. [Pa.] 150.

⁷⁶ *People ex rel. Hegeman v. Corigan*, 195 N. Y. 1, 13, 87 N. E. 792, 796: "So, ordinarily, a criminal intent is an intent to do knowingly and willfully that which is condemned as wrong by the law and common morality of the country, and if such an intent exists, it is neither justification nor excuse that the actor intended by its commission to accomplish some ultimate good. 1 Bishop's Crim. Law, § 341. . . . One may not commit a crime because he hopes or expects that good will come of it. It is no defense to a charge of intentionally committing an act prohibited by law even that the dictates of his religious belief require one to do the act."; *Reynolds v. United States*, 98 U. S. 145.

⁷⁷ *Crawford v. Ferguson*, 5 Okla. Cr. 377, 115 P. 278, 279-280: "A violation of law, when committed even for the purpose of enforcing the law, is not only illegal, but it is anarchy itself."; *Hamp v. State*, 19 Wyo. 377, 406, 118 P. 653, 662; *Charge to the Grand Jury, Quincy [Mass.] 218, 221*: "Levying War against the King is High Treason; as where People set about redressing public Wrongs; this, Gentlemen, the Law calls levying War against the King; because it is going in direct Opposition to the King's Authority, who is the Redresser of all Wrongs."

⁷⁸ *Nails v. Commonwealth*, 228 Ky. 838, 16 S. W. (2d) 474.

⁷⁹ *Sugar Institute, Inc. v. United States*, 297 U. S. 533, 599: "The freedom of concerted action to improve conditions has an obvious limitation. Then end does not justify illegal means. The endeavor to put a stop to illicit practices must not itself become illicit. As the statute draws the line at unreasonable restraints, a cooperative endeavor which transgresses that line cannot justify itself by pointing to evils affecting the industry or to a laudable purpose to remove them."; *Paramount Famous Lasky Corp. v. United States*, 282 U. S. 30, 44.

⁷⁸ *Eastern States Retail Lumber Dealers' Ass'n. v. United States*, 234 U. S. 600, 613.

⁷⁹ *Paramount Famous Lasky Corp. v. United States*, 282 U. S. 30, 43; *United States v. First National Pictures, Inc.*, 282 U. S. 44.

⁸⁰ *Fashion Originators' Guild of America, Inc. v. Federal Trade Commission*, 312 U. S. 457, 468.

⁸¹ *United States v. American Linseed Oil Co.*, 262 U. S. 371, 389.

⁸² *Fashion Originators' Guild of America, Inc. v. Federal Trade Commission*, 312 U. S. 457, 465-466: "In addition to all this, the combination is in reality an extra-governmental agency, which prescribes rules for the regulation and restraint of interstate commerce, and provides extra-judicial tribunals for determination and punishment of violations, and thus 'trenches upon the power of the national legislature and violates the statute.' *Addyston Pipe & Steel Co. v. United States*, 175 U. S. 211, 242."

⁸³ 23 ENCYC. BRIT. 146. See *Denver and Rio Grande Ry. v. Harris*, 122 U. S. 597, 606; *Boyle v. Case*, D. Ore., 18 F. 880, 883-885; *Sanders v. Gilbert*, 156 N. C. 463, 481, 72 S. E. 610, 617.

⁸⁴ *Charles Evans Hughes*, 18 PROC. OF AM. LAW INST. (1941) 24, 29: "Democracy cannot escape its pressure groups. Each interest has its imperious demands. These groups compete in the market place, in the forums of public opinion, in popular elections, and in our legislative halls, but they have no place in the halls of judicial administration. The lamps of justice are dimmed or have wholly gone out in many parts of the earth, but these lights are still shining brightly here. We are engaged in harnessing our national power for the defense of our way of life. But that way is worthwhile only because it is the pathway of the just. It is our high privilege, although our task may seem prosaic, to strengthen the defenses of democracy by commending to public confidence and esteem the working of the institutions of justice in both state and nation."; Note, 2 GEO. WASH. L. REV. 498.

⁸⁵ D. C. CODE (1940) §§ 2-101, 2-102, 2-132, 2-137, 29-719, 29-725, 35-1347. Proceedings instituted by Group Health Association has established that its activities do not violate the insurance laws of the District of Columbia. *Jordan v. Group Health Ass'n.*

addition to those now available, the legislative method is the appropriate one to secure the desired end.

The Government offered evidence that in various instances, over a period of years preceding the indictment, the American Medical Association induced various hospitals to exclude physicians from their staffs because of the physicians' connection with various low-cost, risk-sharing or prepayment plans for medical services. Appellants contend that this evidence was not the type of background evidence approved by our decision in *United States v. American Medical Association*.⁶⁵ Specifically, they object that the Government did not present in detail the nature of the various plans which the Association thus allegedly sought to thwart and that the action of the Association is equivocal, hence as consistent with the enforcement of legitimate ethical standards as with a policy of discouragement of low-cost or risk-sharing or prepayment plans. It is true that in each instance the nature of the plan was not greatly detailed, though the Government's first witness gave a description of prepayment plans in general and described several then in operation, including at least two which were objects of opposition by the Association. We think it was sufficiently shown that these various plans all involved the common element of low cost, and that the attitude of the Association toward each was hostile.⁶⁷ This evidence was admissible as bearing on the intent of the Association in respect of the actions which are the subject matter of the indictment.⁶⁸ Even assuming that this evidence may have been relevant only in respect of the American Medical Association and that it was introduced for that purpose by the Government, nevertheless, as appellants

71 App. D. C. 38, 107 F. (2d) 239. The decision of the District Court included a finding that Group Health's activities do not violate the Healing Arts Practice Act of the District of Columbia. *Group Health Ass'n v. Moor*, D. C., 24 F. Supp. 445, 446-447. This part of the judgment was not appealed. *Jordan v. Group Health Ass'n*, 71 App. D. C. 38, 39, 107 F. (2d) 239, 240.

⁶⁵ 72 App. D. C. 12, 110 F. (2d) 703, cert. denied, 310 U. S. 644.

⁶⁷ For example, in 1936, the State Medical Society of Wisconsin disapproved a plan proposed for the care of employees of the International Harvester Company. The proponents of this plan, who were members of the State Society, refused to resign, and were subsequently tried, found guilty and expelled from the Society on the ground of violations of the By-Laws of the Society and the Principles of Medical Ethics. The expelled members appealed to the Judicial Council of the American Medical Association, which affirmed the action of the State Society. As appears from the opinion of the Judicial Council, the features of the plan were as follows: "1. Unlimited medical and surgical service for \$1.00 per month for a single man; \$2.00 per month for man and wife; \$3.00 per month for man, wife and family. 2. Only diseases excluded from the plan—mental and contagious. Hospitalization not included. 3. There would be no solicitation of patients. 4. All physicians who joined the clinic would benefit from any profits. 5. Patients may select any physician on the staff. 6. Preventive treatment not included in the plan. 7. No written contract between patient and clinic. Participants in plan restricted to those with income of \$200.00 or less per month."

The opinion of the Judicial Council also stated that: "The Judicial Council is distinctly of the opinion that practice under the terms and conditions to which these appellants have agreed with the employees of the International Harvester Company constitutes a violation of Chapter III, Art. VI, (Revised) Sec. 3, of the Principles of Medical Ethics (contract practice contrary to sound public policy)."

In the meantime and following the action of the State Society, Dr. Cutter, Secretary of the Association, had written the Superintendent of Mount Sinai Hospital, Milwaukee, Wisconsin, in the following language: "It has come to our attention, through correspondence with the Medical Society of Milwaukee County, that certain physicians have been expelled from that society through participation in an organization known as 'Milwaukee Medical Center.' It is also reported that certain of these same individuals continue as members of your attending staff with hospital privileges. May we call your attention to the recent resolution passed by the House of Delegates of the American Medical Association, as follows: 'Resolved, That it is the opinion of the House of Delegates of the American Medical Association that physicians on the staffs of hospitals approved for intern training by the Council on Medical Education and Hospitals should be limited to members in good standing of their local county medical societies and that the House of Delegates requests the Council on Medical Education and Hospitals to take this under advisement.' What possibility, if any, exists for observance of the principle laid down in this resolution?"

After a series of temporizing correspondence, Dr. Cutter again addressed the Superintendent of Mount Sinai Hospital as follows: "In view of the fact that we have received no reply to our letter of May 5 and no notification of any action taken with respect to the employment of physicians expelled from the county medical society, we wish to inform you that we are recommending to the Council that Mount Sinai Hospital be removed from the approved intern list and also from the Register of the American Medical Association."

One week later the Superintendent of Mount Sinai Hospital wrote Dr. Cutter that the objectionable physicians had been denied further staff and courtesy privileges at Mount Sinai Hospital by vote of the Executive Committee.

⁶⁸ *Chicago Board of Trade v. United States*, 246 U. S. 231, 238; *Standard Oil Co. v. United States*, 221 U. S. 1, 46-47, 75-77; *Heike v. United States*, 227 U. S. 131, 145; *Baugh Machine Tool Co. v. Aluminum Co. of America*, 2 Cir., 72 F. (2d) 238, 239, cert. denied, 293 U. S. 589; *Patterson v. United States*, 6 Cir., 222 F. 599, 629-630, cert. denied, 238 U. S. 635; *United States v. Lake Shore & M. S. Ry.*, S. D. Ohio, 203 F. 295, 307, appeal dismissed, 241 U. S. 691; *United States v. E. I. Du Pont de Nemours & Co.*, D. Del., 188 F. 127, 134.

sought only to exclude it entirely, rather than merely to limit its prohibitive force, there was, consequently, no error in admitting it,⁸⁹ in any event.

Appellants contend further, in this connection, that: "A misdemeanor such as described in Section 3 of the Sherman Act is not a violation of the law in Texas, Wisconsin, or any other state of the United States. A restraint of intra-state trade in Texas or Wisconsin is not a violation of any law of the United States, and so far as this record discloses, of any state law. Every man has a right to do it, and no finger of scorn is to be pointed at him for doing it. To permit the Government to prove in a case pending in the District of Columbia lawful acts that were performed by the defendant AMA in Texas and Wisconsin is error." But as applied to the present case the premise is incorrect and the conclusion does not follow. In the first place, it is elementary that if the object of a conspiracy is criminal, then evidence of conduct—otherwise lawful—but which is intended to achieve that criminal objective may properly be received to prove the conspiracy.⁹⁰ In the second place, whether the particular conduct was criminal at the time and place where it occurred is beside the point. Evidence has been admitted to prove background, even though it concerned conduct which occurred prior to adoption of the act under which the indictment was found;⁹¹ as well as concerning conduct which occurred before the date in the indictment when it was alleged that the accused persons conspired.⁹² The disputed evidence in the present case was not offered to prove the commission of crimes in Texas, Wisconsin, or other states, but to prove the commission of a crime in the District of Columbia, by proving the background of appellant's conduct in the District of Columbia. What it did in the District was part of a larger plan. Evidence of conduct in other states—which may have been perfectly lawful according to the laws in force in those states—was nevertheless proof of appellant's intent and purpose in acting as it did in the District.⁹³ The cases relied upon by appellants require no other conclusion. One of them is not in point and in both of the others all the acts complained of were committed outside the United States.⁹⁴ In *Eastern States Petroleum Co., Inc. v. Asiatic Petroleum Corp.*, Judge Chase, speaking for the Second Circuit Court of Appeals, put the case in a nutshell when he said: "Likewise, what was done wholly abroad *unaided by acts in this country* must be counted out."⁹⁵ [Italics supplied]

Appellants contend that the verdict of the jury acquitting all the defendants except the American Medical Association and the Medical Society of the District of Columbia, and convicting the two latter associations, constitutes such inconsistency as to require that the verdicts of guilty be set aside. It has been held many times that inconsistency in verdicts does not require the result contended for by appellants.⁹⁶ And this is true even though the inconsistency can be explained by no rational considerations.⁹⁷ The question for us is whether the conviction is consistent with the evidence.⁹⁸ Complete identity of participation in the conspiracy was not necessary upon the part of the participants, either in fact or in law. While such complete identity is not necessary in order to sustain a

⁸⁹ *Greater New York Live Poultry Chamber of Commerce v. United States*, 2 Cir., 47 F. (2d) 156, 159, *cert. denied*, 283 U. S. 837.

⁹⁰ *Aiken v. Wisconsin*, 195 U. S. 194, 206; *Swift and Co. v. United States*, 196 U. S. 375, 396; *Badders v. United States*, 240 U. S. 391, 394; *Duplex Printing Press Co. v. Deering*, 254 U. S. 443, 465; *Falstaff Brewing Corp. v. Iowa Fruit & Produce Co.*, 8 Cir., 112 F. (2d) 101, 108; *Lynch v. Magnavox Co.*, 9 Cir., 94 F. (2d) 883, 889; *Marino v. United States*, 9 Cir., 91 F. (2d) 691, 694, *cert. denied*, 302 U. S. 764.

⁹¹ *Standard Oil Co. v. United States*, 221 U. S. 1, 46-47: " . . . it tended to throw light upon the acts done after the passage of the Anti-trust Act and the results of which it was charged were being participated in and enjoyed by the alleged combination at the time of the filing of the bill."

⁹² *Heike v. United States*, 227 U. S. 131, 145: "The longer it had lasted the greater the probability that he knew of it and that his acts that helped it were done with knowledge of their effect."; *Bausch Machine Tool Co. v. Aluminum Co. of America*, 2 Cir., 72 F. (2d) 236, 239, *cert. denied*, 293 U. S. 589; *Wilson v. United States*, 6 Cir., 109 F. (2d) 895.

⁹³ See *Greater New York Live Poultry Chamber of Commerce v. United States*, 2 Cir., 47 F. (2d) 156, 159, *cert. denied*, 283 U. S. 837.

⁹⁴ *American Banana Co. v. United Fruit Co.*, 213 U. S. 347, 357; *Eastern States Petroleum Co., Inc. v. Asiatic Petroleum Corp.*, 2 Cir., 103 F. (2d) 315, 319.

⁹⁵ *Ibid.*

⁹⁶ *United States v. General Motors Corp.*, 7 Cir., 121 F. (2d) 376, 411, *cert. denied*, 314 U. S. 618; *Bryant v. United States*, 5 Cir., 120 F. (2d) 483, 485; *Dunn v. United States*, 284 U. S. 390, 393; *Steckler v. United States*, 2 Cir., 7 F. (2d) 59, 60; *United States v. Austin-Bagley Corp.*, 2 Cir., 31 F. (2d) 229, 233, *cert. denied*, 279 U. S. 863; *Crichton v. United States*, 67 App. D. C. 300, 303, 92 F. (2d) 224, 227, *cert. denied*, 302 U. S. 702. See *United States v. Bergdoll*, E. D. Pa., 272 F. 498, 505, *cert. denied*, 59 U. S. 585.

⁹⁷ *United States v. Austin-Bagley Corp.*, 2 Cir., 31 F. (2d) 229, 233, *cert. denied*, 279 U. S. 863.

⁹⁸ *United States v. General Motors Corp.*, 7 Cir., 121 F. (2d) 376, 411, *cert. denied*, 314 U. S. 618.

verdict when several persons jointly tried are convicted,⁹⁹ lack of it may be enough to explain away a supposed inconsistency when some are acquitted and others convicted. Thus in *American Socialist Soc. v. United States*, the court said: "The last objection is that the judgment should be reversed, because, if the author of the pamphlet was not guilty, the publishers could not be guilty. It is said that Nearing must have been acquitted on one of two grounds, viz either that the pamphlet itself was innocuous or that he had no intent to obstruct the recruiting and enlistment service of the United States. If the acquittal of Nearing was on the first ground, the society ought also to have been acquitted. We are therefore justified in finding that the acquittal was on the second ground. The statute, in defining the offense, imposes the additional condition that the act shall be done with the specific intent of obstructing the recruiting and enlistment service of the United States. The jury might believe that Nearing did not write these harmful views with the intent of obstructing the recruiting and enlistment service of the United States, and at the same time believe that the Society did print and distribute them with that intent. Such findings would not be inconsistent. This is a matter of fact, of which the jury are the sole judges, and with it we have no concern."¹⁰⁰

Appellants' contention confuses the concepts of corporate and individual criminal liability. When a corporation is guilty of crime it is because of a corporate act, a corporate intent; in short, corporate commission of crime.¹⁰¹ The fact that a corporation can act only by human agents is immaterial.¹⁰² How separate is the identity of the corporate person and the individual person, where criminal liability is concerned, is shown by the fact that a corporation may be found guilty of a crime, the essential element of which is a specific criminal intent.¹⁰³ This has been often held in conspiracy cases.¹⁰⁴ In at least one state it has been held that the corporation and its agents may be separately counted in order to find the two or more persons necessary for the commission of a conspiracy.¹⁰⁵ In the present case a large number of individuals were named as defendants; some of whom were agents of appellants, others who were not. Moreover, as the two corporations were convicted, the requirement of two persons is satisfied in any event. Consequently, for both reasons, the conviction of appellants does not depend upon the guilt or conviction of their agents.

We have carefully examined appellants' other contentions and find them to be without merit. As we read the record the case was tried carefully and fairly; the jury was properly instructed; and the evidence was adequate to support the verdicts.

Affirmed.

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AFTERNOON SESSION

The subcommittee reconvened at 2:30 p. m., pursuant to recess.

Senator SMITH. The next witness is Dr. Parran, Surgeon General, United States Public Health Service. Will you come around, Dr. Parran?

STATEMENT OF DR. THOMAS PARRAN, SURGEON GENERAL, UNITED STATES PUBLIC HEALTH SERVICE, WASHINGTON, D. C.

Dr. PARRAN. Mr. Chairman, the two bills before this subcommittee, S. 1320 and S. 545, might be regarded as alternative approaches to

⁹⁹ *McCandless v. Furlaud*, 296 U. S. 140, 165; *United States v. Anderson*, 7 Cir. 101 F. (2d) 325, 332-333, *cert denied*, 307 U. S. 625; *Thornton, Combinations in Restraint of Trade* (1928) §§ 211, 454.

¹⁰⁰ 2 Cir. 266 F. 212, 214, *cert. denied*, 254 U. S. 637.

¹⁰¹ *United States v. Union Supply Co.*, 215 U. S. 50.

¹⁰² *United States v. General Motors Corp.*, 7 Cir., 121 F. (2d) 376, 411, *cert. denied*, 314 U. S. 618; *United States v. Austin-Bagley Corp.*, 2 Cir., 31 F. (2d) 229, *cert. denied*, 279 U. S. 863.

¹⁰³ *American Socialist Soc. v. United States*, 2 Cir., 266 F. 212, 214, *cert. denied*, 254 U. S. 637.

¹⁰⁴ *Joplin Mercantile Co. v. United States*, 8 Cir., 213 F. 926, 935-936, *aff'd*, 236 U. S. 531; Note, Ann. Cas. 1916C 459; *United States v. MacAndrews & Forbes Co.*, C. C. S. D. N. Y., 149 F. 823, 835-836; *error dismissed*, 212 U. S. 585; *People v. Dunbar Contracting Co.*, 165 App. Div. 59, 61, 151 N. Y. S. 164, 166, *aff'd*, 215 N. Y. 416, 109 N. E. 554; *State v. Eastern Coal Co.*, 29 R. I. 254, 268, 70 A. 1, 7; *Minisohn v. United States*, 3 Cir., 101 F. (2d) 477, 478.

¹⁰⁵ *Standard Oil Co. v. State*, 117 Tenn. 618, 667, 100 S. W. 705, 718, 10 L. R. A. (N. S.) 1015.

the problems which confront us in the field of national health. In many respects, however, they are not comparable. S. 1320 provides for a comprehensive program which embraces five of the six points the Public Health Service has advocated as the components of an effective national-health program: Expansion of public-health services and organizations; construction of needed hospitals and related facilities; education of professional personnel; extension of scientific research; and implementation of a medical-care program. The sixth area of national-health need which S. 1320 does not cover specifically is that of environmental sanitation.

S. 545, on the other hand, does not purport to authorize a comprehensive program. Rather, it addresses itself primarily to one specific area of need—to medical care. To be sure, it contains some provisions for cancer control, for dental care, and for dental research. But the bill basically is directed toward the problem of obtaining personal health services for the medically needy.

In short, S. 1320 would attack the weakness in our National health structure on a broad front. S. 545 proposes an experimental program, aimed essentially at one basic need.

With the committee's permission, I shall limit my remarks to the general features of the two bills, leaving detailed comments to any discussion which may follow at the conclusion of my statement.

It is only in the approach to the problem of medical care that we can contrast the provisions of S. 1320 and S. 545. The former bill would establish a national system of compulsory health insurance to finance comprehensive medical services for approximately 85 percent of the population, through pay-roll deductions, supplemented by general taxation. Administration would be decentralized to a considerable extent to State and local governments.

S. 545, on the other hand, is designed to make available general health, hospital, and medical services to families of low income. Health- and dental-inspection services would be provided to all school children. States also would be assisted in making available dental care for school children and for individuals and families who are unable to pay the whole cost of such care. The program would be financed jointly by the Federal Government and the States on a matching basis.

In testimony submitted before the Seventy-ninth Congress the Public Health Service stated the belief that the health needs of the Nation could be met most effectively and in the shortest period of time through a broad program financed in part through health insurance. This position was based not on a preference for any particular scheme or social organization or pattern of Government action but rather on the conviction that such an approach will bring us more quickly to our health goals than any plan yet suggested.

From our viewpoint the most significant feature of S. 1320 is that it would definitely commit the Federal Government, in cooperation with the States, to a concerted attack on the problem of providing adequate medical care for all our people.

The Public Health Service fully recognizes that neither S. 1320 nor any other legislation of itself could immediately provide adequate medical care for the entire population. There obviously will be some time lag between the inauguration of the program and the develop-

ment of the personnel and the facilities needed to overcome the deficiencies which now exist in many parts of the country.

Senator SMITH. If there would be this time lag, how would we take care of the responsibility that would be the Government's if the compulsory health insurance program were put into effect, and deductions made from pay rolls of the workers, from which they would expect an over-all coverage of health service?

Dr. PARRAN. Mr. Chairman, it is a very important question. I am not sure I have all of the answers, but at least I will venture some suggestions as to ways by which this time lag could be overcome.

At the outset I think we agree until there is a declaration of national policy we are not likely to develop the personnel and facilities as well as if there were a declaration of national policy.

You will recall that S. 1320 contains several titles.

It should be possible, for example, to have the provisions of title III, namely, the development and expansion of health services, and the provisions for aid for medical education and possible liberalization of hospital services and construction, to become effective on a date prior to that on which the pay-roll taxes would become effective. During this interval the country would be aware of what was the national intent and get geared up to provide this new program.

Senator SMITH. They would have to be spending money on the program, it seems to me, before they would be able to return anything from the so-called tax.

Under S. 545 we are asking the States to experiment with this whole thing, and we are giving them grants-in-aid, and I have said to some witnesses, like witnesses from California, "Go ahead, California, and start. We are not putting any limitation on it."

I have a great question in mind as to whether or not we can establish a principle of over-all national taxation and think in terms how you are going to deliver the goods.

The question has been raised by many doctors: How are we going to be able to set something up here without objectionable compulsory features in return for the taxes which would be compulsory?

Dr. PARRAN. I think, perhaps, Mr. Chairman, some of the suggestions I shall venture in my testimony will answer in part some of the fundamental questions you have asked, and if not, I shall be glad to respond further.

Senator SMITH. Go ahead.

Dr. PARRAN. But in addition to the necessary legislative authority, S. 1320 recognizes the obligation of Government to take all necessary steps toward achieving the goal of a healthy nation. It defines the objectives, establishes time limits for arriving at those objectives, and authorizes appropriation of sufficient funds to carry on the program it would set up. Thus, we believe it offers a competent mechanism for improving the Nation's health.

Without doubt, the type of legislation proposed in S. 1320, if enacted, would present many and diverse administrative difficulties. There is no question that some, or perhaps many, of the provisions would require modification in the light of operating experience. But I am convinced that the problems encountered would not be insurmountable. The war has emphasized that the most difficult of tasks can be performed successfully if there is the will to accomplishment.

An unwilling medical professional would present the greatest obstacle.

Senator SMITH. I notice that, and it troubles me at the moment because we know the medical profession is apparently very unwilling to go along with a program of this kind at this time. All the doctors I have talked to feel it should be done by the trial and error method rather than by an over-all program. If they resist it, I do not see how you are going to develop your plan without some attempted method of compulsion.

Dr. PARRAN. The Public Health Service realizes that the issues involved in these bills go far beyond administrative difficulties and beyond methods of financing. They include fundamental questions relating to the political and economic foundations of our national-health structure which are matters of public policy and which only the Congress can resolve.

The testimony of the Public Health Service and of many other witnesses presented before the committee during hearings on the national-health bill of 1945 dealt largely with compulsory health insurance.

In addition, the Administrator of the Federal Security Agency in his statement gave particular attention to the compulsory health insurance approach as embodied in S. 1320. I should like, therefore, to deal largely with an alternative approach—the more limited developmental program.

Senator DONNELL. Have you read the statement of Mr. Watson B. Miller?

Dr. PARRAN. Yes, sir.

Senator DONNELL. Did you hear him testify?

Dr. PARRAN. I did.

The history of health legislation and service in the Federal Government has been characterized by the selective approach to particularly urgent problems. While this process has resulted in some unevenness in development and some difficulty in administration, the record clearly shows substantial progress through this approach. In fact, the present program of the Public Health Service has been along these very lines.

Our earlier efforts were directed toward the conquest of diseases amenable to mass controls—smallpox, typhoid fever, pellagra, and the like. Later, we have sought to control specific diseases of public-health importance, venereal diseases, tuberculosis, mental disease, and cancer.

Senator SMITH. You are speaking of the field of preventive medicine, smallpox vaccination, typhoid fever, pellagra, and the like.

Dr. PARRAN. Yes; that is correct. And in the case of venereal diseases, tuberculosis, mental diseases, and cancer, the present Public Health Service program goes beyond prevention—to supervision and treatment of the individual.

In the case of venereal disease and tuberculosis, it is obvious that an infected individual is a hazard to his fellowman.

In diseases such as mental diseases and cancer, it is obvious that they require a totally different kind of treatment.

In approaching one after another health problem of the Nation, first efforts obviously should be directed toward the sectors of greatest need. The Public Health Service, after years of study, has defined six elements of a national-health program. A brief review of steps toward those six goals may be helpful in identifying our present position and in charting a future course.

1. EXPANSION OF PUBLIC HEALTH SERVICES AND ORGANIZATION

Through legislation enacted since 1935, the public health services of the Nation have been immensely improved. I refer particularly to the provisions of titles V and VI of the Social Security Act, the Venereal Disease Control Act, the National Cancer Institute Act, the Public Health Service Act of 1944, with its tuberculosis-control provisions, and in 1946 the Mental Health Act and the Hospital Survey and Construction Act. The several programs have materially advanced the health of our people.

There remains, however, a great need for extending and strengthening the local health units which are the foundation of our total health structure. For this purpose further Federal aid is needed. Over 1,000 counties—one-third of the counties of the Nation, and most of them rural counties—are without the benefits of full-time public health services.

In terms of life and health, this means that thousands of deaths and thousands of disabilities which occur today are preventable. If we are to reduce illness to a minimum, lessen the present burden of sickness care, prevent disease before it starts, build a more fit race, we must extend public-health services into all areas now without these services and intensify them everywhere. This weakness and even lack of local health structure already has proved a serious deterrent to the full effectiveness of the recently inaugurated mental-health and cancer-control programs.

Senator SMITH. I may say I agree with you fully in these paragraphs. I think that that is a recognized practical field which we can move toward, can move forward in, but it is this larger question of over-all health insurance which is the troublesome one.

Dr. PARRAN. I agree, Senator, and Congress has been generous in the authorization of funds, but we are nearly up to the ceiling in the amount of funds authorized under present laws.

2. CONSTRUCTION OF HOSPITALS AND HEALTH CENTERS

The Hospital Survey and Construction Act enunciates a national policy to deal with this sector of our total health problem. It represents a comprehensive approach to the provision of hospitals and related facilities. The current hospital survey and construction program has its limitations and imperfections. Further development and extension, probably along the lines of title III of S. 1320, undoubtedly will be required. I believe, however, that since it is so late in the present session amendments could well be deferred for another year so that we may gain more experience with the present terms of the Hospital Act.

3. EDUCATION OF PROFESSIONAL PERSONNEL

Present and prospective shortages of well-trained medical and related personnel pose an urgent problem demanding immediate attention. I view this as the greatest obstacle to improving the Nation's health. There are serious shortages in all categories of health workers today, aggravated by a serious maldistribution favoring the urban centers. Even the most conservative estimates indicate that these

current shortages will become progressively more acute. These estimates are based upon present demands and do not take into consideration the added service which would be required by either S. 545 or S. 1320.

4. EXTENSION OF RESEARCH

In the field of research there has been considerable progress in recent years. Enactment of Public Law 410 by the Seventy-eighth Congress gave to the Public Health Service broad authority for research into the prevention, cause, and cure of the diseases of man. This legislation has been strengthened by the research provisions in regard to mental health and cancer control. With the additional legislation now pending before Congress, especially the bill to establish a National Science Foundation, the Federal Government will have created an adequate statutory basis for a strong, integrated program of research within and outside of Government which is essential to the advancement of national health.

5. ENVIRONMENTAL SANITATION

While great advances have been made in recent decades toward overcoming environmental health hazards, we are still far from the goal of providing a sanitary environment for all our people. One major sanitation hazard in early need of attention is the extent of pollution of our streams and waterways. Legislation sponsored by Senators Taft and Barkley and comparable bills in the House directed toward this specific problem is now being considered by the Congress. A further extension of Federal aid as contemplated by these bills is necessary if we are to round out this important element of our national health program.

6. IMPLEMENTATION OF A MEDICAL-CARE PROGRAM

Over many years, governments have assumed increasing responsibility for providing medical care for specific diseases and for specific groups within the population. Since Elizabethan times, Anglo-Saxon societies have accepted some degree of responsibility for the sick poor. In more recent years, care of the mentally ill and of the tuberculous has been recognized as a public function. Diagnosis and treatment for venereal disease is now offered in programs operated cooperatively by the Federal and State Governments. In addition, medical care is provided veterans and other categories of Federal beneficiaries at Federal expense.

Except for such groups, however, there is as yet no Nation-wide program to aid in providing adequate personal health services. This is a conspicuous weakness in our total health program. There is general agreement that a solution to this problem is fundamental to the health of the Nation. There is similar agreement that the cost of adequate medical care is beyond the means of a large proportion of the sick and disabled.

This brief review of our present situation, I believe, highlights three areas of urgent need: First, there is a lack of public health services in many parts of the country and particularly in our rural regions; second, there are not enough physicians, dentists, nurses,

and other health personnel; third, there is a substantial part of our population which does not receive adequate medical care. The Congress, in my view, should direct its attention simultaneously to these three areas.

The success of a medical-care program, whether as contemplated in S. 1320 or in S. 545, will depend in large part on a strong local health organization. It is axiomatic that the preventive and curative aspects of medical care are inseparable. The relationship between the provision of medical care and adequate numbers of health personnel is obvious. If more people are to get more medical care, we shall need more doctors, dentists, and nurses to give this care.

I should like now to turn to the legislative steps which I believe should be taken to meet these three needs.

(1) *We should ensure adequate health services in every community.*—This can be accomplished by increasing the amounts of Federal grants to States and by weighting the aid in proportion to the need, with special consideration for rural areas. The pattern of Federal-State-local cooperation already is well established. The current methods of granting aid to the States furnish a sound basis. The statutory foundation for necessary expansion of public health services could be provided by amending the provisions of section 314 (c) of the Public Health Service Act of 1944 along the lines indicated in title III (A) of S. 1320.

(2) *We should develop a national program of aid for the training of health personnel.*—Such aid probably will be needed both by institutions and individuals. As a first step in developing such a program, detailed surveys should be made—State by State. The Public Health Service, with the assistance of a competent advisory group broadly representative of the public, the professions, and the educational institutions, would be prepared to cooperate in such surveys, analyze, and appraise the findings, and submit specific recommendations to the Congress.

The Public Health Service already has begun studies of this problem. These studies are being undertaken jointly with the appropriate Council of the American Medical Association. In addition, we have had informal discussions with the dental profession. Also, as a result of our wartime experience in nurse education, we are continuing to consult with the nursing, hospital and educational groups concerned with nurse training with a view to developing a satisfactory program for the future.

The Congress could facilitate a definite program for professional education and training in the health sciences through a relatively modest appropriation to meet the Federal share of the cost of surveys conferences and reports. A statement of the interest of this committee in such studies and reports would be helpful as a basis for submitting an appropriation estimate.

(3) At least a start should be made in providing funds through taxation insurance or both toward the goal of making available adequate medical care for all the people. S. 545 represents a modest approach toward this goal, S. 1320 a comprehensive approach. The choice of approach is a matter for Congress to determine; but I, for one, believe there should be no undue delay in the full attainment of this goal.

If the Congress elects initially to provide only a limited approach to a medical-care program, most of the concepts of title II of S. 545, which would create a new title VII in the Public Health Service Act, seem to me to be sound, with some modifications which I shall specify.

State surveys as contemplated in S. 545 obviously are necessary. Their usefulness would be enhanced, if they were to include the three areas in which I have recommended simultaneous action and if they were directed also toward the determination on a State basis of the relative urgency of need.

A limited program should attempt to meet first needs first. In some cases, incomes may not be the most reliable index of urgent need. There are many areas in our country, particularly rural areas, where few, regardless of incomes, have ready access to adequate medical care. Likewise in some serious illnesses, including the chronic diseases, the cost of adequate care is prohibitive even to persons in the middle- or higher-income brackets. Also, the most effective way to attack our dental health problem may be to concentrate on dental care for children. In this case, age provides a better index of priority than income.

Any Federal legislation should make it clear that each State would be permitted to develop a health program more comprehensive than the minimum required and to operate it in a single administrative pattern, using its share of the Federal grant in any appropriate way. Obviously, it would add to the complexity and cost of administration to have one program for persons of low income and another for other persons.

S. 545 very wisely assigns primary responsibility for the administration of the program to the State and local governments. As I have already indicated, I believe that Federal legislation should give the States even wider latitude on program content, subject to minimum Federal standards. I agree with the New York Academy of Medicine that enabling legislation should clearly authorize and promote the provision of comprehensive, as opposed to limited, medical-care services.

The authors of S. 545 have repeatedly emphasized that one of its principal objectives is to establish 48 "State laboratories" for practical experimentation in new and improved methods of providing or assuring medical-care services to all our people. I should like to suggest three important areas of fruitful exploration:

(1) Further experimentation is needed in new and improved methods of making high-quality medical care available in a more efficient and economical manner. I should like to endorse the emphasis which the New York Academy of Medicine has placed on the organization of group practice and special diagnostic centers. This was one of the two principal recommendations of the Committee on the Costs of Medical Care, under the chairmanship of Dr. Ray Lyman Wilbur, distinguished Secretary of the Interior under President Hoover, past president of the American Medical Association, and chancellor of Leland Stanford University. The other was for voluntary health insurance.

Senator DONNELL. May I interrupt there?

Dr. PARRAN. Yes, sir.

Senator DONNELL. You say this:

I should like to endorse the emphasis which the New York Academy of Medicine has placed on the organization of group practice and special diagnostic centers.

Do you likewise endorse the last sentence appearing on page 11 of your mimeographed paper? Do you endorse the New York Academy of Medicine's recommendation?

Dr. PARRAN. The other recommendation was made by Dr. Wilbur. I was fully in accord with the recommendations of the committee when the recommendation was made.

Perhaps I can clarify my position by saying I am not a person who believes in all or nothing. I believe sooner or later we shall need a system of health insurance and taxation, or a combination of both.

The ways we attain that goal are something for Congress to determine. I am sure from experience that voluntary prepaid medical care would be a step in the direction of the total goal I have stated.

Senator SMITH. You think from your observation those voluntary plans have been reasonably successful—the Blue Cross?

Dr. PARRAN. The Blue Cross particularly, and the Blue Shield.

Senator SMITH. I just wonder whether your over-all feeling is they have done good work in that field?

Dr. PARRAN. I think it was a great forward step, Mr. Chairman, when the medical profession finally, after years of opposition, endorsed the principle of the voluntary health insurance.

I think all of the experience we can gain will be of value to Congress and to the people in charting a future course.

(2) We need to learn better how to coordinate the activities of medical research and teaching institutions with the administration of medical care services, in order to improve standards through leadership in this dynamic science.

(3) I believe the bill should contain some specific provision for reviewing and evaluating State experience with various methods of providing medical care and for making results of such an evaluation available to all of the States.

It would be well if the bill clearly authorized experimentation along these three lines.

S. 545 wisely recognizes the need for some equalization in the allocation of funds among the States. I would suggest also that provision be made for a variable matching ratio to enable the poorest States to raise the necessary matching funds. Again, I would emphasize special consideration of the needs of disadvantaged rural areas.

While the \$200,000,000 annual appropriation authorized for the financing of this program would, together with State funds, permit a substantial program to be inaugurated, there can be little doubt that this amount would need to be increased once the program is under way. I would, therefore, prefer to see the bill authorize increased appropriations after the first year or two of operation.

Senator SMITH. I think the authors of the bill—that is, S. 545—I for one, thought we would feel our way and get a lot of information during that period to determine whether that was a sound program.

Dr. PARRAN. Yes; my statement says "after the first year or two." I would agree to changing the language to "after the first few years of operation."

Senator SMITH. I thought we could test it and see how much further we could go.

Dr. PARRAN. Yes, sir.

The promotion of health and treatment of disease are integral parts of one problem. It is the total health of a single individual, the total

health of the family, that we seek to conserve. Integration of preventive and curative health services, therefore, is essential. While S. 545 conforms to this principle in requiring unified administration of all State health programs, it appears to violate the principle in its provisions relating to Federal administration. I am in agreement with the points of view expressed in this connection by the Association of State and Territorial Health Officers, the American Public Health Association, and the New York Academy of Medicine.

In its present form, S. 545 would allocate administrative responsibility for the direction of the new programs of medical, hospital, and dental care services to separate units of a new agency. These provisions would permit, if not actually create, a dangerous schism within our Federal health structure. The scientific statutory authority vested in the directors of the several new offices, as contrasted with the very general definition of the Administrator's functions, invites separate and uncoordinated administration. The specification of the several component units of the agency dealing with related aspects of health would have the effect of reducing the functions of the Public Health Service substantially to quarantine and preventive health work. Moreover, S. 545 in its present form would tend to complicate and confuse well established Federal-State relationships.

Senator SMITH. Let me pause there. I gather from that statement you do not think that in terms of over-all health the Public Health Service has a special function. What would you think the Public Health Service would be over-all?

I am not quite clear as to what you visualize as the goal. I may say we had the testimony of Mr. Miller this morning.

I would appreciate your comment as to the best administrative way of dealing with health.

Dr. PARRAN. Mr. Chairman, I hope ultimately to see a Department of Health under a departmental officer.

Senator SMITH. Do you mean to say you would rather see an Under Secretary of Health?

Dr. PARRAN. No. Ultimately I hope to see a Department of Health under the direction of a Cabinet officer. Since that time seems remote, my next preference is for health to be included in a combined Cabinet department embracing also education, social security, and related functions, as provided by S. 140. Even this well-intentioned bill should be modified so that the three Under Secretaries would serve as general assistants to the Secretary, rather than as heads of operating bureaus, as the bill seems to contemplate.

Senator DONNELL. You say ultimately you hope to see a Department of Health under the direction of a Cabinet officer.

Dr. PARRAN. That would be my view.

Senator DONNELL. Would you favor a Cabinet officer who would have as his sole duty the operation of the Department of Health? Is that right?

Dr. PARRAN. I would ask, Senator Donnell, that you either refer to my statement on page 14, or permit me to repeat it, because I cannot answer "Yes" to your question.

Senator DONNELL. The only reason I asked is, you say "ultimately I hope to see a Department of Health under the direction of a Cabinet officer."

Do you mean there that a Cabinet officer should have the complete and sole duty of the operation of a Department of Health?

Dr. PARRAN. That is right. That is correct.

Senator DONNELL. Or would you favor a Department of Health under a Cabinet officer who would have other duties as well?

Dr. PARRAN. The latter is my second choice.

Nowhere have I seen any strong sentiments or any disposition on the part of Congress to establish a separate Department of Health. The more closely the Federal Administration can follow the pattern of State administration, the more nearly the line can be kept clear from the health department of the State to the Cabinet department here.

In the absence of any particular prospect of a special Department for Education, another for Health and another for Social Welfare, then my second choice is that we should continue to be under a head who would be Secretary of Health, Education, and Security. Have I made my point clear?

Senator DONNELL. Yes. I understand your first choice to be the creation of a Cabinet position—a Cabinet officer who would have as his sole duty the operation of the Department of Health. Is that correct?

Dr. PARRAN. That is correct.

Senator SMITH. I am glad Senator Donnell brought that out. They all agree with you, but they do not go as far as you go. I am profoundly interested in that. It is the kind of thing where if you once take a step, you may get blocked and cannot reverse your situation if you are in the wrong. It is a very serious matter.

Dr. PARRAN. It is indeed, Mr. Chairman, and I would recall that there is obviously room for a wide difference of opinion.

Senator SMITH. No question about it.

Dr. PARRAN. Many competent people see this problem from one or another angle. I believe at one time we had a Department of Commerce and Labor but that was split, and we have created a Department of Labor and a Department of Commerce. I believe, in view of the underlying experience, Congress may take the second step.

Senator SMITH. We are debating on the policy of separate departments of the War and Navy, or whether it shall be one.

Dr. PARRAN. If the Congress is determined to establish an independent health agency in the face of strong support for a combined department, as provided in S. 140, then I believe that the provisions of S. 545 relating to the qualifications of the Administrator of the agency place an unwise and unnecessary limitation on the President's choice of appointees. The role of the Administrator, as I view it, would be to provide leadership and coordination of health programs in the light of statutory policies. This role places a premium on statesmanship and administrative ability, rather than on experience in medical practice alone. Technical leadership of the professional programs could be assured through suitable qualifications required of the heads of constituent units of the agency, who desirably should be drawn from the career services.

Finally, Mr. Chairman, I urge you to consider the underlying, the primary need for competent health personnel in our Government. Career opportunities must be sufficiently attractive to draw a fair

proportion of the best minds from each of the health professions. This is not now the case.

Ambitious national health programs—such as these being considered by this subcommittee—no matter how wisely the law be drawn, will fail unless additional competent minds can be induced to aid in the tasks of administration and research.

In all seriousness, I will say that unless substantial financial relief is given promptly to our present health personnel, our present health laws, excellent though they be—yet limited as compared with those you are considering—may profit us nothing.

Senator SMITH. Dr. Parran, S. 545 provides for \$200,000,000 a year.

Everybody knows \$200,000,000 a year could not cover the entire health needs of 140,000,000 people.

Would you not say it were more desirable to get an appropriation of that kind because of the matching features? Would it not be desirable to move at least in that direction today toward these objectives you have in mind?

Dr. PARRAN. Mr. Chairman, I have been engaged in public-health work for a long time, and there was a time when the proposal of \$200,000,000 appropriation would have seemed like the millenium.

I believe any funds should be spent under laws wisely drawn, which do not create obstacles to later expansion in the interests of advancing national health.

I would emphasize the necessity for moving in three ways all together at the same time: Preventive medicine, training of personnel, and medical care.

Senator SMITH. I want to apologize to you for having held you over until this afternoon, but you were here this morning and you saw the reason for the delay.

Senator DONNELL, have you any questions?

Senator DONNELL. Dr. Parran, in S. 1320 there is a considerable portion of that bill devoted to details having to do with decentralization, State functions, et cetera.

I call to your attention the provision at the bottom of page 39:

All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

And, also:

The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

By "the title" I am referring to title II, which is prepaid personal health-service benefits, which I take it is the compulsory health-insurance feature of the bill.

You have studied that bill in detail.

Dr. PARRAN. I have tried to study it, but I cannot qualify as an expert.

Senator DONNELL. Is there any provision you know of anywhere in the bill that would take away from the Federal Security Administrator this direction and supervision over the national-health insurance, or take away from that Board the power to perform such functions as it finds necessary to carry out the provisions of the compulsory health-insurance title?

Dr. PARRAN. Senator Donnell, I am not a lawyer. Therefore, if I make a mistake in responding to your question I hope you will forgive me.

There are many places where the power of the Federal Security Administrator is either taken away entirely or circumscribed.

I recall your statement which you read this morning together with the sentence beginning on page 39, line 22, in conjunction with the succeeding sentence. It is my understanding that the Board shall consist of five persons, three of whom shall be appointed by the President by and with the advice and consent of the Senate, and two others who shall be the Surgeon General of the Public Health Service and the Commissioner for Social Security.

The Surgeon General and the Commissioner for Social Security are appointed by the President and confirmed by the Senate and the three members would likewise be appointed by the President and confirmed by the Senate.

The Federal Security Administrator has no authority under these provisions to modify, change, approve, or disapprove of the regulations.

If the bill does not mean that I would venture to suggest that the bill be clarified.

Senator PEPPER. Would you allow me to ask?

Senator SMITH. Yes, Senator Pepper.

Senator PEPPER. You suggested something analogous, in having an understanding when the committee reported out favorably Reorganization Plan No. 2 that that did not give the Secretary of Labor authority to displace the authority which the Administrator of Wages and Hours had.

It was largely a matter of putting wages and hours into the Department of Labor for housekeeping matters, but you are thinking with respect to directives that should emanate from the Board, and it was the intention of the act that they should emanate from the Board rather than the Federal Security Administrator?

Dr. PARRAN. I was referring to the first line on page 40 which provides that the Board shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

Senator DONNELL. Do you regard the making of regulations and standards specifically authorized to be made in this title and other regulations not inconsistent with this title to be a function of the National Health Insurance Board?

Dr. PARRAN. That is my understanding.

Senator DONNELL. I call your attention to the language of the sentence just preceding that, which says—

all functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

Dr. PARRAN. I am not here to defend this language. I think I have stated my view as clearly as I can that the power to make regulations and standards should be vested in a group.

Senator DONNELL. You think then that the bill does give the Federal Security Administrator as a matter of law any power over the making of regulations, and that the bill ought to be amended and

changed so that the power to make those regulations should be in the Board rather than the Federal Security Administrator?

Dr. PARRAN. That is my best judgment; yes.

Senator DONNELL. It would appear you answered my first question when you said the making of regulations is a function of the Board? I think that is the language I have quoted.

Dr. PARRAN. Yes. Senator Donnell, may I say I had responded only fractionally to the very important question you interposed.

Senator DONNELL. Yes.

Dr. PARRAN. And I would like—

Senator DONNELL. Would you like to respond fully?

Dr. PARRAN. Yes. I think your question was directed to the fact whether the responsibility—

Senator DONNELL. Yes.

Dr. PARRAN. I pointed out—

Senator DONNELL. That is with respect to regulations?

Dr. PARRAN. It is.

Senator DONNELL. Very well.

Dr. PARRAN. I should like to point out some other respects in which the provisions of the bill deprive the Federal Security Administrator of much power.

Any State wishing to do so may assume responsibility for the administration of the benefits in the State by submitting a plan which complies with the conditions set forth in section 242 of the bill. The requirements in S. 1320 that States submitting personal health service benefit plans must be permitted to administer the program constitutes a major difference in this respect between S. 1320 and its predecessor, S. 1606, since under S. 1606 the Federal Security Administrator could utilize State and local agencies, but only to the extent the local agency saw fit.

I say parenthetically the principle endorsed by Senator Murray and his colleagues for administration by the Board is much more sound than the provisions of S. 1606, which would vest much of that authority in the Surgeon General alone.

Once a State plan has been approved, the State assumes full responsibility and authority to administer benefits in the State, including such functions as:

1. Medical services, hospital services, and State resources available under section 202 (a) and section 242 (a).

2. Maintaining necessary contractual and other relationships with doctors, dentists, nursing services, hospitals, and other persons and organizations who furnish benefits under the act, or who represent such persons, including:

(a) Passing upon their qualifications to furnish benefits (secs. 211 and 216);

(b) Negotiating terms and conditions of agreement for furnishing of health service, such as method of payment for such services (sec. 218); amount of fees and their payment (sec. 219); type or types of service to be furnished; the patients to be served; the records to be kept; the reports to be made, et cetera;

(c) Negotiating or entering into agreements with such persons directly or through their duly authorized representatives (secs. 215 and 216);

(d) Determining the amount due under agreements and pay the amounts due (sec. 232 (c));

(e) Investigating alleged breaches of agreement, providing opportunity for a hearing and an appeal and terminating agreements or taking other appropriate action (secs. 217 (d), 232 (d), and 262).

3. Continuing the responsibility of the State agency, to assure that health services are available to insured persons when and as needed, entertaining and adjusting their complaints, providing appeal machinery, hearing and deciding appeals, provide for judicial review, and so forth (secs. 232 and 262).

4. Deciding upon and taking special measures to alleviate shortages in medical personnel and facilities (secs. 242 (a) (5) and 256).

5. Appointing and supervising administrative officers and employees within the State, and the members of State local advisory and professional committees, designating local health service areas, allocating health funds throughout the State, and generally fixing the administrative pattern and method of administration throughout the State (secs. 231, 235, and 242).

Senator DONNELL. Thank you, Doctor. Now, Doctor, referring to section 231 in order that personal health service be made available promptly and in a manner best adapted to local conditions, practices, and needs, responsibility for administration of the benefits provided under this title in the several local health service areas shall be decentralized as fully as practicable to local administrative committees and local administrative officers, acting with the advice and assistance, and as provided in this part, of local professional committees, and, in the case of local administrative officers, the advice and assistance of local area committees.

Who makes the determination of what is "as fully as practicable" in your judgment under the terms of this bill?

Dr. PARRAN. That is a matter which the State agency would determine. As I view this language, it would seem unwise to lay a blanket order upon a State agency that all of its functions must be decentralized to the local area. This, as I view it, would state a congressional intent to have the bill operated, so far as practicable, with the maximum of local control, local administration, and local standards.

Senator DONNELL. You will observe there is nothing in section 231 which says who makes that determination as to what is "as fully as practicable." You agree with that, do you not?

Dr. PARRAN. Yes, sir; and may I say that I hope that neither you nor the authors expect me to be competent to defend the language.

Senator DONNELL. We are not the authors of S. 1320.

Dr. PARRAN. I understand that. I hope that in the course of such searching testimony as this committee is having and will have on this and other measures that the bill may be further improved and perfected, as in my experience so often has been the case with legislation as introduced.

In other words, I am saying I hope you will forgive me if I can't defend precisely every phase in the bill as being the ultimate.

Senator DONNELL. I don't believe anybody could do that.

Senator MURRAY. That is the situation in all legislation, is it not? You have found that to be true that no bill is perfect when first filed, have you not?

At the time this bill was first filed, it was publicly stated that we didn't regard it as the final answer, and that we expected as a result of extensive hearings, there would be opportunity to improve it.

Senator DONNELL. Doctor, I call to your attention the contents of a portion of page 34.

Dr. PARRAN. Senator Donnell, there has just been handed to me across the press table a further answer to your earlier question, which I was not able to answer.

Senator DONNELL. Very well.

Dr. PARRAN. It is required on page 33, line 19, as one of the requirements of the State plan that the State plan shall provide for the decentralized administration of this title in the State in accordance with part C for the designation of local health-service areas, and so forth. In other words, I was not able to say who determines "as fully as practicable." It would seem in the light of what has been drawn to my attention that the State plan should be considered in relation to the language which you quoted on page 25, line 2, "fully as practicable."

Senator DONNELL. I don't think the conclusion you draw is justified for the reason that subdivision 3 on page 33 says nothing more than that the State plan of operation shall provide for decentralized administration of this in accordance with part C, and that is the section from which I read, which does not say who makes the determination of what is "as fully as practicable."

So, I think subdivision 3—very respectfully I suggest to you—on page 33 does not answer the question.

Dr. PARRAN. Undoubtedly we are wasting your time to debate the legal point.

Senator DONNELL. No, sir; I am asking these questions on the theory that your answers should be helpful, and I am sure they are.

Now, doctor, in this connection, however, I call to your attention, and I was just about to do this before you called to my attention this matter, the immediately succeeding subparagraph on page 34. There is a description of the State plan of operation. As you will recall, section 242 (a) says that any State desiring to assume responsibility, and so forth, may do so for a period prescribed in (c) if it is undertaken to administer the benefits and had approved a State plan of operation, and then subdivision 4 on page 34 provides such methods of administration, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Board shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Board to be necessary for the proper and efficient administration of such benefits in the State.

Obviously, I take it that you and I would agree that there is left to the Board, which in turn according to page 39, administers all of its functions under the direction and supervision of the Federal Security Administrator, the power to determine what methods of administration, including methods relating to the establishment and maintenance of personnel standards on a merit basis are necessary for the proper and efficient administration of the benefits in the States.

The ultimate determination under subdivision 4 rests thereafter in the hands of the Federal Security Administrator. That is true, isn't it?

Dr. PARRAN. It is not true in my view.

Senator DONNELL. Why not?

Dr. PARRAN. This subsection 4 seems very familiar. I believe the exact language is found in other laws, the Social Security Act and other laws on the statute books. Perhaps some of my colleagues can cite more specifically where it is.

This merely, as I understand it, means that a State merit system shall be set up for appointment of the administrative and professional personnel in the program. The same requirement is in operation in reference to all our current health programs, and this seems to me to follow the current pattern of Federal-State cooperation in health programs.

Senator DONNELL. Doctor, I would like to call two facts to your attention in connection with your answer. In the first place, this section is not limited to the merit system standards, but that is only one of the subjects which are covered by subdivision 4. It is provided in subdivision 4 that the State plan shall provide such methods of administration, including methods relating to the establishment and maintenance of personnel standards on the merit basis. With respect to the exception noted in parenthesis, as are found by whom?—by the Board—to be necessary for the proper and efficient administration of such benefits in the States. As I see it—and not undertaking to debate the proposition—the language is perfectly clear that this National Health Board has the authority vested distinctly by those sections to determine what methods of administration, including those relating to personnel standards on a merit basis, are necessary for the proper and efficient administration of the benefits in the States.

Else why should the Board—"by the Board"—be in subdivision 4 at all? Doesn't that completely answer the response which you have made to the inquiry in regard to subdivision 4 on page 34?

Dr. PARRAN. Senator, I think one must read this language in connection with all the other provisions of the bill.

Senator DONNELL. Yes.

Dr. PARRAN. I must say, not being a lawyer, I am not prepared to debate with you these legal interpretations. I would be wasting your time. I would only ask what other language you might suggest as being more suitable to carry out this particular purpose.

Senator DONNELL. Well, may I state this, Doctor? Without debating each of these subdivisions as to what power is given to the Board, obviously, there is some power vested in this National Health Insurance Board by this bill.

Dr. PARRAN. Yes.

Senator DONNELL. And all functions, whatever they may be, that are vested in that Board—and I quote from page 39, "shall be administered by the Board under the direction and supervision of the Federal Security Administrator."

That is true, isn't it?

Dr. PARRAN. I have already tried to answer that question. I think we are whipping a dead horse to keep pursuing it.

Senator DONNELL. Regardless of that, Doctor, that is what the bill says.

Dr. PARRAN. You have read the language of the bill. I have one interpretation of the authority of the Board versus the authority of the Administrator, and you have another.

Senator DONNELL. Very well. In your statement at page 4 I observe a transition to an entirely different subject. You point out on page 4 that the Administrator of the Federal Security Agency in his statement, which was given this morning, gave particular attention to the compulsory health insurance approach, and then you say that you would like, therefore, to deal largely with an alternative approach, the more limited developmental program, which leads me to ask, Doctor, whether or not you have over a period of years expressed yourself as being favorable to compulsory national health insurance.

Dr. PARRAN. The Public Health Service is on record favoring compulsory national health insurance.

Senator DONNELL. Are you personally on record to that effect?

Dr. PARRAN. I am trying to recall, Senator. Perhaps I can answer your question and I shall try to be brief. I think we make too much of certain words, which have become fighting words, like "compulsory" versus "voluntary" or "health insurance" versus "taxation." Insurance if it is compulsory, is a tax. Every tax we pay is insurance, and so we are dealing with semantics in a way.

Also, while emphasis has been placed upon the voluntary nature of S. 545, I would point out that the Congress might provide sufficient inducements, levy general taxes to such an extent that no citizen except the most wealthy could afford to stay uninsured, and thereby by indirection through the power of taxation and yet under the guise of a voluntary system would create a compulsory system.

In some of the Scandinavian countries the practical result is that most all of the population is insured because the inducement is so great that nobody can afford to stay out of the system.

Now, I am trying to respond further.

Senator DONNELL. Go ahead.

Dr. PARRAN. I do not feel prepared to have a personal opinion as to whether it is more convenient for the Congress to exercise its taxing power in terms of a pay roll deduction or an earmarked income tax. It is a matter quite beyond my competence. I believe and I have striven to state in my testimony that I think there should be no property qualifications for health, that we should as rapidly as possible strive toward the goal, which cannot be reached tomorrow or perhaps even in a decade, of providing an equal opportunity for health for all of our people.

Senator DONNELL. Doctor, you addressed the Jackson County Medical Society in Kansas City, Mo., some years ago, did you not?

Dr. PARRAN. I recall that very pleasantly.

Senator DONNELL. That was August 20, 1943?

Dr. PARRAN. Thank you for refreshing my mind as to the date.

Senator DONNELL. It was at a luncheon at the Hotel Muehlbach?

Dr. PARRAN. Yes.

Senator DONNELL. At that time did you discuss the Wagner-Murray-Dingell bill?

Dr. PARRAN. I am not sure I discussed it by name. I certainly discussed the elements of a national health program, six, as we have categorized them, of which the matter of medical care was one.

Senator DONNELL. Did you inform the members of the Jackson County Medical Society that you were not consulted about the preparation of the Wagner-Murray-Dingell bill and had no part in the framing of that proposed legislation?

Dr. PARRAN. I may have said that. Certainly, it is a fact, as Senator Murray, I believe, will testify.

Senator MURRAY. That is true.

Senator DONNELL. Doctor, is it not a fact that primarily your emphasis over some years has been on public health activities such as sanitation works, pure water supplies, large-scale eradication of threats to health of great numbers of persons, rather than upon any subject of governmental compulsory health insurance? Is not that true?

Dr. PARRAN. That is partly true.

Senator DONNELL. Well, in what part is it not true?

Dr. PARRAN. It is not true in that I have not neglected to attempt to familiarize myself with the subject of compulsory and of voluntary health insurance as well as with the mechanisms for the better and more efficient distribution of medical care. Senator, in my statements over the past years I have tried, as in my statement this afternoon, not to add to the area of controversy but to find more common points of agreement. Until recent years the issue, it seems to me, was over-simplified. It was a fighting issue—either we have compulsory insurance and a national health program or no compulsory health insurance, and no national health program.

I have tried to put the prepayment of medical care in proper perspective to the other elements of a national health program, concerning which you have quoted me very accurately.

In other words, I have tried to see the total picture and hoped that the Congress in its wisdom would take one step after another in meeting one after another of these lacks.

At the present time, I am urging only that we move forward simultaneously on the three sectors which I have mentioned in my testimony.

Senator DONNELL. Doctor, you have not regarded the absence of compulsory health insurance as the greatest obstacle to improving the Nation's health, have you?

Dr. PARRAN. No. I have not for the reason, I think—and I believe and I hope there is general agreement by the members of the committee and everyone—that it is more important to prevent a case of sickness than it is to spread the cost of treating that case of sickness.

Senator DONNELL. As you have said in your statement today, you view the present and prospective shortages of well-trained medical and related personnel as the greatest obstacle to improving the Nation's health.

Dr. PARRAN. That is correct.

Senator DONNELL. That is correct, is it not?

Dr. PARRAN. It is.

Senator DONNELL. Did you deliver an address before the California Academy of Medicine at San Francisco, Calif., on August 26, 1939, entitled "Medicine in a Changing World"?

Dr. PARRAN. I made an address in 1939, and I assume you have quoted the date correctly.

Senator DONNELL. Did you at that time make this statement?

The national health program wisely leaves to the States the decision as to whether or not health insurance, either voluntary or compulsory, should be adopted in any State.

Dr. PARRAN. May I see your reference, sir? I am afraid I have made too many speeches to remember the exact texts of all. I hope they are not too inconsistent. This seems to be my language, and the leading sentence is as follows:

We must all concern ourselves actively to provide more and better medical care for the needy. With equal zeal we must see to it that changes should not be made which may impede continuing progress in the medical sciences. Steps toward national health should seek not only to extend medical service but vastly to improve it, and at the same time to avoid any revolutionary change in our present form of medical practice.

Senator DONNELL. That is August 26, 1939. A little further down on the page is this language, and I ask you again whether or not this was included in your address:

The national health program wisely leaves to the States the decision as to whether or not health insurance, either voluntary or compulsory, should be adopted in any State.

Dr. PARRAN. Yes; I think in that connection I was referring to the original Wagner-Murray bill.

Senator DONNELL. That is the bill S. 1620, introduced February 28, 1939. I assume you wouldn't remember that date, but I have the bill here, and that was the one pending at the time you delivered this address in California.

Doctor, did you make any other addresses since or before that time in which you expressed the same view that it is wise to leave to the States the decision as to whether or not health insurance, either voluntary or compulsory, should be adopted in any State?

Dr. PARRAN. I think I may have statements along that line about that time. Actually, I believe, and I hope you will agree, as I have tried to state in my earlier testimony, that the fundamental questions which you are considering here, Mr. Chairman and members of the committee, really go very deeply into our whole political and economic philosophy.

On that score I profess no competence. I have devoted myself to the technical and professional aspect of what broadly we call public health. In other words, it is a matter of congressional policy how the Congress decided in 1935, after very careful consideration, as I recall it, that certain parts of the Social Security Act should be federally administered, certain parts should be by way of grants to the States, and State systems set up. That is a matter which I think is in your competence, sir, and on which I would not hold any firm or authoritative opinion.

Senator DONNELL. And, Doctor, you were a member, were you not, of the Interdepartmental Committee to Coordinate Health and Welfare Activities, supported by the President in August 1935, following the passage of the Social Security Act?

Dr. PARRAN. I was not appointed in 1935. I took my present position in April 1936, but I was a member of that committee in the late thirties.

Senator DONNELL. That committee originally was appointed in 1935, as I understand it, but you were appointed by the President in October of 1938. That is correct; is it not?

Dr. PARRAN. I forget the date.

Senator DONNELL. You were on that committee; were you not?

Dr. PARRAN. I was.

Senator DONNELL. That committee did issue a report in 1938; namely, the Report of the Technical Committee on Medical Care; is that correct?

Dr. PARRAN. Such a report was issued.

Senator DONNELL. Did you concur with the findings in that report?

Dr. PARRAN. Yes.

Senator DONNELL. Well, I call to your attention the fact that in part 2 of that portion of the report which refers to medical care for the medically needy is this recommendation:

Recommendation 3—

this is in black-face type—

Federal grants-in-aid to the States toward the costs of medical-care programs for recipients of public assistance and other medically needy persons.

Then I call your attention to this language:

It is proposed that the Federal Government through grant-in-aid to the States implement the provision of public medical care to broad groups of the population:

(1) To those for whom the local State and Federal Governments, jointly or singly, have already accepted some responsibility through the public assistance provisions of the Social Security Act, through the work-relief program, or through provision of general relief;

(2) To those who are able to obtain food, shelter, and clothing from their own resources, are unable to procure necessary medical care.

The program would be developed around and would be based upon the existing preventive health services. It would be an addition to the programs and costs involved in recommendations (1) and (2) but would need to be closely related with the services provided under those recommendations.

The program contemplated in the present recommendation would provide medical services on the basis of minimum essential needs. It would include medical and surgical care, with necessary diagnostic services, medicine, appliances, hospitalization, exclusive of the period of maternity, and care of tuberculous and mentally diseased, besides nursing care and emergency dental care.

I call to your attention, Doctor, that all of this recommendation No. 3 appears, following a short paragraph reading as follows:

The foregoing evidence points clearly to the need for further public financing of medical care for the groups of medically needy persons who are unable from their own resources to pay the cost of care on any basis. In many communities and some whole States local fiscal capacity is insufficient to support adequate medical care without the aid of Federal funds. The charity of private physicians and resources of voluntary institutions are inadequate to meet the demands of this group for medical care.

The Technical Committee, therefore, believes that some plan of financial cooperation between the States and Federal Government is necessary to secure adequate medical care of the medically needy population and submits the following recommendations.

Then there are the recommendations as I have quoted previously. No. 3 is Federal grants-in-aid to the States toward the costs of a medical-care program for recipients of public assistance and other medically needy persons.

Did you concur in that recommendation?

Dr. PARRAN. Yes.

Senator PEPPER. What was the date of that?

Senator DONNELL. 1938.

Dr. PARRAN. There were other recommendations in the report also.

Senator DONNELL. I understand. But you concurred in that one?

Dr. PARRAN. Yes, sir.

Senator DONNELL. I want to call to your attention, Doctor, the first Wagner bill. You are familiar with it. We spoke of it here a few minutes ago, No. 1620, and I ask you whether or not—that was introduced in the Senate February 28, 1939—and I ask you whether or not that bill, known as the National Health Act of 1939—in the first place, was that the one you were talking about in San Francisco when you spoke?

Dr. PARRAN. That is my recollection.

Senator DONNELL. In the second place, is that not a bill which merely relates to grants to States, as illustrated on page 2, title 5, "Grants to States on Maternal and Child Welfare"; page 5, "Payment to States"; page 10, "Approval of State Plans"; page 13, "Payments to States"; page 15, "Operation of Plans"; page 16, "Public Health Work and Investigations"; page 18, "Approval of State Plans"; page 20, "Payment to States"; and on page 25, title 12, "Being an amendment to the Social Security Act, title 12, 'Grants to States for Hospitals and Health Centers'"—with various other references to approval by States and payment to the States; and then title 13, on page 34, "Grants to States for Medical Care"; and again on page 41, title 14, "Grants to States for Temporary Disability Compensation."

Is it not true that that bill from cover to cover is a bill providing for grants to States in aid?

Dr. PARRAN. That is correct.

Senator DONNELL. And it is based on the same identical theory of the grants-in-aid in S. 545, is it not?

Dr. PARRAN. The approach in each of the two bills is somewhat similar; and you will recall, Senator Donnell, in my formal testimony I said if the Congress decides to adopt a limited approach to this problem, that the basis, the concept of grants to the States, aid to the States in developing better medical care, is all to the good with the amendment I have suggested.

Senator DONNELL. I recall that.

Senator MURRAY. May I ask a question there?

Senator DONNELL. Yes.

Senator MURRAY. Did the medical profession accept this bill and support it?

Dr. PARRAN. Quite the contrary.

Senator MURRAY. They didn't support this?

Dr. PARRAN. Quite the contrary.

Senator MURRAY. How did that happen? I assumed they are entirely in accord with the examination that is going on here. Is not that a fact? Is it not a fact that they support that kind of program now?

Dr. PARRAN. They seem to, Senator Murray, and I think one must recall that in this connection, just as medical science changes and grows, so do our social concepts change and grow, and that is true of the medical profession as well as of other groups of the population.

We are all familiar with the fact that it is only in recent years that the medical profession has accepted the concept of voluntary health insurance.

Senator MURRAY. They didn't even accept the group insurance proposals that were developed in the country a few years ago.

Dr. PARRAN. So far as I know, the American Medical Association is not on record as favoring group medical practice. I may be misinformed; but, so far as I know, that has not been featured in their program.

Senator MURRAY. So this has been in the course of study during all these years, and new ideas and thoughts are being developed in regard to the kind of medical care we should have in this country.

Dr. PARRAN. Yes, Senator. Much that I learned in medicine thirty-odd years ago has proven, in the light of further knowledge, not to be true. Our knowledge grows by accretions, and we modify our views as a result.

I have always thought the same thing was true in regard to the social aspects of medicine and, in fact, to social problems generally.

Senator MURRAY. A lot has been learned in recent years with reference to the need for some sort of national system that would make medical care more available to the people; isn't that true?

Dr. PARRAN. That certainly is my view.

Senator DONNELL. I am wondering if you might permit me to complete my examination. I was pursuing a certain line, if the Senator doesn't mind.

Senator PEPPER. I would like to ask one thing.

Senator DONNELL. Yes.

Senator PEPPER. If I understand you, what you mean to tell us is that the medical profession has now caught up to the 1939 version of the Wagner-Murray-Dingell bill. Excuse me, Senator.

Senator DONNELL. Surely. Dr. Parran, I noted with much interest that to which you referred a few moments ago, namely, your statement that you have given to us that—

If the Congress elects initially to provide only a limited approach to a medical-care program, most of the concepts of title 2 of S. 545 seem to me to be sound, with some modifications which I shall specify.

That is what you were referring to a moment ago?

Dr. PARRAN. That is correct.

Senator DONNELL. Doctor, in view of the reference to title II and the fact that you said "title VII" in the mimeographed copy, I want to get our record clear. Do you have a copy of S. 545 before you?

Dr. PARRAN. Yes; I do.

Senator DONNELL. Would you be kind enough to turn to page 12?

Dr. PARRAN. All right.

Senator DONNELL. Title II, to which you refer, in the sentence which I have read and quoted a moment ago, is the title II which begins on page 12; is it not?

Dr. PARRAN. Yes; and specifically, Senator Donnell, I was referring to the language on the top of page 14 in that part of my testimony—"Title VII—General Medical Service for Families and Individuals With Low Income"; and then there is a new title to be added to the Public Health Service Act.

Senator DONNELL. In other words, the title II to which you refer in the sentence which I quoted—

Most of the concepts of title II of S. 545 seem to me to be sound, with some modifications which I shall specify—

that title II which begins on page 12 of S. 545 and includes within it various amendments to the Public Health Service Act, including the amendment which would be known as title VII, appearing on pages 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and part of 27 of S. 545; is that correct?

Dr. PARRAN. It is correct, if I may make a minor and technical correction.

Senator DONNELL. Yes.

Dr. PARRAN. In the part of my testimony to which you refer I was making reference to the language of S. 545, beginning at the top of page 14.

Senator DONNELL. And continuing for how many pages? That continues down through what page?

Dr. PARRAN. The whole \$200,000,000 proposal.

Senator DONNELL. That would run on through as to the general medical service to line 7 on page 27?

Dr. PARRAN. Correct.

Senator DONNELL. And then does your comment to which I have referred, namely, that most of the concepts of title II seem to you to be sound, with some modifications which you shall specify, apply also to title VIII, beginning on page 27 of S. 545 at line 8 and running through page 40 at line 8?

Dr. PARRAN. Yes; substituting the term "dental" for the general principles; yes. I tried to be brief in my statement.

Senator DONNELL. And also does your commendation of the concepts, with the modifications to which you referred, apply also to the remainder of the act from page 40 on down through page 47?

Dr. PARRAN. From page 40 through 44, title IX—proposed title IX—Public Health Act, further research and training in regard to dentistry. The Public Health Service is on record as favoring dental research, and I believe almost the same provisions are contained in a separate bill, which I think I was told the committee reported favorably a few days ago.

Senator SMITH. It is on the calendar now. I reported it yesterday.

Senator DONNELL. So your comment applies on page 40 through page 44, proposed title IX?

Dr. PARRAN. Yes, sir; with emphasis on the need for dental research.

Senator DONNELL. And does your commendation, with modifications referred to in your statement, apply likewise to the portion of the bill beginning at line 19 on page 44 and running down through line 6 on page 46?

Dr. PARRAN. That is a complicated question, Senator. I must reiterate my objection to the administrative provisions of S. 545, and the miscellaneous provisions which you have just stated relate, among other things, to such administrative provisions.

Senator DONNELL. Yes, sir. Very well, Dr. Parran. Now, Doctor, I shall not trespass but just a short while further on your time.

The American Medical Association, to which reference has been made a few minutes ago, constitutes possibly 80 to 90 percent, does it not, of the members of the profession who are practicing at this time?

Dr. PARRAN. Certainly a very large percentage.

Senator DONNELL. And its house of delegates is selected through a process selection of doctors from all over the United States. That is correct, is it not?

Dr. PARRAN. The delegates are elected by States or counties; yes.

Senator DONNELL. They come together periodically and they act as a body, which expresses the opinion of the American Medical Association, or purports to do so, does it not?

Dr. PARRAN. Yes.

Senator DONNELL. You know, as a matter of fact, Doctor, I assume, that the American Medical Association has very strongly expressed on more than one occasion its opposition to compulsory Nation-wide health insurance?

Dr. PARRAN. I am quite familiar with that attitude.

Senator DONNELL. And that is the most recent expression of that particular organization, is it not?

Dr. PARRAN. So far as I know, it is. I think the testimony before your committee would show that.

Senator DONNELL. That is all, Doctor. Thank you very much.

Senator SMITH. Senator Murray.

Senator MURRAY. The provisions in this bill, in S. 545, with reference to dental and health services are the same provisions that are in the bill passed last year and which is pending now and has just been reported to the Senate?

Dr. PARRAN. That is my understanding.

Senator PEPPER. Doctor, I believe you stated in your opening statement that S. 1320 made what you regarded as a more comprehensive approach to the problem of adequate medical care to the people than, in your opinion, was made by S. 545.

Dr. PARRAN. That is correct, Senator Pepper—much more comprehensive.

Senator PEPPER. One of the things S. 1320 directly attacks, which I believe you stated in response to questions of Senator Donnell, is the question of inadequate professional personnel to meet the health needs of the country.

Dr. PARRAN. That is correct.

Senator PEPPER. So far as you recall, is there any provision made in S. 545 for that approach?

Dr. PARRAN. There is not, so far as I know.

Senator PEPPER. Now, Doctor, I ask this as one of the devout and fervent sponsors of this bill, because the question is often asked of us, and such a question has been indicated during these hearings by Senators. The question is asked: How will it be possible if we have an inadequacy of technical personnel today, to put into effect a system which will provide means for the purchase of so much medical care that is contemplated by No. 1320? I think it would be extremely valuable, not only to the committee and the Senate, but to the public at large, to know what is the general point of view of informed people with respect to that subject.

Assuming the Congress would enact S. 1320 in its present form or in some similar form, how would it be implemented?

Dr. PARRAN. I would suggest a staggered time table, Senator. The first beginning date, in my view, should be for a program to upbuild our preventive health services, upbuild the local health units, without which neither S. 545 nor 1320 could operate most effectively.

We need preventive health services to blanket the Nation, and we need to intensify the services in areas which have only a partial or even a skeleton force.

At the same time, I would hope that the act would authorize substantial aid to medical education concurrently with the intensified preventive services, because on that score, as well as on the treatment side of the problem, additional personnel are needed.

Perhaps the provisions of the Hospital Survey and Construction Act should be liberalized, as I have indicated—its time to be extended, the amounts authorized thereunder to be increased—if the Congress has in mind the broad comprehensive program as contemplated under S. 1320.

Senator SMITH. May I interrupt? Up to that point, would you put the pay-roll tax on or are you holding off?

Dr. PARRAN. I think the pay-roll tax should follow after some period of time, which the Congress could determine more wisely than I.

Senator SMITH. You would finance those beginning steps much as S. 545 calls for?

Dr. PARRAN. Except that S. 545 doesn't contain either one of the substantial initial steps that should be taken; namely, much broader support to current local health services, except for dental care.

Senator SMITH. It would, in cooperation with the State health organizations, if they see fit to put their money in that field.

Dr. PARRAN. Perhaps, Mr. Chairman, we do not have a meeting of minds as to terms, but the primary purpose of S. 545 is to give \$200,000,000 for the medical care of the medically needy. I would put the first emphasis—I would make the initial step a further intensification of efforts to prevent disease, minimize the risk of illness rather than to assume the current volume of illness and seek to spread the cost through taxation or insurance.

The next step, Senator Pepper, in further response to your question, should be the imposition of the pay-roll tax, and that date should be several months or even a year or two or more, in advance of the passage of such a comprehensive provision.

In making this statement, I am expressing my professional point of view and not attempting to express the views of anyone else.

Senator PEPPER. That is what I want because that question is often asked.

Dr. PARRAN. If I may just conclude that line of thinking—unless an act is passed which does set a national policy, we shall never bestir ourselves to get geared up to do this total job.

Senator PEPPER. In other words, the act is somewhat like the planning of the war in the highest level. The Joint Chiefs of Staff, for example, lay down the strategy and lay down the objectives, and then you set in motion the various programs and plans that are designed to implement these objectives that have been declared.

Now; you say you think it will be necessary to lay down clearly what our objectives are and what we propose to try to accomplish and then we set in motion the machinery to try to reach those aims. But it isn't likely that you are going to set your machinery and implementation in motion unless you have clearly declared your objectives; isn't that true?

Dr. PARRAN. That is a clear statement with which I agree.

Senator PEPPER. Now Doctor, how long have you been a medical doctor?

Dr. PARRAN. I was graduated in 1915.

Senator PEPPER. And have you spent most of your professional life, as you indicated a moment ago, in the Public Health Service?

Dr. PARRAN. I have, Senator Pepper.

Senator PEPPER. Out of that experience of yours has there come within your personal knowledge the existence of cases of tragic unfilled need of medical care and medical service to the people of our country?

Dr. PARRAN. A great many instances, Senator, through the years.

Senator PEPPER. Is it your opinion and have you learned out of your knowledge in your present position that today the medical care being afforded to the people of this country is greatly inadequate compared to their needs?

Dr. PARRAN. It is in its distribution. We have the finest medicine and medical education and medical science in the world. The torch of Esculapius seems to have been passed to our hands in this field of science. Our problem is to turn this great humanitarian asset to wider usefulness, to continue to nurture and develop medical science, to continue to elevate the quality of medical care, to make it more widely available at a price which the people can afford to pay.

Senator PEPPER. Doctor, although I doubt that you would be able to unequip yourself by your own testimony, you disclaimed any competence in the field of general social purpose and administration, but would you venture as a citizen to express an opinion as to whether that wide distribution of these magnificent services that we have to give health care to the people is in the direction of democracy and out of regard for the dignity of all people, both poor and rich?

Dr. PARRAN. Yes, sir; I think that one of the next great areas in human progress—in social progress, scientific progress in this country—can be this whole field of health. It was during the first half of the last century when there was fought out in this country the issue of equal opportunity for education. I believe in this century, and I hope long before it is ended, we shall have fought out successfully the issue of an equal opportunity for health for all of our people.

Senator PEPPER. And that analogy is very telling, it seems to me, Doctor. There are a certain number of our people who have the money to send their children to private schools, and who think it is desirable to send their children to private schools, either sectarian or non-sectarian, but by and large, the pattern of America is for the poor boy and rich boy and the poor girl and the rich girl to sit in the same kind of seat in the same room and get their instruction from the same teacher, and in other respects, as far as school children's experience is concerned, to be on the democratic level in our country. You say that you hope that the same thing will apply with respect to the equality of access to medical care by all of the people.

Now, you have expressed an opinion, Doctor, in your statement on page 2 at the bottom of the page, and I thought you put it very well, where you summed up in a cautious yet clear way your conviction about this matter. You say in the last paragraph of page 2:

In testimony submitted before the Seventy-ninth Congress the Public Health Service stated the belief that the health needs of the Nation would be met most effectively and in the shortest period of time through a broad program financed in part through health insurance. This position was based not on preference for any particular scheme of social organization or pattern of Government action but rather on the conviction that such an approach would bring us more quickly to our health goals than any plan yet suggested.

That represents your convictions out of a long period of public health service and many years of experience as Surgeon General of the United States?

Dr. PARRAN. That is my mature professional judgment.

Senator PEPPER. Now, Doctor, you haven't heard any of the authors of this bill claim that it pretends to perfection or that it presumes perfection, have you?

Dr. PARRAN. Quite the contrary.

Senator PEPPER. You have heard from both the authors of the bill and those who favor it that it is simply a step in the direction of greater health care for the greatest number of people and that, as Senator Murray says, defects will develop, trial and error will show through experience the necessity of change, but it is in the direction of the best health care for the largest number of people.

Doctor, I want to ask you one other question. Reference has been made to the experience of other countries. Would you just summarize briefly what are the medical plans in the other countries of the world?

Dr. PARRAN. That is a very large order, Senator Pepper.

Senator PEPPER. I realize that, and I don't mean for you to go into general details. Is it or is it not a fact that in practically all of the more advanced countries of the world some approach beyond the pay-for-service fee-for-service medicine has been made on the part of the governments?

Dr. PARRAN. The governments in most of the countries of the world, most of the western democracies, have undertaken some one or another form of health insurance. However, I would have you bear in mind that the experience in Great Britain, for example, which was started in 1912, has proved inadequate, and it is being changed under the stimulus of the conservative government headed by Mr. Churchill and being carried forward by the Labor Party.

That was a limited program. It insured the worker himself, but gave no protection to the dependent members of his family. It did provide, and most health insurance schemes do provide for cash payments in lieu of wages when one is sick. Up to now this important point has been overlooked in testimony. I think Mr. Mitchell may later develop it. However, it doesn't make sense to me for a person when he is unemployed because a factory is closed to get a cash payment and yet if he has tuberculosis or pneumonia, not to get payment in lieu of wages, except as has been brought out, in the case of Rhode Island.

Senator PEPPER. Congress has already laid down that principle in the amendment to the Railway Labor Act, which went into effect in July of this year.

Dr. PARRAN. I understand it has.

Senator PEPPER. Were you going to refer to any countries?

Dr. PARRAN. I was thinking, first of all, that I don't believe we should start as of 1912 when medicine was a very different science. The Scandinavian countries have a peculiar capacity for cooperation. Their systems have been built primarily upon the inducement basis of heavy government subsidy of taxes for hospital care, for example, and medical education and other things, so that no person really can afford not to join the system. I hope that out of the hearings before this committee, Senator Pepper, we will avoid the mistakes of other health insurance attempts and create a truly American system. I believe it will ultimately be the judgment and wisdom of the Congress and ultimately the judgment and wisdom of the people as to the questions of compulsory, voluntary, the payments paid out of taxes, the amount paid by pay-roll check-off, the amount the employers pays, the amount of employee pays. They are beyond my competence, and they are matters for your competent hands.

Senator PEPPER. What criterion do you lay down that any plan should observe? Is it not the fact that it should be adequate in character and within reach?

Dr. PARRAN. Desirably it should be as adequate as possible. Adequacy, like life, liberty, and the pursuit of happiness, good health for all, removal of economic barriers for every citizen in this field of health is an ideal which, broadly speaking, this country has sought to attain during more than 150 years, and so I am not so concerned as to how far the Congress may go this year or next year as that we continue to make progress without undue delay, and that such progress as we make should not set up barriers to more effective development in future years.

Senator PEPPER. Well, now, there is being paid a cost. That is, those who do not get the medical care which will either spare their lives or improve their health are paying the price for the delay and inadequacy of the program, are they not?

Dr. PARRAN. That is correct, and that is the reason I would underline the words "without undue delay."

Senator PEPPER. Thank you very much.

Senator MURRAY. Mr. Chairman, at this point I would like to have inserted in the record a collection of statistics which I have had compiled in my office with reference to the need of medical care. I have two sheets here, one entitled "Health Insurance, Fact Sheet No. 1," and the other entitled "Health Insurance, Fact Sheet No. 2." It starts out with the statement that two people out of every three, approximately 97,000,000 Americans need help to meet the cost of serious illness. Through these sheets at the bottom of each page I have reference to the authorities from which these statistics are taken. They are taken, for instance, from the Factual Data on Medical Economics, pamphlets issued in 1939 from the Bureau of Medical Economics, American Medical Association, and other statistics of that kind.

I would like to have them inserted in the record. There is authority for each of the statements we have there.

Senator SMITH. Very well. They will be included in the record at this point.

(The two documents referred to above are as follows:)

[Fact sheet I]

HEALTH INSURANCE

I. How many people in the United States need help to meet the cost of serious illness?

1. Two people out of every three, approximately 97,000,000 Americans, need help to meet the cost of serious illness.¹

II. How often are people ill?

1. Among each 1,000 persons, during a normal year: 1 out of 3 will be sick once, 1 out of 7 will be sick twice, 1 out of 20 will be sick three times. In addition, many more will suffer unrecognized illnesses, such as heart diseases or cancer in the early stages, so that over half the people in the country are sick at least once during the year.²

2. At least 7,000,000 people in the United States are disabled by sickness or other disability in any 24-hour period, half of them for 6 months or more.³

(a) One person out of every 20 is afflicted by sickness or disability in any 24-hour period.

III. How many doctors are there in the United States?

1. There were 180,496 registered physicians, including all types of specialists, in 1942.⁴

(a) We had about 135,932 "effective physicians" in 1943.⁵

IV. Is there a shortage of doctors in the United States?

1. Yes. There is a 40- to 50-percent shortage, taking a standard of 1 physician for every 1,000 potential patients.⁶

(a) There would be only 1 active physician for every 1,000 to 1,500 potential patients, as against a recognized standard of 1 for every 1,000, if doctors were distributed evenly across the country.⁶

(b) However, there is less than 1 active physician for every 3,000 people in 18 percent of the Nation's 3,070 counties; and 81 counties have no active doctor at all.⁷

V. How many hospitals and hospital beds are there in the United States?

1. There were 1,738,944 hospital beds in 6,511 hospitals in 1945.⁸

(a) However, there is no approved general hospital in 41 percent of the Nation's counties, with a total population of 15,000,000 people;⁹ and 48 percent of our counties have less than the recognized standard of 4.5 beds for every 1,000 people.⁹

VI. How much do illness and death cost the people of the United States?

1. About \$15,000,000,000 a year. This is the estimated total hidden cost of sickness and disability, wage loss to workers, and cost to business.¹⁰

(a) The estimated annual cost of sickness and accidents, in medical costs and loss of earnings alone, due to sickness and premature death, is \$3,000,000,000.³

2. It has been estimated that the people of the United States will spend \$5,499,963,211 in 1947 for medical care, including supplies and insurance.¹¹

(a) In contrast with this, we spent \$8,700,000,000 in 1946 for alcoholic beverages—50 percent more for alcoholic beverages than for every form of medical care, including supplies and insurance.¹²

¹ Families with incomes under \$3,000 need help to meet the cost of serious illness (Factual Data on Medical Economics," pamphlet issued in 1939 by the Bureau of Medical Economics of the American Medical Association). 69 percent of the United States population live in such families (National Survey of Liquid Asset Holdings, Spending and Saving: Bureau of Agricultural Economics, U. S. Department of Agriculture, July 1946).

² I. S. Falk, C. Rufus Rorem, and Martha D. Ring. The Cost of Medical Care, Publication No. 27, Committee on the Costs of Medical Care, University of Chicago Press. (Figures are minimum, for recognized illnesses only.)

³ Senate Subcommittee Report No. 5 (Health Insurance), July 1946, p. 1.

⁴ A. M. A. Directory, 1942, 8 (latest issue).

⁵ A. M. A. Journal, vol. 121, p. 1163 (1943): Total registered physicians, 1943: 179,039; difference represents those not practicing because of advanced age, physical disabilities, and other reasons.

⁶ Senate Committee Print No. 5, 79th Cong., July 8, 1946, p. 35.

⁷ Senate Subcommittee Report No. 5, 79th Cong., July 1946, p. 1.

⁸ World Almanac, 1947, p. 773.

⁹ Senate Committee Print No. 3 (National Health Act of 1945), March 1946, p. 52.

¹⁰ Federal Security Agency fact sheet, The Health of the Nation, June 1, 1946, p. 2.

¹¹ The Medical Market—Forecasts for 1947 (Modern Medicine).

¹² Department of Commerce, April 30, 1947 (AP dispatch, Washington, New York Times).

VII. How much do we spend for research for new treatments and cures to save ourselves from death and disability?

1. It is estimated that only about \$20,000,000 a year, from voluntary and Federal sources, is being spent for research to find causes and new treatments for diseases.¹³

(a) In contrast with this, the Department of Commerce reported in 1943 that approximately \$275,000,000 is being spent each year for industrial research.¹⁴

(b) Congress appropriated \$29,866,200 for the Department of Agriculture alone in 1947, for research in the control and cure of plant and animal diseases.¹⁵

VIII. Would a national health insurance program cost the people of the United States more than they spend at present for medical care?

1. The proposed health insurance program would cost the people less, on the average, than they spend at present, as shown by the following table:¹⁶

Annual earnings	Estimated present expenditures ¹	Proposed bill ²
\$500 to \$1,000.....	\$25. 12	\$15-\$30
\$1,000 to \$1,500.....	57. 91	30- 45
\$2,500 to \$3,000.....	89. 88	75- 90
\$3,000 to \$5,000.....	133. 07	90-150

¹ Study of Family Spending and Saving in Wartime, 1941 and the first quarter of 1942. August 1942, U. S. Bureau of Labor Statistics and Bureau of Home Economics.

² 3 percent of earnings (1½% percent paid by employee, 1½% percent by employer).

IX. How many people in the United States are not covered by any form of health insurance?

1. At least 105,000,000 people are not covered by any sort of medical insurance plan.¹⁷

X. How many people are covered by voluntary health insurance plans?

1. Only about 35,000,000 people in the United States were covered by any sort of health insurance plans in 1945. (These figures probably involve considerable overlapping of coverage.)¹⁸

2. Only about 3,500,000 people were covered by comprehensive medical care plans in 1945.¹⁹

3. After about 14 years, only about 21,755,766 people, about 16 percent of the people in the United States, were covered by Blue Cross hospitalization plans as of July 1, 1946.²⁰

(a) It would take 27 years to enroll all the people of the country in Blue Cross plans, if the highest annual rate of enrollment to date were to continue.²⁰

(b) Only about 20 percent of all admissions to general hospitals in 1945 were covered by Blue Cross.²¹

¹⁷ See the following table:

American private foundations, 1940.....	\$4, 700, 000
National Cancer Institute (U. S. Government), 1946-47.....	1, 772, 000
National Institute of Health (U. S. Government), 1946-47.....	5, 966, 948
Veterans' Administration—National Research Council (approximate).....	1, 000, 000
American Cancer Society, 1946.....	2, 500, 000
National Foundation for Infantile Paralysis, 1946.....	1, 858, 826
Medical schools and teaching hospitals (estimated).....	2, 500, 000

Total..... 20, 297, 774

¹⁸ Report of survey released by Department of Commerce in 1943.

¹⁹ Budget of the United States, fiscal year ending June 30, 1948.

²⁰ The Federal Government will, however, need to spend additional funds on hospitals, training of doctors and nurses when necessary, etc., in order to implement a national health insurance program.

²¹ Senate subcommittee Rept. No. 5, 79th Cong., July 1946, p. 6.

²² World Almanac, 1947, p. 772. (Total Blue Cross coverage, 23,132,508—Canada, 1,376,743; United States, 21,755,766.)

²³ Highest enrollment in 1 year, 1945-46, 4,338,928. (World Almanac, 1947, p. 772.)

²⁴ World Almanac, 1947, p. 772.

XI. What do public opinion polls show about popular demand for health insurance?

1. In a national poll in 1944:²² 82 percent thought something should be done to make it easier for people to get medical care; 85 percent thought social security should include doctor and hospital care; 58 percent were willing to pay 2½ percent pay-roll deduction to provide the money (the proponents of the present bill suggest only 1½ percent deductions).

[Health insurance fact sheet II]

I. How many people in the United States need help to meet the cost of serious illness?

1. Two people out of every three who live in the United States—about 97,000,000 Americans—need help to meet the cost of serious illness.¹

(a) This statement is based on an estimate made in 1939 in a publication of the American Medical Association, that families with incomes under \$3,000 need help to meet the cost of serious illness.¹

(b) However, by 1945 the cost of living index had increased by 29 percent over 1939; and in April 1947, the index was 50 percent higher than in 1939.²

(c) Therefore, it is reasonable to assume that many people with incomes over \$3,000 now need help to meet the cost of serious illness.

II. What is the annual loss to the United States because of sickness, disability, and premature death?

(A) In terms of people, the United States lost:

1. In 1945, excluding those who died in the armed forces overseas, 1,401,719 Americans, through death. Of these:³ (a) 11 percent or 162,006 were under 20 years of age; (b) 8 percent or 112,442 were aged from 20 to 39; (c) 19 percent or 274,448 were under 40 years of age; (d) 23 percent or 321,921 were aged from 40 to 59.

This means that (e) 42 percent or 596,369 of the Americans who died in this country in 1945 were under 60 years old.

2. About 1,000,000,000 days of disability each year from chronic illnesses.⁴

(a) There are approximately 22,000,000 disabling illnesses every year in the country as a whole.⁵

(1) Each of these illnesses lasts, on the average, about 57 days.⁵

(b) Over 40 percent of the Nation's selectees were found unfit for military duty.⁶

(1) At least 17 percent of those found unfit had defects which were remediable; many more had preventable defects.⁶

(B) In terms of production, the United States lost:

1. About 600,000,000 man-days annually.⁷

(a) Illness and accidents cause the average industrial worker to lose about 12 days from production each year.⁷

(b) More than 75 percent of the 25,000,000 chronic disease cases in the United States are among people in the productive years from 15 to 64; half of these people are less than 45 years old; 16 percent of them are under 25.⁸

(C) In terms of money, the United States lost:

1. An estimated \$8,000,000,000 annually, half in medical costs and half in loss of earnings due to sickness and premature death.⁷

(a) It is estimated that American workers lost \$560,000,000 in wages in strikes during the first 6 months of peace; at this rate, the annual wage loss

²² National Opinion Research Center, University of Denver. (Quoted in Federal Security Agency fact sheet, *The Health of the Nation*, June 1, 1946.)

¹ Families with incomes under \$3,000 need help to meet the cost of serious illness (Factual Data on Medical Economics, pamphlet issued in 1939 by the Bureau of Medical Economics of the American Medical Association). 69 percent of the United States population live in such families (National Survey of Liquid Asset Holdings, Spending and Saving: Bureau of Agricultural Economics, U. S. Department of Agriculture, July 1946).

² Bureau of Labor Statistics: 1939 yearly average, 99.4; 1945 yearly average, 128.4; April 1947 (monthly average), 156.1 (1935-39=100).

³ U. S. Bureau of Vital Statistics.

⁴ George St. J. Perrott, U. S. Public Health Service: *The Problem of Psychosomatic Disease*, article in *Psychosomatic Medicine*, January 1945.

⁵ Public Affairs pamphlet, *Who Can Afford Health?* by Beulah Amidon, 1944, p. 9.

⁶ Senate subcommittee Rept. No. 5, 79th Cong. (Health Insurance), July 1946, p. 1.

⁷ Senate subcommittee Rept. No. 5, 79th Cong. (Health Insurance), July 1946, p. 1.

⁸ George St. J. Perrott, U. S. Public Health Service: *The Problem of Chronic Disease*, article in *Psychosomatic Medicine*, January 1945.

would be \$1,120,000,000 in contrast with the \$8,000,000,000 lost through sickness and premature death.⁹

2. It is estimated that the total hidden costs of sickness and disability wage loss to workers and costs to business totaled in 1943 not less than \$15,000,000,000.¹⁰

III. What do we spend on health, compared with what we spend on other things?

1. In 1942, the American people spent only about 3 percent of the total national income on medical care.¹¹

(a) It has been estimated that the people of the United States will spend \$5,499,963,211 in 1947 for medical care, including supplies and insurance.¹²

(1) This is less than 3½ percent of the national income in 1945 (latest figure available.)¹³

2. In contrast with this, the people of the United States, to protect our lives against a possible enemy, will spend 50 percent more for armed defense this year than for all types of medical service, to protect ourselves against disabilities and deaths of our people.

(a) Proposed expenditures for national defense in 1947-48: Army and Air Force, \$5,240,900,000;¹⁴ Navy, \$3,469,761,000,¹⁵ or a total of \$8,710,661,000 for national defense, as against \$5,499,963,211 for medical care, supplies, and insurance.

3. In contrast with the estimated amount of \$5,499,963,211 which the people of the United States will spend in 1947 for medical services, supplies, and insurance, the same people in 1946 spent \$8,700,000,000 for alcoholic beverages. This is an average of \$89 a year for liquor for each person over 18 years old.¹⁶

(a) 50 percent more is spent on liquor than on all health services in a year.

IV. How many doctors are there in the United States? How much do they earn?

1. In 1942, there were 180,496 registered physicians in the United States, including all types of specialists.¹⁷

(a) In 1943, the number of "effective physicians" was estimated at 135,932.¹⁸

2. Taking a standard of 1 active physician for every 1,000 patients:¹⁹

(a) In 1941 there was approximately 1 active physician for every 1,400 to 1,500 people in the United States (if doctors had been evenly divided throughout the country.)²⁰

(b) However, in 1944, 553 counties in the United States (18 percent of the total of 3,070 counties) had less than 1 active physician per 3,000 population (the "danger line"), and 81 counties (over 2½ percent had no active doctor.²⁰

3. The national net average income of American doctors in 1941 was \$5,047; but this figure was overweighted by top-bracket specialists.²¹

(a) About 25 percent had net incomes of less than \$2,000.²¹

(b) About 16 percent had net incomes of less than \$1,000.²¹

(c) About 12½ percent had net incomes of \$10,000 or more.²¹

V. How many hospitals are there in the United States?

1. In 1945, there were 1,738,944 hospital beds in 6,511 hospitals in the United States.²²

(a) However, approximately 15,000,000 Americans, living in 40 percent of the Nation's counties, have no recognized general hospital.²³

⁹ United States News, March 1, 1946.

¹⁰ Federal Security Agency fact sheet, Health of the Nation, June 1, 1946, p. 2.

¹¹ Spent for medical care in 1942, \$3,710,000,000 (America's Needs and Resources, published by Twentieth Century Fund, 1947); national income, 1942, \$122,232,000,000 (World Almanac, 1947).

¹² The Medical Market—Forecasts for 1947 (Modern Medicine).

¹³ National income, 1945, \$160,952,000,000 (World Almanac, 1947, p. 395).

¹⁴ Amount recommended by Appropriation Committee as of June 3, 1947 (New York Times).

¹⁵ Amount passed by House as of June 3, 1947 (New York Times).

¹⁶ Department of Commerce, April 30, 1947 (AP dispatch, Washington, New York Times).

¹⁷ AMA Directory, 1912, p. 8 (latest issue).

¹⁸ AMA Journal, vol. 121, p. 1163 (1943): Total registered physicians, 1943: 179,039; difference represents those not practicing because of advanced age, physical disabilities, and other reasons.

¹⁹ Senate Committee Print No. 5, 79th Cong., July 8, 1946, p. 35.

²⁰ Senate Subcommittee Rept. No. 5, 79th Cong., July 1946, p. 1.

²¹ Senate Committee Print No. 4, 79th Cong., March 1946, p. 17. (Figures from Survey of Current Business, vol. 23, No. 10, October 1943.)

²² World Almanac, 1947, p. 773.

²³ Senate subcommittee Rept. No. 5, 79th Cong. (Health Insurance), July 1946, p. 1.

(b) Taking 4.5 beds per 1,000 population as the standard for hospitals:²⁴ (1) Only 11 percent of the counties of the United States meet this standard;²⁵ (2) 48 percent of the counties in the United States have under this standard;²⁶ (3) 41 percent of the counties in the United States have no approved general hospital.²⁷

(c) 16,257,402 patients were admitted to hospitals in 1945, or an average of about one out of every eight people in the United States.²²

2. Of 15,800,000 patients admitted to registered hospitals in 1944:²⁸ 95.1 percent or 15,000,000 were admitted to general hospitals having 54 percent of total beds; 2.9 percent or 500,000 were admitted to special hospitals having 3 percent of total beds;²⁹ 1.4 percent or 200,000 were admitted to nervous and mental hospitals having 38 percent of total beds; 0.6 percent or 100,000 were admitted to tuberculosis hospitals having 5 percent of total beds.

VI. How much do we spend for research for new treatments and cures to save our people from death or disability?

1. It is estimated that only about \$20,000,000 a year is being spent for research to find cures and new treatments of diseases.³⁰

(a) In contrast with this, the Department of Commerce reported in 1943 that approximately \$275,000,000 is being spent each year for industrial research.³¹

(b) In 1947, Congress appropriated \$29,866,200 for the Department of Agriculture alone, for research in the control and cure of plant and animal diseases.³²

(c) In contrast with the 1947 total appropriation of \$104,088,516 for the United States Public Health Service, Congress made a total appropriation of \$744,489,692 in 1947 for the Department of Agriculture.³³

VII. How much more would a national health insurance program cost the people of the United States than they spend under the present system?

1. It is estimated that about \$5,499,963,211 will be spent by the people of the United States for medical care in 1947, including medical services, medicines and supplies, and health and accident insurance.³⁴

2. In a study made in 1941, it was found that money spent by sample family groups for medical care was distributed as follows:³⁵

	Health and accident insurance	Medicines and supplies	Medical services	Total
Groups with incomes between \$500 and \$1,000----	\$2.13	\$9.16	\$15.14	\$25.12
Groups with incomes between \$1,000 and \$1,500--	4.48	16.28	37.15	57.91
Groups with incomes between \$2,500 and \$3,000--	7.83	18.06	63.99	89.88
Groups with incomes between \$3,000 and \$5,000--	11.39	33.99	107.69	153.07

²⁴ Public Health Bulletin, No. 292, Health Service Areas. Issued by U. S. Public Health Service, 1945, p. 5. (Estimate does not include beds for patients suffering from tuberculosis or mental disorders.)

²⁵ Senate Committee Print No. 3, 79th Cong. (National Health Act of 1945, and Hospital Survey and Construction bill.) March 1946, p. 52.

²⁶ Senate Committee Print No. 4, 79th Cong. (National Health Act of 1945), March 1946, p. 20.

²⁷ Includes maternity, industrial, eye-ear-nose-and-throat, children's orthopedic, isolation, convalescent and rest, etc.

²⁸ See the following table:

American private foundations, 1940 (latest estimate)-----	\$4,700,000
National Cancer Institute (U. S. Government), 1946-47-----	1,772,000
National Institute of Health (U. S. Government), 1946-47-----	5,966,948
Veterans' Administration—National Research Council (approximate)---	1,000,000
American Cancer Society, 1946-----	2,500,000
National Foundation for Infantile Paralysis, 1946-----	1,858,826
Medical schools and teaching hospitals (estimated)-----	2,500,000

Total----- 20,297,774

²⁹ Report of survey released by Department of Commerce in 1943.

³⁰ Budget of the United States, fiscal year ending June 30, 1948.

³¹ The Medical Market—Forecasts for 1937 (Modern Medicine).

³² Study of Family Spending and Saving in Wartime, 1941 and the first quarter of 1942. August 1942. U. S. Bureau of Labor Statistics and Bureau of Home Economics.

3. Family expenditures for medical care under the proposed national-health insurance bill,³³ for people in comparable income groups, would be as follows:³⁴

Insurance premiums at 3 percent

Annual earnings:		
\$750	-----	\$22. 50
\$1,250	-----	37. 50
\$2,500	-----	75. 00
\$3,600 and over	-----	108. 00

4. The above two tables show that the total average family expenditures for medical care under the national-health insurance bill (2) would be lower than they were in 1941 under the present system.

Senator PEPPER. I want to ask a few more questions. Do you think it is an easy matter for either the Federal Government or State authorities to lay down a means test which is to be the criterion for the giving of medical care such as is contemplated in S. 545?

Dr. PARRAN. It would be a difficult task. It would offer difficulties because, for instance, a person's status will change. We may well assume that he will be needy if it is necessary for him to be hospitalized for 6 months and to have 3 nurses a day during the critical part of his illness. Most of us would be needy under those circumstances. He may not be needy for visits to the dentist or a visit to the doctor. He may be out of a job today and be needy, and tomorrow he may have a job and be able to pay a part of his medical expense.

However, I don't mean to say that a means test is impossible administratively, difficult as it would be, because of the experience we had in New York State during depression days. The policy was developed of providing medical care for persons otherwise self-sustaining, especially rural families who had food and some clothing and shelter, but no cash in hand with which to meet medical costs.

Senator SMITH. You mean the medically indigent as distinguished from the indigent; is that correct?

Dr. PARRAN. That is correct, Mr. Chairman. In other words, this has been done and to some extent is being done by welfare agencies and in the administration of our relief laws.

As to the social desirability of such a means test, that is quite another thing.

Senator PEPPER. Would you state to us out of your experience as Surgeon General of the United States and your experience with the Public Health Service whether or not the appropriation contemplated by S. 545, together with the funds which the States must put up to match the Federal appropriation, will provide adequate health care to the people of the United States?

Dr. PARRAN. It would fall far short of doing that, Senator Pepper, and as I understand it, the authors of the bill recognize that.

Senator SMITH. The point is being constantly made as though it is supposed to be an over-all coverage. That is not claimed. It is a step in the direction of the kind of health service we want to arrive at.

³³ Introduced in May 1947, by Senators Wagner, Murray, Chavez, Pepper, Taylor, and McGrath.

³⁴ Senate Committee Print No. 5. 79th Cong., July 8, 1946, p. 158.

Dr. PARRAN. I hope I was quoting correctly.

Senator SMITH. Quite correctly.

Senator PEPPER. If the theory of S. 545 is carried out—that is not requiring the individuals to make a public contribution or contribute through a tax or any other kind of compulsory payment, but the money is provided out of the Treasury—does that approach what might be called the socialized system of providing medical services free to the people, free of any direct contribution from them other than through taxes or through the insurance system?

Dr. PARRAN. I think that is a question primarily for the taxation experts because a compulsory contribution is a tax such as income tax is a tax.

Senator PEPPER. I don't know if you happen to know, and I am not sure I am right, but it is my understanding that one difference, for example, between the Soviet system and the British system is that the Soviet system does not require any tax from the citizens. The citizen goes to a hospital and gets medical care, goes to a doctor and gets medical care, just as a man or woman in the Army or Navy goes to the dispensary or to the hospital and get medical care as a service furnished by the Government without paying directly for the service; whereas in Britain they are required to make payments, some kind of pay-roll tax, or some sort of compulsory payment.

Am I correct in that general understanding?

Dr. PARRAN. That is my understanding.

Senator PEPPER. If we furnished through the method of S. 545, the State appropriation, that would be a little nearer to the Soviet system than to the British system, would it not? I am sure the authors would not want to be in that position.

Senator SMITH. I object to the comparison. They both are taxes, either way you put it, pay-roll tax or the others. It is not insurance, it is a tax. Each fellow pays according to his means. The Government undertakes to perform the service.

I would like to ask you this question: Would you think it wise, assuming we adopt a plan like S. 1320, to have the compensation paid in dollars and let the person use the dollars to get the service or should we have an elaborate scheme to determine the set-up of doctors working it out?

Dr. PARRAN. The only way I can see you have any choice of doctors is to be paid money benefits just as we pay unemployment benefits. You would have the patients use that money for contracting for any service needed. That would be in line with our unemployment compensation. That would be the comparison.

If a person has tuberculosis, why not pay for that as well as unemployment?

Senator SMITH. I admit that analogy, but then you get money benefits and then you get into this complicated question of how to deal with the medical profession.

Dr. PARRAN. I would favor money benefits only in partial compensation for wages lost by the breadwinner, by the wage earner, and not for the giving of professional service. I don't believe that a system of cash benefits would be nearly so effective as service benefits.

Senator SMITH. To organize the service and make it practical is the problem.

Dr. PARRAN. It is a tremendous job in a country as huge and diverse as this.

Senator SMITH. I want to emphasize the point that it does differ from the social-security idea where you do expect under your unemployment and social-security to pay out cash benefits under such contingencies. This program contemplates organizing, developing, and getting under obligation on the part of the Government to deliver a service. We have got to take that as part of the program, and that is the thing that we have got to explore, very thoroughly before we turn over our whole country to something as new and novel and different as that; and I haven't yet been convinced that any country that tried it has shown any success whatever. I haven't been convinced of that. It is just a question of how we can do this thing in the most practical way, and whether you call it a compulsory health insurance or call it anything else, it is a tax. Any thing you are compelled to pay is a tax.

Senator DONNELL. The bill back in 1939, the Wagner bill, S. 1620, was that a bill as you construe it for the provision of health insurance for needy persons or was that one for the general public at large? I call your attention to page 34 of that bill. I will just read a little of section 1301:

For the purpose of enabling each State so far as practicable under the conditions in such State, especially in rural areas and among individuals suffering from severe economic stress to extend and improve medical care, including all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability, and to develop more effective measures for carrying out the purposes of this title, including the training of personnel, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$35,000,000—

and so forth.

Dr. PARRAN. Senator Donnell, I hoped you would sense—in fact I know you do—the importance of the word “especially in rural areas and among individuals.”

Senator DONNELL. Yes.

Dr. PARRAN. While the related provisions of S. 545 seem to be limited to the provision of medical care for needy persons.

Senator DONNELL. Could I ask you one further question about S. 1320? There has been much emphasis made, not so much today, but in earlier testimony, on this matter of the so-called means test. Now, I call your attention to the fact that, which of course you know, section 204 (a) of S. 1320, the Murray bill, provides as follows:

Every individual shall be eligible for benefits under this title throughout any benefit year—

after he receives payments, and so forth.

Then section 205 (a) is entitled “Provision of Benefits for Non-Insured Needy and Other Individuals,” and reads as follows:

Any or all benefits provided under this title to individuals eligible for such benefits may be furnished to individuals (including the needy) not otherwise eligible therefor, for any period which equitable reimbursements to the account on behalf of such needy or other individuals have been made, or for which reasonable assurance of such reimbursements have been given, by public agencies of the United States, the several States, or any of them or of their political subdivisions, such reimbursements to be in accordance with agreements and working arrangements negotiated with such public agencies. Services furnished to such needy or individuals as benefits shall be of the same quality, be furnished

by the same methods, and be paid for through the same arrangements as services furnished to individuals eligible for benefits under this title.

I ask you whether or not it is a fact that in order to determine who the needy persons are to whom any or all of these benefits provided under the title in S. 1320 may be furnished—I say in determining who are these needy persons, would not it necessarily involve a test of some kind to determine whether they are financially capable or not?

In other words, is there not a means test provided there to the extent that S. 1320 provides for benefits for persons who are not eligible under the earlier definition of the bill?

Dr. PARRAN. Senator Donnell, I understand this section to contemplate two groups of individuals, generally speaking. They are those who have already been subjected to a means test and are recipients of relief. This seems to be an invitation to the local public-welfare authorities to pay into the fund equitable reimbursements so that persons on relief or those who have been declared by the public-welfare officers to be medically needy would get care under the one administrative system.

Secondly, I interpret the wage range to be an invitation to the States and their political subdivisions to permit the joining of the system by the public employees.

Senator DONNELL. However, Doctor, this section 205 (a) does provide that benefits provided under this title, any or all of the benefits, may be furnished to individuals, including the needy, not otherwise eligible therefor.

Dr. PARRAN. It provides that. I would again underline the fact that the other provisions of S. 1320 would in times of normal employment perhaps embrace as many as 85 percent of the population, so that the volume of medically needy persons would be much less than contemplated under S. 545, and in respect of most of the "needy persons" referred to in section 205 (a), their needs for all necessities of life probably would have been already determined.

Senator MURRAY. To be determined by the States.

Dr. PARRAN. It would have been determined precisely by the local public-welfare agencies.

Senator MURRAY. They wouldn't be on the pay rolls. Our bill contemplates all those receiving medical care are people having deducted from their pay certain sums each month so that these people who would be needy would be people who are not employed or who are unable to be employed; and, therefore, it would be a very simple matter to determine who they are because the State would be able to furnish the list and there would be no need for a means test under the administration of this act.

Senator DONNELL. Doctor, do you know of any means test by which you can find out whether a person is needy without imposing some sort of means test?

Dr. PARRAN. I don't know of any way.

Senator MURRAY. The State determines that.

Senator DONNELL. The State would determine it in any case.

Senator MURRAY. The State has already determined it; I assume the people are on relief.

Senator DONNELL. The point I am making is that under S. 1320 there is a provision as follows:

Any or all benefits provided under this title to individuals eligible for such benefits may be furnished to individuals, including the needy.

Now, you know of no way by which it can be determined whether a person is needy without applying some test?

Dr. PARRAN. I know of no other way.

Senator DONNELL. One final question, and that is this: Have you made any study as to the cost to the Nation of putting into effect S. 1320?

Dr. PARRAN. I have not made any detailed studies of that question, Senator Donnell. The current amount which we are paying for medical care is estimated—and we have no firm basis for a precise estimate—at around \$5,000,000,000. How much more would be required to carry out all of the provisions of S. 1320 I am not prepared to say.

Perhaps the social-security people, who have made more studies of this problem than I, would be prepared to offer testimony on that point.

Mr. Chairman, with your permission I should like to offer for insertion in the record a statement of 2½ pages entitled, "Need for and Costs of Additional Medical Personnel and Facilities." The next is "Costs of Training Needed Medical Personnel." In offering this I do so with some temerity, since there has been no national agreement as to the extent of need for Federal assistance in connection with training of physicians and related personnel. We would hope that during the coming year we can develop, as I indicated in my testimony, more facts dealing with this program.

I have a short note of one page on "State Variations in Mortality," which is one indication of unmet national medical needs.

Here is a further note on the need for new hospital facilities, with some revised estimates as to the over-all cost in the light of present construction costs, which information supplements the information we submitted to this committee in connection with the hearings held on the Hospital Survey and Construction Act.

I have another note on the status of the State hospital survey and construction program, in which there is listed the number of additional beds being proposed by three States which have submitted plans and have had their plans approved, over-all State plans for hospital construction. This gives us for the first time the results of detailed State surveys in these three States for which plans have been approved during the past 2 or 3 days.

Senator SMITH. That is in the light of last year's bill?

Dr. PARRAN. That is correct, Mr. Chairman.

Senator SMITH. They will be inserted in the record.

(The documents referred to above are as follows:)

THE NEED FOR AND THE COSTS OF ADDITIONAL MEDICAL PERSONNEL AND FACILITIES

A. THE NEED FOR MEDICAL AND RELATED PERSONNEL

1. *Physicians.*—Tremendous confusion exists concerning the adequacy of the Nation's supply of physicians. Distinction must be made between the effective economic demand for doctors' services and the potential requirements that would be necessary to meet the real needs of the population. Under the current circumstances, the total number of physicians may possibly be sufficient to meet the going demand for their services—at least in certain urban centers. In times of economic crisis, however, when purchasing power is deficient, an apparent doctor surplus may even appear, as in the depression of the 1930's.

In terms of need, however, as distinguished from effective demand, the deficiencies are serious, and will grow more pronounced in the future. With the development of programs which remove the financial and geographical barriers to medical care, and which create additional facilities for the rendering of health services, the present rate of production of physicians will prove increasingly inadequate. Moreover, there is little disagreement with the facts concerning the serious maldistribution of doctors, leaving many rural and other areas badly underserved.

Supply of physicians by 1960.—Every calculation indicates the deficiency of physicians to be expected by 1960. It can be estimated that some 111,000 new doctors will be graduated by 1960 at current rates of production. In this time 77,000 will retire or die, leaving a net increase of 34,000.

However, known requirements can be expected greatly to exceed this net increase in number of physicians. An estimated deficit of 30,000 physicians by the year 1960, calculated merely on the basis of current demand, is shown in the following table:

Estimated deficit in supply of physicians, 1940-60

	<i>Number of physicians</i>
Increased needs:	
To take care of increased population at 1940 rates of physicians to population-----	27,000
Army, Navy, Veterans' Administration, Public Health Service-----	16,000
Health officers and physicians in new hospitals for tuberculosis and mental disease-----	5,000
Physicians for new hospitals and health centers under Hospital Construction Act-----	16,000
Total -----	64,000
Gain by excess of graduates over deaths and retirements-----	34,000
Net deficit -----	30,000

This 30,000 deficit relates only to the numbers of physicians at current proportions, plus the specific needs of an expanding population and certain public programs. If we are to attempt any estimate of the actual need for more adequate services, such as that for general practitioners in local communities, additional personnel will be necessary. Using the average physician-population ratio in the 12 best-supplied States to represent an attainable standard of "adequate care," then still another 30,000 practitioners would be needed to raise all States to this level by 1960.

The estimated total number of physicians, including specialists and public-health administrators, which would be required for "adequate care" in 1960 reaches a minimum of 270,000 when based on the standards of the 12 currently best-supplied States. Since only about 175,000 doctors were reported in 1940, and only about 209,000 can be anticipated at current rates of production by 1960, the achievement of the desired goals will require a substantial increase in the current output of our medical schools extending over a long period of years.

Obviously, any feasible increase in the training program now would be well justified by the need. The production of the 30,000 additional doctors needed as a minimum by 1960 would hardly be achieved before that date even with a 50 percent increase in annual output by existing schools. Actually, a training program starting in 1948 would produce no finished doctors until 1953. Thus, nearer a 75 percent increase in the number of graduates during the years before 1960 would be necessary to produce the doctors needed to meet existing commitments by that date.

2. *Dentists.*—There is no question about the absolute and relative shortage of dentists, now and in the future. The present total number of dentists, some 75,000, cannot begin to meet the need for dental care. The accumulated dental neglect in the population is so great that it has been estimated that 800,000,000 hours of work would be required to do the job. This would take 400,000 dentists working full time for 1 year on just existing defects. The most conservative estimates indicate an immediate requirement of about 100,000 active dentists, if dental hygienists are trained and used to a larger extent than they are now. One hundred and sixty-five thousand dentists are needed if present conditions of practice remain unchanged.

Maldistribution of dentists is even more acute than with physicians, with many rural areas totally lacking in dental services. The Department of Agriculture estimated in 1941 that the general ratio of dentists to population in rural areas was 1:4,200, while the urban proportion was three times better, or 1:1,400. The seemingly modest national goal of 1 dentist to every 1,400 persons, to be reached by 1960, would require the doubling of the present output of our dental schools.

3. *Nurses*.—Similar immediate, as well as future, shortages of nurses exist. The American Nurses Association estimated in 1946 that 359,500 nurses are needed and only 317,800 available, leaving a national deficit of 41,700. The tremendous maldistribution of nurses is reflected in the 1940 ratio in Mississippi of 62 nurses per 100,000 persons, as against the Massachusetts ratio of 402 per 100,000.

There has been an alarming drop in nursing school enrollment in 1947, even though a vast increase is needed in the production of nurses if the current deficit of 42,000 is to be overcome. And this, of course, does not include the additional numbers which will be needed to staff the new programs now getting under way.

B. COSTS OF TRAINING NEEDED MEDICAL PERSONNEL

No exact means exists of computing the total cost of the Nation's needed medical training program. Certain aspects of the problem are, however, known today.

Regardless of the need for any expanded activities, all authorities warn us that the existing medical schools are in serious financial straits. Weiskotten has stated¹ that one-half the schools operate on totally inadequate budgets; Johnson has reported² 25 schools below the minimum budget level; Raymond Allen has stated³ that the total medical school budgets must be doubled by 1960.

Any estimation of the cost of training additional medical personnel must be qualified by several important factors. In the first place, considerable funds would be necessary to effect needed improvements in the existing schools without producing a single extra physician. At a minimum, to bring the lowest third of the present schools to the minimum budget level suggested by Weiskotten¹ would cost between \$2,000,000 and \$3,000,000 a year. At a maximum, to meet the suggestion of Allen³ and bring the teaching of such vital subjects as psychiatry, industrial medicine, preventive medicine, and tropical medicine to a proper level probably would require an annual increased expenditure of \$40,000,000. In the former case no increase in enrollment would be provided for; in the latter case an increase of perhaps 10 percent.

Another major factor is the cost of constructing and maintaining the hospitals and clinics necessary to medical teaching. How much of such costs can be attributed to medical care and how much to medical education has not been satisfactorily computed.

Finally, it should be clearly stated that any achievement of the desired personnel goals will quite probably involve the establishment of new schools or additional facilities in the old ones. The initial capital costs of establishing new medical, dental, or nursing school facilities must, of course, be added to the figures presented below as the estimated total costs of producing the needed additional personnel (at current unit costs for student training).

1. *Physicians*.—In light of the present inadequate financial position of many of the medical schools, it is obvious that considerable financial outlay will be necessary to produce the additional doctors estimated to be needed throughout the country. Most estimates of the cost of medical education per student per year range between \$1,500 and \$2,000, with dental training running about the same or slightly lower. (An additional \$1,000 or so should be added if living costs to the student are to be considered.)

As shown above, a minimum of 30,000 doctors is needed by 1960 in addition to the expected number of graduates at current rates of production. Therefore, it can be estimated that \$180,000,000 would be required to finance this training, considering that the medical course covers 4 years, and using the \$1,500 per student per year figure. It is clear that the schools themselves cannot finance this expansion. Tuition fees seldom exceed one-third of the unit cost to the school, averaging about \$540 for private schools and \$300 for State-supported schools. Thus, at least \$120,000,000 will be needed from sources other than tuition fees to finance the minimum increase in doctors felt to be needed by 1960.

¹ Weiskotten, H. G.: Financial Support of Medical Education, Journal of the Association of American Medical Colleges, vol. 22, No. 1, 1947.

² Johnson, Victor: Support of Medical Education by Student Fees, *ibid.*

³ Allen, Raymond B.: Medical Education and the Changing Order, The Commonwealth Fund, 1946.

This is about \$10,000,000 per year over the period of the next 12 years. It should be repeated at this point that this amount of money would not begin to finance the needed improvements in existing schools, nor would it cover the costs of the new plants that would be necessary if the full personnel deficit is to be eliminated.

2. *Dentists.*—Similarly, the most modest estimate of an immediate need for at least 25,000 more dentists implies a training cost of a minimum of \$100,000,000, figuring a 4-year dental school course and \$1,000 per student per year unit cost after subtraction of tuition fees paid by students.

This is an immediate need, but even if projected ahead until 1960 (at which time many more dentists will actually be needed), a minimum annual expenditure of some \$8,000,000 will be necessary. The inadequacy of the present dental schools to overcome the shortage is, perhaps, even more pronounced than that of the medical institutions.

3. *Nurses.*—It is almost impossible to give any reliable figures for the unit costs of nurses' training, due to the extremely wide variations in costs at the various nurses' schools. A very rough gage can be obtained from the Federal cadet nurses' training program during the war, when the average cost of training a nurse (including small stipends to the students) totaled about \$1,200. Using the 1946 deficit figure of 42,000 nurses it may be estimated that the total cost of financing the training of the needed numbers of nurses would be about \$50,000,000.

If these costs are also to be spread over the years until 1960, the annual outlay would have to be in the neighborhood of \$4,200,000. It must be repeated that these figures are exceedingly rough, and that the items here included for tuition, uniforms, etc., might be paid for in part by the students themselves during a peacetime program.

STATUS OF STATE HOSPITAL SURVEY AND CONSTRUCTION PROGRAM

State plans

Three State plans, those from Mississippi, Indiana, and North Carolina, have been received in the central office, and those from Mississippi and Indiana already have been recommended for approval. Others, including Oklahoma, have been completed and are in transit from the district office. Our district staffs estimate that approximately 40 States will have plans completed before the end of this calendar year.

The plans which we have had an opportunity to study here are the result of a remarkable amount of careful planning. These plans have been submitted by Indiana, North Carolina, and Mississippi.

	Number of beds		
	Existing acceptable	Additional	Total
Indiana:			
General.....	7,203	8,123	15,326
Chronic.....	79	6,696	6,775
Tuberculosis.....	1,136	1,917	3,053
Mental.....	8,264	8,673	16,937
North Carolina:			
General.....	8,510	7,916	16,426
Chronic.....	0	6,668	6,668
Tuberculosis.....	1,830	1,660	3,490
Mental.....	6,072	10,598	16,670
Mississippi:			
General.....	2,988	5,989	8,977
Chronic.....	125	3,855	3,980
Tuberculosis.....	458	1,975	2,433
Mental.....	4,408	5,542	9,950

New health centers and auxiliary facilities have been planned, as follows:

	Health centers	Auxiliary facilities
Indiana.....	36
North Carolina.....	89	14
Mississippi.....	53	159

The facilities planned for these three States as listed above coincide quite closely with the earlier estimates making up our over-all total. If the other States coincide as closely as the three we have studied, our over-all estimates will apparently prove to be quite accurate.

C. THE NEED FOR NEW HOSPITAL FACILITIES

In 1945 and 1946 we presented over-all estimates of need for hospital facilities in support of the Hill-Burton bill. These estimates, except for health centers, were based upon data published by the American Medical Association as related to hospital areas throughout the country. In making these estimates the following need factors were used: General hospitals, 4.5 per thousand population; tuberculosis hospitals, 2.5 per average annual tuberculosis death; mental hospitals, 5 per thousand population; chronic disease hospitals, 2 per thousand population; and public-health centers, 1 per 30,000 population.

The following table shows the number of new beds needed in each category as well as the estimated need for replacements:

Type	Units needed	Estimated unit cost	Total estimated cost	
			New	Replacement
General hospitals:				
New beds (deficit).....	169,579	\$6,000	\$1,017,474,000	
Replacement beds.....	83,889	6,000		\$503,334,000
Tuberculosis hospitals:				
New beds (deficit).....	65,189	5,000	325,945,000	
Replacement beds.....	17,313	5,000		86,565,000
Mental hospitals:				
New beds (deficit).....	208,963	3,000	626,889,000	
Replacement beds.....	99,583	3,000		298,749,000
Chronic hospitals, new beds (deficit).....	270,173	3,000	810,519,000	
Public health centers.....	4,503	60,000	270,180,000	
Total cost:				
New (deficit).....			3,051,007,000	
Replacement.....				888,648,000
Both.....			3,939,655,000	

The unit cost shown in the table is prewar and believed to be reasonably accurate.

These facilities at the unit price listed would have cost more than \$3,000,000,000 for new units plus \$888,000,000 for replacement units, or a total of \$3,939,655,000.

We are advised by the Engineering News Record that the construction cost index in 1940 was 201.7, and in June of this year, 303.4, or, in other words, a general rise in construction cost of slightly more than 50 percent. Whereas the estimated prewar cost of the facilities needed would have been approximately \$4,000,000,000, the same units would not apparently cost about \$6,000,000,000.

The \$375,000,000 authorized in the Hospital Survey and Construction Act when matched 2 to 1 will be \$1,225,000,000. The total program, therefore, will amount to a relatively small percentage of the total need (18 percent). It is certain, of course, that a considerable amount of privately financed construction will go on, particularly in metropolitan areas, without Federal assistance. At the present time there is no way of estimating the quantity of such construction.

NOTES ON STATE VARIATIONS IN MORTALITY

The last decades have witnessed a marked reduction in the death rate. We as a Nation take great pride in pointing to the progress we have made in reducing the deaths from tuberculosis, diphtheria, typhoid, and other communicable diseases. The decline in infant mortality has been largely responsible for the increase in average life expectancy. This decline is deservedly emphasized because infant mortality is recognized to be a sensitive index of general health conditions.

The infant-mortality rate for the country as a whole stood at 40 deaths per 1,000 live births in 1944. When we consider that the rate in 1915 was 100, we can gauge the extent of our progress. But when we note today there are still some States with such rates as 89 and 69 we begin to appreciate how much more

will have to be done before we can really feel complacent about our health progress.

There are 24 States which exceed the infant-mortality rate for the country. If we could bring these States to the national average, it would mean a saving of 8,500 lives per year. The saving would be double this figure if the national rate were the same as that now prevailing in our best 5 States.

A great saving of lives would be effected if we could bring to all sections of the country the progress that has been made in our best States. When we observe that the range among the States is such that maternal mortality is relatively 4 times as great in one as in another, cancer and disease of the heart three times as great, and pneumonia two times as great, we begin to realize the magnitude of the task before us.

Many of the causes of death, such as pneumonia and diseases associated with childbirth, are preventable, and therefore good prevention programs are needed. For others, we need more intensive research to discover etiology and cure, and increased facilities and personnel to lessen the suffering of the sick.

TABLE A.—Mortality in 1944, by place of residence

[Data not adjusted for age]

	Per 1,000 live births		Per 100,000 population, 1944					
	Infant mortality	Maternal mortality	Total mortality	Tuber-culosis	Cancer	Diabetes	Diseases of heart	Pneu-monia
United States.....	39.8	2.3	1,064.7	41.3	129.1	26.4	315.4	61.7
Alabama.....	45.5	3.7	928.6	45.0	73.9	11.7	181.2	73.7
Arizona.....	68.8	3.0	972.7	¹ 122.9	80.9	² 8.3	170.7	68.8
Arkansas.....	34.7	2.8	817.3	46.5	74.4	11.0	169.4	68.1
California.....	34.5	1.7	1,037.0	43.7	131.8	21.6	327.1	53.2
Colorado.....	49.4	2.5	1,068.7	36.5	126.2	19.2	277.9	82.9
Connecticut.....	30.7	1.5	1,065.5	37.2	165.6	35.4	357.6	44.0
Delaware.....	48.7	1.5	1,177.7	43.3	126.8	29.9	359.8	65.1
District of Columbia.....	44.8	2.1	880.7	58.6	115.1	22.3	247.1	³ 41.6
Florida.....	45.5	3.3	992.0	34.7	92.4	17.4	222.2	62.8
Georgia.....	44.5	3.6	912.4	35.4	71.1	11.9	177.9	71.6
Idaho.....	34.0	2.5	⁴ 876.2	20.4	100.3	17.8	229.1	54.2
Illinois.....	32.4	1.8	1,140.6	41.6	160.6	34.0	399.6	43.5
Indiana.....	34.5	2.0	1,151.8	35.7	135.0	27.7	334.4	65.1
Iowa.....	33.1	1.8	1,149.8	15.0	157.9	28.3	354.7	66.1
Kansas.....	33.3	1.8	1,044.8	20.1	130.0	27.0	297.9	53.3
Kentucky.....	46.7	2.5	1,079.7	65.7	102.9	18.6	264.2	⁵ 89.3
Louisiana.....	46.3	3.4	929.9	45.7	92.6	16.1	245.0	68.8
Maine.....	46.7	2.3	1,295.1	35.2	170.0	25.6	381.6	73.3
Maryland.....	41.5	1.9	1,064.5	62.3	122.0	28.6	324.2	58.8
Massachusetts.....	33.1	1.8	1,241.5	40.8	182.7	37.5	448.2	66.8
Michigan.....	37.9	1.7	1,001.9	33.4	128.0	26.8	313.2	52.6
Minnesota.....	31.3	1.4	1,053.8	27.6	149.6	29.0	321.5	67.5
Mississippi.....	44.1	3.8	949.6	38.2	74.2	13.6	164.2	65.0
Missouri.....	37.6	2.2	1,177.1	41.4	146.6	25.2	350.3	84.9
Montana.....	36.1	1.5	1,218.0	37.6	146.5	27.1	357.1	64.5
Nebraska.....	33.0	1.7	1,037.5	17.4	137.1	27.4	297.1	59.7
Nevada.....	50.2	2.3	1,053.2	48.6	101.0	12.8	229.6	68.4
New Hampshire.....	37.7	2.8	1,353.7	23.0	⁶ 187.4	38.9	446.4	80.7
New Jersey.....	34.0	1.6	1,147.4	44.5	165.2	35.6	392.3	49.1
New Mexico.....	⁷ 89.1	⁸ 4.0	1,034.1	64.9	⁹ 63.6	10.2	¹⁰ 144.6	82.9
New York.....	32.8	1.9	1,205.9	47.9	178.7	¹¹ 42.6	¹² 453.7	52.0
North Carolina.....	45.4	2.9	832.2	35.1	65.9	14.4	180.9	56.4
North Dakota.....	35.4	1.8	968.6	16.3	123.2	28.0	263.2	52.4
Ohio.....	38.5	1.9	1,173.6	40.8	146.8	32.4	356.5	66.1
Oklahoma.....	41.2	2.4	917.0	42.6	99.8	16.3	205.8	61.7
¹³ Oregon.....	30.5	1.8	1,083.6	25.3	137.3	21.8	306.9	58.9
Pennsylvania.....	40.0	2.5	1,194.5	43.5	151.1	36.6	385.2	71.2
Rhode Island.....	35.3	1.8	1,075.6	38.4	137.4	37.2	385.0	57.0
South Carolina.....	54.9	3.7	945.0	34.4	66.1	16.3	188.1	75.4
South Dakota.....	34.9	1.8	1,011.7	31.9	129.6	23.5	267.3	56.8
Tennessee.....	45.5	2.8	971.2	65.6	89.0	13.1	209.4	78.9
Texas.....	50.4	2.5	894.9	45.4	82.2	14.6	196.0	62.0
Utah.....	33.9	1.4	817.5	¹⁴ 12.0	90.0	18.3	243.4	42.2

Footnotes at end of table.

TABLE A.—Mortality in 1944, by place of residence—Continued

	Per 1,000 live births		Per 100,000 population, 1944					
	Infant mortality	Maternal mortality	Total mortality	Tuberculosis	Cancer	Diabetes	Diseases of heart	Pneumonia
Vermont.....	40.6	1.9	¹ 1,373.6	39.9	169.4	35.4	441.3	69.4
Virginia.....	47.1	2.6	898.7	42.0	81.2	17.0	224.5	61.6
Washington.....	33.8	1.6	1,062.1	34.1	129.2	22.3	327.1	59.2
West Virginia.....	52.0	2.2	968.8	44.6	89.2	18.5	224.5	69.3
Wisconsin.....	32.0	1.8	1,064.7	24.4	152.2	32.3	333.6	55.4
Wyoming.....	41.2	¹⁶ 1.9	887.3	13.2	94.3	21.0	232.2	53.8

¹ High State, Arizona, 122.9.

² Low State, Arizona, 8.3.

³ Low State, District of Columbia, 41.6.

⁴ Low State, Idaho, 876.2.

⁵ High State, Kentucky, 89.3.

⁶ High State, New Hampshire, 187.4.

⁷ High State, New Mexico, 89.1.

⁸ High State, New Mexico, 4.0.

⁹ Low State, New Mexico, 63.6.

¹⁰ Low State, New Mexico, 144.6.

¹¹ High State, New York, 42.6.

¹² High State, New York, 453.7.

¹³ Low State, Oregon, 30.5.

¹⁴ Low State, Utah, 12.0.

¹⁵ High State, Vermont, 1,373.6.

¹⁶ Low State, Wyoming, 0.9.

Source: (a) Maternal mortality by age and race, United States and each State, 1944, Vital Statistics—Special Report, vol. 25, No. 7, Department of Commerce, Census, June 26, 1946; (b) Vital Statistics of the United States, 1944, pt. II, U. S. Department of Commerce, Bureau of Census, 1946, table I. Death rates for selected causes.

Senator PEPPER. I have a letter dated May 9 of this year, one paragraph reads as follows:

At long last there is to be a congressional investigation of several situations in the FSA. The House Committee on Expenditures in Executive Departments has just set up a subcommittee on publicity and propaganda in executive departments. My blueprint is to be made the basis of the first investigation. Obviously, I can be of some real service in this connection.

That is signed by Dr. Marjorie Shearon, Post Office Box 4034, Chevy Chase, Md. I offer that for the record.

Senator SMITH. Very well.

(The document referred to above is as follows:)

[Copy]

MAY 9, 1947.

To My Readers:

At the request of Senator Smith I am discontinuing my news releases.

As I stated at the time, I accepted the appointment as consultant with reluctance and misgivings. Both have increased. For some time I have been considering other plans. When they have been completed, I shall notify you.

Since I notified you 10 days ago that hearings on S. 545 would begin on May 21, there has been a period of uncertainty as to further plans. I finally received the green light this morning at the first full session of the Health Subcommittee on Labor and Public Welfare. Today I am issuing official invitations for specific days.

The new WMD bill will be introduced on May 12. Hearings on that bill will follow immediately after those on S. 545. I have a list of 42 witnesses to be heard on the WMD bill. I am now arranging the schedule within the limitations of possibly nine sessions for S. 545 and six for the WMD bill. Senator Smith would like to keep the hearings for the two bills within a 4-week period. I do not see how that is possible.

At long last there is to be a congressional investigation of several situations in the FSA. The House Committee on Expenditures in the Executive Departments has just set up a Subcommittee on Publicity and Propaganda in such departments. My Blueprint is to be made the basis of the first investigation. Obviously I can be of some real service in this connection.

Not being able to write personal letters in the quantity required, I adopted the weekly releases. Now that these are to be discontinued, there will be no way to communicate with you except very occasionally. The accounts of those

who have sent stamps will be adjusted as soon as I am able to attend to the matter.

I am going ahead with the third printing of the Blueprint, and shall continue to fill orders. The pamphlet becomes of especial importance in view of the introduction of the new WMD bill.

I should like to take this occasion to thank you for many kind expressions of interest in what I have endeavored to do in the public interest. Pressure groups have been trying for months to have me silenced. It is important to them that I should not present the facts about political developments affecting medicine, especially at this time. At this moment my only comment is that during the 35 years of my professional life, I have never made any decision as to my own next step on the basis either of expediency or of financial rewards. In the few remaining years of my professional career I shall not change a lifetime pattern regarding my own conduct. I think the issues at stake are of very great importance, I do not intend to play a passive or negative role.

MARJORIE SHEARON, Ph. D.,
Chevy Chase 15, Md.

Dr. PARRAN. Thank you very much. I hope in my comments as a result of an effort to save your time and be brief I have not appeared to be dogmatic.

Senator SMITH. I appreciate very much the substance and spirit of your testimony.

I have on the list of remaining witnesses Katharine Lenroot of the Children's Bureau and William L. Mitchell, Acting Commissioner for Social Security. I don't know who wants to come first. We have a requirement of the committee that prepared statements be presented, so I would prefer to have the prepared statements and then comments on them.

Miss LENROOT. Mr. Chairman, I am here to amplify and answer any questions that I can in regard to Mr. Mitchell's statement.

Senator SMITH. Very well.

STATEMENT OF WILLIAM L. MITCHELL, ACTING COMMISSIONER FOR SOCIAL SECURITY

Senator SMITH. Mr. Mitchell, I take it you are here as Deputy Commissioner of the Social Security Administration. I take it you are appearing for the Social Security Administration.

Mr. MITCHELL. That is right. If the committee would like, I have prepared a summary of that more lengthy statement which is just about half its length.

Senator SMITH. Yes; I would like to have you present that. However, we will include your longer statement in the record at this point. (Mr. Mitchell submitted the following brief:)

STATEMENT OF WILLIAM L. MITCHELL, ACTING COMMISSIONER FOR SOCIAL SECURITY, ON S. 545 AND S. 1320

Mr. Chairman, I wish to express our regrets that Mr. Altmeyer, the Commissioner for Social Security, is not able to be here to testify at these hearings on behalf of the Social Security Administration. He is abroad, serving temporarily as Executive Secretary of the International Refugee Organization. I am sure that he would have been glad to have had this opportunity to come before your committee. He has a very deep interest in the subject under consideration, to which he has given much attention over a period of more than 25 years, and he regards it as one of the most important aspects of our whole American program for social security.

The Social Security Administration has administrative responsibilities for several programs which are directly in the fields with which S. 545 and S. 1320

are concerned. The Children's Bureau, part of this Administration, administers the Federal-State programs providing health services for mothers and children and for crippled children. The Bureau of Public Assistance, also part of this Administration, administers the Federal-State aspects of public assistance programs. Under those State programs the welfare agencies of the States and localities expend many millions of dollars a year either to provide needy persons with funds for the purchase of their own medical care (for this there is Federal aid), or to pay for medical care provided to needy persons (for this there is no Federal aid).

In addition, the Social Security Administration has a broad responsibility under law for "studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age pensions, unemployment compensation, accident compensation and related subjects" (Social Security Act, sec. 702).

Ever since 1935, when the Social Security Act became law, the Social Security Board and its successor, the Social Security Administration, has undertaken to carry out its responsibilities and obligations under this provision of law. It has drawn upon its facilities, including the experience of its program bureaus and the studies made by its research bureau, to determine the areas of economic insecurity in which no provisions have been made or in which the provisions are found to be inadequate, to measure and define the existing needs, and to develop recommendations on the basis of carefully worked out plans.

PRIOR SOCIAL SECURITY BOARD RECOMMENDATIONS

Our administrative and research experience, and that of other agencies working in this field in the last decade, have confirmed beyond all doubt the opinions, now widely held, that health is basic to the security of the individuals and families that make up our population, and that health services should be made more adequate and more readily available to our population than they are now. Mr. Altmeyer summarized our opinion as follows, when testifying before the Committee on Education and Labor last year:

"The lack of adequate measures to cope with sickness and with sickness costs, constitutes the most serious gap in provisions for social security in the United States. This lack affects all areas in the country, all age groups, and nearly all income levels. Of course we should strengthen our public health programs, in order to prevent all illness and disability, that is preventable. But since most illness and most disability cannot yet be prevented, steps must be taken to make adequate medical care more accessible to all. The most practical method of working toward this goal is to distribute medical costs among large groups of people and over a period of time" (hearings on S. 1606 79th Cong., p. 172).

These remarks by Mr. Altmeyer, then Chairman of the Social Security Board, had been preceded by a long series of studies made under the direction of the Board, and by recommendations submitted over a period of years to the President and the Congress. For example, the Annual Report for 1938 contains the following:

"The Board believes that there is widespread interest in extension of the social security program on the part of the general public, of workers, employers, professional groups, farmers, and others. It believes also that this concern includes a conviction that promotion of the Nation's health is a major goal for the near future" (Third Annual Report, p. 20).

The Fourth Annual Report of the Social Security Board (1939) said:

"The Board wishes to reiterate its endorsement of the goals and principles proposed in the national health program with respect to both the services necessary to prevent sickness and maintain health and earning power and the measures to protect workers and their dependents against the loss of income occasioned by temporary or chronic disability" (pp. 16-17).

In the Fifth Annual Report (1940) we find the following:

"There is one major risk to economic security for which there is yet no provision in the social-security program and only inadequate provision under other legislation—the risk of medical costs and of wage loss during illness or during temporary or permanent disability. In his capacity as a member of the Interdepartmental Committee to Coordinate Health and Welfare Activities, the Chairman of the Board has shared in the report and recommendations transmitted by that body to the President and the Congress. The Board wishes to reiterate its

endorsement of the goals and principles proposed in that report on a national-health program" (p. 15).

Similar recommendations continued to be made annually. The last report submitted by the Board (1946) said:

"To attain the objectives of a social-security program, the Board believes social insurance and public assistance, separately or in combination, must provide against all common hazards to livelihood among all groups of the population. Our present provision for social security in the United States is seriously deficient in both these respects" (p. 427).

And the Board's recommendations for particular programs included, among others, the following:

"Insurance against costs of medical care, including payments to physicians, dentists, nurses, hospitals, and laboratories, with provision for decentralization of administration and utilization of State administration * * *" (p. 430).¹

I cite these excerpts to emphasize again that the opinions expressed by Mr. Altmeyer last year, and which I reiterate, were the product of many years of deliberation, and they were the unanimous recommendations of the Social Security Board. The Board's consistent urging of more adequate provisions for health services and for protection against sickness costs was primarily the result of observations from all areas in which our personnel had dealings with persons in need of aid and for whom our present programs give only partial aid or none at all. It is still our conviction that the inadequacy of health provisions and the inadequacy of social security against sickness remain among the serious threats to economic security in this country.

In this connection, I want to express our opinion that a program for security against the costs and losses caused by sickness is inherently both a social-security program and a health program. Both aspects must be taken carefully and fully into account. A sound program will be one that is effectively coordinated with other measures for social security and with other measures for health. Moreover, a health-security program will fail to meet existing needs if it provides only for needy persons; an adequate program must also deal with the problems of self-supporting people.

GENERAL RECOMMENDATIONS OF THE SOCIAL SECURITY ADMINISTRATION

Since Commissioner Altmeyer testified comprehensively at the Senate hearings last year, and his testimony is available in the published record,² I have not undertaken to reassemble and repeat the grounds for our recommendations. The picture has not changed materially since then; there is no reason to believe that needs have changed in any basic way. Resources for constructive measures have increased through the return to civilian life of many medical and related practitioners who had been in the armed forces, and through the enactment of Federal legislation to provide aid for State surveys of hospital resources and for the construction of some of the needed facilities.

I would like to identify four broad problem areas in which constructive programs are needed. My remarks about them should be considered in conjunction with those contained in Mr. Miller's and Dr. Parran's testimony.

1. *Prevention of disease, disability, and premature death.*—While the Social Security Administration does not have primary administrative responsibility in this field, it is responsible for the health programs administered by the Children's Bureau, and it deals all the time—through the social insurance and the public assistance programs—with insecurity and dependency resulting from disease, disability, and premature death. Consequently, the Administration has a responsible interest in the adequacy of the public health programs. It believes that strong preventive programs are essential elements in any broad undertaking for the social security of the American people.

We appreciate that the Congress has already gone a long way, over the past 12 years, in developing and financing public health programs. But we are also aware that much still remains to be done. From our point of view in administering social-security programs, there is not much sense or economy in spending large sums of money merely to repair social and human damage that can be prevented from occurring. We are confident that the social insurance programs will be strengthened and the public assistance programs will be substantially

¹ A more extensive excerpt from the Annual Report for 1946, giving the basis for the Board's recommendation, is attached.

² Hearing before the Senate Committee on Education and Labor on S. 1606 (79th Cong.), pt. 1, pp. 169-208.

reduced if health is improved and if sickness, disability, and premature death are diminished.

2. *Health services for mothers and children.*—The special health needs of mothers and children have long commanded the special and sympathetic attention of the Congress. As a result, special Federal-State programs for these groups have been in operation since 1935, when they were established under the Social Security Act. Despite their limited financial resources, the present programs for maternal and child health services and for crippled children's services have made large contributions to the national health and welfare. Much more needs to be done and much more money could be wisely invested in these Federal-State programs.

Last year the Children's Bureau presented to the Senate Committee on Education and Labor, in testimony on S. 1606 and on S. 1318,³ comprehensive statements setting forth the health and medical needs of mothers and children in this country. While each State now has a maternal and child health and a crippled children's program operating under title V of the Social Security Act, the objective of having essential services available to all mothers and children who need them has not been reached in any State. This is true in part because the primary emphasis has been on areas of special need and not on State-wide coverage, but more importantly because there have not been sufficient funds or sufficient qualified personnel to make the services available.

These programs, with their emphasis on community planning, are very important if we are to assure that essential care of good quality—the kind that modern medical science knows how to furnish—is provided to mothers and children wherever they live.

The special economic problems which confront families with children give added emphasis to the importance of developing a national health program designed to make health and medical services readily available at the time they are needed. The cost of rearing children—of providing food, clothing, shelter, medical care, and other necessities—is unevenly distributed among the population. In times of prosperity, as well as in times of depression, children are heavily concentrated in families of low income. Sickness occurs more often in childhood than in any age period except in old age. Chronic illnesses, requiring special kinds of care over long periods of time, are relatively common among children. The majority of families with children are therefore confronted with the problems that result from the combination of relatively small financial resources and small ability to pay for medical care, and relatively large need for such care.

3. *Medical care for needy persons.*—Much is being done to meet medical as well as other requirements of needy persons through the Federal-State assistance programs for the needy aged, dependent children, and needy blind, and under the State and local programs for other needy persons. But there are serious inadequacies in the achievements and important deficiencies in our present programs. Three may be singled out for special mention here. (a) The present Federal programs deal with only three categories of needy persons. If Federal aid is to be made adequate and effective, it needs to be broadened to apply to all persons requiring assistance, regardless of age or the nature of their handicaps. (b) The present Federal financial aid to the State public assistance programs is on a uniform percentage basis, regardless of the financial resources of the States. If it is to be fully helpful to the States, the Federal aid should be made more generous to the relatively poor States. (c) The present laws treat medical care in the same way as other necessities such as food and shelter. Federal sharing is now limited to payments to needy persons up to specified amounts. States now use various methods to provide medical services to recipients: Some States make payments to recipients and often exceed the Federal sharing limits; some pay direct to the practitioner or hospital providing the care without Federal funds; others use both methods. There is an important and widely recognized need that the Federal law should give more flexibility to the States to enable public assistance agencies to use either or both of these methods with Federal financial aid.

I appreciate that these problems concerning provisions for needy persons involve many details that ordinarily arise in connection with welfare rather than with health legislation. But they are directly pertinent to these hearings, since the bills that are before you include special provisions for the medical care of needy persons.

³ Hearings on S. 1606, 79th Cong., pp. 1442–1508; hearings on S. 1318, 79th Cong., pp. 128–200.

In this connection I would emphasize that any action which you may contemplate in this area should, I believe, take full and careful account of the inherent and inevitable interrelations between health provisions for the needy and other general provisions for them, especially if the health services were to be administered separately. When assistance authorities look at the budget needs and the budget deficiencies of people who apply for aid they have to take health needs into account. What decisions they make in each individual case, therefore, have to take account of medical-care provisions under health programs if medical services for the needy are separately provided. Coordination is, therefore, important lest there be gaps or overlaps, and both the welfare and health programs suffer as a result.

4. *Prepayment of medical costs for self-supporting families.*—The largest problem area to which I direct attention concerns the general field of prepayment for medical care. The nature and the dimensions of this area suggest that the Congress should not confine its attention to the medical needs of those who are forced to seek public aid for essentials of living or for those who are under some very low income amount, but should also consider provisions for that large proportion of the population—ordinarily self-supporting—who cannot manage the costs of medical care on an individual or family basis or who can do so only with great difficulty or sacrifice. The need for such provision is now widely accepted, as is the use of the prepayment method as the means. As Mr. Miller pointed out, major differences of opinion have, for the most part, narrowed down to a choice between the alternatives of voluntary and compulsory insurance. We believe "that the simplest, most economical, and most effective basis for medical care insurance would be through Federal legislation to establish comprehensive protection" (Annual Report, 1946, p. 442).

These four problem areas are not altogether separate or additive; the content of each one has to be considered in light of the others. The scope of public-health developments through community provisions and the scope of special provisions for mothers and children are interrelated. Also, both of these programs deal with sectors that are important for the third, medical care of the needy. And all three of these programs have important interrelations with the characteristics of a prepayment program for self-supporting persons.

In making any decisions as to legislation with respect to any of these four areas, we recommend—

(a) A public-health program that will, as soon as practical, and along lines suggested by the Administrator and the Surgeon General of the Public Health Service, assure all needed community-health services throughout the country;

(b) A comprehensive national system of social insurance against medical costs (and also against earnings lost on account of disability);

(c) A program of maternal and child-health and crippled-children's services sufficient to assure, as soon as practical, all needed services not otherwise available; and

(d) A more adequate public-assistance program, including authorizations for State use of Federal funds for the financing of medical care of the needy through the facilities of the social-insurance system.

HEALTH SECURITY THROUGH SOCIAL INSURANCE

Before turning to some specific comments on the bills under consideration, I want to include at this point some general remarks about the use of the prepayment principle to achieve protection against medical costs. Mr. Altmeyer stated our views on this subject, in some detail, at last year's hearings; I believe a brief summary, adapted from his testimony, will provide some useful benchmarks for my subsequent remarks.

First, let me point out that the experience of the Social Security Board, and of its successor the Social Security Administration, through nearly 12 years of administration has vindicated the soundness of the social-insurance approach to economic security. That experience has reinforced the basic policy, which goes back to the beginnings of our social-security legislation, to place main reliance for the long run upon social insurance as a sound and stable basis for social security, so that public assistance—which is a necessary supplement—will to the maximum extent practicable become reduced to a minimum by the protections afforded through an expanding and maturing system of social insurance.

The Administrator has already pointed out that until a few years ago there were sharp differences of opinion as to the needs of this Nation for health security. The testimony presented last year in the hearings on S. 1606 and that which has

been presented before this committee in the course of the current hearings indicates the general agreement among most informed and interested groups that we do have large unmet health needs. In fact, the areas of agreement go beyond the admission of needs; there is also general agreement on how to meet many of these needs, and the areas of agreement include the importance of budgeting against the costs of medical care through prepayment. The major differences of opinion on a health-security program are whether the insurance should be voluntary, for particular groups here and there, and limited to plans sponsored or controlled by medical societies, or whether it should be compulsory, nationwide, covering as many people as possible, and be under public control.

Voluntary insurance.—The costs of sickness have been distributed for some people through voluntary insurance plans for many years. But only a few million persons in our total population of 142,000,000 have what can be termed relatively complete protection against medical bills. By far the largest enrollment in voluntary health insurance for service benefits is in the Blue Cross hospital plans. Membership has grown tremendously within the past 10 years, but it still covers only about 20 percent of the population of the United States. This membership is heavily concentrated in some of the States, and particularly in their medium-sized and large cities and their environs. Rural membership is very small. As of April 1, 1947, 10 States with about 46 percent of the population had over 70 percent of the enrollment. The Blue Cross plans have demonstrated, on the one hand, the relative ease of insuring a substantial fraction of the middle-income group against hospital costs and, on the other hand, the great difficulty of insuring the low-income or rural groups through voluntary methods. In general, even these plans have failed to insure those who most need this protection—the low-income groups and those in rural areas where health personnel and facilities and the financial support for them are least adequate.

The difficulties of enrolling the public in voluntary hospitalization plans are small compared to those of medical-care plans. Voluntary prepayment medical-care plans whose members are entitled to service benefits have an enrollment of between 7 and 8 million persons (about 5 or 6 percent of the population). Even these organizations differ greatly in the scope of services provided; various limitations are placed on the amount of care furnished, membership in these organizations is frequently restricted to those below a specified age or income, and persons with preexisting disabilities may be excluded entirely or be entitled only to services having no relation to their preexisting ailments.

At present about two-thirds of these 7 to 8 million persons covered by medical care plans that provide service benefits are members of plans sponsored by State and county medical societies. The American Medical Association, which formerly opposed or discouraged all forms of health insurance, now favors voluntary health insurance plans that are under the aegis of State or local medical societies or have their approval.

With the exception of medical society plans in the States of Washington and Oregon, the scope of care provided by these medical-society plans is generally highly restricted—primarily to obstetrical services and surgical care, though some of these plans also offer care for hospitalized illnesses of nonsurgical character and a few include care in the office and home after the patient has paid for the first few calls. The Washington and Oregon local plans have been in operation for a number of years (they antedate the recently adopted AMA policy of supporting voluntary insurance) and they are not representative of the medical society plans generally. The typical medical-society plan is limited to "catastrophic" illness, includes little or nothing in the nature of preventive measures, is expensive and often either limits the membership to those under a specified income or allows the doctor to make additional charges for those with incomes over a specified amount or those using a private room in the hospital. Therefore, families having incomes above a specified amount have only uncertain insurance protection in such plans. Quite a few of the medical-society plans provide only limited indemnity payments, rather than service benefits, and the trend among the newer plans may be in the direction of this pattern.

Comprehensive protection under voluntary plans, with their uniform premiums, would be more expensive than most persons could afford to pay. Voluntary health insurance as it now exists in the United States covers a small fraction of the population in need of such protection. Its services are usually incomplete, and its charges are high in comparison with services provided. The organized plans themselves are very unevenly distributed throughout the country and are very unevenly available to different segments of our population.

During the war years there was a rapid increase in commercial group insurance through which employees are reimbursed in cash for all or a portion of their hospital and medical fees (principally surgical). Policies of this type formerly covered only employees, but recently the coverage in many instances has been extended to employees' dependents. Last year, 8 or 9 million persons had contracts for hospitalization indemnity payments; of this number about 6 million were also eligible for surgical indemnities. Although this provides some protection, insurance of this type is not a satisfactory substitute for comprehensive insurance protection. Both the number of persons served and the benefits received are too limited.

In addition, many people have contracts for limited indemnification of medical costs under individual commercial insurance policies (industrial life, accident, and health, etc.); but the total number is not known reliably and the amount or scope of protection against medical costs is small relative to the national need.

Judged by the population it covers and by the scope of the protection it provides, as against national needs, the achievements of voluntary insurance are small. This failure is not due to lack of effort, earnestness, or skill on the part of individuals or organizations sponsoring those programs; nor, as appears from public opinion polls and other evidence, is it the result of lack of interest on the part of the American people. The rapid enrollment of Blue Cross and medical-society plans in many places indicates that even the restricted protection offered by these plans is welcomed by the public.

The limited accomplishment of voluntary insurance is probably mainly due to the fact that the task is too large and too difficult to be accomplished by organizations or associations representing only a portion—and in most instances a very small portion—of the public. No type of voluntary plan for comprehensive services—alone and unaided by governmental effort or funds—has ever even approximated, either here or abroad, the goal of including all of the population in a region. As a rule, those who are most in need of protection, especially by reason of low or uncertain income—are not covered. Voluntary insurance is necessarily expensive or restricted, because it is constantly exposed to an adverse selection of risk among those who enroll or stay enrolled. Experience the world over has shown that only through government action can large-scale or complete coverage be achieved. It is, of course, conceivable that American experience might prove the exception, but general experience makes this unlikely, and those who advocate this possibility are in effect pitting their guesses or hopes against experience. It might be noted that a number of representatives of voluntary insurance plans who have testified have in effect admitted this, and they have suggested public subsidy to support the coverage of low-income groups. Their suggestion raises the complex questions involved in the transfer of public funds to private agencies.

The economic and social reasons why voluntary programs have not succeeded, and are not likely to succeed, have been expressed on at least two occasions by the American Medical Association.⁴

Experience persuades us that a comprehensive health-insurance program must rest on a method of financing which makes it possible for families to budget the costs in accordance with ability to pay. These costs are held to a minimum through broad and compulsory coverage, avoiding the financial and related problems of adverse selection. Perhaps the greatest value of voluntary health insurance has been the experience gained in learning how to operate compulsory health insurance.

A national system of health insurance.—In order to be altogether adequate and successful, health insurance must make it possible for everybody to have ready access to adequate medical care, both preventive and curative. If this cannot be achieved from the outset, the program that is adopted should lend itself to growth, with comprehensive services and national coverage as the goal. To the greatest extent practicable, care should be provided for the dependents of insured workers on the same basis as for the worker. As far as is practical, the insurance program should be extended by supplementary agreements or otherwise to cover all noninsured groups who are in need of protection. All existing medical personnel and facilities meeting reasonable standards that wish to participate should be utilized to the maximum degree, and the remuneration

⁴ Medical Care for the American People. Chicago, 1932. Minority Report No. 1, Committee on the Costs of Medical Care (approved by the house of delegates, AMA), pp. 163, 164; A Critical Analysis of Sickness Insurance, bureau of medical economics, AMA, Chicago, 1938, p. 22.

ation for services should be adequate. The quality of service must not be sacrificed to economy; that would be false economy. Both physician and patient should be assured freedom of choice. Professional groups, as well as the public, should participate in determining policies. Adequate provisions should also be made to stimulate professional education, research, and prevention of disease and disability.

A program of this scope will require sufficient medical personnel and facilities to provide comprehensive services, and these should be sufficient in number and location throughout the country in a manner which will make at least minimum basic services available to everyone. The program will have to encourage the training of needed personnel and the construction of needed facilities. The cost of such a program must be broadly distributed over groups in the population. The system must be so designed as to provide benefits to the insured regardless of his individual ability to pay and where he is residing at the time he is in need of services.

These, I think, are the main criteria by which an American plan for prepayment of medical costs should be judged.

Separate State-by-State systems are not likely to be established, witness the fact that every State which has considered this approach has been reluctant to act by itself. A joint Federal-State approach is more likely and more practical than such separate State action. However, in our opinion the logical, the efficient, and the economical way to have a national system of health insurance is to establish a truly national system with explicit provisions for decentralized administration.

SOME GENERAL COMMENTS ON S. 545 AND S. 1320

Since our detailed comments on S. 545 and S. 1320 are included in the Agency reports on the two bills, submitted to the committee and attached to our testimony, I shall not take your time to repeat them at any length. I want only to mention a few points.

These two bills offer quite different approaches to the national medical-care problems. As between the narrow and limited approach of S. 545 and the broad and comprehensive approach of S. 1320, we favor the latter. As between the means-test or income-test pattern of eligibility for medical care under S. 545 and the insurance pattern of coverage and eligibility under S. 1320, we strongly favor the latter. We believe that, insofar as may be practical, health security should be achieved by giving more people, and if possible all people, insurance protection, rather than by requiring them first to reach destitution or dependency and then meet the requirements of a means test, or by making provision for public subsidy of prepayment plans for those who meet a low-income test.

Our comments on the National Health Agency, and its characteristics specified in S. 545, are incorporated in our Agency report on the bill and have already been discussed by Dr. Parran.

S. 545 makes no provision to strengthen or extend the special programs for mothers and children. From past experience, the provision which it does make for periodic physical examination of school children is likely to be uneconomical of money and professional services if there is not also new provision for treatment and correction of the illnesses, defects, or handicaps that are uncovered. The provision for dental examinations and services separate from other health services for children is not desirable, and the very small sums provided would be quite sufficient to do more than a small fraction of what is needed.

The absence of many needed Federal and State standards in S. 545 would endanger the effectiveness of the intended program and might also have undesirable repercussions on other Federal-State programs in which we and the State agencies have worked out sound cooperation.

The probable conflicts, gaps, and overlaps between the program contemplated by S. 545 for needy and low-income individuals and families and the public-assistance programs are likely to lead to serious confusions and wastes for reasons which I have already indicated. The effects of S. 545 on our maternal and child-health programs and our crippled-children's programs are likely to be of the same general kind.

Some of the grant-in-aid provisions of S. 545 are ill adapted to the needs of the program; the equal-matching requirement is likely to work a hardship on the relatively poor States (which are most in need of Federal aid), and would run counter to the need, in Federal-aid programs generally, for variable grants

adapted to the financial resources of the States. Great care must be taken not to create, within States, undesirable competitive financial situations among grant-in-aid programs. This is an important reason for our efforts toward uniform or rationally related Federal-aid provisions in different grant-in-aid programs. The same kind of reasoning supports a number of other objections, cited in our report on the bill, against lack of certain administrative standards, excessive controls lodged in special professional groups, insufficient controls over public funds that may be paid out to private organizations, and the absence of safeguards for the rights of persons to be aided by the program and of those desirous of providing services under it.

In light of Mr. Altmeyer's testimony of last year and the opinions I have expressed, we commend S. 1320 to your favorable consideration. As indicated in our report on this bill, we think its provisions show considerable improvements at many points over those that were contained in S. 1606 (79th Cong.) which we also recommended favorably.

The Social Security Administration concurs in the comments which the Administrator of the Agency and the Surgeon General of the Public Health Service have already made with respect to the declaration of purpose (title I) and the development and expansion of community-health services (title III).

The Administration particularly commends the system of prepaid personal health service benefits contemplated by title II. We believe that the present bill is sound and realistic in its positive provisions, in recognizing and taking into account limitations in benefits that may have to be made in the first years of operation, in providing time for the "tooling up" period, in lodging very broad administrative responsibilities and discretions in the States, and in providing for coordination of the administration of health programs at Federal and State levels, and for coordination of health and social-security programs at the Federal level. Administration of the system should turn out to be practical and administrative costs moderate. Certainly, administration will not require anything like the fantastically large staffs estimated by some critics of the bill. The broadening of coverage (over that in S. 1606) by inclusion of Federal employees is sound, since we believe coverage should be as broad as practical. We think that the combination of national assumption of obligations and national financing, on the one hand, with decentralized Federal-State administration, on the other, is well designed to meet a Nation-wide problem and yet take account of diverse needs and circumstances.

We have not completed our studies of the costs and financing of S. 1320. Since the costs are likely to be similar to those which we estimated for S. 1606 last year, we refer to our earlier testimony on this point as giving approximate guides. The financial provisions appear to be approximately adequate. As was the case for S. 1606, the financing of S. 1320 would call for separate legislation, involving decisions as to the allocation of costs among the persons to be insured, their employers, and general revenues. We assume that such decisions would be made with full regard for social-insurance finances as a whole and for general tax and fiscal policies.

CONCLUSION

While we endorse the objective of S. 545 to make medical, hospital, dental, and public-health services available to every individual, we cannot subscribe to many of its specific proposals or specifications. We think it would be regrettable to make provision for health services for needy and near-needy persons only, except as a means of strengthening the public-assistance programs, while failing to make provisions for the self-supporting population that also needs help in obtaining more and better health services. If only a fractional program is to be considered favorably by the committee, we hope it will consider some of the alternatives mentioned in our Agency report of S. 545.

We support S. 1320 both for its comprehensive objectives and provisions. We think it proposes in sound ways to stake out the interest of the United States in the health of the population and to indicate the readiness of the Federal Government to help toward health progress. It would give substantial and needed aid for community-health services, and it would build a national social-insurance system for prepayment of medical costs—a system that could give most of the population increased access to such services while at the same time greatly relieving them of burdensome costs.

[Excerpt from the Annual Report of the Social Security Board (sec. 6, Annual Report of the Federal Security Agency), 1946, pp. 439-443]

MEDICAL CARE

In the first full-length Executive message on the subject in American history, President Truman on November 19, 1945, proposed a five-point program for the construction of additional hospitals and related facilities; the expansion of public health and maternal and child-health services; governmental aid for medical education and research; the prepayment of medical-care costs through a comprehensive health-insurance program; and protection against the loss of wages from sickness and disability.

Great strides have been made in the United States in the last few decades in the reduction of sickness and death rates, especially in the earlier years of life. That reduction, however, reflects chiefly improvement in the field of communicable diseases such as typhoid fever, diphtheria, and tuberculosis and is attributable in large measure to the success of public-health measures affecting the water supply, sewage disposal, and food handling and to immunization, case-finding, and other tax-supported community services. Further gains must largely depend on improvement in preventing and treating the so-called degenerative diseases of middle age and old age—for instance, cancer and heart disease, the death rates for which have increased rather than decreased—and on more nearly adequate medical services for persons suffering from other diseases that cannot be prevented or controlled by mass methods. Progress in preventing needless suffering and death and promoting the Nation's general level of health therefore hinges largely on provisions for individual diagnosis and care. Hence the importance of emphasizing methods that would assure to all persons ready access to adequate individualized medical services.

Development of hospitals and community-health facilities in places now without them should help to remedy the alarming—and probably increasing—lack of physicians in rural and poverty-stricken areas.⁵ Doctors prefer to practice where they can have ready access to hospitals, laboratories, and other essentials of modern and well-paid medical practice. The concentration of physicians in large cities is due in part to the fact that cities possess such resources. A more equitable distribution of health facilities should encourage a better distribution of skills and services.

The last two points in the President's program deal with the cost of medical care to the individual and the loss of earnings when sickness strikes. Reference has been made to the magnitude of the loss of earnings resulting from disability and the very limited extent to which disability benefits now available replace such losses. Equally important is the problem of paying for adequate medical care, which concerns not only wage earners but also the population as a whole. An increase in hospital facilities and in medical personnel is of limited value unless sick people can afford to use them. Cost remains the principal barrier to adequate medical care and is as much a reason for limited services in low-income areas as is the lack of facilities. Few people are able to meet the expense of severe or prolonged illness out of current earnings. For many families such illness means the exhaustion of savings and serious—often overwhelming—debts. Fear of economic disaster frequently keeps families from calling a doctor at the time when his services could be most effective. Much of the value of early diagnosis and treatment is thus lost.

In the aggregate, the financial burden of illness is not excessive. The Nation's bill for health services of all kinds, including services by doctors, dentists, and nurses, hospitals, and public-health agencies, and the cost of medicines and appliances, amounts to about 4 or 5 percent of the national income. The problem lies in the uneven incidence of this burden. In a given year most families have only nominal expenditures for medical care; others are overwhelmed. Except on a prepayment basis, it is, for all practical purposes, impossible for an individual or family to budget for medical care. These two characteristics of medical care cost—their unpredictability for the individual family and their manageable proportions when averaged—provide the basis for the President's recommendation that medical costs be put on a prepayment basis.

Prepayment of medical-care costs is not a new principle. In all States but Mississippi most employers in commerce and industry are required to carry the

⁵ For Federal legislation enacted after June 30, 1946, see pp. 521-522.

cost of treatment for work-connected injuries, and most of them do so through insurance. Workmen's compensation, under which about \$150,000,000 was spent for medical care in 1945, is the only prepayment plan in the country covering any substantial group of workers on a compulsory basis. The prepayment principle has also been used in a number of voluntary medical-care plans. The principal limitations of such voluntary plans have been inadequacy of coverage, restrictions on services, limitations on membership, inability to adjust contributions to income, and relatively high costs.

In June 1946, about 21.7 million persons, or 15.7 percent of the civilian population, were members of Blue Cross plans, which provide for prepayment of hospitalization costs. About 6,000,000 persons were subscribers to voluntary prepayment plans under medical society, private group clinic, consumer, employer, and Government auspices. About one-third of them, primarily Blue Cross members, were eligible only for surgical care in a hospital; the others were entitled to relatively complete service. Another 8 or 9 million persons, including dependents, were covered for all or part of this hospitalization costs through group policies issued by commercial insurance companies; group policies to indemnify surgical costs also were in force for about 6,000,000 of these persons and their dependents. Several million individuals—the exact number is not known—held personal health or accident policies issued by commercial insurance companies.

Federal, State, and local governments have assumed some responsibility for the care of certain groups in the population. The Federal Government provides medical care of varying degrees of completeness for members of the armed forces, merchant seamen, and some veterans. The Federal Government also furnishes treatment for work-connected disabilities sustained by its employees, pays for maternity and infant care services received by wives and children of enlisted men in the armed forces, and maintains institutions for persons afflicted with leprosy. Institutional care of persons suffering from tuberculosis and from mental disease or deficiency is generally a State responsibility. Local units of government provide most of the hospital care given persons with communicable diseases. State and local governments share in varying proportions the cost of medical care to the needy sick. All three levels of government contribute toward programs for maternal and child health and services for crippled children.

In the fiscal year 1944-45, expenditures to carry out governmental health and medical functions amounted to more than \$1,000,000,000, excluding care of members of the armed forces but including care of veterans and public-health services. Tax funds, in other words, provided about 1 dollar in 5 of the Nation's total health bill. Of the governmental dollar, about 32 cents came from the Federal Treasury and about 68 cents from State and local resources.

There is general agreement on the desirability of a larger governmental contribution to the cost of keeping the Nation in good health; the only major differences of opinion are on the most appropriate way of making it. Some suggest that it should take the form of more free care to needy persons and to persons of low income. Although, by and large, the medical care of needy persons is undoubtedly insufficient and more ample provision should be made for that purpose, free care on a means-test basis is not the solution to the problem faced by the great majority of normally self-supporting persons. Such persons can and would prefer to pay for their medical care through some system of prepayment that distributes medical costs over groups of people and periods of time, rather than seek free care after they have been reduced to dependency. Experience both here and abroad indicates the effectiveness of achieving this objective through a health-insurance program under governmental auspices, financed out of periodic contributions by employers and employees. Extension of governmental responsibility for the Nation's medical services, the Board believes, can best be effected through a program of this type.

Such a program, it should be understood clearly, does not represent socialized medicine but is a method of insurance payment. Through it, families that are ordinarily self-supporting make small regular contributions to a fund from which payments are made to doctors, hospitals, and others for care rendered to them as insured patients. Persons dependent on public funds can be covered through payment to the insurance system of contributions on their behalf, and thus can receive medical care just as others in the community receive it, without the stigma and inadequacy often associated with "poor law medicine."

With assurance that their bills for needed services will be paid from the fund to which they have contributed, insured persons can be free to seek medical advice

at an early stage in illness, when the chances for prevention and cure are greatest. Patients can and should be free to choose their doctor from all who elect to participate in the system and to change doctors if they wish; doctors should also be free to reject patients. Individual doctors and groups of doctors should be free to choose the method by which payments will be made to them from the insurance fund. There need and should be no fear of regimentation of patients, practitioners, or hospitals. On the contrary, just as the removal of the cost barrier would enable the insured person to seek the care he needs, so it would free doctors and hospitals to employ the scientific techniques and devices best suited to treatment of the individual without fear that the cost will be more than he can pay. The system thus would give room and incentive for improving standards of service, and would encourage research and education to extend the knowledge and use of better methods of preventing and caring for sickness and disability. Both practitioners and institutions would have far greater assurance than at present of steady and adequate income. That assurance would make for better distribution of medical personnel as well as greater and better use of existing resources.

The Board believes that the simplest, most economical, and most effective basis for medical-care insurance would be through Federal legislation to establish comprehensive protection. Such a law might authorize use of State and local official agencies—and, when they contribute to administrative efficiency and economy, of private agencies—in administration of the program and use of public and private agencies, facilities, organizations, groups, and individuals in furnishing services to insured persons. In any event, subject to national standards, administration of benefits should be decentralized under arrangements worked out locally with doctors, hospitals, and others concerned. The general pattern of arrangements with doctors and hospitals should be designed with the collaboration of professional organizations, with careful regard for circumstances in a region, State, or locality, and with wide latitude for the participation of existing organizations and use of all other resources for medical and health services. Policies and operations in each area of administration—Federal, State, and local—should be guided by advisory bodies representing the contributors to the system and the groups that furnish services. A system of medical-care insurance need not, and in the opinion of the Board should not, supplant many existing group arrangements for medical care for persons who may wish to use the services they offer.

Mr. MITCHELL. Mr. Chairman, I wish to express our regrets that Mr. Altmeier, the Commissioner for Social Security, is not able to be here to testify at these hearings on behalf of the Social Security Administration. He is abroad, serving temporarily as executive secretary of the International Refugee Organization. I am sure that he would have been glad to have had this opportunity to come before your committee. He has a very deep interest in the subject under consideration, to which he has given much attention over a period of more than 25 years, and he regards it as one of the most important aspects of our whole American program for social security.

The Social Security Administration has administrative responsibilities for several programs which are directly in the fields with which S. 545 and S. 1320 are concerned. The Children's Bureau, part of this Administration, administers the Federal-State programs providing health services for mothers and children and for crippled children. The Bureau of Public Assistance, also part of this Administration, administers the Federal-State aspects of public-assistance programs. Under these State programs the welfare agencies of the States and localities expend many millions of dollars a year either to provide needy persons with funds for the purchase of their own medical care—for this there is Federal aid—or to pay for medical care provided to needy persons—for this there is no Federal aid.

In addition, the Social Security Administration has a broad responsibility under law for—

studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age pensions, unemployment, compensation, and related matters. (Social Security Act, Sec. 702).

Ever since 1935, when the Social Security Act became law, the Social Security Board and its successor the Social Security Administration have undertaken to carry out its responsibilities and obligations under this provision of law. It has drawn upon its facilities, including the experience of its program bureaus and the studies made by its research bureau, to determine the areas of economic insecurity in which no provisions have been made or in which the provisions are found to be inadequate, to measure and define the existing needs, and to develop recommendations on the basis of carefully worked out plans.

PRIOR SOCIAL SECURITY BOARD RECOMMENDATIONS

Our administrative and research experience, and that of other agencies working in this field in the last decade, have confirmed beyond all doubt the opinions, now widely held, that health is basic to the security of the individuals and families that make up our population, and that health services should be made more adequate and more readily available to our population than they are now. Mr. Altmeyer summarized our opinion as follows, when testifying before the Committee on Education and Labor last year :

The lack of adequate measures to cope with sickness and with sickness costs constitutes the most serious gap in provisions for social security in the United States. This lack affects all areas in the country, all age groups, and nearly all income levels. Of course we should strengthen our public-health programs in order to prevent all illness and disability that is preventable. But since most illness and most disability cannot yet be prevented, steps must be taken to make adequate medical care more accessible to all. The most practical method of working toward this goal is to distribute medical costs among large groups of people and over a period of time. (Hearings on S. 1606, 79th Cong., p. 172).

The conclusions of the Administration are the result of several years of deliberation and study. The Social Security Board, the predecessor of the Administration, by unanimous action of its members has formally recommended, each year since 1938, the use of social insurance techniques as a protection against the economic insecurities arising from sickness and disability. We are still of the conviction that the inadequacy of health provisions and the inadequacy of social security provisions against sickness remain among the most serious threats to economic security in this country.

A program for security against the costs and losses caused by sickness impresses us as being inherently both a social-security program and a health program. I would not wish to minimize one or the other. A sound program is one that would deal with both coordinate-ly. Moreover, as we appraise existing needs it is self evident that they will not be met by a health program restricted to needy persons. People normally self-supporting must likewise have protection.

GENERAL RECOMMENDATIONS OF THE SOCIAL SECURITY ADMINISTRATION

Since Commissioner Altmeyer testified comprehensively at the Senate hearings last year, and his testimony is available in the published

record, I have not undertaken to reassemble and repeat the grounds for our recommendations. The picture has not changed materially since then; there is no reason to believe that needs have changed in any basic way. Resources for constructive measures have increased through the return to civilian life of many medical and related practitioners who had been in the armed forces, and through the enactment of Federal legislation to provide aid for State surveys of hospital resources and for the construction of some of the needed facilities.

I would like to identify four broad areas in which constructive programs are needed. My remarks about them should be considered in conjunction with Mr. Miller's and Dr. Parran's testimony. They are—

1. Prevention of disease, disability, and premature death.
2. Health services for mothers and children.
3. Medical care for needy persons, and
4. Prepayment of medical costs for self-supporting families.

My first point, prevention of disease, has already been adequately covered by Dr. Parran. The Social Security Administration does not have responsibility for it, although we do have a direct operating interest in view of the health programs administered by the Children's Bureau which is part of Social Security Administration. I mention this problem area because of our belief that a strong preventive program constitutes a necessary foundation for the building of an effective insurance system of medical services for individuals and for strengthening social security generally.

Since Miss Lenroot is here and will testify specifically on the programs of the Children's Bureau I will comment only briefly on the second point, that is, health services for mothers and children. It seems trite to point out that the future of the Nation continuously rests in the hands of its children. Families with children are confronted with special economic problems many of which are directly attributable to the costs of medical care. Children are heavily concentrated in families of low income, and sickness occurs more often in childhood than in any other period of life except in old age. I wish merely to emphasize the special needs of children and to recommend a program of maternal and child-health and crippled-children's services sufficient to assure, as soon as practical, all needs and services not otherwise available.

The third area is, "Medical care for needy persons." Our present categorical assistance programs make certain provisions for the health needs of these groups. They are seriously deficient, however, in at least these respects:

1. The present Federal programs deal with only three categories of needy persons. If Federal aid is to be made adequate and effective it needs to be broadened to apply to all persons requiring assistance, regardless of age or the nature of their handicaps.

Again I point out that only the aged, dependent children, and the blind are covered. All other people who are needy are in need of this type of assistance.

2. The present Federal financial aid to the State public assistance programs is on a uniform percentage basis, regardless of the financial resources of the States. If it is to be fully helpful to the States, the

Federal aid should be made more generous to the relatively poor States.

Senator SMITH. I think in S. 545 we tried to make those distinctions.

Mr. MITCHELL. After the allotment is made, the State, as I understand it, must put up dollar for dollar for the funds it actually gets; whereas, we would recommend what we call a variable grant formula whereby the money that actually goes to the States is not on a dollar-for-dollar basis, but the poorer States would get more than \$1 for the dollar they put up.

Senator SMITH. I think that under our program the thing is worked out percentage-wise, as I recall our plan. We have the educational bill, and I thought in both this bill and the educational bill we recognized that the State would pay 25 percent in some cases and more than that in other cases.

Mr. MITCHELL. I wish anyone would correct me who knows the answer, but I think I have the correct answer, that in making up the formula for allotment to the States S. 545 takes into account population and fiscal capacity of the States, but that formula only determines the amount available to the State which it will match dollar for dollar. There are States which don't have that many dollars. We propose that once the allotment is worked out, the States would have to put up money inversely in relation to their wealth.

Senator SMITH. That is a problem we will develop. We are working that out in connection with the educational bill as well, and I imagine we can work out a similar plan in both cases. Mr. Cornell tells me your general idea is correct as far as this bill is concerned. I agree with you there ought to be a differentiation of some sort.

Mr. MITCHELL. The present laws treat medical care in the same way as other necessities such as food and shelter. Federal sharing is now limited to payments to needy persons up to specified amounts. States now use various methods to provide medical services to recipients; some States make payments to recipients, and often exceed the Federal sharing limits; some pay direct to the practitioner or hospital providing the case, without Federal funds; others use both methods. There is an important and widely recognized need that the Federal law should give more flexibility to the States to enable public-assistance agencies to use either or both of these methods with Federal financial aid.

I believe I might interpolate at this point that there is before the Congress at the present time a bill called the Cooper-Forand bill that would undertake to correct some of the difficulties that I am referring to here.

In any case any legislation in this area should take fully into account the interrelation between health provisions for the needy and other general provisions for them. In calculating public-assistance benefits the States are required to give consideration both to resources and to need—including health needs. If medical care is provided under health programs separate from assistance, coordination between the two is imperative lest there be gaps or overlaps which would cause both welfare and health programs to suffer.

The fourth and largest area to which I would like to invite your attention concerns the economic insecurity experienced by normally self-supporting families which is caused by the costs of medical care.

The studies which we and others have made plus our experience in administering other types of social insurance have pointed clearly to the need for protection against the costs of medical care for these ordinarily self-supporting groups. As the Administrator has pointed out there is already wide acceptance of the need for such protection. The differences of opinion have been narrowed down largely to a choice between the alternatives of voluntary and compulsory insurance as the solution. We favor the latter and sincerely believe it to be a practical, and economical method of assuring the needed protection.

HEALTH SECURITY THROUGH SOCIAL INSURANCE

Before commenting on the bills under consideration, I would like to touch briefly upon the use of the prepayment principle as a basic protection against medical costs. Mr. Altmeier went into this quite thoroughly at last year's hearings. I propose merely a brief summary.

First, may I suggest that the successful experience we have had in administering large programs of social insurance is strong evidence of the soundness of that approach to economic security. It has tended to validate the basic policy embodied in our original social security legislation which is to place main reliance for the long run upon social insurance as a sound and stable basis for social security. Public assistance has and will continue to be a necessary supplement, but its significance should tend to diminish to a minimum in the face of the protections afforded through an expanding and maturing system of social insurance.

VOLUNTARY INSURANCE

Our preference for compulsory social insurance does not mean that we are not conscious of the values of voluntary insurance—and I would like to underline that. As a matter of fact, I wrote this summary last night at home, and I find that the space I have devoted to voluntary insurance and some of the things I have said about it may appear disparaging, which I do not mean at all. I feel it has made a tremendous contribution.

Our preference for compulsory social insurance does not mean that we are not conscious of the values of voluntary insurance, nor of the great progress which that system has made in recent years. In our judgment, however, the national needs are of such magnitude and are fraught with so many complications as to be beyond the scope of any voluntary system. Despite the progress which has been made, only a few million persons in our total population of 142,000,000 have what can be termed relatively complete protection against medical bills. Even in the case of Blue Cross hospitalization plans only about 20 percent of the population receive this partial protection and this membership is heavily concentrated in a few geographic areas, particularly in medium- and large-sized cities. Rural membership is very small. Recent figures show that 10 States with 46 percent of the population have over 70 percent of the enrollment. Certain of these plans, while demonstrating the practicability of covering a substantial fraction of the middle-income group against part of the risk of medical care costs, have at the same time shown the great difficulty—even the impracticability—of insuring low-income or rural groups through voluntary methods alone. They have failed in general to meet the problem in the areas of greatest need.

Voluntary plans offering service benefits have enrolled perhaps between 7 and 8 million persons—5 to 6 percent of the population. The protection afforded differs greatly. In some, benefits are restricted to certain age or income groups and others exclude costs of servicing preexisting disabilities.

Despite the earlier objections of the American Medical Association to all forms of health insurance, about two-thirds of the 7 to 8 million persons covered by medical care plans that provide service benefits are covered by plans sponsored by State and county medical societies. The American Medical Association now favors voluntary health insurance when sponsored by the State or local societies. Again, these plans for the most part are limited to catastrophic illness. They are expensive and customarily permit extra charges if the insured has income beyond a specified amount. Quite a few of these medical society plans provide only limited indemnity payments—not service benefits—and the trend may be in this direction.

I am informed that commercial group insurance has been extended in the past few years to cover some 8 to 9 million persons for all or a portion of their hospital fees. About 6,000,000 of them are also eligible for surgical indemnities. In addition, many people have commercial individual insurance policies providing limited indemnification of medical costs, but the number covered and the protection provided is very small in relation to the national need.

No type of voluntary plan for comprehensive services—alone and unaided by governmental effort or funds—has ever even approximated, either here or abroad, the goal of including all of the population in a region. As a rule, those who are most in need of protection—especially low-income groups—do not get it. The accomplishments of voluntary insurance have doubtless also been limited by the fact that it is expensive and restricted. This is necessarily so because it is customarily exposed to an adverse selection of risk. I am informed that even some of those favorably disposed toward voluntary insurance plans have testified that universal coverage under them cannot be achieved. They have suggested public subsidies to support the coverage of low-income groups. To do so would, of course, raise a whole new set of complex questions.

A NATIONAL SYSTEM OF HEALTH INSURANCE

Experience persuades us that a comprehensive health-insurance program must rest on a method of financing—

Senator DONNELL. Pardon me, Mr. Mitchell. I notice in your statement here you have something which reads as follows:

The economic and social reasons why voluntary programs have not succeeded and are not likely to succeed is that they have been prevented on two occasions by the American Medical Association.

Do you mean to delete that or are you leaving that in?

Mr. MITCHELL. That is true, as indicated in my lengthy statement. What I am reading here is a very considerable summarization of that longer statement.

Senator MURRAY. The full statement is going in the record?

Mr. MITCHELL. I hope so.

Senator SMITH. Yes; that is included in the record.

Senator DONNELL. You are leaving the full statement in?

Senator SMITH. Yes.

Mr. MITCHELL. To continue: Which makes it possible for families to budget the cost in accordance with the ability to pay. These costs are held to a minimum through broad and compulsory coverage, avoiding the financial and related problems of adverse selection. We feel that we must set our sights upon a program that will make it possible for everybody to have ready access to adequate medical care, both preventive and curative. If, as a matter of public policy, we find it impractical to accomplish everything we want at the outset the program adopted should lend itself to growth. We should like to see dependents of insured workers made eligible for care on the same basis as for the worker. The program, to be successful, must assure high-quality services through personnel and facilities which meet reasonable standards. Remuneration for services should be such as to attract and keep high-grade personnel. Both physician and patient should be assured freedom of choice. Professional groups as well as the public should participate in determining policies, and adequate provision should be made to stimulate professional education, research, and prevention of disease and disability.

Senator DONNELL. You regard that statement that "both physician and patient should be assured freedom of choice" as quite an important commentary; do you not?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. Very well.

Mr. MITCHELL. It is recognized that present professional personnel and facilities are inadequate, both as to number and location, to assure the availability of all needed services at the present time. Thus the program should be such as to encourage training of personnel and the construction of needed facilities.

Among the alternative methods of administration we favor the joint Federal-State approach, but so arranged as to assure a thoroughly national system. State-by-State systems are not likely to be established because of interstate competition, uneven State resources, and so forth, and a completely Federal system, while feasible in many respects, would have to be safeguarded so as to assure decentralization of administration, and responsiveness to local needs, demands, and customs.

GENERAL COMMENTS ON S. 545 AND S. 1320

Detailed comments on S. 545 and S. 1320 are incorporated within the reports submitted to the committee by the Administrator and which are attached to our testimony. I wish only to make a comment or two. Of the two bills we, of course, favor the broad and comprehensive approach of S. 1320. Likewise we feel that the social insurance method as utilized in S. 1320 is definitely superior to and is more consistent with existing program than the means test system provided for in S. 545.

S. 545 provides for the establishment of a National Health Agency which would include certain activities now lodged in the Federal Security Agency. This in the opinion of the Social Security Administrations would be a mistake. I would involve the loss of the advantages which we now have as a result of having a single administrative agency responsible for many of the closely related programs in the field of health, education, and social security. Coordination of both policy

and administration would be made more complex, and the complexities would occur at a time when simplicity and consistency are more needed than ever before.

We are concerned also about the failure of S. 545 to set out standards such as would establish a sound basis for Federal-State cooperation in the administration of this program. Again we draw upon our experience in the administration of existing Federal-State programs to suggest that administration is improved and program objectives have more likelihood of accomplishment if the rules of the Federal-State relationships are set out clearly in the statute.

Some of the grant-in-aid provisions of S. 545 in our judgment are not well adapted to the needs of the program; equal matching requirements are likely to work a hardship on the relatively poorer States which are the ones most in need of Federal aid. In this respect we would recommend a system of variable grants adapted to the financial resources of the States.

As Federal-State programs of cooperation involving Federal grants-in-aid have become more numerous and have necessitated the appropriation of progressively larger sums of Federal money, the need for uniformity and consistency in Federal policy has become increasingly evident. In fact, Senator Morse sponsored a successful resolution which provided authority to make an investigation of this problem. The Federal aid provisions of S. 545 differ in many respects from similar provisions in going programs and would not in our judgment constitute a sound pattern for guiding further action in this field.

In conclusion, we commend S. 1320 to your favorable consideration. We regard it as a considerable improvement over its predecessor S. 1606, which was introduced in the Seventy-ninth Congress. Title 2, providing personal-health-service benefits through a system of social insurance, is closely related to the established field of activity of the Social Security Administration. We particularly endorse that title and believe its provisions are sound. We endorse especially the provisions which lodge very broad administrative responsibilities and discretion in the States and those which provide for coordination of the administration of health programs at Federal and State levels and for the coordination of health and social-security programs at the Federal level. We have no hesitation in expressing our judgment that the system can be administered effectively and economically. Certainly, the administration will not require anything like the fantastically large staffs estimated by some critics of the bill. Similar estimates were made by opponents of the original Social Security Act.

The financial provisions of the bill appear to be reasonable and adequate. As was the case in S. 1606, the financing of 1320 will call for separate legislation involving decisions as to the allocation of costs among the persons to be insured, their employers, and general revenues.

While we endorse the objective of S. 545 to make medical, hospital, dental, and public-health services available to every individual, we cannot subscribe to many of its specific provisions or specifications. Except as a means of strengthening existing public-assistance programs, we would regret to see provision for health services restricted to the needy or near needy. The self-supporting portion of our population also needs help in obtaining more and better health services.

Senator SMITH. I would like to ask you this question, Mr. Mitchell: Your experience with the social-security programs has been setting up

the machinery for collecting the funds and the program for distributing funds?

Mr. MITCHELL. Yes, sir.

Senator SMITH. You haven't had any experience with distributing, controlling, or handling a service? That is the thing that troubles me.

Mr. MITCHELL. The Children's Bureau has.

Senator SMITH. I want to hear from Miss Lenroot on this, but if you have a program of compulsory health insurance where the people are taxed for something they expect to get, you will have the responsibility, of course—the Government will have—of delivering the service the people expect to get. That is perfectly obvious, and that is the big problem we are wrestling with.

We feel those who favor S. 545 are on safe ground. I can't see the practicability at the moment of putting this over-all coverage on now. I don't think we could deliver the goods in 10 or 20 years.

The testimony has been that way, and Dr. Parran sees the necessity of going slowly. He wouldn't put on the over-all compulsory health insurance now. I take it from your testimony that you think it could be done.

Mr. MITCHELL. I don't think there is any specific recommendation in here on that. I have avoided that aspect of it because it is not involved in present legislation, and I recognize the fact that another committee of Congress would have to give that consideration.

It would be my belief that the problems of putting the program completely into effect would have to be very seriously considered in reaching conclusions as to the financing of it. It would be a considerable time, I am sure, before we were fully tooled up and implemented throughout the whole system to make those benefits actually available to the beneficiaries.

I would think that Congress in its wisdom would not impose a contribution that would provide the money for full service at the outset of the program, but that the financing would be graduated over a period of time and would be related to the ability of those agencies that had the responsibility for implementation to get tooled up to do the job.

Senator PEPPER. May I interpolate?

Senator SMITH. Go ahead.

Senator PEPPER. Mr. Mitchell, when you start building hospitals and training personnel you have got to have some objective.

Mr. MITCHELL. Yes, sir.

Senator PEPPER. You have got to know relatively how many people will be expected to use the hospitals and receive the services of the personnel. I think it is a fair interpretation of Dr. Parran's testimony that his view was that we should lay down the principles of S. 1320 or something like that. That is, that we are going to set up a system of medical coverage that will pertain to some 85 percent of the people of this country directly and then possibly through grants-in-aid will affect the major part of the rest of the population; and then, having declared that objective, we start out to prepare the steps by which to reach that.

We start training the personnel that can furnish medical care to that number of people—the required number of technicians and nurses and the required number of buildings and facilities, and then

we are advancing on the broad front in the provision of those facilities and that personnel.

Then, he said, as I understand him, that a year or something like that—possibly more—before we are ready to take on the load, we should be able to anticipate it, and then we should apply the tax principle and begin the payment.

Was that your general idea?

Mr. MITCHELL. Yes, sir. As a matter of fact, I have a sentence in my testimony that is just about along those lines:

Thus the program should be such as to encourage training of personnel and the construction of facilities.

Senator PEPPER. But if you build the hospitals to take care of all those people and start training the doctors, unless you devise a better method of getting that medical care through financial ability to acquire it, these hospitals will stand idle and there won't be anybody to use them. They can't pay for them unless the Federal Government money is going to give the service.

Mr. MITCHELL. Yes.

Senator MURRAY. In order to establish a system contemplated under this bill, we have got to start. We have got to first enact a bill and declare what the policy is to be and what the program is to be. Otherwise, if we undertake to wait until more doctors are educated, more hospitals built, they never will be built.

Mr. MITCHELL. I strongly agree with that point of view.

Senator MURRAY. We would be stymied.

Mr. MITCHELL. That is right. I don't think that the day of full implementation would be as long off as many people would think because we have already established basic facilities. We have wage records and have developed the techniques of the field organization and have skilled personnel.

Senator PEPPER. In other words, you could just add this tax on to the one you are already collecting.

Mr. MITCHELL. Even that wouldn't be a complication, except that more people would be covered than are under the present program.

Senator MURRAY. We have all of the facts available to us with reference to the need and to the fact that we are short of personnel and all that. We know all the facts. What we need now is to develop a program, put it into effect, and follow it up with the necessary provision of taxes and methods of paying for it.

Mr. MITCHELL. Yes.

Senator SMITH. Mr. Mitchell, if you are willing to stay a few minutes, I want to ask Miss Lenroot if she will give us her little story with a word as to the maternity and children's program.

STATEMENT OF KATHARINE LENROOT, REPRESENTING THE CHILDREN'S BUREAU

Miss LENROOT. I think it is not necessary to comment further on the need, except to stress that the place to begin in building good health among the people is in early childhood because it is in the earliest years of life, naturally, that the foundation for good health is laid. That means beginning before the child is born, in the maternity period.

Dr. Eliot and I gave testimony last year in connection with the hearings on S. 1318 and on S. 1606 with reference to that. The Congress

doubled the appropriations made available for maternal and child health and crippled children last year. Since then we have gone forward, extending services into new types of care for crippled and handicapped children and in the child health and maternity program.

Serious gaps still exist. We are reaching only approximately 100,000 crippled children each year; whereas, the number of children handicapped from serious disease is 500,000 in the case of rheumatic fever, 1,000,000 with hearing defects, 500,000 with orthopedic defects, and so on.

I want to stress that it seems to me the objectives of these two bills before us are the same, namely, to make good health services and medical care available to the people, but that there are differences both as to the character of the program and as to the timing or the comprehensiveness of the plans that may develop. There are also differences as to administrative provisions.

I wanted to comment from the point of view of the experience of the Children's Bureau with reference to the character of the program. It was in 1917 that my predecessor, as Chief of the Children's Bureau, Miss Lathrop, first proposed a public program for the care of maternity and infancy. The elements of that program still constitute the goals toward which we are striving except that the word "infancy" has been extended to include children of all ages. The fundamental concept which has characterized the work of the Children's Bureau and cooperating State agencies is that good-health services for mothers and children are not confined merely to a method of paying the bill.

In other words, it is not within the ability of either parents or individual practitioners to do all that needs to be done for children. It is not merely a matter of payment: It is a question of developing comprehensive programs which will be aimed at the health of the child and will consider all the problems of the child—whether they are medical or social in character.

This involves additional considerations. For example, we are developing special projects. Nine States have already developed such projects since last year in the case of children with cerebral palsy. To care adequately for these most pathetic children requires finding the children, good medical and psychological diagnosis, treatment centers, educational methods, good nursing and medical social service activity when required to help parents to face the problems of these children and to provide for them the very special understanding and service that is needed. The children may also need periods of care outside their own homes.

The same is true in the case of rheumatic fever where prolonged convalescent care outside the home or prolonged service in the home by nurses and social workers, as well as physicians, may be necessary.

It is something like the problems we were faced with in the development of atomic energy, that one individual or one special type of service by itself couldn't do the whole job, but that it involved bringing to a focus upon the needs of the child what could be contributed by various specialties and by the social and educational as well as the health services. Therefore, the provisions of S. 1320 for expanding the maternity and child health and crippled children's program, having in mind this comprehensive approach to the problems of the child, are of vital importance, and any program of comprehensive medical care, whether financed by insurance or by general taxation, should include provision for developing and expanding these community programs for serving children.

The second point that I want to make is that it seems to me very difficult to divide our children into two groups—that is, those economically needy and those not needy. This is true not only because of the reasons stated by earlier witnesses as to the character of the medical need, but also because many parents and children who may not be in economic need would be unable to get access to the kind of comprehensive and well-rounded program that I have outlined unless there were public facilities available.

In my opinion, we shall not succeed in providing optimum opportunity for the children of the United States for health, and certainly no country can afford to do as much to insure the health of its children, unless we are willing to proceed from the point of view of organizing comprehensive community services that will be available to all desiring to take advantage of them, with no economic barriers whatever.

As Dr. Parran had compared health and education, I would also stress the importance of a view of medical care and health services for children, which is comparable to that we now have in relation to education. In S. 545 there are two provisions which are exceedingly interesting to us. One is a provision for school health examinations and provision for dental examinations and care of those in need of dental services whose families because of economic need are not able to purchase dental care. These provisions are separate from the provision for general and maternal health services. Experience has shown in the dental programs that it is very wasteful of time, to say nothing of other problems involved, if the dentist only determines that some need exists and if he cannot go ahead and give corrective service.

The same is true with reference to the school-health program. Our chairman is one of the authors of a school-health bill pending before the Senate. The main difficulty with the school-health program in years past is not that we did not try to give examinations, but that defects found in examinations were so frequently not corrected.

Now, as to the administrative provisions. In S. 545 there are two serious problems from our point of view. The first is that the health services are taken out of the Children's Bureau and put in the new health agency. The Children's Bureau since 1912 has stood for a service to the children of the country which takes into account all of the needs of the child and brings to bear upon his needs the social as well as the health services and facilities.

It is our experience that we cannot make as much progress in any aspect of our work if the work is broken up along functional lines as if we keep these services together and have the possibility of relating what is done for the child from a social point of view and also to what is done from the health point of view. It is also vitally important that the services from the health point of view be in the same agency or department of Government which has the educational services.

Senator SMITH. There would be coordination with public school work?

Miss LENROOT. Yes.

Senator SMITH. Would this be handled from the Federal level or State level through cooperation?

Miss LENROOT. It would be on both. There has been close cooperation between the Office of Education and Children's Bureau, and also close cooperation on the State level.

Senator SMITH. I was interested to know that that increase enabled you to move forward into this area with success.

Miss LENROOT. The States are accomplishing some very interesting things. Then within the National Health Agency itself, under the provisions of S. 545, as already pointed out, the maternity and child-health functions are split between the Office of Maternal and Child Health and Office of Medical Care and the Dental Office, and that would seem to me to put in great jeopardy the services for children that were contemplated by the bill.

Although I did not want to discuss figures, since those have been presented several times before this committee and the hour is late, I want to point out that with an approach of the kind that the Children's Bureau has stood for and with the cooperation of the State agencies and the medical profession and the public, great things have been achieved. I have just been given figures which show that if the 1934 maternity and infant mortality had still prevailed in 1945 there would have been 60,000 more deaths among infants and 10,500 more deaths among mothers in that year.

However, I want to point out also that the death rate in States with the highest rates are still three or four times as great as in the States with the lowest rates, so that we still have a very long way to go.

Senator PEPPER. Excuse me. That shows that the suggestion Dr. Parran made is well-founded, that we haven't got an equal distribution.

Miss LENROOT. That is correct, Senator Pepper, far from it and we are only taking little nibbles at the problem. We could save the lives of thousands of premature babies who now die each year if we had an organized program everywhere. There again is a field where you can't just pay for care, where you have to have organized incubator service and transportation and all the other things that go into the care of premature babies.

It seems to me, Mr. Chairman and members of the committee, that we have a great advantage here in having the various proposals put before us and having the time given that you have given to receiving the views from so many witnesses from such varied fields of experience; but I hope very much that we will not have to delay very much longer in establishing a policy that we are going to do whatever is necessary to be done for the health, at least of the mothers and children of the country. We cannot go forward and assume the responsibilities that we have to assume in the world today unless we take care that the lack of efficient health services and lack of good medical care among so many of our people is corrected to the greatest possible extent. Our best hope of doing that is to begin with the children, but to expand these programs for children as fast as possible until the whole population is served.

Senator SMITH. Thank you very much. Senator Donnell, do you have anything?

Senator DONNELL. I have just a very few questions. I want to ask Miss Lenroot one question.

I didn't understand just what you said about the dental provisions of S. 545.

Miss LENROOT. I pointed out that the dental provisions emphasize dental examinations and only provide for corrective treatment for indigent children or needy children and that it is not economical to provide dental examinations for children without at the same time

being able to take care immediately of minor deficiencies and also where the need exists for extensive dental work.

I also pointed out that the dental care should be associated with a general child-health program.

Senator DONNELL. You were referring to being unable to pay the whole cost of such care in accordance with the provisions of this title?

Miss LENROOT. Yes, I was referring to that.

Senator DONNELL. I would like to ask Mr. Mitchell a very few questions. Mr. Mitchell, the statement which you have given us this afternoon, was that prepared entirely by yourself?

Mr. MITCHELL. No, sir; it was not.

Senator DONNELL. Who collaborated in the preparation of that statement?

Mr. MITCHELL. Well, staff members of the Children's Bureau and the Bureau of Public Assistance and the Bureau of Research and Statistics.

Senator DONNELL. Did Mr. Wilbur Cohen assist you on it?

Mr. MITCHELL. He sat in while going over the rough draft. I don't know if he participated in the development of the original draft.

Senator DONNELL. Who drew the original draft?

Mr. MITCHELL. I think it was the composite effort of several brains including my own.

Senator DONNELL. Do you know who provided the major portion of the statements that you have given, whose thought enters into it primarily?

Mr. MITCHELL. Well, I would say despite his absence, Mr. Altmeyer's thought enters into it to a very considerable extent because we drew heavily on his testimony of last year.

Senator DONNELL. He has been gone about 2 months?

Mr. MITCHELL. Longer than that, since about the 1st of March.

Senator DONNELL. He didn't actually help in preparing this statement?

Mr. MITCHELL. No, sir.

Senator DONNELL. Who was it that actually drew the first draft of the statement?

Mr. MITCHELL. I frankly don't know.

Senator DONNELL. You don't know?

Mr. MITCHELL. No, sir.

Senator DONNELL. At whose request was it drawn?

Mr. MITCHELL. Mine.

Senator DONNELL. Whom did you request to draw it?

Mr. MITCHELL. I asked Mr. Cohen to arrange to have it done.

Senator DONNELL. Mr. Wilbur Cohen?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. He is here today?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. He did have it done?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. Don't you think, Mr. Mitchell, that he had a great deal to do with the preparation of it himself? Didn't he tell you so?

Mr. MITCHELL. No; he didn't. Really, as Mr. Miller said this morning, I am not trying to fence. I don't know who has more words in this than anybody else. I know I have quite a few in there myself.

Senator DONNELL. Mr. Mitchell, have you studied compulsory health insurance yourself?

Mr. MITCHELL. Not in the detail that would make me an expert in the field; no, sir.

Senator DONNELL. Have you read any book on the subject?

Mr. MITCHELL. Well, I have read a great deal of literature on the subject.

Senator DONNELL. Have you read any book on it?

Mr. MITCHELL. No; I have not read a book, I don't think.

Senator DONNELL. Aren't you sure you have not?

Mr. MITCHELL. All right, I will say I am sure.

Senator DONNELL. I am not asking you to say it unless you are sure.

Mr. MITCHELL. I don't recall I have.

Senator DONNELL. You don't recall ever reading a book on compulsory health insurance?

Mr. MITCHELL. I have read many pamphlets, et cetera.

Senator DONNELL. You would probably recall it if you had read a book on the subject?

Mr. MITCHELL. I think I would, although I have read quite a few books.

Senator DONNELL. You would recall it, though?

Mr. MITCHELL. I will make the statement I have not.

Senator DONNELL. Who are the authors of these pamphlets you have read on the subject?

Mr. MITCHELL. The professional staff members of the Social Security Administration primarily.

Senator DONNELL. Which ones?

Mr. MITCHELL. But also of the Children's Bureau, who have written on the same topics, and I have read a great deal of the testimony before these committees that have given consideration to health insurance.

Senator DONNELL. Are any of these people in the departments that you refer to experts, so far as you know, on the subject of compulsory health insurance?

Mr. MITCHELL. I would say so.

Senator DONNELL. Which particular individual wrote a pamphlet that you can remember right now?

Mr. MITCHELL. Mr. Falk.

Senator DONNELL. He has been here today throughout this hearing and is here now?

Mr. MITCHELL. That is right.

Senator DONNELL. And have you ever read any pamphlets by anybody else on compulsory health insurance?

Mr. MITCHELL. Miss Klem.

Senator DONNELL. The person who testified before the House committee?

Mr. MITCHELL. Yes; and by Mr. Fisher, the subject of concern to the Committee on Executive Expenditures.

Senator DONNELL. The man considering going down to New Zealand to look over the situation?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. Are there any other persons that you have read from on other subjects?

Mr. MITCHELL. Well, there have been many others, but I don't recall their names.

Senator DONNELL. You don't recall anybody else from whose writings you have read on that subject?

Mr. MITCHELL. No, sir.

Senator DONNELL. You remember the name of the pamphlet by Miss Klem on that subject?

Mr. MITCHELL. No.

Senator DONNELL. Or by Mr. Fisher?

Mr. MITCHELL. Mr. Fisher, I don't recall the exact title, but it was on the New Zealand system.

Senator DONNELL. He has studied the New Zealand situation quite a good deal, hasn't he?

Mr. MITCHELL. Yes.

Senator DONNELL. Is he from New Zealand?

Mr. MITCHELL. No, sir.

Senator DONNELL. Has he been down there?

Mr. MITCHELL. No; he has not. He is probably, so far as I have been able to find out, probably the person in the United States that knows more about the New Zealand system than anybody else, but he has developed his knowledge through literature and through the very considerable assistance he has received from the New Zealand Legation here in town.

Senator DONNELL. Is he here today in this room?

Mr. MITCHELL. I don't think so.

Senator DONNELL. Has he been here today?

Mr. MITCHELL. I have not seen him.

Senator DONNELL. But he has never been down there to New Zealand to go over this subject down there?

Mr. MITCHELL. No.

Senator DONNELL. Has he ever written to the Christian Science Monitor on that subject?

Mr. MITCHELL. I never heard of it.

Senator DONNELL. Do you know that extensive articles have appeared in the Christian Science Monitor dealing with the various aspects of the system in New Zealand? Do you know that?

Mr. MITCHELL. No, sir.

Senator DONNELL. You have not read those articles?

Mr. MITCHELL. Not the Christian Science Monitor.

Senator DONNELL. Have you read the American Medical Association minority report, which is mentioned in your footnote? You say on page 17:

The economic and social reasons why voluntary programs have not succeeded, and are not likely to succeed, have been expressed on at least two occasions by the American Medical Association.

Mr. MITCHELL. I recall that I did read that some little time ago, but I am not responsible for the notation there and I wouldn't accept the responsibility for discussing that in any detail.

Senator DONNELL. Did Mr. Cohen put that in?

Mr. MITCHELL. I don't know. Mr. Cohen is here and can answer for himself.

Senator DONNELL. You don't know who put it in, but you remember that you have read the American Medical Association minority report; is that right?

Mr. MITCHELL. Yes, I do.

Senator DONNELL. How long has it been since you read it?

Mr. MITCHELL. It has been a considerable time.

Senator DONNELL. Well, why did you undertake to say in here, or whoever put that in, that the minority report set out why voluntary

programs have not succeeded and yet failed to mention the fact that the minority report to which you refer tells about the objections to compulsory health insurance also? Why did you omit that phase of it in this article?

Mr. MITCHELL. Well, I have already indicated to you frankly that I was not responsible for this particular point. I relied on the professional staff and their accuracy in reporting the facts.

Senator DONNELL. You have read the minority report to which reference is made here and which is set forth in the footnote under that sentence?

Mr. MITCHELL. That is right.

Senator DONNELL. Let me just read you a few sentences here from that minority report. I am quoting from "Medical Care for the American People, the Final Report of the Committee on the Costs of Medical Care," published by the University of Chicago Press, page 165 :

The objections to compulsory health insurance are almost as compelling to this minority group as are those to voluntary insurance. The operation of every form of insurance practice up to the present time has resulted in a vast amount of competitive effort on the part of practitioner groups, hospitals, and lay-controlled organizations. Such competition tends to lower the standards of medical care, degrade the medical personnel, and make medical care a business rather than a profession. Proof of this is at hand in our own experience in this country with the only compulsory system with which we have yet had to deal, workmen's compensation. The results named above are prevalent in many States. This is the rule to which there are a few notable exceptions. Under workmen's compensation groups are soliciting contracts often through paid lay promoters, laymen are organizing clinics and hiring doctors to do the work, standards of practice are being lowered, able physicians outside of the groups are being pushed to the wall; the patient is coerced by his employer to go to a certain clinic; and the physicians largely under the control of the insurance companies. These are not visionary fears of what may happen, but a true picture of widespread evils attending insurance practice. We should need no better example of what must happen to medical care if compulsory insurance is extended to families.

Why didn't you mention that minority report when it emphasizes that the American Medical Association has told the economic and social reasons why voluntary programs have not succeeded?

Mr. MITCHELL. This expressed a fact, and there was no intimation that the American Medical Association had ever indicated any approval of compulsory health insurance.

Senator DONNELL. Mr. Mitchell, you know very well, do you not, that this sentence that is set out in here, unless somebody would go and get the minority report and look it up, would leave the inference that the American Medical Association at least on two occasions had told why voluntary programs had not succeeded and wouldn't leave any inference that they have ever said anything about a compulsory program. Isn't that a fair inference?

Mr. MITCHELL. I don't think so.

Senator DONNELL. Now, Mr. Chairman, I ask leave to have two items inserted in the record. I do not have the matter at hand at the moment, but there are two authorities cited here, one of which I have read from.

Senator SMITH. Very well, they may be presented later.

Senator MURRAY. Mr. Mitchell, you assume that this testimony was for the benefit of the Senators, do you not?

Mr. MITCHELL. Yes, sir.

Senator MURRAY. You didn't think any of the Senators would be deceived by your failure to mention that, did you?

Mr. MITCHELL. I didn't have that feeling. I read this with the greatest of care to assure myself I was accurately expressing my own feelings in the matter, as well as expressing what I believe to be the policy of the Social Security Administration and Federal Security Agency.

Senator DONNELL. At the same time, you did not give to the members of the committee the information that in these two cases the American Medical Association, in at least one of them, has set forth these objections to compulsory health insurance at the same time along with the objections to the voluntary insurance? There is nothing like that indicated by this sentence, is there?

Mr. MITCHELL. No, sir.

Senator DONNELL. Now, Mr. Mitchell, who wrote that sentence? You say you didn't write it. Who vouched for that to you? Did Mr. Cohen or Mr. Isidore Falk?

Mr. MITCHELL. Neither of them. The document was prepared by the professional staff, probably a half a dozen people.

Senator DONNELL. I would like to know who is responsible for that sentence. We would like to know.

Mr. MITCHELL. I will be glad to find out.

Senator DONNELL. Can you not tell us now?

Mr. MITCHELL. No, sir; I don't know.

Senator DONNELL. Do you know any of them besides Mr. Cohen?

Mr. MITCHELL. I know Mr. Falk participated.

Senator DONNELL. You know Mr. Cohen and Mr. Falk participated?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. What other persons?

Mr. MITCHELL. I think Miss Larsen of the Children's Bureau; Miss Goodwin or a member of her staff of the Bureau of Public Assistance. Beyond that, I do not know.

Senator DONNELL. Beyond that you do not know. Very well. Mr. Mitchell, you mentioned that you regard the matter of freedom of choice, which is referred to on page 18 in the sentence, "Both physician and patient should be assured freedom of choice," as being quite an important statement.

Mr. MITCHELL. Oh, yes.

Senator DONNELL. And you would regard a system which does not insure freedom of choice both to physician and patient as subject to very serious objections, would you not?

Mr. MITCHELL. I would say so, although I don't set myself up as a qualified witness to discuss the details of the purely medical aspects of this.

Senator DONNELL. You have not studied the bill S. 1320 to determine whether there is an assurance of freedom of choice to physician and patient, have you?

Mr. MITCHELL. Yes, sir; I have gone over it and feel it does.

Senator DONNELL. Have you read the bill?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. All of it?

Mr. MITCHELL. Yes.

Senator DONNELL. Have you read S. 545?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. Who was the author of this supplement that is attached to your statement here from the annual report of the Social Security Board, 1946, pages 439 to 443?

Mr. MITCHELL. Well, the person who wrote the words, I think, was Miss Mary Ross.

Senator DONNELL. Miss Mary Ross. You mean she wasn't the stenographer, but that she was the composer?

Mr. MITCHELL. That is right.

Senator DONNELL. And is she still with the Department?

Mr. MITCHELL. No, sir; she is no longer a regular employee.

Senator DONNELL. What has become of her?

Mr. MITCHELL. She has retired to private life and is doing freelance writing, I believe.

Senator DONNELL. Have you read any other reports of the American Medical Association except this minority report No. 1 that is referred to here in this footnote?

Mr. MITCHELL. I have read at one time or another the literature of the association.

Senator DONNELL. Have you read any literature in regard to the experience in Great Britain with compulsory insurance?

Mr. MITCHELL. I have read some. I have read the Beveridge Report.

Senator DONNELL. You have read the Beveridge Report?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. Have you read anything on the Scandinavian countries' experience in that field?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. How long ago was that?

Mr. MITCHELL. A year or so.

Senator DONNELL. You don't make the contention that you are an expert in compulsory health insurance?

Mr. MITCHELL. No, sir.

Senator DONNELL. You are Acting Commissioner for Social Security and have never specialized in a study of health insurance?

Mr. MITCHELL. No, sir; I have not.

Senator DONNELL. Where were you born?

Mr. MITCHELL. I was born in Newark, N. J., but I left there in a very short time.

Senator DONNELL. Where did you go to school?

Mr. MITCHELL. In the public and high schools of Port Washington, Long Island, and then in Georgetown University in Washington.

Senator DONNELL. Did you take a degree at Georgetown?

Mr. MITCHELL. I studied foreign trade at Georgetown and then entered the United States Department of Commerce. Prior to going to Commerce I was in the insurance business at the headquarters office of Great American Insurance Co. for 4 years.

Senator DONNELL. The Great American Insurance Co.?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. Where is that located?

Mr. MITCHELL. One Liberty Street, New York City.

Senator DONNELL. Is that a health-insurance company?

Mr. MITCHELL. No, sir; everything but life.

Senator DONNELL. Everything but life?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. That is fire insurance, accident, casualty, automobile, et cetera?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. You were in that 4 years?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. You did not finish Georgetown University?

Mr. MITCHELL. I finished for the certificate, which is what I was a candidate for. That is a 2-year course and I finished that.

Senator DONNELL. You received that certificate?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. In what year did you receive that?

Mr. MITCHELL. 1923.

Senator DONNELL. Did you go into the insurance business right after that?

Mr. MITCHELL. No; I was in the insurance business after I got out of high school and then for at least one summer while I was going to college.

Senator DONNELL. So your insurance experience, then, was between the time that you entered high school and the time you left college?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. And the college is Georgetown University, as you have recited?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. What did you do right after you left college?

Mr. MITCHELL. I went with the United States Department of Commerce and I stayed with them for about 11, maybe 12 years, in several capacities. In their offices in New York, Louisville, Norfolk, Atlanta, Ga., and here and was abroad for a short time.

Senator DONNELL. You left the Department of Commerce in what year?

Mr. MITCHELL. I left the Department of Commerce, I think, in 1933 when I became the State Director for the National Recovery Administration in Georgia, and was subsequently made Regional Director for the National Recovery Administration.

Senator SMITH. Would you be kind enough to send a brief statement to the clerk of this committee concerning your subsequent experience after you went to the National Recovery Administration?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. I ask that this be set forth in the record.

Senator SMITH. Very well.

(Subsequently Mr. Mitchell submitted the following memorandum:)

I joined the staff of the United States Department of Commerce in 1923 here in Washington and subsequently served in the district offices of the Department in New York, Louisville, Ky; Norfolk, Va.; and Atlanta, Ga., respectively, as Commercial Agent, Assistant District Manager, and District Manager. Late in 1933 I transferred to the National Recovery Administration where I became State Director for Georgia and subsequently Regional Director for the seven South-eastern States. During this period I also served as State Director for the National Emergency Council.

Early in 1936 shortly after the enactment of the Social Security Act I went with the Social Security Board as Director of the Bureau of Business Management and some 3 years later was made Assistant Executive Director in which position I served until July 1946 when the three-member Board was abolished. In 1941 I was Associate Director in charge of operations of the United States Employment Service, and returned to my position as Assistant Executive Director when the War Manpower Commission was established. In July 1946 I was made Deputy Commissioner for Social Security which is my present capacity although I am serving as Acting Commissioner in the absence of Mr. Aitmeyer.

All told I have had over 25 years of uninterrupted service with the Federal Government in a fairly wide range of administrative capacities.

Senator PEPPER. I just want to ask one question of Miss Lenroot. You are not so much concerned in the method that the Congress adopts. I daresay what you are interested in is that we provide some adequate way by which the children and mothers of this country can get the medical care which their physical needs will require?

Miss LENROOT. That is right; and that it be associated adequately with other programs for children.

Senator PEPPER. But you do think that we ought to think very seriously before we sacrifice lives of mothers and children in order to save dollars?

Miss LENROOT. I do, indeed, and I am afraid of any barriers such as a means test which might tend to make it more difficult for children to get the care they need.

Senator PEPPER. It has been your experience that a means test tends to deter the receipt by people of the medical care needed—that is, women and children?

Miss LENROOT. The reports that have come to me would indicate that.

Senator MURRAY. Mr. Mitchell, the sentences which appear in your statement, and about which you were interrogated a moment ago, appear in your statement beginning at page 13. They refer to the AMA and voluntary programs, and you were there discussing voluntary insurance exclusively. Is that not true? Page 13 is headed "Voluntary Insurance."

Mr. MITCHELL. That is right.

Senator MURRAY. You were not discussing compulsory insurance, were you?

Mr. MITCHELL. No, sir.

Senator MURRAY. Exclusively voluntary insurance?

Mr. MITCHELL. That is right.

Senator MURRAY. And your reference here is to the effect that the economic and social reasons why voluntary programs have not succeeded and are not likely to succeed have been expressed on at least two occasions by the American Medical Association, and you have a footnote there showing where you got this idea?

Senator SMITH. Isn't it true that you show at the head of your statement that you are discussing both bills, S. 545 and S. 1320, and a little later in the same statement you get into the field of compulsory insurance, and it seems to me it would have been proper, as Senator Donnell pointed out, to point out that the American Medical Association found objections to that as well. Otherwise we are a little bit led astray.

Senator DONNELL. There is, just two sentences further on, the intermediate sentence being:

Experience persuades us that a comprehensive health insurance program must rest on a method of financing which makes it possible for families to budget the costs in accordance with ability to pay.

Immediately after that sentence, which is the only one intervening sentence between the reference to this voluntary program, the only sentence between that and then the next one is this:

These costs are held to a minimum through broad and compulsory coverage, avoiding the financial and related problems of adverse selection.

Compulsion was in the mind of whoever wrote that.

Senator MURRAY. It didn't mislead me. I knew that the American Medical Association is against compulsory insurance and I think every member of this committee knows that. I think the people of the country know pretty well that the American Medical Association is opposed to compulsory insurance.

Senator SMITH. If there are no further questions, the committee will adjourn until 9:30 tomorrow morning.

(Whereupon the subcommittee adjourned at 6:10 p. m., to reconvene at 9:30 a. m., Thursday, July 10, 1947.)

NATIONAL HEALTH PROGRAM

THURSDAY, JULY 10, 1947

UNITED STATES SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 9:30 a. m., in the committee room in the Capitol Building, Senator H. Alexander Smith presiding.

Present: Senators Smith (presiding), Donnell, Murray, and Pepper.

Senator SMITH. All right. The committee will please come to order. I understand that Mr. Nelson Cruikshank is here in place of Mr. Matthew Woll, vice president of the American Federation of Labor, and I will ask Mr. Cruikshank if he will come forward and give us his statement. Will you just state for the record, Mr. Cruikshank, your background and how you happen to be here representing Mr. Woll?

STATEMENT OF MATTHEW WOLL, SECOND VICE PRESIDENT AND CHAIRMAN, COMMITTEE ON SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR, PRESENTED BY NELSON H. CRUIKSHANK, DIRECTOR, SOCIAL INSURANCE ACTIVITIES

Mr. CRUIKSHANK. Mr. Woll was yesterday called back to New York. I saw him at a conference yesterday and he told me that he had sent a telegram to the clerk of the committee—I do not have a copy of that telegram—but he stated that in the telegram he authorized me to speak for him before the committee and to present the position of the American Federation of Labor.

Senator SMITH. That is all right, then.

Mr. CRUIKSHANK. I believe Mr. Rodgers has the telegram. It was addressed to him and he will make it part of the record.

Senator SMITH. We will make this telegram from Matthew Woll, vice president of the American Federation of Labor, part of the record.

Mr. CRUIKSHANK. I am presenting this as his statement and therefore it might be better to read the statement and then if the committee wishes to ask me any questions in line with the authorization given me by Mr. Woll they can do so.

Senator SMITH. I think that is all right.

Senator DONNELL. May I ask, Is this your statement or is it composed by Mr. Woll or by somebody else?

Mr. CRUIKSHANK. Well, it was prepared in conjunction with a number of people, and a draft was sent to Mr. Woll, which he corrected and made some amendments to, and then sent back, so that it is really his statement.

Senator DONNELL. At any rate, it was prepared by a number of people and a draft sent to him, and he made some corrections and sent it back?

Mr. CRUIKSHANK. So that it is his statement.

Senator DONNELL. Well, that remains to be seen, of course, whose statement it is, but did you have anything to do with the preparation of it?

Mr. CRUIKSHANK. I had some part in it; yes, sir. I believe he transmitted the copy in accordance with the rules of this committee—transmitted a copy with a covering letter stating it was his statement.

Senator SMITH. This telegram from Mr. Woll—I will read it at this point for the record. It is addressed to Mr. Rodgers, clerk of our committee:

Regret unforeseen circumstances prevent my being in Washington to present testimony on health bills July 10, as scheduled. Am asking Nelson H. Cruikshank, our director of social insurance activities, to present the position of the American Federation of Labor before Senate subcommittee. The statement presented by Mr. Cruikshank will be the same as that forwarded to you with my letter of July 3. Mr. Cruikshank has full authorization to represent position of American Federation of Labor before your committee.

MATTHEW WOLL,
Second Vice President, American Federation of Labor.

Mr. Cruikshank, will you proceed?

Mr. CRUIKSHANK. My name is Nelson H. Cruikshank and I am director of social insurance activities for the American Federation of Labor. I am presenting the following statement at the request of Mr. Matthew Woll, second vice president of the American Federation of Labor and chairman of its social security committee. Mr. Woll regrets that unforeseen circumstances prevent his appearance before your committee this morning. He has asked me to present the following statement on his behalf as representing the approved position of the American Federation of Labor with respect to both Senate bill 1320 and Senate bill 545.

Senator SMITH. Might I ask you a question, Mr. Cruikshank?

I understand from that telegram—perhaps I read it wrong—that you were chairman of the social security committee of the American Federation of Labor.

Mr. CRUIKSHANK. No, Mr. Chairman.

Senator SMITH. Mr. Woll is chairman of the social security committee?

Mr. CRUIKSHANK. Yes, sir.

Senator SMITH. And what is your position?

Mr. CRUIKSHANK. Director of social insurance activities, a staff position.

Senator SMITH. I see. Proceed.

Mr. CRUIKSHANK. On behalf of the 7½ million men and women who today make up the American Federation of Labor, I am here this morning to support the national health insurance program as proposed in S. 1320 and to register our opposition to the Taft governmental charity bill.

For several weeks now you have been listening to representatives of the medical, dental, and hospital groups give their reasons why they prefer the Taft bill, S. 545, as a means of meeting this country's great need for medical care. Is it not significant that, despite the ample opportunity given to proponents of S. 545 to present their views, not one representative of a people's group has come forward to endorse this bill before your committee?

I do not mean to ignore or disparage the remarks made by the distinguished representatives of the medical profession who appeared before this committee. Indeed, their technical opinions on medical care should be—as I am sure they will be—fully weighed and evaluated. However, I submit that as professional men, they can scarcely be considered outstanding authorities on the economic problem of how people can best pay their medical bills.

Senator SMITH. I notice all the way through here you use the pronoun "I." Is the "I" Mr. Matthew Woll or is the "I" Mr. Cruikshank?

Mr. CRUIKSHANK. The "I" is Mr. Matthew Woll.

Senator SMITH. You began by saying "My name is Nelson H. Cruikshank, and I am director of social insurance activities," and so on, and "I am presenting the following statement" and then you go on "I" in other places. I cannot be quite sure whether you are speaking for yourself or Mr. Woll.

Mr. CRUIKSHANK. You can make it "we" if you wish, but it is Mr. Woll, because he transmitted this document officially to you over a letter of transmittal bearing his signature.

Senator SMITH. All right, Mr. Cruikshank, proceed.

Mr. CRUIKSHANK. I was saying that as professional men doctors can scarcely be considered outstanding authorities on the economic problem of how people can best pay their medical bills. That is a problem that our more than 7,000,000 members and their families must constantly face. That it is a pressing problem is borne out by the fact that sickness and disability are the two most important reasons for poverty in our country, barring the problem of unemployment during severe depressions.

It is time that we do something about this problem. That is why I am here this morning: to tell you what the millions of workers in the American Federation of Labor want done about this problem. At our last annual convention in Chicago, the delegates unanimously passed a declaration in support of compulsory health insurance which reads in part:

A national system of health insurance providing health services to all workers and members of their families. Such a system should be augmented by grants-in-aid to the States out of general revenues of the Federal Government for: (1) The construction of health facilities, (2) training of medical personnel, (3) medical research, (4) expansion of public-health services, and (5) continuing and extending the present program of maternal and child-health services.

A comprehensive national program of social security must include * * * services to all workers and members of their families. * * * The need for some national action in this field is no longer denied by the opposition. The issue now is whether medical care should be extended as a charity and in accordance with public-welfare concepts or whether it should be made universally available by an extension of the insurance principle. We reaffirm our unflinching support of the insurance principle.

For the information of your committee and for the record I submit herewith a copy of the entire declaration on the subject of social in-

insurance, which was unanimously adopted by the sixty-fifth convention of the American Federation of Labor held in Chicago, Ill., last October.

(The declaration of the sixty-fifth convention of the American Federation of Labor follows:)

DECLARATION OF THE SIXTY-FIFTH CONVENTION OF THE AMERICAN FEDERATION OF LABOR—SOCIAL INSURANCE (UNANIMOUSLY PASSED AT CHICAGO, ILL., OCTOBER 17, 1946)

The principles embodied in the legislation introduced in the Seventy-ninth Congress pursuant to the declaration of the sixty-fourth convention of the American Federation of Labor (the Wagner-Murray-Dingell bill, S. 1050—H. R. 3293) are reaffirmed. The goal and objective of the American Federation of Labor remains the development of a comprehensive national program of social security for all workers not otherwise covered by an existing program, built upon the solid foundation of contributory social insurance. Such a program must include:

1. A system of insurance providing benefits based on past earnings for the aged, the survivors of deceased workers, and the permanently disabled. These benefits must be sufficient to maintain a decent standard of living without reliance on public or private charity. The coverage of the present program needs to be extended to the remaining 40 percent of workers not now protected, and the age of retirement should be lowered by at least 5 years for men and 10 years for women workers.

2. A national system of unemployment insurance providing benefits based on past earnings and with minimum benefits adequate to maintain for even low-income workers a decent standard of living. All involuntarily unemployed workers, including those unemployed by reason of temporary disability, should be eligible. The administration of such program should be the responsibility of the United States Department of Labor.

3. The reestablishment within the United States Department of Labor of an adequate national employment service.

4. A national system of health insurance providing health services to all workers and members of their families. Such a system should be augmented by grants-in-aid to the States out of general revenues of the Federal Government for: (1) The construction of health facilities, (2) training of medical personnel, (3) medical research, (4) expansion of public-health services, and (5) continuing and extending the present program of maternal and child-health services.

5. A unified public-assistance program providing grants-in-aid to the States adjusted to the relative needs of the States in order to provide more equitable assistance to all needy persons.

Your committee recommends that the committee on social security work with the president of the American Federation of Labor in preparing and submitting to the Eightieth Congress legislation designed to meet the above-stated needs and objectives. In the preparation of such legislation special care should be exercised to see that in the development of policies and in administration it provides for full participation of the representatives of the workers covered by the program.

The growing interest in and increasing public support for inclusive health insurance of the kind sponsored by the American Federation of Labor requires that special attention be given this phase of the program. The extensive hearings on the federation's health-insurance bill (S. 1606—H. R. 4730) resulted in a great increase in public understanding of the proposal. The need for some national action in this field is no longer denied by the opposition. The issue now is whether medical care should be extended as a charity and in accordance with public welfare concepts or whether it should be made universally available by an extension of the insurance principle. We reaffirm our unflinching support of the insurance principle.

Your committee recommends that in addition to the safeguards written into the earlier health-insurance proposals, such as those protecting the right of free choice of physicians, the following provision be included in any health-insurance legislation: (1) A specific requirement that local agencies be given the maximum amount of control possible in the operation of the program, (2) provision for the continued operation of all such existing health programs that can provide suitable medical services, such as those developed by labor organizations, by cooperatives, and by other voluntary groups, and (3) maximum participation in local admin-

istration of the program by both the medical profession and by those who represent the recipients of medical care.

The Hospital Survey and Construction Act passed by the Seventy-ninth Congress requires the appointment of a hospital advisory council in each State. Your committee recommends that each State federation of labor be urged to take steps immediately to secure representation on these important State councils.

Pending the enactment of legislation establishing a comprehensive national social-security program there is much that needs to be done within the States to improve the present unemployment-compensation programs and the employment services. Your committee recommends that the splendid efforts of the State federations of labor to amend their State laws in accordance with the four specific standards adopted by the sixty-fourth convention be continued.¹ We recommend that in addition steps be taken in the States to provide the following: (1) To free the State employment services from policy control by the State unemployment compensation agencies, (2) benefits to workers whose unemployment is due to sickness or other disability. (This is especially pertinent to the 10 States where funds can be made immediately available from employee contributions—only 2 of which now pay such benefits.)

The State federation of labor and members of our affiliated unions who serve on State unemployment compensation commissions or advisory boards can render invaluable assistance to the national program by demanding that their respective State administrators cease the lobbying activities against the social-security program of the American Federation of Labor which they have been carrying on in the National Capital either as individuals or through the Interstate Conference of Employment Security Agencies.

We recommend for the favorable consideration of all national and international unions, State federations of labor, and city central bodies affiliated with the American Federation of Labor that social-security committees be appointed in each of these affiliated organizations for the purpose of assisting in the promotion of the social-security program of the American Federation of Labor.

WORKMEN'S COMPENSATION

While the ultimate goal of the American Federation of Labor is a comprehensive, unified system of social insurance, it is recognized that workmen's compensation—the oldest of the social insurances in America—is embodied in separate State laws. These laws vary widely in the protection they afford wage earners and a review of their effectiveness is long overdue. The American Federation of Labor favors for all States—

1. Compulsory insurance under workmen's compensation laws, covering all workers without exception.
2. Coverage by exclusive State funds, eliminating the profit motive from a program designed to give protection to workers and their families.
3. Minimum weekly benefits sufficient in amount to support the worker and his family during incapacity due to injury without his having to rely on additional aid from public or private charity. (Present maximum benefits of \$15 to \$20 per week existing in many States fail to meet this standard.)
4. Full coverage for every type of industrial disease with no lesser payments in cases of disability from disease than from injury.
5. Effective enforcement of accident-prevention laws and regulations by every available means.
6. The establishment of workmen's compensation committees in each State federation of labor which, with the aid of competent legal experts, will study their State laws and assist in carrying out the above principles by (a) proposing and supporting legislation to improve their laws; (b) keeping in touch with workmen's compensation commissions to see that administration is on a high level and the rights of workers protected, (c) cooperating with the United States Department of Labor and with the American Federation of Labor in creating more uniformity in the workmen's compensation laws and eliminating special provisions which favor employers, such as reduced amounts for silicosis cases, unusual proof for hernia cases, waivers, etc.; and (d) cooperating with rehabilitation agencies.

NOTE.—The four standards relating to State unemployment compensation laws referred to on page 2 and which were adopted by the sixty-fourth convention are as follows:

¹ Standards referred to are appended to this declaration.

1. That the present limitations existing in some States on coverage by the number of employees employed in an establishment or by an employer be removed.
2. That maximum unemployment benefit payments be increased to \$25 per week.
3. That the maximum period for which benefits can be paid to eligible workers be raised to 26 weeks.
4. That the restrictive disqualification provisions which prevent workers who are involuntarily separated from their employment from drawing benefits be modified so as to remove the penal provisions from the State unemployment insurance systems and restore the traditional freedom of workers to change their employment.

Mr. CRUIKSHANK. Here are copies of that, Mr. Chairman, if you wish to have them.

This action of the convention is not the first evidence of interest in this subject or of support for the enactment of health insurance. The concern of the American Federation of Labor and its affiliated bodies with matters of health goes back for over 40 years when our State branches began to consider enactment of workmen's compensation laws. We have likewise been vitally interested in the health aspects of the work place and in the living conditions affecting our workers and their families as evidenced by our long struggle in behalf of sanitation laws and for better housing.

In the convention of the American Federation of Labor held in 1938 there was adopted a resolution brought forward by the California State delegates favoring national health insurance. Significantly that same year the Wisconsin federation brought forward a resolution condemning the position of the American Medical Association in opposition to voluntary health insurance plans. Both of these resolutions were adopted by the convention of the American Federation of Labor.

In 1939 again the American Federation of Labor convention adopted a statement submitted by its executive council endorsing national compulsory health insurance.

Again in 1941, 1942, and 1944 the convention adopted resolutions favoring the establishment of a national health-insurance program. There was no convention held in 1945 due to wartime conditions and in 1946 the convention adopted the declaration which I have submitted for the record.

The Taft and Murray bills have this in common: They recognize the great need existing for medical care in our country today. They also recognize that a major reason for inadequate medical care is the people's inability to pay for it. But there the similarity ends.

The Taft bill seeks to meet this need by offering the American people Government charity. In a country that always prided itself on the virtues of independence, and self-reliance, this is, to say the least, a surprising solution. Even though we disagree with Senator Taft's estimates he has asserted that his bill would provide medical care on the basis of proven need to about one-quarter of our population. If we were to accept the American Medical Association's statement made in 1939 that people with incomes under \$3,000 cannot afford comprehensive medical care, then the goal of Senator Taft's bill would be to provide medical care through a Government dole to the greater part of our population. Taking into account the decline in the value of the dollar, a \$3,000 income in 1939 had the same purchasing power as a \$4,500 income today. Applying the AMA estimates to people

earning less than \$4,500, it would mean approximately 90 percent of our families at present need some financial help in securing comprehensive medical care.

Section 2 (c) of the Taft bill proposes that it shall be the policy of the United States—

* * * to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status * * *

Does this mean that Congress is prepared to commit itself to a program of state medicine through the Taft bill? Since when have we come to admit that our economic system is such a failure that no solution can be found to furnishing needed medical care except by providing charity to 90 percent, or even Senator Taft's estimate of 25 percent, of our population? The American Federation of Labor rejects that solution as being completely unacceptable and incompatible with our American tradition.

We recognize there are times when public assistance is a necessity as in the case of people who for one reason or another are without income and unable to meet the daily living expenses of food, clothing, and shelter. For this group of indigents public assistance is essential to provide not only daily necessities but also whatever medical care is needed. Both the Taft bill and Murray bill have made provision to help States carry on their current programs for these unfortunate people. At most, this group constitutes only about 4 or 5 percent of our population.

Indeed, the present appropriations as set forth in the Taft bill are just about adequate to this care of this small section of our population.

It is in the treatment of the medically indigent that the major disagreement between the two bills arises. By medically indigent we mean those who are able to pay for the daily necessities of life, but cannot finance completely the costs of catastrophic illness. It is impossible to define this group according to income. A man making \$2,000 a year may not be considered medically indigent if he and his family manage to get through the year without any illness. A man, however, making as much as \$10,000 a year may find his current income spent and his savings exhausted if he and his family should run into a siege of serious illness.

Since such a person does not become medically indigent usually until a catastrophic illness occurs, it then is too late to enroll him in a voluntary plan. Whether a means test would require a family to use up its savings or to draw on its credit at the bank before receiving aid under the Taft bill are questions we should like to have answered. To date no adequate explanation has been put forward of how the means test will or can be applied to determine medical indigency. Yet this is the pivotal point upon which the Taft bill revolves.

The fallacy in the Taft bill lies in the assumption that medical expenses can be met by the individual on the same basis as the predictable costs of food, clothing, rent, and so forth. Indeed, Senator Taft made such a comparison when he testified here before you on the first day of the hearings. To treat these types of family expenditures the same way is to ignore the fundamental fact that most of us are unable to budget in advance for our individual medical expenses because of their unpredictability.

Although unpredictable for the individual, it is possible to estimate how much sickness will occur in a given year for the country as a whole. The solution to our problem thus becomes self-evident. Each individual contributes, together with his employer, a small percentage of his income each year into an insurance fund. With the risk spread over a large enough group of people, it is possible to provide comprehensive insurance against the costs of medical care at a reasonable sum for any one family. The fact that doctors and the people alike have accepted the voluntary medical insurance plans is proof that the insurance principle is workable.

The problem then becomes one of leaving medical care to voluntary plans or instituting a national insurance fund. Granted that voluntary plans have recently shown a rapid growth, the fact still remains that less than 3 percent of our people today get anything like comprehensive medical care under such plans. Little, if any, emphasis is placed on preventive care in the majority of voluntary plans available to the public today. Moreover the premium rate charged by voluntary plans for limited services makes the costs of the services received beyond the bounds of what many of our lower income groups can afford to pay. The temptation not to carry insurance or to drop it if one has had a fairly long period of good health leads to an adverse selection of members under voluntary plans. Although voluntary plans can and are playing an important part in our Nation's health program they offer little hope as the final answer to our overall health needs.

Considering how well accepted our social-security program for old age and survivors' insurance is today, I have never been able to understand the furore that is being raised by certain small groups over the proposal that insurance against the costs of medical care be financed by a similar pay-roll tax. Surely the principle of social security is well enough recognized today that charges of "fascism," "socialism," and so forth, can be dismissed as completely irrelevant. In analyzing the criticisms against pay-roll financing of a comprehensive national health-insurance system let the arguments be measured against our other social-security programs of old-age and survivors insurance and unemployment compensation in determining their validity.

In considering other arguments against national insurance, I hardly need point out to this committee that such a label as "socialized medicine" is mischievous and untrue when applied to the Murray bill. One suspects that opponents have deliberately mislabeled S. 1320 in order to turn the public against the bill before it has even had time to consider the bill's provisions. Such tactics are not fair play, and show a fear on the part of opponents to meet the issues of the bill on their merits. Under an insurance system any charge of socialization reveals either a woeful ignorance of the provisions of the bill or a real misunderstanding of the term "socialism."

The criticism that the Murray bill will lead to centralization and bureaucracy is worthy of more consideration. The proponents of the bill were well enough impressed with this danger, as brought out in the hearings last year, that they revised their bill to provide for

greater decentralization. Under the new provisions of the bill, it is stated that—

it is the intent of Congress that the benefits provided under this title be administered wherever possible by the several States. * * * (Pt. D, sec. 241.)

States in turn are required to submit a plan of operation which, among other minimum requirements, must provide for decentralized administration in designating local health-service areas and in selecting members of local area committees.

Part D, in effect, provides for decentralized control but not at the expense of lowered medical standards. Providing minimum Federal standards is extremely important where Federal Government funds are involved. Experience with the operation of unemployment compensation and the employment service has shown the wisdom of maintaining some kind of Federal standards to protect State systems from becoming the tools of certain special interests.

Critics of S. 1320 have also pointed out that given our present facilities and medical personnel, it would be impossible to provide comprehensive medical care to everyone in the country at this time. This admission on the part of the medical profession is a major victory for those of us who have been concerned for a long time about the shortages in the field of medicine. We agree that we need more doctors, more dentists, more nurses to do a thorough job. But we should also respectfully like to point out that the only way we are going to get more doctors is to train more; the only way we are going to get more hospitals is to build them. We have seen no indication on the part of the American Medical Association leadership that having recognized the shortages, they are undertaking a major campaign to remedy the situation.

It was during the war that the AMA came to Washington to argue convincingly before a Senate committee that premedical students should be exempt from the draft because of the serious shortage of doctors anticipated in the postwar period. Now that the war is over and the shortage is all too apparent, why hasn't the AMA continued to fight with the same vigor to keep the medical schools from cutting down their wartime enrollments? The fact that under the pressure of war the medical schools were able to turn out 7,000 extra doctors is proof that, given a little time, we could lick our postwar shortage. Yet look what is happening. According to Albert Q. Maisel in the May 7 issue of *Colliers* magazine, medical schools, with only a few exceptions, are cutting back to peacetime enrollment and continuing their policy of discriminating against admitting students from certain groups in our society.

Senator DONNELL. Have you seen that issue of *Colliers*?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. Have you read that article?

Mr. CRUIKSHANK. Yes, sir.

If AMA were to give the same kind of vigorous leadership in the fight to establish more medical schools and to increase student enrollment that it has in combating national health insurance, it might now have some positive contribution to its credit.

Despite the over-all shortage, immediate enactment of a national insurance program could still help to lessen the severity of the doctor shortage in certain areas by bringing about a better distribution of doctors. With 80 to 90 percent of our population able to pay its medical bills through the insurance fund, doctors could then afford to practice in the more isolated and poorer sections of the country. Hospitals, likewise, could be built in those areas, once the people were able to pay their own way. The alternative offered in the Taft bill of subsidizing doctors in economically poor areas is far less satisfactory in that people would still have to depend on charity for whatever medical care they need. It would also prove a perennial drain on the Nation's budget to subsidize these doctors year after year.

Despite the testimony of some doctors before this committee, workers are not satisfied with insurance that covers only their hospital bills and the medical care they receive while in the hospital. Together these two items make up far less than one-half of their total medical bill. Workers want comprehensive coverage, to include preventive, diagnostic, and curative care—without having to worry about the financial cost of keeping healthy. Until we can divorce medical care from the immediate ability to pay we will not have overcome our problem. The Taft bill still places its main emphasis on ability to pay in keeping healthy. The Murray bill offers the practicable alternative of paying insurance and spreading the costs of medical care over a lifetime and among millions of family groups.

Today the principal opponents of a national health insurance system are the spokesmen for the medical profession. This is not to overlook the fact that a number of doctors have declared openly, and many more off the record, their strong support of the Murray bill. Looking at the past record of prepayment plans, to group medicine, and its later reversal of its stand on these issues, perhaps it is not too much to hope that the pressure of public opinion will again bring the leadership of the A. M. A. to see the merits of a compulsory health-insurance system.

We sincerely hope that this will come about. But whether or not it does, we think it unwise if Congress lets the opposition of less than 1 percent of our population stand in the way of what millions of workers earnestly want, namely, a self-respecting method of maintaining their health and that of their families.

Senator SMITH. I think we all agree that, as you said in there, what we are trying to bring about is what they want. The question is, What is the practicable way to do it?

I would like to ask you this question: Suppose a worker in a factory has his pay roll compulsorily reduced by whatever the percentage may be—1, 2, or 3 percent, according to the approximate purpose—what do you visualize he is expected to get for having that taken out of his pay check every week? What is he to get in the way of service? I am not talking about money now. I do not want to get mixed up now the difference between a money return from a man contributing to a social-security fund to a certain degree, and a service. I am asking you now what service will that worker expect to get?

Mr. CRUIKSHANK. That would all depend, sir, on the terms of the legislation under which the pay-roll deduction was made.

Senator SMITH. You are asking for medical coverage. You are saying that the voluntary plans are not adequate. I admit they are

not adequate up to date, have not been worked out in the way they could be adequate. We have had lots of testimony that it would be very hard to work out any kind of insurance plan that would give over-all coverage at any time that a person has an ache or pain and sends for a doctor and then the doctor comes and gives him a pill. I mean there is danger, you see, in trying to generalize on this. We want to get a sound solution of it. There is no question about the sincerity of your statement, no question about your wish to do this, no question about our desire to do it; what we are trying to find out is a practical way to do it so that when a man makes a payment compulsorily of money taken from him whether he wants to pay it or not, he certainly wants to know what he is going to get. How are you going to organize it so he will get it? If you answer me and say, "We are going to give him so many dollars per week while he is sick," that is one answer, but that is not the purpose of this bill. The purpose of the bill is to give a service and have the Government of the United States guarantee the service.

Mr. CRUIKSHANK. That is right, sir, and that is what we support, but the expectancy of what the worker would expect to get would be the terms of the legislation enacted, and those terms would, of course, prescribe the amount of the pay-roll reduction, and they would also describe and set forth the amount of service and kind of service that the worker would expect.

Senator SMITH. In S. 1320 is that laid down? I have not seen it in any of these bills. We have not even claimed to be able to express those terms in S. 545. Where is it laid down in S. 1320?

Mr. CRUIKSHANK. Medical service is defined in S. 1320, and there it is defined in a very comprehensive way, which is the bill which we should hope to have enacted. We support a three-way financing; that is, we believe that it should be supported by a contributory insurance system on the part of the worker, also on the part of the employer, because the employer has derived a benefit from the healthy work horse, and the general public, a contribution out of the general revenues of the Government because there is a general social value deriving out of a healthy worker and a healthy population, not only in terms of national defense and emergency, but in terms of production, in terms of the whole operating economy. I think the bill S. 1320 sets the method by which it can very practically be brought about.

Senator SMITH. And you think that the Government of the United States should fulfill the responsibilities that apparently will be placed on it by S. 1320, without any further clarification?

Mr. CRUIKSHANK. I have unbounded confidence in the ability of the Government, my Government, to bring about a program and to administer efficiently this plan. I know there are people who do not have that confidence, but I do.

Senator SMITH. Even without having it experimented on a smaller scale? You would have national coverage in one fell swoop?

Mr. CRUIKSHANK. We have never been very successful in so-called experiments by States. States lag behind the Federal Government almost always. We had, for example, unemployment compensation for almost 100 years. We had it first in 1850; not quite 100 years in Europe. In 1933 only one State in the United States, after 83 years of a chance to experiment—only one State had taken the opportunity to

experiment, and even its law was not operative until after the Federal Government acted.

Senator SMITH. Of course that is a matter of judgment as to the wisest way to deal with it by a method of trial and error.

Mr. CRUIKSHANK. That is a matter of historical fact, the history of our Government, in our Nation, with respect to social legislation. We never had child labor law protection until we had the enactment of the Fair Labor Standards Act.

Senator SMITH. We also had, when the framers framed the Constitution of the United States, a vivid picture of what might happen if the Government controlled everything in the center, and decentralization of authority in Government was one of the principles written into the United States Constitution. We have two conflicting political theories behind those two ideas, one of which has the view that the Federal Government should do everything in the total fields.

I am one of those who believe that we profit by trial and error by the States. They ought to be the ones that undertake it. I am willing to have the Federal Government come in and participate, as S. 545 does, and give grants-in-aid to the States, but I want to say to them: "Your problems are the problems of your States. Now, work that thing out and give us the benefit of your experience." And then let the next State do likewise, and by that process in time we will get a better solution than by having a few people sit down, because they may have theories, and write a complete blueprint for the whole country and put upon the country by compulsion in one complete piece of legislation.

That is the difference that I am trying to argue with you. I am not interested in your attack on the means test, because they are both means tests that way. The pay-roll tax is a tax, and the means test is applied, because those who can pay more, pay more; those who can pay less, pay less. I have no quarrel with that. That is the fundamental principle in all social insurance. I am sure that is all right. I am sure I have no objection to that, but don't call it "insurance." It is not insurance; it is a tax for total coverage.

Mr. CRUIKSHANK. I disagree with you entirely, Senator, for all the history of development of social insurance the world over is of that kind, even in private insurance, a field of insurance that carries workmen's compensation and provides medical care.

Senator SMITH. What I was trying to say is—and I don't want to get into a discussion of insurance principles, because I disagree with you—that pay-roll taxes for any form of insurance are just straight taxes. Those who pay less get just the same treatment as those who pay more, but an insurance principle provides for a premium to cover what the table shows that the cost of doing a certain job is.

Take life insurance, for example. The person gets a certain coverage. Everybody pays exactly the same as the next person, and we don't have the premium based on whether you can pay more or can pay less. This proposal is not a real insurance principle. Any insurance man will tell you that. It is not an insurance principle. I am not quarreling with it except I do not want it to be called an insurance principle and the other called a "means test" when in principle they are just the same.

Mr. CRUIKSHANK. Senator, I should have to respectfully disagree with that opinion for the record, as vigorously as possible, because

when we say "social insurance" we are consciously modifying the fact of the words "social" and "social insurance," though it does hinge on some aspects that are comparable to private insurance, it is still social insurance, and the world over today is accepting the concept of social insurance, and when one says "social insurance," that has a very definite concept in the terminology of social students the world around.

Senator SMITH. I am glad you mentioned that for the record—put the word "social" in—because you are talking about something different from ordinary life insurance and ordinary accident insurance, or any other kind of insurance.

You speak of it in the ordinary sense, and that is what I want to bring out—that distinction—that social insurance is a pay-roll tax, for example, on everybody to take care of some people.

Mr. CRUIKSHANK. However, I would like to point out that there are other insurances that render services other than tax-paid. Workmen's compensation is one of them, paid partly in cash and partly in services. There are others even in the private field.

If I belong to the American Aid Association, I get service and not cash for my coverage, an unpredictable kind of service—repair of my car in the event of accident. So that there are, even in the private insurance fields, areas in which service is rendered rather than cash payment.

Senator SMITH. I am not questioning that fact. I am just saying that I want to have you make it clear to us when you speak of this pay-roll tax, as I recall it, to take care of over-all coverage, that you are not speaking of a fund that will pay so many dollars to a person to get this medical coverage; you are speaking of a fund that will bring about some kind of service from the Government in some way, somehow, organizing the medical profession under the direction of the Federal Government to give the service that the Government undertakes to buy.

Mr. CRUIKSHANK. Yes, sir.

Senator SMITH. And if the doctors are unwilling—and the Government is not going to try to compel them to do it—if they are unwilling to do it, the question comes up, What kind of organization shall the Government set up to provide medical care that they have undertaken to provide when they accept the compulsory tax? Those are difficult problems that appear to me to be in the picture that we have got to think through very carefully before we pass this particular legislation.

Mr. CRUIKSHANK. We can't think them all through in advance, but we have tried to anticipate them.

Senator SMITH. For example, you want tomorrow to pass a pay-roll reduction tax, compulsory on everybody in this country, without being prepared the same day to furnish the service that that person would properly expect if that deduction were made?

Mr. CRUIKSHANK. Yes; that is, we will anticipate, and we have frequently discussed the fact that it would probably be necessary to have a difference in dates from the time of the application of the deduction plan and the payment of the services.

Senator SMITH. Then you mean you would contemplate a period of time during which you will educate doctors, build hospitals, prepare the country to take over this program?

Mr. CRUIKSHANK. Yes, sir.

Senator SMITH. How many years do you think that would take?

Mr. CRUIKSHANK. That we do not know, but it would have to be worked out constructively with those responsible for the administration of the services—and I emphasize “constructively.” It could not be worked out by just name calling.

Senator SMITH. No; let us get away from name calling. I am really trying to get an answer. I am not concerned with your attack on the AMA, nor the attack of the AMA on your position. I do not care anything about that. What I want to get at is just how you would do it. How would you pay for the education of the medical profession to bring them up to the necessary numbers, and for all the hospitals and for all the development of the Public Health Service that Dr. Parran so well advocated yesterday, in the interim period before you begin to collect the money by this tax plan?

Mr. CRUIKSHANK. The bill S. 1320 provides a system of grants-in-aid which is pretty well spelled out in detail. So is the method of payment spelled out. That would depend upon the development of such programs by the doctors themselves, through their advisory committees.

The payment for the construction of hospital facilities and health centers, we think of this bill gearing in very definitely with the Hospital Survey and Construction Act passed by the last Congress.

Senator SMITH. Any bill that we pass will gear in with that, of course.

Mr. CRUIKSHANK. But we pointed out at that time that we felt one of the great deficiencies of that bill taken alone, although we supported it fully, we did point out at that time that one of the deficiencies of the bill was that it required, in its plan of operation, a showing of the ability to continue the operation and payment locally on the part of each of these facilities that were built under an approved State plan, and we pointed out that in some of the areas that needed it most, needed the facilities most, you could not get them because they were the very areas that could not carry on the operation of a hospital program after this facility was built, and a health insurance program would very definitely dovetail right into that and meet that deficiency in the construction program.

Senator SMITH. How long do you figure it would take to get all this national organization set up before we would be justified in compulsorily taking money from all of our workers, and their expectation that they were going to get adequate medical service? How many years would it take?

Mr. CRUIKSHANK. I would not want to venture a guess. I do have this experience, though, that I have usually, in judgments that I have made on matters of that kind—underestimated the ability of this country to meet a need. I confess I was one of those who thought that the President's program in 1941 of 50,000 airplanes a year was fantastic. In 18 months we were turning out 75,000 airplanes a year.

Senator SMITH. I admit all that, but I am still compelled to say that you have different modifications. You had a war condition then, where you have a peace condition now, and you have certain resistances that you must overcome.

Mr. CRUIKSHANK. I think that is very fortunate if that is true, Senator, if we cannot gear facilities and the enterprise and good will

of all people to meet its health needs as effectively and as heroically and as enthusiastically as we can gear it for war, it is a sad situation.

Senator SMITH. I grant that that is true, but in war your Chief of Staff has to determine what the program is and say "This is the program. Everybody is geared to that program to save the country."

Now, you have a situation where there is a difference, and a legitimate difference of opinion as to the best way to accomplish the purpose. I am just as anxious to see national health established as you are. I do not yield to anybody on that. I am the son of a physician and I have lived in the whole atmosphere of health, and yet I can legitimately differ with you that this is the only plan, that we should immediately pass that plan and force everybody to accept the law, until we have educated our people to be able to accept the plan. We will not do it with just a piece of legislation, and when you say you cannot predict the number of years ahead, how can Senator Donnell and Senator Murray and I predict the number of years before we can put the tax into effect?

Mr. CRUIKSHANK. I believe it would be entirely possible if this bill were to be enacted today or tomorrow, to draw into the Government the voluntary expertness and ability of people, construction people, laborers, physicians, hospital administrators, and others, who would be able to develop a plan of program, and be able to set goals which would answer the questions precisely.

Senator SMITH. That is exactly what we have tried to do in the spirit of S. 545, that is to say to every State that has this problem, "Study this problem and give us a report on your solution. Show us how you are progressing from year to year. We will give you grants-in-aid today and we want your imagination, your ingenuity, your decentralized point of view, to be put on this problem," and not try to bring out a complete set-up all at once.

Mr. CRUIKSHANK. S. 545 just subsidizes the State programs, without any standards, and spends Federal money without any standards.

Senator SMITH. I don't want Washington to determine the standards. We have stated objectives in S. 545. Now, it is up to the States to use their ingenuity and decentralize the thinking of this country to say to the State of Washington, to the State of Delaware, "Do a little thinking independently and work this thing out." That is what we are trying to do in S. 545, and I think that is the right approach to the problem, to use 48 laboratories and not one; and not say that because they have not discovered this, that, or the other thing before, they are no good. Otherwise, we are going to move to a more centralized government in this country, and while I do not share the view, and I do not call it "socialized medicine," that is the direction of socialized medicine.

Mr. CRUIKSHANK. S. 545 does other things, too, with the means test.

Senator SMITH. I am giving the philosophy of S. 545 as distinguished from the philosophy of S. 1320. That is all I am trying to point out. I will sit down with you gladly and say, "Well, S. 545 with respect to this and this and this is not perfect." We do not claim it is perfect.

Senator Murray is very certain in saying he knows his bill is not perfect. He wants it to be improved. That is why he is here, why we are trying to get advice on either of these approaches.

Mr. CRUIKSHANK. Physicians themselves have appeared before this committee and registered many objections to S. 545, and significantly, some of their outstanding objections are those relating to the very objectives of the programs.

Senator SMITH. Well, that is an opinion, of course. Generally speaking, you have two different approaches, and that is what we are trying to get light on. I will not pursue that further. I just wanted to bring out that difference, and I will ask Senator Donnell if he has any questions. I appreciate very much, Mr. Cruikshank, your approach and your support and your answers. I think you have helped clarify what this difference in view is in approaching it in this manner. It has been very valuable to us.

Senator DONNELL. Mr. Cruikshank, what study have you personally given to the subject of compulsory health insurance?

Mr. CRUIKSHANK. Senator, I try to be cooperative with the committee, and I will answer your question but in answering it, I should like to say that I do not think it is relevant, because I am not here—

Senator DONNELL. If I can interrupt you on that, if there is anything more relevant than that, I would not know what it is. You come here advising this committee and expressing the views of 7,500,000 people, telling us what we should do and what we should not do, and when I ask you what study you have made of the subject yourself, you tell us it is not relevant. Of course, you will answer this question.

Mr. CRUIKSHANK. If you ask me, sir, as you just have, what is more relevant, I will tell you.

Senator DONNELL. Well, the question that is asked you is, What study have you personally give to the subject of compulsory health insurance?

That is a question that is relevant and proper, and you will please answer it.

Mr. CRUIKSHANK. I have been studying and reading various items and articles for the past several years on the matter. I first became acquainted with the matter of social insurance when I was a member of the Governor's mission in the State of Connecticut to set up the old-age and survivors' insurance program, or, as it was then called, the State old-age pension, in 1934.

Senator DONNELL. Now, you say you studied items and articles. Have you ever read a book by anybody on the subject of compulsory health insurance in any country in the world?

Mr. CRUIKSHANK. I have read books, yes; and I would be glad to submit the names and authors and publishers of some of those books if you wish.

Senator DONNELL. Let us get them right now.

Mr. CRUIKSHANK. I do not recall just the names now.

Senator DONNELL. Give us one.

Mr. CRUIKSHANK. It is an irrelevant question, sir. I am here, Mr. Senator, to talk about the thing in which I am most competent, and that is the need and the experience of the people who are members of our unions for health insurance. On that I am expert, and on that I will present the opinions of the American Federation of Labor.

Senator DONNELL. I will ask you, sir, if you will tell us the name of one book that you have ever read.

Senator MURRAY. Mr. Chairman, the witness has answered him and I do not think his question is relevant.

Senator DONNELL. Will the Senator allow me to state my question?

Senator SMITH. Just a minute. Let us hear the question.

Senator MURRAY. I know, but I want the record to show that I am objecting to this course of browbeating the witness. I think it is unfair and I think it is absolutely wrong. [Applause.]

Senator DONNELL. Mr. Chairman, I want this man from the CIO here admonished that there is to be no applause in this room. He showed himself a year or so ago before this committee.

Senator SMITH. If there is any disorder of any kind in this room, we cannot conduct the hearing with that kind of demonstration.

Senator MURRAY. Mr. Chairman, we had a couple of women here the other day who listened to the course of examination of witnesses and then refused to go on the stand. I do not think it is good, sound legislative method when you bring a witness here who has already stated that he is not an expert in one field, that he is here for another reason, to continue to insist on his answering the questions which he says are not in his field.

Senator SMITH. Senator Murray, let me just personally, as chairman of the subcommittee—it seems to me if the witness is appearing here as he says he is, as director of this program for the A. F. of L., and he is making very distinct recommendations that we adopt the program of compulsory health insurance, I think it is entirely relevant for Senator Donnell to ask him what he knows about the subject that he is recommending we legislate on. I think we are entitled to ask any witness who comes in here what his background is to qualify him to testify on the provisions of a bill which certainly calls for very far-reaching effects, and if we cannot ask the witness' qualifications, I think our whole hearing might as well be adjourned.

I think it is perfectly proper. There is no browbeating in asking a question of a witness as to what his background is in this particular field. I think it is perfectly proper questioning and you can ask the same questions of other witnesses, and I have heard them asked many times of witnesses on the other side.

Senator MURRAY. We have never tried to browbeat and bulldoze the medical profession but an effort has been made to connect up with socialism or communism in some fashion every witness who has come here so far who appears to represent the working class. We have not treated the medical profession in that manner. We could very well, when representatives of the American Medical Association were on the witness stand, have asked them disrespectful questions.

I do not ask questions like that. I do not think that such a course is fair. I would not do it. I would not stoop to such tactics.

The gentleman has been very courteous. He has been very fair in his statement here. He says that he is not an expert in that field. He is here for a different purpose entirely, and I do not think it is fair for this committee to undertake to browbeat him and bulldoze him in the manner in which the hearing is proceeding at this time.

Senator DONNELL. Mr. Chairman, I certainly resent the use of any such term as "browbeat" or "bulldoze" and I want to say this, that if I cannot ask this witness a question as to what he knows about the subject of compulsory health insurance—which is the subject matter of S. 1320 with respect to which he comes here in advocacy of—he says "I am here this morning to support the national health program

as proposed in S. 1320"—if we can't ask him what he knows about that subject, we have certainly arrived at a very useless function of this committee. I not only shall ask him that, but I am going to continue on that line of questioning until I find out whether this witness does know anything about it.

Senator MURRAY. Let me say for the record now that the witness has already stated very clearly what he knows about compulsory insurance.

Senator DONNELL. He hasn't shown very much knowledge of it yet, and I want to find out what he knows.

Senator MURRAY. That is all right. He has stated what he has read on the subject. He has stated what he knows about it, and he has stated what his experience has been. Now why is it necessary to go any further when he says he does not recall at this moment what particular books he has read, but says he is willing to furnish the committee with a statement containing the books or pamphlets that he has read, if the committee requires it?

Senator DONNELL. Mr. Chairman, I respectively submit that the Senator from Montana is too good a lawyer not to realize that we have a right to cross-examine this witness and not to have an ex parte statement filed here 10 days after this hearing, without opportunity for cross-examination.

I renew the question, sir. Can you tell us the name of any book by any author on compulsory health insurance in any country in the world that you have ever read?

Senator MURRAY. I object to the question on the ground that he has already answered and this is mere repetition, redundant and filling up the record with unnecessary verbiage.

Senator SMITH. I will ask the witness to answer Senator Donnell's question.

Mr. CRUIKSHANK. I do not believe that I can. First let me say this, that the Senator's question is not directed to what he stated is his purpose, asking a person—

Senator DONNELL. The question that I have asked, Mr. Chairman, does not call for a comment by the witness on the Senator. I am asking him a question as to the name of any book he has ever read.

Mr. CRUIKSHANK. The purpose of the Senator was to find out what I know. Why don't you ask me questions about social problems?

Senator DONNELL. I want to say that this witness is not here to admonish this committee. I am asking him a question as to what books he has read. If he can't tell us, let him say so; if he can, let him say so.

Senator MURRAY. Mr. Chairman, as an American citizen, I submit that this witness is entitled to make a statement of what he understands the question to be, and I think he has a right to make any statement he wishes in connection with this matter, and I do not think he should be interrupted and stopped as he has been here. He should be allowed to complete any statement he wishes to make at any time. He is an American citizen. This is not a star-chamber proceeding.

Senator SMITH. I think the witness can make his statement. Go ahead, sir. Make your statement, but I would like to have you answer Senator Donnell's question.

Mr. CRUIKSHANK. I shall address myself to the question, sir; but I should only like to point out that asking a person what he has read is not the way to find out what he knows. I could have brought in—

I heard you ask that question before, and I could have brought in a list of books and filed them for the record here and it would not mean anything. If you wish, sir, to find out what I know about social insurance, ask me questions about social insurance, not what books I have read.

Senator DONNELL. The question is: What books have you read?

Mr. CRUIKSHANK. I am not required to read any.

Senator DONNELL. Mr. Chairman, I object to this witness undertaking to refuse by indirection to answer this question. If he cannot answer it, let him say so.

Senator SMITH. I think that Senator Donnell is entitled to have the question answered. We will not get anywhere with these hearings unless the witnesses answer questions.

Senator MURRAY. Mr. Chairman, I am getting tired of these proceedings, too. I think it is a disgrace to submit American citizens to a cross-examination of this kind. The witness is a gentlemanly, courteous, mild witness, trying to give this committee the benefit of his knowledge and experience, and this cross-examination is not designed to bring that out. It is to try to discredit him, try to impute that he has not any knowledge or understanding of the problems of compulsory insurance, and the witness says he has, and that he wishes they would ask him what he knows about compulsory insurance.

Senator DONNELL. I renew my question as to what books by any author on health insurance in any country you have ever read.

Mr. CRUIKSHANK. Social Security in the United States by Stewart.

Senator DONNELL. Wait a minute. Social Security in the United States?

Mr. CRUIKSHANK. Again I am not sure of the exact title.

Senator DONNELL. That is the title, substantially?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. What Stewart is that?

Mr. CRUIKSHANK. I believe it is Maxwell Stewart.

Senator DONNELL. Does it contain anything about compulsory health insurance in the United States?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. Have we ever had compulsory health insurance in the United States?

Mr. CRUIKSHANK. It discusses the subject thoroughly.

Senator DONNELL. All right, that is one book.

Mr. CRUIKSHANK. I have read the Beveridge report. I have read a great many pamphlets and publications of various governmental agencies. I have read some of the reports of the New Zealand Health Agency.

Senator DONNELL. What have you read by the New Zealand Health Agency?

Mr. CRUIKSHANK. That is the point. I do not recall exactly what the title and the number of the pamphlet is. I have read the reports published by their agency.

Senator DONNELL. What agency?

Mr. CRUIKSHANK. The agency that administers the health-insurance program in New Zealand.

Senator DONNELL. Do you remember the name of that agency?

Mr. CRUIKSHANK. No; not by exact name.

Senator DONNELL. Approximately?

Mr. CRUIKSHANK. Well, the Ministry, or something like that.

Senator DONNELL. Health Ministry of New Zealand? Any other books?

Mr. CRUIKSHANK. Not that I can list right now. I can send you some. But may I say this, that I have spent a very short time in each land. I have conferred with people in the British Government who were responsible for health-insurance administration and programs. I have contributed to medical journals including the New York Medical Journal, in an article entitled, "What Labor Expects of Medicine."

I have addressed various sections of the American Medical Association. I have addressed various State medical associations in their conventions, and for about 2½ years I was in charge of the administration of the medical-care program here in this country.

Senator DONNELL. Where was that?

Mr. CRUIKSHANK. Under the Farm Security Administration, and Director of Migratory Labor Camp Programs, which also had the responsibility for the administration of a health program.

Senator DONNELL. Have you ever read the book by Mr. I. S. Falk entitled "Security Against Sickness, a Study of Health Insurance"?

Mr. CRUIKSHANK. No, sir.

Senator DONNELL. You have not read that published in 1936 by Doubleday, Doran & Co.? Do you know Mr. Falk?

Mr. CRUIKSHANK. Yes; I know Mr. Falk.

Senator DONNELL. Now, I would like to find out just a little something about your statement.

Senator MURRAY. Before you leave that, Senator, I would like to ask the witness, have you attended the hearings of the Senate Committee on Health Insurance at different times?

Mr. CRUIKSHANK. Yes, sir.

Senator MURRAY. Have you read the testimony in the record of the many witnesses?

Mr. CRUIKSHANK. Oh, yes; I read the complete record of the hearings of this year.

Senator MURRAY. Have you access to the American Medical Journal?

Mr. CRUIKSHANK. Yes; I have read it.

Senator MURRAY. You have read those articles on compulsory insurance?

Mr. CRUIKSHANK. Yes, sir.

Senator MURRAY. And they have helped you to form an opinion?

Mr. CRUIKSHANK. Yes, sir.

Senator MURRAY. That is all.

Senator DONNELL. Mr. Cruikshank, in regard to this statement, I just want to find out just who it is that really is responsible for the statement which you have given here this morning.

Mr. CRUIKSHANK. Mr. Matthew Woll is responsible for the statement.

Senator DONNELL. I would like to go into that, please. Who wrote the statement as it was originally drafted?

Mr. CRUIKSHANK. At that point, Senator, I will raise vigorous objection. Let me say this: I have come here with the thought that this committee, as so very kindly explained by the chairman, is a committee that is searching for ways in which it can make recommendations to the Congress as to a means of meeting our admittedly serious health

problem in this country. To my knowledge, I have not committed any crime. I want to be as helpful as I possibly can, but the searching question as to who pushes the pencil or punches the typewriter in making a statement which has been transmitted to us over the signature of the second vice president of the American Federation of Labor does not matter. And on that I will stand.

Senator DONNELL. Mr. Cruikshank, there was no request of you to tell the name of the person who pushed the pencil or punched the typewriter. I want to know who composed this statement. You presented the statement here. You answered the question of the chairman, saying that where the pronoun "I" appears it may be understood as "we." Now, I want to know something about who is responsible for the preparation of it, who prepared it. I am not asking who wrote with the pencil, or who punched the typewriter. That was not the question at all. What I want to know is who composed the statement. I respectfully ask you to tell us.

Senator MURRAY. Mr. Chairman, I understood that the witness stated that he was submitting this statement for Mr. Matthew Woll and that he was offering himself as a witness as to that for cross-examination, and to give the committee the benefit of his knowledge and advice and experience in connection with the problem that is before us. It seems to me wholly irrelevant who prepared the various parts of the statement. If the statement as completed has been adopted by Mr. Woll as his statement, then it becomes Mr. Woll's statement, no matter who participated in the discussions that led to the final drafts.

Senator DONNELL. Mr. Chairman, this statement expresses opinions—says, "I have never been able to understand the furor that is being raised," and so forth. I hardly need point out to this witness "I this" and "I that." I want to know who the "I" is, whose thoughts are in this document. That is why I am asking this witness, and he understands the question, I think, very clearly.

I would like to find out first who participated in the first step toward the preparation of this statement, what particular individual.

Mr. CRUIKSHANK. Mr. Senator, I think it is clearly stated in the paper itself that the signer of the statement is presenting the views and opinions of the American Federation of Labor, and as a part of that we submit a program that was adopted by the democratically elected delegates to the convention of the American Federation of Labor, and he shows how the statement gears into the program adopted by it.

Now, in using the first person singular, it is simply a grammatical device, but is all modified by the fact that in the opening part of it he clearly states that it is presenting the opinions and position of the American Federation of Labor and its members.

Now, who formulates—when you ask me a question, I could ask, who wrote the question for you? It might be Dr. Shearon.

Senator DONNELL. It might be, yes.

Mr. CRUIKSHANK. But it is your question, sir, and I answer it then, as yours.

Senator DONNELL. I have no objection to answering the question as to who wrote it, Mr. Cruikshank. I am now—

Mr. CRUIKSHANK. I might also ask who helped him write the questions, but I will not, because that is not relevant. When you ask a

question as a Senator of the United States, it becomes your question, and I address myself to it. When Mr. Woll submits this in accordance with the provisions and the rules of your committee over his signature, 72 hours in advance, it becomes his statement.

Senator DONNELL. Mr. Chairman, I asked him this: Who took the first step toward the presentation of this statement? What particular individual took that step? That is the question I asked the witness, and I will ask him to answer it.

Mr. CRUIKSHANK. I hesitate very much to appear discourteous, but as a means of registering my objection to that kind of questioning and to the relevancy of it, I shall not answer until subpoenaed by the rules of the committee.

Senator DONNELL. In other words, you decline to answer the question?

Mr. CRUIKSHANK. I do, sir, on the ground of its being irrelevant.

Senator MURRAY. I might add that the statement itself speaks for itself, and it is not necessary to state who took the first step in preparing this statement.

It shows right on the face of it that it is the statement of the American Federation of Labor, and this man comes here is a spokesman, a representative of that organization. I think he should be not humiliated as he has been here.

Senator DONNELL. Mr. Chairman, if there is any humiliation, I see no basis for it. This gentleman has come here to testify. He has presented the statement. He says he has presented it at the request of Mr. Matthew Woll. He says that Mr. Woll has asked him to present the statement in behalf of Mr. Woll. I have asked this witness to tell us who prepared this statement and who took the first step on it. It is perfectly relevant, perfectly proper. This purports to express certain exceedingly important opinions, experiences, observations. The man, woman, or whoever it was who sent it announces that he has never been able to understand certain things, makes criticisms of the American Medical Association, and here we are precluded by the answer of this witness who undertakes to determine the relevancy of questions to ascertain whose views these are.

I am going to ask you some more questions. Did you have anything to do with the preparation of this statement yourself?

Senator MURRAY. I object to that as repetitious.

Senator DONNELL. All right. I will withdraw that question.

Senator MURRAY. It has been asked several times.

Senator DONNELL. I will withdraw it in that form, but I am going to ask you: What part did you have, if any, in the preparation of the statement?

Mr. CRUIKSHANK. I think that is the same question, Senator. Let me say this—not to appear to be hiding behind anything—if there are any parts of this question as to the contents or connotation that you would like to ask me about, I will be glad to address myself to the content of the paper.

Senator DONNELL. I will ask you whether you prepared the third paragraph of this paper?

Mr. CRUIKSHANK. That is exactly the same question, sir.

Senator DONNELL. Mr. Chairman, is this witness here to answer questions, or to tell the committee what questions the committee has

a right to ask? I am inquiring of this witness right now whether you propose to answer questions or not.

Mr. CRUIKSHANK. Mr. Chairman—

Senator SMITH. I see no harm in the witness answering the questions. If you cannot answer them, say you do not know; if you are willing to answer them, say so. That is another matter. You are not under subpoena. There is no way to compel you to answer the questions.

Mr. CRUIKSHANK. I would really prefer to answer them. I mean it would be easier.

Senator SMITH. I think it would be better to answer them. I do not see why all this fuss about answers to questions.

Mr. CRUIKSHANK. I do not answer them because there is implication of their relevance, and I am not subscribing to that implication, and I do not subscribe to it.

Senator SMITH. I do not think it is proper for the witness to determine the relevancy of a question, if he can answer the question.

The Senator has a perfect right to ask him in a hearing like this. I think the witness should answer. It is no concern of his as to the relevancy.

Senator MURRAY. I suggest that the witness read that third paragraph and then undertake to answer it to the best of his ability.

Mr. CRUIKSHANK. If you wish the position of the American Federation of Labor with respect to the opinions expressed here, I think I am as thoroughly acquainted with it as anybody you could call in here.

Senator DONNELL. Mr. Cruikshank, the question was—which you understood just as clearly as I understand it—whether you prepared or had anything to do with the preparation of the third paragraph of this statement, the paragraph which begins with the words “for several weeks now.”

Mr. CRUIKSHANK. Yes, I did; but I did not write it.

Senator DONNELL. Who wrote it?

Mr. CRUIKSHANK. Mr. Chairman, I feel this: I am in charge of a certain office in the American Federation of Labor. I am given certain responsibilities. How far does this have to go back? I have, under objection, agreed that I had a part in the preparation of this paper. I have gone, under objection, into agreement to a specific paragraph. Then it comes to just exactly what the Senator said he was not interested in at first, Who pushed the pencil and punched the typewriter?

Senator DONNELL. That is not the question I am asking. I am asking you who composed that paragraph. Did you compose it?

Mr. CRUIKSHANK. Let me tell you now. No; I did not.

Senator DONNELL. Who did?

Mr. CRUIKSHANK. Let me tell you how these things are developed. First there is committee action. There is a policy committee on social security in the American Federation Labor and I submit this as being very relevant to the question as to how these statements come up.

Senator SMITH. Go ahead. I would like to know how it is done.

Mr. CRUIKSHANK. The policy committee meets, and certain proposals are put before them. I occupy a staff position similar to that

of an executive secretary of the committee. Certain proposals come up, sometimes certain specific legislation in various forms. We go over them. Certain policies are developed. We make notes on those policies. We do not usually have a stenographic report. Then in regard to certain positions and policies we are directed, I, as director of social-insurance activities, and very often the people who are economists, who are in charge of research and education, sit in on those committees.

We prepare draft statements. They are adopted by the committee. Then they are referred by the committee, as this was, for example, adopted and developed in just that way—referred by the committee to the convention. The convention refers it to a committee.

Senator DONNELL. You are referring now to the resolutions adopted in Chicago?

Mr. CRUIKSHANK. Yes, sir. Then that is referred to a committee on resolutions, who report favorably or unfavorably upon it. It is discussed from the floor and then passed much as any other democratic organization.

Now, when it comes to the preparation of a thing like this, Mr. Woll, being an elected official and in a policy-making position in the American Federation of Labor, in two capacities, second vice president and chairman of the social security committee, is informed by telephone from Mr. Green that he is asked to appear. Mr. Woll writes or calls or telegraphs us and asks if our various offices—in this case, my office—if we will prepare something which he can look over in time for him to look at it. I get in touch with our research offices, and we have a little meeting. We discuss certain policies. We start with this.

Senator DONNELL. By "this" you mean the resolution adopted at the Chicago meeting?

Mr. CRUIKSHANK. Yes. We recognize that we had to make the statement for Mr. Woll in line with the adopted policy of the American Federation of Labor. Certain parts of it are given over to certain people. They are brought back. They are geared together. They are placed side by side. The grammatical construction and so forth are tempered in the best of our ability to make them presentable, and when we finally get it to the point where I, or the director of research, go over it—which, in this case we both did—it is then forwarded to the person who makes the declaration, makes the statement. He makes such amendment or changes as he considers necessary. He sends it back. It is duplicated and mimeographed in our office, and he signs it and it becomes his statement when he signs it.

Senator DONNELL. If I may interrupt you, who is the director to whom you referred a moment ago?

Mr. CRUIKSHANK. Research and education, Miss Thorne. Now, we all participated in this thing, and Mr. Woll participated in it.

Now, the detail as to who prepared a certain paragraph, that would be almost impossible to say, because they are mulled over and rehashed and revised, and developed in kind of a group consultative process.

Senator DONNELL. I think that is a very helpful and courteous response and it gives us a clear idea of how it is done.

May I ask you—you said earlier in your testimony, in response to one of my questions early this morning, that there were five or six persons who cooperated in the preparation of this statement.

Now, would you tell us, please, who those persons were, by name?

Mr. CRUIKSHANK. The people that are responsible for it are myself and Miss Thorne, because we are responsible for two different offices.

Senator DONNELL. But I mean, Mr. Cruikshank, the names of the persons who are responsible, outside of yourself.

Mr. CRUIKSHANK. The staff people's statements become our statements, and as we present them to Mr. Woll, they become his statement when he corrects it and revises it and sends it back to us.

Senator DONNELL. What I asked was, the names of the persons.

Mr. CRUIKSHANK. I do not recall—I do not know all of them because I do not know what part exactly Miss Thorne farmed out in her office, certain parts of it.

Senator DONNELL. I will not push that further. Do you know Ida C. Merriam?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. She is connected with the staff of Mr. Falk, is she not?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. Did she assist in the preparation of this statement you presented.

Mr. CRUIKSHANK. Definitely not. This did not go out of our own possession.

Senator DONNELL. Do you know Miss Peggy Stein, Washington representative of the Nation's Health?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. Did she cooperate in the preparation of this statement?

Mr. CRUIKSHANK. Not to my knowledge. Possibly some one from my staff has talked to Miss Stein at some time. I do not know that they did or did not, in the preparation of this statement.

Senator DONNELL. Do you know a person by the name of Glen Slaughter?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. Did Glen Slaughter attend a certain meeting called by Mr. Isidore Falk and held on December 10 and December 11, 1946, being a conference of a labor research group of some 37 organizations?

Mr. CRUIKSHANK. He attended at my request. I was out of the country at the time, and he attended at my request.

Senator DONNELL. He attended at your request, and he was present during the presentation of the various matters which were discussed at that time?

Mr. CRUIKSHANK. I think he was.

Senator DONNELL. Have you read those proceedings?

Mr. CRUIKSHANK. I have looked them over; yes, sir. I do not believe I have read all of it, or every word, but I have glanced over them when I got back to this country.

Senator DONNELL. Do you remember, among other things, that Mr. Falk, in opening the meeting of December 10, 1946, at 2 p. m. had this to say:

I want to take only a minute or two to draw certain contrasts between the two major pieces of legislation, the Wagner-Murray-Dingell bill and the Taft bill.

As against the Wagner-Murray-Dingell approach as a contributory insurance plan, the Taft bill approaches to the problem of providing medical care are through selective public charity.

The second contrast I would draw between them is that the Wagner-Murray-Dingell bill has a national approach, the use of State and local administrative agencies for the administration of a system which is basically national. The Taft bill provides a basically Federal-State approach.

Did you read that portion of those proceedings?

Mr. CRUIKSHANK. I believe I did; yes, sir.

Senator DONNELL. And you know, as a matter of fact, do you, from your study of the proceedings of that conference held on December 10 and December 11, which was issued in a booklet for use of members of the Labor Research Group and Staff of the Social Security Administration, not for general distribution, bearig this title, "Summary of Proceedings of the Conference of the Labor Research Group, December 10 and December 11, 1946, Federal Security Agency, Social Security Administration, Bureau of Research and Statistics"—you know that that document, the primary text that runs through it is opposition to S. 545 and advocacy of S. 1320, and that most of these proceedings relate to compulsory health insurance? You know that, do you not?

Mr. CRUIKSHANK. I did not detect that as I read it.

Senator DONNELL. You did not?

Mr. CRUIKSHANK. No, sir. I looked at it as an analysis of bills. I know that the Social Security Administration is directed by Congress to make a continuing study of the extension of our social insurance system.

That was a compromise that went back to 1935, when social security was first ventured into by this country, and a recognition that we were not going as far in the development of a social security program as other agencies have, and therefore we gave this agency responsibility for continuing study in this field.

Now, if they had not continued the study of various proposals, they would not have been carrying out the mandate of Congress.

Senator DONNELL. Mr. Falk, you know, is with the Bureau of Research and Statistics of the Social Security Administration?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. Do you regard the provisions of S. 1320 in regard to the free choice of physicians by a patient as an improvement over S. 1606 in that regard?

Mr. CRUIKSHANK. Well, I think it spells it out further. Let me go back again to the statement which I submitted for the record and from which I quoted this morning, and call to your attention the third paragraph on page 2. This is the declaration of the American Federation of Labor:

Your committee recommends that, in addition to the safeguards written into earlier health-insurance proposals, such as those protecting the right of free choice of physicians, the following provision be included.

Senator SMITH. May I ask you where you are reading that?

Mr. CRUIKSHANK. Beginning with the third paragraph on page 2 of the declaration.

Senator DONNELL. The statement made in Chicago.

Senator SMITH. That is this resolution. I have the wrong document. I see it now.

Mr. CRUIKSHANK. In addition to protecting the right of free choice of a physician, the committee recommends that the following provision be included:

(1) A specific requirement that local agencies be given the maximum amount of control possible in the operation of the program; (2) provision for the continued operation of all such existing health programs that can provide suitable medical services such as those developed by labor organizations, by cooperatives, and by other voluntary groups; and (3) maximum participation in local administration of the program by both the medical profession and by those who represent the recipients of medical care.

When our social security committee looked over a copy of S. 1320 they examined it specifically with reference to that recommendation of the convention of the American Federation of Labor, because if S. 1320 had not met those standards, the committee would not be in a position to endorse S. 1320, but it was their opinion and vote of the committee that it did represent those standards, did reflect those standards, and therefore was acceptable to them, including the free choice of physicians.

Senator DONNELL. Mr. Cruikshank, I wonder if you think that the items of additional provisions which are advocated in the paragraph from which you have read, referred to in the Chicago proceedings, relate to the right of free choice or if at issue, a subject matter over and above the right of free choice of physicians?

Mr. CRUIKSHANK. It is over and above.

Senator DONNELL. It is additional subject matter?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. What I want to get at is, do you think that S. 1320 is an improvement over S. 1606 in the matter of the right of free choice of physician? If so, why do you think so?

Mr. CRUIKSHANK. Well, my recollection is that as we examined it we thought it was. Now, just exactly in what particulars I do not at the moment recall.

Senator DONNELL. However, you have reached the conclusion that it is an improvement?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. I must not take much more time here this morning, but you were referring to some language along the line that the experience with State handling of these matters of a social nature had been rather disappointing, the States were lagging behind, were slow—something to that effect—I may not quote you with accuracy. I hold in my hand a publication, a reprint No. 2685 from the Public Health Report, volume 60, No. 52, December 28, 1945, pages 1551 to 1564, entitled "Notes on Compulsory Sickness Insurance, 1939 to 1944."

This is written by Adela Stuke, assistant statistician, United States Public Health Service. Do you know Miss Stuke?

Mr. CRUIKSHANK. No, sir.

Senator DONNELL. I call your attention, and I would like to have it in the record, this language near the conclusion of that article by Miss Stuke, entitled as I have indicated:

Undoubtedly there are many and varied reasons for enactment of so little compulsory sickness legislation in the States. It is often difficult to ascertain why certain bills are treated with either open opposition or complete indifference, but some of the reasons for the lack of enthusiasm displayed in the States for

legislation of this type are revealed in the several reports mentioned earlier in this paper. A brief summary follows:

(1) Passage of compulsory sickness insurance legislation would be an entering wedge into the field of compulsory budgeting of personal expenditures and would amount to "an infringement on an individual's liberty."

(2) During the present emergency people have been encouraged to buy war bonds, thus building up cash reserves, and there should be relatively few who will be unable to care for themselves for some time to come after the war.

(3) In spite of much employment and higher incomes, the burden of taxation is already so great that both workers and employers can ill afford to pay for additional insurance.

(4) Group insurance plans between employers and employees and private hospitalization plans especially designed for the low and middle income groups have developed at a phenomenal rate, thus lessening the need for compulsory insurance.

(5) State legislation may be retarded in some States because of uncertainty concerning possible Government centralization of all types of social insurance including a new Federal program of permanent and temporary disability.

On the whole, it appears then, that although more States are becoming cognizant of the possibility of compulsory sickness insurance as a means of protecting individuals who become ill or temporarily disabled, most State legislatures have as yet been hesitant to take positive action.

I call attention to the fact that this is issued by the United States Government Printing Office, Washington, 1946, and on the inner fly-leaf appear this words—

Federal Security Agency, United States Public Health Service, Thomas Parran, Surgeon General, Division of Public Health Methods; G. St. J. Perrott, Chief of Division, United States Government Printing Office, Washington, 1946. For sale by the Superintendent of Documents, United States Government Printing Office, Washington, D. C. 25. Price, 5 cents.

Mr. Cruikshank, I observe among others mentioned there by Miss Stuke, the statement that the burden of taxation is already so great that both workers and employers can ill afford to pay for additional insurance. Have you studied the probable cost of placing S. 1320 into effect?

Mr. CRUIKSHANK. Well, I have made some study of that. As a matter of fact, last year we introduced into the record in the hearings on S. 1606 quite a complete study of the cost, anticipated cost, and I assisted in the preparation of that study.

Senator DONNELL. I take it—if I am wrong, please correct me—that you would agree that it is not, in your judgment, likely that the amount of the total cost would be derived from the pay-roll tax alone? In other words, I take it you would agree that, in addition to the pay-roll tax, there would be a contribution made from the general revenue of the United States Government?

Mr. CRUIKSHANK. Yes, sir; that is our position.

Senator DONNELL. For instance, I note in the publication which Dr. Shearon has just handed me, and which was issued by the American Enterprise Association, proposal for health, old-age and unemployment insurance, a comparison with 1943 and 1945, and back here in an article by Earl E. Muntz appears this sentence near the close of it on page 64:

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.

May I ask you, Mr. Cruikshank, whether or not your study would enable you to express an opinion as to the correctness of the percentage therein mentioned?

Mr. CRUIKSHANK. Yes, sir; they are completely erroneous to use a polite word, and last year we introduced—that thing was presented to us last year, and we introduced an analysis of those figures. We showed how erroneous they were and they are in the record of the hearings on S. 1606.

Senator DONNELL. I am glad you called attention to that.

Mr. CRUIKSHANK. I would like to comment, though, that much of this discussion on costs is not very realistic because many of the opponents of health insurance, when they discuss cost discuss it as if it were a net additional cost; that people now in some way or other are paying or meeting their medical bills somehow or other, and they spend between 4 and 5 billion dollars a year on it.

Now, if we just share that kind of cost and do as the Good Book says, "Let the strong bear the burdens of the weak," and thus fulfill the law of Christ, we are on the health insurance basis; we are not adding to the whole over-all cost. But many of these presentations, such as that of Muntz, indicate that they are net additional costs, which they are not.

It is a different method of bearing the same costs.

Senator DONNELL. Are you sure that Mr. Muntz takes that position?

Mr. CRUIKSHANK. That position is implied through there. I mean it is one of the assumptions of his analysis.

Senator DONNELL. I quite agree with you, Mr. Cruikshank, that there is a certain amount of expense already incurred. Of course there is. I do not mean to say that the expenditure under the Government insurance would be entirely a brand new additional amount. I do not mean that at all and I would be very much surprised if Mr. Muntz in this book says such a thing, and I call attention to the fact that Mr. Muntz as stated here is from New York University. I do not know whether he is a member of the faculty or not. Perhaps you know whether he is?

Mr. CRUIKSHANK. He was at one time. So was I, as a matter of fact.

Senator DONNELL. Did you know Mr. Muntz when you were there?

Mr. CRUIKSHANK. No, sir.

Senator DONNELL. As compared with the 50 percent which he estimates would be required by way of Federal subsidy, by which I take it he means contributions from the general revenue, in place of that 50 percent, are you able to give us at the present moment, from your recollection, the percent you think would be more accurate?

Mr. CRUIKSHANK. No; I do not recall just now. It has been about a year ago. But it is all in the record. We made a complete analysis of that statement and filed it with the committee. That is here.

Senator DONNELL. I am glad you mentioned that, and it will be borne in mind by our committee.

Senator SMITH. Is there any change in the picture you put in last year? Can we check those with your present conclusions on this phase, very important phase of the whole picture?

Mr. CRUIKSHANK. I believe so; yes, sir. I do not recall offhand that we would make any fundamental change in that analysis.

Senator SMITH. I would be happy if you would look at the record at your convenience and if there are any changes I would like you to make them for us and send them to us for the record.

Mr. CRUIKSHANK. I will be glad to do that.

Senator SMITH. If you have a revised version of that same study.

Senator DONNELL. I can join in that suggestion, which I think is an excellent suggestion and I am very glad to have it. Do you recall, Mr. Cruikshank, who it was that presented evidence on this, whether it was you personally or someone else?

Mr. CRUIKSHANK. Mr. Green testified, and he was asked the question. I accompanied him as consultant when he testified. He was asked the question on cross-examination, and he made some general statement and then offered to file an analysis of cost, which he did.

Senator DONNELL. That is what you referred to?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. Thank you very much, Mr. Cruikshank.

Senator SMITH. Just one more question. I hope that in this revised statement, if you file one, you will bring out for us—I would like to know your estimate of the over-all cost, and I agree with you it is probably being paid today, a good part of it, but your theory is to change the instance of the cost from this group to this group, so that everybody bears the expense of taking care of this over-all health need?

Mr. CRUIKSHANK. That is right, sir.

Senator SMITH. I would like you to show in your figures what you think that total cost—how much of it you think could properly be borne by the compulsion pay roll tax reduction, and how much could be borne out of general taxation. Those are differences I would like very much to see.

Mr. CRUIKSHANK. However, in any comparison we have to point out that there are a great many hidden costs. There are the unmeasured costs of the lack of preventive care, for example, because I do not think it is ever possible to determine them. There are other hidden costs that might be dug out. They are contained in specific, individual cases.

For example, there are a number of cases that I have known of where people in emergency cases have had to go to the hospital, and they are kept waiting at the entrance office, the admission office of the hospital, and sometimes they are kept waiting where there are internal hemorrhages or an appendix about to burst, or something very serious. We had a fellow here not long ago who fell off a truck and was hit. He was not admitted into the hospital. He was put into the broom closet of the hospital, so he would not be on the records of the hospital because he lacked identification. His coat was on the truck from which he had been knocked, was picked up off the sheet, no identification was on him, and they did not know who would pay the bill, so for about 24 hours he was left in the broom closet of the hospital.

Senator SMITH. Where was that?

Mr. CRUIKSHANK. New York—that is a little bit off the subject—but the point I am making is that many times people are kept waiting in the admission office, the outer office of the hospital, until it is determined who is going to pay for the bill. Sometimes it is at night, but the fellow has to go out and mortgage his automobile or mortgage his household goods or go to a loan shark, and I know case after case where people are paying 36 percent a year interest on bills, hospital bills, and some of them have been paying them now for 8 or 9 years, and have paid back the principal several times, for some hospital bill that they had to meet in an emergency. That is the cost of medical care under the present system but it does not show up in the figures.

Senator SMITH. And is a very serious charge and if you have a book and page that you can give us for the record, I would like to follow that up. I would like very much to know if any hospital is doing the things you talk about, because my experience has been with those that I have known, hospitals in New York, that they take care of emergency cases, bring them right in, and if you have evidence to the contrary, I would like to know it.

Mr. CRUIKSHANK. It happens every day.

Senator SMITH. I would like to have some cases of it, because I know people connected with hospitals in New York that would like to have that evidence.

Mr. CRUIKSHANK. It happens all over the country, so far as I know.

Senator SMITH. A story like that might get wide credence. Naturally, it is a very terrible thing and we want to be very careful that we know just how much of that is done. It ought certainly to be followed up and I would like personally to know about it.

Senator MURRAY. Could you furnish us with a statement on that?

Senator SMITH. I would like to have it for the record and if you will give us a number of sample cases in important cities like New York, Washington, D. C., Baltimore, Philadelphia, Boston, I would like to have it in this record to show that that sort of thing is being done. I would like to follow it up.

Senator MURRAY. I think there are probably thousands of people in the country that would contribute some information along that line.

For instance, I think that very few people of fair means have not had the experience of being required to be good for the payment of an operation. I have had that experience, where a person was taken to a hospital and was held there until they contacted me and had my assurance the bill would be paid.

I think that is a common experience in the United States.

Mr. CRUIKSHANK. Well, as a matter of fact, looking back to our old former figure in the administrative program, where I was in charge of the migratory labor program section—that is where we started our health program—the poor people, the people that produced our food are confronted with an emergency, a case of a delivery of a child, and the camp manager would call up a doctor—what I am saying is not a charge against the doctor, because he had to make his living too, and we are in favor of his getting his fee, but before he would come out he would have to know who was going to pay the bill. We had hundreds of babies delivered by midwives and amateurs without benefit of a doctor, because we were not able, until we established that program, to assure the doctor of his being paid for his services, and that is why we had to set up that kind of program.

Senator SMITH. I am not speaking for the doctors.

Mr. CRUIKSHANK. It happens with both doctors and hospitals.

Senator MURRAY. You cannot expect doctors to provide medical care to everybody who comes along. I know in my State of Montana the doctors in one of the counties have left because they were unable to make a living. Finally there was only one doctor left in the county and he told me that it was impossible for him to remain any longer. He had a family and children to support and he was compelled to move out. That was in a part of the State that was hit by the drought and the farmers there had been unable to make a living for a couple

of years, and this doctor had been unable to receive pay for his services, and naturally, he could not remain any longer.

That condition of affairs can be found in many sections of this country. I think every witness who has come here has testified that the doctors have tried to do the best they could. They have been very wonderful in giving assistance to unfortunate people who are hit with sickness suddenly or have an accident, and so forth, but there is a limit to which they can go. It seems to me that it is no reflection on the medical profession to have a bill of this kind introduced. Nevertheless the American Medical Association has always taken the position that there was no great problem in this country. They even opposed voluntary insurance to start with, and it is only in recent times that they have come to recognize that there is a problem. At first, they contended that there was no problem at all. Is not that true?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. Just for convenience in cross-reference, my attention has been called by Dr. Shearon to the fact that in the letter from Mr. Green, which I think is the one which Mr. Cruikshank refers to, May 17, 1946, he mentions this pamphlet that has the price as set forth at page 518, and there follows thereafter a statement on pages 518 and 519 of part I of the hearings on S. 1606 in April 1946. I think that is what you are talking about?

Mr. CRUIKSHANK. Yes, sir.

Senator SMITH. Is there anything further?

Senator MURRAY. No. If you have any further statement to make, we will be glad to have you do so, in regard to the questions asked you here today.

Senator SMITH. I have especially in mind those things that you put in last year, or were put in last year, to see that they are brought up to date.

Mr. CRUIKSHANK. Yes, sir.

Senator SMITH. Any changes that have been made, we would like to have them. I should be personally interested in some evidence of the inability or the unwillingness of hospitals to take care of emergency ambulance cases.

Mr. CRUIKSHANK. Yes, sir.

Senator SMITH. Thank you very much.

Senator DONNELL. Mr. Chairman, I ask that there be incorporated at this point in the record an article from the National Republic of July 1947 entitled "The Case Against Socialized Medicine" by Lawrence Sullivan, and that if possible the pictures that appear therein be reproduced; if that is not possible, that the language under the various pictures be set forth, as to the nature of the picture above.

Senator SMITH. What is the document?

Senator DONNELL. It is from the National Republic of July 1947. That is a trade journal.

Senator MURRAY. What industry does it represent?

Senator DONNELL. I do not know. It is some trade journal.

Senator SMITH. Is there any objection?

Senator MURRAY. Well, it does not say where it is published or what organization sponsors it. It seems to me there should be some way of identifying the author of this and the sponsors of it.

Senator DONNELL. If the Senator objects on that ground, I will withdraw it and we will secure the information that is suggested.

Senator SMITH. I think it is quite proper to answer that, but I will say I have accepted all of the exhibits offered to date, without going into those questions, on the assumption that the Senator offering the material recognizes its relevancy.

Senator DONNELL. Mr. Chairman, if it is agreeable to the Senator from Montana I will offer it with the assurance that the data as to where it is published and what trade journal it is, will be supplied. Is that agreeable to you, Senator Murray?

Senator MURRAY. Yes, and any other information given in connection with it, as to who sponsored it, who authorized it, and whether it was a paid article.

Senator DONNELL. I cannot undertake to supply all that. That has never been done before.

Senator SMITH. We will have to go through our whole record and make a lot of changes if we do that.

Senator MURRAY. On the face of it, it looks like a brazen piece of propaganda. That is the principal reason I do not think it is proper to put it in the record.

Senator DONNELL. I think, Mr. Chairman, in view of the point made by the Senator as to the lack of identification of where it is published, I would prefer to withdraw it at this time, and we will secure the information as to where it is published and what the trade is, and reoffer it later.

Senator SMITH. Offer it at a later meeting.

Senator DONNELL. Yes, sir.

Senator SMITH. It is so ordered. I understand that Mr. Jacob S. Potofsky, who was to be here today, is being represented by Mr. James B. Carey, secretary-treasurer of the CIO. Mr. Carey, are you coming here in place of Mr. Potofsky?

Mr. CAREY. No, sir. If I may, I would rather like to explain that.

Senator SMITH. Very well, sir.

STATEMENT OF JAMES B. CAREY, SECRETARY-TREASURER OF THE CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. CAREY. Mr. Chairman and members of the committee, I am James B. Carey, general secretary and treasurer of the Congress of Industrial Organizations.

I testify here as the chairman of the CIO's committee on health. As a result of my absence from this country, traveling abroad, it was necessary to provide someone to testify on this important piece of legislation.

Senator DONNELL. May I interrupt, Mr. Chairman? Is Mr. Carey appearing on behalf of the Amalgamated Clothing Workers' representative, or is he appearing independently and in addition to that?

Mr. CAREY. That is what I intend to explain.

Senator DONNELL. I just wanted to be clear on that.

Mr. CAREY. I am testifying as a representative of the entire Congress of Industrial Organizations including the Amalgamated Clothing Workers. Mr. Potofsky had a statement that I hope will become part of the record, if the committee has no objection to the statement prepared by Mr. Potofsky submitted for incorporation in the record of the committee hearings.

Senator DONNELL. Mr. Chairman, I have no objection, but does Mr. Carey have an additional statement?

Mr. CAREY. Yes, sir.

Senator DONNELL. Has that been furnished to our committee?

Mr. CAREY. Yes, sir; it has.

Senator DONNELL. I have not seen it.

Mr. CAREY. I am sorry. It was submitted.

Senator SMITH. I have both statements here, one by Jacob S. Potofsky, general president of Amalgamated Clothing Workers of America and member of the executive board of Congress of Industrial Organizations, on behalf of the Congress of Industrial Organizations in support of the National Health Insurance and Public Health Act of 1947, before a subcommittee of the Senate Committee on Labor and Welfare, and so on. That is the statement to which you refer, Mr. Carey, that you would like to have introduced in the record?

Mr. CAREY. Yes, sir.

Senator SMITH. At the close of your own remarks?

Mr. CAREY. Yes, sir.

Senator SMITH. We will be glad to incorporate that in the record. Now, you are presenting your own statement, testimony of James B. Carey, secretary-treasurer of the CIO?

Mr. CAREY. Yes, sir; that is correct.

Senator DONNELL. May I ask, if the clerk will tell us—I am not making any objection, but I would like to know when Mr. Carey's statement arrived. I had not seen it until this morning.

Mr. CAREY. I am sure it was sent. Has the committee clerk received it?

The CLERK. It came this morning.

Mr. CAREY. It was sent yesterday.

Senator DONNELL. Very well.

Senator SMITH. All right, Mr. Carey, we will be glad to have you.

Mr. CAREY. There are some corrections in this statement and therefore I would like to call attention to them as I go along.

Senator SMITH. The reporter will make the corrections as you call attention to them.

Mr. CAREY. I am appearing here as an administrative officer of the Congress of Industrial Organizations to state the position of our 6,000,000 members and their 18,000,000 dependents with regard to the need for protecting their health and that of all the people.

A great deal of testimony has been offered for and against both of the bills that are pending before your committee. I want to make it perfectly clear at the outset that we are urging endorsement by your committee of Senate bill 1320 identified in its title as the National Health Insurance and Public Health Act of 1947.

This bill was introduced by Senator Murray for himself and likewise for Senators Wagner, Pepper, Chavez, Taylor, and McGrath. We do more than urge the endorsement of the committee for S. 1320 as against S. 545. We oppose this latter bill, which was introduced by Senator Taft for himself and for Senators Smith, Ball, and Donnell, as just another charity relief proposal intended to allay the grievous complaints of the very poor. We do not believe that the needs of the American people, the most self-respecting and self-reliant people on earth, can be met or should be met with charity measures. We believe that the health of the people can best be safeguarded by themselves,

acting in their own behalf through the orderly process of government to which they rightfully look for protection of their general welfare. The National Health Insurance and Public Health Act of 1947 would enable them to achieve the end they seek by affording them an orderly system, financed jointly by themselves and their employers, to meet their needs in the field of health insurance and health of the community.

There are a number of phases from which the bills pending before you can be discussed, and I will endeavor in the time allotted to me to cover some of them.

At the present moment our Nation appears to be in a wave of hysteria regarding this sacrosanct thing we call industrial production. Many, many speeches have been made about the need for production by spokesmen for the National Association of Manufacturers and similar groups of employers.

According to these gentlemen production and more production is the be-all and end-all of our national life. Their pronouncements have been echoed by a great many Members of Congress, including a number of widely publicized Senators.

We have even had legislation imposed upon the American worker recently by the Congress, designed allegedly to prevent loss of production through work stoppages, strikes, lock-outs, and too much union activity under the democratic process; and those in Congress who urged this legislation and voted for it were quite frank in saying that they were interested in nothing but production, more production, endless production of industrial goods.

Senator SMITH. I would like to interrupt this to make this personal comment. I voted for that legislation because I thought it was wise legislation. I did not vote for it because I was interested in nothing but production, more production, endless production. I did it because I felt it my responsibility in the Senate here to support it as a fair approach to the problem. I am on the committee to study the legislation, to see how it works and I hope to confer with yourself and others on the labor side, with members on the manufacturers' side, and not in the spirit of criticism, not in the spirit of trying to increase the differences between management and labor, but in a spirit of trying to see how we can get together and work for the future of America and welfare of all of our people.

Mr. CAREY. I appreciate your statement, Senator.

Senator SMITH. I want to make that statement because, frankly, I voted for it because it was in that spirit I have just expressed, not because I wanted production, production, nothing but production. Of course, I feel that production is important. You do, too. We all know we must have production.

Mr. CAREY. If industrial production for its own sake is to be the high objective of our national existence, it seems to us that the Congress and your committee might well turn their attention to the necessity of building the health of all the American people so that we can produce more and attain this maximum production about which we hear so much with no preventable delays that could be charged to ill health, disease, or even the common cold.

Spokesmen for organized labor have testified repeatedly before congressional committees that they too are interested in production, and in such things as full employment at the guaranteed annual wage

which would assure continuity of production. We believe there should be a job for every willing and able worker in this country. We believe that enforced idleness of willing and able workers through limitation of production by industrial management is a national crime.

We are likewise of the firm opinion, and we will assume that the Congress agrees with us, that all willing workers should be able to work; that is, they should be possessed of the good health and well-being that will enable them to perform the jobs assigned to them. Like other groups, we do look at the materialities in a situation, and this is one of them. We even believe that production is important, so long as it is production for the use of all of the people. That is one of our material reasons for supporting Senate bill 1320 and opposing the charity dole proposed in Senate bill 545.

I have brought this material aspect of the public health to the attention of your committee because of the widespread, hysterical interest in production. I do not see how anyone could possibly reconcile a statement made one day that all employed workers must be kept on the job, even if the courts are to be drafted to make them stay on the job, and then announce on the next day that idleness induced by sickness of a worker or some member of his family is not so important after all.

Wholly aside from this purely materialistic view of the national health is the decision that must be made as to what the American people deserve.

I feel I will not be challenged when I state that the results of the democratic process during the 172 years of our national existence stand as indisputable proof that our philosophy of government is in general the most successful yet evolved by man.

But our comparatively high standard of living cannot be attributed solely to the wisdom of the 79 Congresses that preceded this one nor solely to the planning ability of industry management. The accomplishments must be credited to the whole people down to the humblest toiler who dug in the ditch.

And yet, while our system is the best, and I believe it to be the best, our accomplishments are far from perfect. It is the judgment of the CIO, of its 6,000,000 members and their dependents, that the time is now here for them and the rest of the American people to reap some lasting rewards for what they have accomplished. We believe the opportunity to enjoy good health through the prevention of disease and other manifestations of ill health that beset mankind should be one of those rewards. We believe this can be accomplished best through an orderly system of health protection such as that outlined in the National Health Insurance and Public Health Act of 1947.

If health care and disease prevention were not national problems, there would be no need for this subcommittee to meet. Unfortunately, however, the statistics reveal that the American people are far from enjoying a general state of good health. It is true, of course, that our armed forces were in a superb state of health or in such physical condition to attain such a state of health under basic training.

However, we cannot overlook the fact that more than 20,000,000 disabling illnesses, lasting a week or longer, occur in the United States in the course of each year. I cite these figures from Public Affairs

pamphlet, "Who Can Afford Health." A practical measure of these figures is apparent when we look at the rejection rates under the Selective Service System. Several times the standard of the armed forces was lowered, but even when those standards were at their lowest point, rejection rates of men called to the colors to protect the general welfare of the Nation ran about 40 percent. Those figures are common knowledge.

Of these 20,000,000 disabling illnesses to which I have referred as striking at our population, two out of three of every three victims need aid of some kind to help meet the cost. If these figures are guess work, they are the guesswork of the Bureau of Medical Economics of the American Medical Association as outlined in "Physical Data on Medical Economics" issued in 1939.

These figures are supported by the current data of the Federal Reserve Board on family incomes. The situation has even been measured in terms of money by the United States Senate. One of your own subcommittees estimated that \$8,000,000,000 a year was the annual toll of sickness and accident in medical costs and loss of earnings due to sickness and premature deaths. These figures can be verified by reference to Senate subcommittee report No. 5, published in July 1946.

It is our view that the Federal Government has a duty to subsidize the health of the people when the people themselves cannot protect their own well-being under the rugged individualism that has been carried out with a vengeance in the field of health. Denunciation of subsidies, of course, is a pet political device. Those who denounce subsidies pretend not to see the record of our Government and its people. The Government has spent vast sums, sums far in excess of the combined cost of all our wars including World War II, to subsidize various activities of the people. The CIO does not criticize, for example, expenditure by the Federal Government of the vast sums that have gone into the building of highways throughout the country. These highways were necessary for the development of our huge automotive manufacturing facilities. Without them, our huge automotive manufacturing factories would not now be in existence. Commercial aviation likewise has been subsidized with vast sums in this country through the building of airfields and terminals which our commercial air lines could not possibly have financed by themselves. The lumber producers have been subsidized through forestry conservation; the farmers have been subsidized by the adoption and carrying out of over-all programs that would aid them in producing more and better crops, more and better livestock, and more and better fibers for the manufacture of clothing. We approve of all of these subsidies.

We do not indulge in hypocrisy when subsidies are mentioned. We consider any opposition to health subsidies of the American people rank hypocrisy. We consider our American people the greatest resource the country has.

We are of the opinion that S. 1320, the national health insurance and public health bill, presents a positive and constructive program. Its principles are in accordance with those that have repeatedly been endorsed by conventions of the CIO, by our affiliated international unions and by our State, county, and city industrial union councils. You can rest assured that the expressions of these various meetings, held in the open under the watchful eye of the American press, were

expressing the view of the individual CIO member and his dependents.

The bill which we support would cover the cost of medical care for all employed and self-employed persons and those receiving old-age or survivors benefits. Needy persons who could not be insured by their own earnings for one reason or another could be insured by public agencies, not as charity cases but as Americans who deserve health protection and good health because they are Americans. Payments would be made out of the insurance fund for services by a family physician, a specialist, a hospital, or a laboratory.

Everyone would have free choice to get these services from among all the doctors and hospitals that chose to take part in the program. S. 1320 would contribute to a higher quality of medical service by making aid available for medical research and the further training of doctors, dentists, and other technical health specialists.

One of the outstanding attributes of S. 1320 is that it would impose no compulsion on anybody. Americans do not like compulsion any more than they like charity. The bill would give free rein to the group practice of medicine such as the Mayo Clinic or cooperative organizations for medical care. It would provide funds for the States to help them expand their public-health services and to build more hospitals. Physicians would be free to enter or stay out of the program if they chose. If they decided to participate in the program, they could choose the basis on which they would be remunerated, either by salary, by a fee for service, or on a per capita basis.

The national health insurance and public health bill does not specify how the funds should be raised, but the annual appropriation would equal 3 percent of earnings up to \$3,600 per year, presumably to come from social insurance premiums levied one-half on employed persons and one-half on their employers. Additional sums would be appropriated from general revenues to cover specified items of service such as dental care and home nursing. The total could not exceed 3½ percent of earnings in the first 3 years or 4 percent in the second 3 years. At that time Congress could review, revise, and extend the program in the light of the experience gained. The system would be administered by an over-all Federal board, but the direct administration of services and funds would fall mainly upon the States and the local communities. The bill would supplement, not supersede existing voluntary plans now in existence, or that might be set up by groups of citizens in the future. The CIO believes that the enactment of S. 1320 would encourage the growth and extension of voluntary plans, just as the national old-age-benefit system has encouraged the growth and extension of voluntary pension plans throughout American industry.

The National Health Insurance and Public Health Act of 1947 should not be confused in the public mind with the Wagner-Murray-Dingell health bill, on which I testified more than a year ago. I regret, of course, that the Wagner-Murray-Dingell social-security bill was not enacted by the Seventy-ninth Congress, and I likewise regret that its provisions are not receiving the favorable attention of this subcommittee.

S. 1320 is by no means a substitute for the Wagner-Murray-Dingell bill. It does lift out of that bill and lay before the Eightieth Congress that most important phase of social security, and that is the health of the people.

When I make that statement, I am thinking in terms of the national welfare as well as in terms of the individual's. The bill on which I am urging favorable action by this committee does fit into a needed expanded program of social security. It can be considered a first step in that direction. Its medical care and public health insurance sections fit into legislation that will eventually be enacted for full employment, higher and reasonable minimum wages, a guaranteed annual wage, expanded and increased old-age benefits, larger unemployment-compensation payments, and other measures calculated to conserve the well-being of the people.

The whole broad program is that of social security, and I repeat that the time has come for the people of America to begin to reap the reward of their ability and initiative in terms of better health. The more delay that ensues, the worse the problem will become. Our population is growing much faster than our present wholly inadequate health facilities. The result will be that more and more families will be forced through no fault of their own into desperate conditions. There is grave need at the moment to combat disease and illnesses; but there is even greater need to prevent them.

I want to make it perfectly clear that the CIO was organized to help the poor and the needy. That is the primary reason for our existence as a great labor movement. We want the poor helped, but we do not believe they can be helped adequately or decently by the provisions of S. 545 which is the Taft charity bill. This bill proposes to do little, and much of what it proposes is bad. For the great majority of the American people, it could and would do nothing at all for about 2 years, because State legislatures, most of which will not meet again until 1949, would have to match the appropriations described in the Taft bill. There is nothing to compel a State to act at all. Even when they do decide to accept the Federal aid offered them, the great majority of people would still receive virtually no benefit. Of course, a few sops are tossed in for everybody, such as dental examinations for school children and cancer clinics. S. 545 would provide medical care for those of low income, and this spells a dole to those at the lowest level, along with the degrading pauper's oath and the means test.

To this end Federal funds would be turned over to the States under the Taft bill, with an appalling lack of standards to see that they are used properly. This absence of standards is unprecedented. It can be argued, of course, that the Taft charity program would cost less in terms of funds. In our judgment, it would be money thrown away, not in the sense that money spent on the poor is thrown away but in the sense that the national welfare, the well-being of all of the people, which is our major concern, would be enhanced very little. The American people deserve better than a miserable program, aimed to help only the miserable.

Congress has not enacted a printed word or furnished a penny in the last 4 years to set up any dignified program for general relief. We believe that a long step forward will be taken if the Congress enacts S. 1320. We likewise consider that a long step backward would be taken if this subcommittee endorsed by even a scant majority S. 545.

There is another important consideration which I will mention in conclusion. I mean the moral obligation of the Congress to the

people. Regardless of our varying religious beliefs or the lack of them, it is an inexorable provision of the natural law that man is a social animal. He was made to live in society and living in society implies working with other members of that society for the common good of all in the respective community. When this principle is disregarded, when men exercise their individualism fully without regard to others or their welfare, when in short, individuals do as they please or band together in little minorities to do as they please, there is a violation of natural law and a moral offense. It is only when the processes of society are carried out in orderly fashion that we have a healthy society. The framework of society, within our continental borders, can be described as the United States Government. Through its processes, all citizens render to one another their common obligations, and most certainly it is a common obligation to serve, protect, and extend the health of the entire community, not on a basis of charity but on a basis of justice, the obligation of one man to another.

In conclusion I point out that this subcommittee can base its favorable endorsement of S. 1320 on any one of the three considerations I have mentioned. It can base its endorsement on support of the Deity of increased production; it can base its endorsement on the reward of their industry to which the American people are entitled; or it can base its endorsement upon the provisions of the natural law. The CIO urges the committee to endorse S. 1320 regardless of its motive for such endorsement.

Senator SMITH. Mr. Carey, I have enjoyed hearing your presentation, although I am bound to feel that you do not quite make a fair comparison between the two bills. However, I will not go into that at the moment.

On the assumption that you favor S. 1320 I want to ask you the question I asked Mr. Cruikshank a little while ago. How long would you estimate it would take to organize in the United States by the building of hospitals, the educating of physicians, and so on, so that it could meet the obligations that it would assume, the Government would assume, by enacting the legislation asking the people to pay for this service which they would be entitled to expect? In other words, what time lag would there be to get the organization all set up so that when we do tax people we can be sure that we can give them what they are paying for?

Mr. CAREY. That would be a difficult question to answer and give a definite time.

Senator SMITH. Would you agree with me that there would be a time lag there, that we would have to do a lot of work setting up medical schools and hospitals?

Mr. CAREY. I think it should be recognized as possible. It should have some beginning, with a broad program set forth so it is understood; and then, as time goes on, as we gain experience, we can perfect the program we have set forth. I do not think of it in terms of setting forth a blueprint in which you can say that the following objectives can be accomplished as of a certain date.

Unfortunately—and that is perhaps one of the reasons that I express my regret that the Murray-Wagner-Dingell social security bill was not enacted last year—we would be a year ahead now, I believe, in carrying out our objectives to see improved service in the medical field for the people of this country.

Senator SMITH. Well, you still leave me in a little bit of a quandary. You see, the theory—I am sorry that you just pushed S. 545 aside as being a charitable goal, because that is not the purpose of the bill. The purpose of it is the trial-and-error method, the attempt to challenge all of our States, give them health in that challenge to develop the program to meet this over-all health need, especially the poor people for whom you are making a good case, a very fine case, we all agree. The question is, How to do it? Can we do it by developing an over-all National Federal program, put it in to effect, and say, "Yes; we have got a time lag of 2, 3, 4, 5, 10 years until we get to the point ultimately where we can tax everybody and tell them, 'After you pay this tax, you have a right to look to the Government of the United States to deliver this service' "?

Mr. CAREY. May I express as clearly as I possibly can, it is our considered opinion that we prefer to have no health bill at this time than to enact S. 545.

Senator SMITH. Well, it is fair to say that there may be a difference of opinion on that among people who are just as sincere as you are in their desire to help the situation. Nobody can take an arbitrary position on one bill as all right and the other one as all wrong; that there is nothing good in that bill and we will not have it.

Mr. CAREY. I hope we are not presented with the choice that we have S. 545 or no bill.

Senator SMITH. You just decline to take over any program that would seem to try intelligently to challenge the States to set up organizations to experiment with this and see what is the best way to deal with it? Nobody yet has convinced me, as a practical matter, of any plan that would do what is attempted to be done by this so-called over-all coverage of medical care. I have not seen it and I would welcome it if I could see it. I just think that the way you approach this is because it claims to be an over-all coverage; you want over-all coverage that is legitimate. Of course you do. So do I, but just because you claim that this does that, that it will work, and you are putting the Government into a very difficult position when you say everybody should be taxed, and then call on the Government for over-all medical coverage, it still is a long way between that tax and over-all coverage. If you say that everybody should be taxed and a common pot should be set up, and when somebody is sick, draw out funds from it, that is a different matter; but if you say you are going to draw out services, you have not yet indicated any presentation of a plan that will make it practical. That is what we are working for. I do not feel that S. 1320 gives us that assurance, and I have got the responsibility of voting for a bill, and, if I tax your workers, to be able to say to them, "Yes; when you pay this tax which we compel you to pay, I will deliver you the service."

Mr. CAREY. Senator, I am merely presenting the opinion of the workers as we find it through the processes of our organization, that should you support this bill, S. 1320, you would be doing it with the full support of the people that are employed in American industry, by and large. I think you will find that, despite the fact that there was no relationship in the preparation of this material, I could easily fully subscribe to the statement made by the representatives of the American Federation of Labor and likewise the American Federation of Labor

could fully subscribe to the statements that I make here. And that is true of every organization dealing in this field that I know of, that is, dealing in the field of representing the thinking and needs of the American working people.

Senator SMITH. Well, you are expressing what we can concede there is a need for—I am not arguing with you on that—and that we would like to see met, and you are saying that it is your opinion that this is the best way to meet the need. That does not prove the case. It does not give me a blueprint to work on as to the kind of legislation we should pass if my Government is going to assume the responsibility of giving this over-all medical coverage.

Mr. CAREY. I was directing my remarks to the fact that you felt the burden of responsibility in imposing taxation on the people in order to carry out the plans covered by S. 1320.

Senator SMITH. That is involved.

Mr. CAREY. I say that that would be, as we understand it, carrying out their wishes. That would be meeting their desires.

Senator SMITH. You would not ask me to do that this year, when you know perfectly well we could not deliver the goods. You would not want us to tax anybody, and then if they wanted medical help say, "Very sorry, but it is going to take 10 years to organize this."

Mr. CAREY. Yes, sir; I would. I would want you to be responsive to the needs of the people and carry out their expressed desires, and that would be immediate favorable recommendation by the subcommittee of the enactment of S. 1320.

Senator SMITH. Without suggesting to us how we can deliver the responsibility we have assumed by that system of taxation?

Mr. CAREY. This would not be the end-all and be-all. We would have to give it consideration, all these questions relating to it, but I am meeting directly your suggestion that we do not have a plan acceptable to the people, in that we do not have a plan.

Senator SMITH. No; I am not saying acceptable to all people. I said a plan that would convince us that it was practical. I am trying to have you tell me how we are going to develop a system of setting up medical schools to fill the lag in the number of medical practitioners, in the number of dentists.

All the evidence shows that we are short of doctors, short of dentists, short of nurses, short of hospitals. We might start now a program by making provision for further education of doctors and dentists and so on, but when you get to the place that you are taxing all your people on the representation that you are going to give medical coverage, I want to go a further step and ask how long it is going to take to do this. That is the first thing here. And when are we going to be able to deliver along the line that we have promised?

You know as well as I that from anybody taxed for this service and who does not get the service, there will be quite a big roar and criticism of the Government. I am trying to get the practical side of it, because we have to develop legislation here if we are going to do something along this line, and our alternative is simply that we make Federal appropriations, grants-in-aid to the States and say, "Go on; experiment with this thing and find out what is the best way to set up a program that will take care of the workers."

I am just as much for the principle as you are, but I think the other approach is better—the trial-and-error method. I think that will get

us there sooner than the over-all approach, the only difference between us; and for you to imply that because we are in favor of one bill and not in favor of the other, that you have all the virtue on your side and all the right on your side and all the Christian ethics on your side, I take issue with that, because I just decline to have anyone say that I am not sincere in trying to solve this problem, as sincere as you are, and I can differ with your solution, and I can challenge you to show me how your solution will work, and I think you should be able to show us some program as to how it will work, not just come in here and support S. 1320 which the average member of your organization does not understand—has just been told that if he submits to a tax of so much per week he will get a fund to take care of his sickness—it would be fine if he could do it.

Mr. CAREY. On that, too, Mr. Senator, we differ. I might say that the average member of the CIO is as much concerned as any member of this Senate concerning health questions.

Senator SMITH. I have not questioned that.

Mr. CAREY. And I will go further, Senator, and say that this is a question that has been thoroughly discussed within the ranks of labor organizations in this country. Fortunately, it has received a great deal of attention.

You ask me to set forth to you the results that will be found under this legislation, should S. 1320 be enacted. I cannot do that. I cannot even give you a date as to when we shall obtain some results that will be reasonably satisfactory because there are a great number of factors involved in this. One would be the kind of assistance as co-operation that this kind of legislation will receive from the medical profession.

Senator SMITH. That is very important.

Mr. CAREY. I know that it is a changing situation. I have reason to believe that eventually the medical profession will be wholeheartedly in support of the principles contained in S. 1320, but I cannot say that as of now, nor can I tell you when that will come about; but as to whether the people want Senate bill 1320, I can say "yes" and I think that would be a matter that should concern the members of this committee.

Senator SMITH. What they say "yes" to—and I am entirely sympathetic with them; I wish I could say "yes" to it, too—they say "yes; we will be very glad to pay so much a week to go into a fund so that if we are sick we will have an over-all medical coverage". Of course they would say "yes," and that would be sound for them to say "yes" and that is what they are saying "yes" to; that is what you are saying "yes" to here. We all agree with that. I do not have any difficulty in saying "yes" to that. I am just asking you the steps—the bell for the Senate has just rung, and under the rules we will have to recess for a few minutes until we are able to obtain consent of the Senate to continue, so there will be a recess of 4 or 5 minutes until we get word from the Senate that we can proceed.

(Whereupon, at 12 o'clock noon, a recess was taken.)

Senator SMITH. The committee will come to order and the hearing will be resumed. Mr. Carey is still on the stand. When we recessed, Mr. Carey, I was discussing with you the different approaches to the solution of this problem, and trying to point out that we are all anxious

to solve the problem, and I suggested that I could see very readily how the members of your large organization—as you say, 6,000,000 members and 18,000,000 dependents—would, of course, be glad to join the plan—I think they would—whereby, by weekly payment into a fund, they would be assured over-all medical protection. I know I would, if I could do that, because all of us have what is known as catastrophic illnesses—operations, something of that sort. But our problem as legislators, without prejudice, is to try to find out the best way to bring about that result. You have stated that you feel and your group feels that the S. 1320 approach is the correct approach to it and you feel that that would work. I just raise the practical question of the intermediate steps we would have to take in educating the medical profession, in getting more men into the medical profession, more hospitals, more public health centers, and better organizations of our States and counties, getting down to the lowest level, so that everyone would be adequately taken care of.

How long would it take to organize that before we could call upon our people to pay for that service? And I think you are quite correct in answering that you cannot predict how long that will take. It is hard for any of us. But you have stated and other witnesses have stated that you feel the membership of the CIO would be willing to be taxed today and look forward to that in 10 years, or whatever time it might take.

Now, that is the position where I would raise a question as to whether we realize the full significance of that, because I think anybody who begins to pay into this so-called social insurance fund would be entitled to the service from the time he pays in. Those who pay this year should be entitled to something this year. I am troubled by that feature of the program, I admit.

Mr. CAREY. The bill itself does not provide for the services. It provides for the payment of the cost; it provides the kind of organization—and I might say that I speak primarily as an organizer and administrator—and one parallel that we would have is that when we invite workers to join a union, they might be members of that union for some time before they can receive any actual benefits from it in the form of a contract negotiated, providing certain wages, hours, and working conditions in their behalf. And we quite frequently have instances in our society where that takes place. It is not as you purchase a sack of sugar, putting the money down; but the advantage of the proposal now before us is that we will have better health services as a result of this process that is proposed in S. 1320.

Senator SMITH. I might suggest this, that I could see the analogy where you say: "Yes; we will have a plan, and anyone who wants to join the plan, and whoever joins the plan puts money into the pot and gets the benefit of the use of that money for the services."

I agree that that could be turned over to a certain individual, the actual money, and let him go and buy the services; but what gets me rather upset is that the Government is to furnish the services. On the voluntary basis, I have no trouble at all because I myself pay premiums into a hospital fund, and you have probably paid into some sort of a hospital fund, or you have in your union certain welfare funds. But those are on the voluntary basis. This is compulsory. On the voluntary plan a person does not have to join if he does not want to; but this plan suggests that everyone has to join—make it

compulsory by the Government, and compulsory deductions from pay rolls, even though they may not want to pay it, and you cannot convince me that everybody unanimously would want to pay; some may not want to, may not believe in it. I have talked to some people who objected to the imposition of any kind of a medical plan, claiming it was a matter of personal judgment.

Would you contemplate that they would be taxed, too?

Mr. CAREY. Yes, sir; the same way I would contemplate taxing for education. There are even some people who do not believe in education for women, or something.

Senator SMITH. My point only is that in developing an over-all plan, we have got a good many steps to take in organizing so that we can deliver the thing that we engage to deliver, and we say to people, "You shall pay this money into the pot." You say that your group would be willing to pay today on the expectation that this will be developed and you may get it in 5 years and there may be others that will, but there are numbers who will not be willing to pay. I am just pointing out some of the difficulties that we, as legislators, have to face. I am not arguing with you one way or the other. You have one approach; I have another.

I believe in the trial-and-error-method. I believe the philosophy of S. 545 is sound. I do not look upon it as a charity bill. I look upon it as a waiting, a trial processing by subsidizing grants-in-aid to the States to work out their public health set-ups.

I was talking to Dr. Parran yesterday, not connected with the hearing, but I asked him how many counties had a public-health service—and there is a step you should take, you should have a public-health officer in every county. That could be done by the principle in S. 545.

Mr. CAREY. I do not think, Senator, you are intending to indicate that the benefits would be speedier under S. 545 than under S. 1320?

Senator SMITH. Personally, I think they would. I think they would if we challenge the States to get busy and work out their problems, talk about them. And the States are interested in it; I have talked with people in many States and they are very keen about it and want to have a crack at it. I don't know whether you read a very interesting study that appeared by the New York Academy of Medicine, Medicine in the Changing Order, recognizing the very thing we are talking about.

Mr. CAREY. I can understand why the consideration of the enactment of S. 1320 would cause some people that heretofore have been opposed to any system of health insurance to favor the plan. And I say that I believe that the opponents of health measures would prefer to have S. 545 than to have S. 1320.

Senator SMITH. I think that is a totally unfair comment. That is just a personal view; I do not think it is true. I think there are people who are eager to see a plan worked out, and they can support S. 545 without being charged with being opponents of any plan. I have got to criticize your statement in that respect. But that is your complete statement. That is in the record. Mine is in the record. We just differ on that approach, and my criticism of your statement is that you seem to think of the two contesting groups, that any who do not take your view must necessarily be against what we all want to accomplish. That is not true, and the sooner we get into the attitude,

with the splendid groups you represent—and I say that advisedly—you have a splendid organization; I have talked with your leaders, and I have great respect for them; you are doing a wonderful work but you do have a chip on your shoulder, maintaining that everybody is against you who happens to be on the other legislative side, and that is not true—the sooner it will be seen that we are trying to work to our objectives.

Mr. CAREY. We recognize honest differences of opinion, but I think I would have no reason to believe, as a representative of labor, that people are against us, without good and sufficient reason, and the people of labor are against people that are not of labor. It works both ways. I have criticized fellows on the other side just as much as I have criticized my labor friends. I think it is a rather deplorable thing that there should be such prejudice and opposition to this common problem of the American people.

Senator SMITH. Are there any questions?

Senator DONNELL. I would like to ask a few questions.

Mr. Carey, I understood you to refer a little while ago to the desire to secure under S. 1320, health services, and it was the view of your organization that they will be secured. Am I correctly interpreting your statement?

Mr. CAREY. Yes.

Senator DONNELL. I wonder if you have examined some of the details of S. 1320, with a view of determining just what the quality of service is that is provided by that bill and is guaranteed by the bill.

Have you studied it with that in mind?

Mr. CAREY. Not with that in mind. The bill itself provides the services and provides payment for the services. I would think that under S. 1320 we would have better health standards in the United States. I say that after the consideration our organization has given to all the principles involved here. I do think that through this orderly process that would be contained in the provisions of Senate bill 1320, we would be breaking new ground and we would be doing it in a way that is consistent with the traditions of our country. It would improve our opportunities in the future, even to the extent of improving the opportunities to break ground in the medical field itself, where we have had tremendous progress, but we have not been able to translate the progress that was made in the development methods in the medical field to all the people, and S. 1320 would enlarge our opportunities to have the people, all the people, receive the benefits of the progress made in this important field.

Senator DONNELL. Mr. Carey, I appreciate your desire for better health services. We all concur in this, and I readily understand, in reading the declaration of purpose as set forth in S. 1320, that it specifies very laudable ultimate purposes. The development of adequate health services stated in this preamble—

is essential to maintain and improve the efficiency, security, and well-being of the American people.

Then it is provided further on, on pages 4 and 5, that the Congress finds and declares that—

to promote the general welfare of the people of the United States, the Congress hereby establishes a national health program—

among other things—

to enable patients to have more effective free choice in selecting their physicians.

Do you think S. 1320 gives a more effective free choice in selecting physicians than prevails under the existing system?

Mr. CAREY. Yes, sir.

Senator DONNELL. You think it does? It also provides in this preamble that Congress establishes a national health program to provide adequate health services consistent with the higher standards of quality. Do you think that S. 1320 carries out that objective of providing adequate health services consistent with the highest standards of quality?

Mr. CAREY. Yes, sir.

Senator DONNELL. And your support of the bill is, in part at any rate, based on your view that this bill does carry out those two objectives, namely, the patients to have more effective free choice in selecting their physicians than prevails under the existing system, and that that bill likewise provides adequate health services consistent with the highest standards of quality?

Mr. CAREY. Yes, sir.

Senator DONNELL. Now, we have had quite a little discussion here in the testimony from time to time on this matter of free choice in selecting the physicians. I am not going to burden the record, or you either, this afternoon in discussing that, but I wanted to make it clear that in your support of this bill you are activated and influenced in considerable part, I take it, by the thought that this bill will enable patients to have more effective free choice in selecting their physicians. That is correct, is it not?

Mr. CAREY. Yes, sir.

Senator DONNELL. And if the bill falls short on that, you will be disappointed in your expectation under the bill? That is true, is it not?

Mr. CAREY. Yes, sir.

Senator DONNELL. Likewise, if the bill falls short in providing these adequate health facilities and highest standards of quality, you will also be disappointed?

Mr. CAREY. Yes, sir.

Senator DONNELL. Have you examined the provisions of the bill as to what kind of hospital services are guaranteed under the bill?

Mr. CAREY. I will say yes.

Senator DONNELL. Do you remember what they are?

Mr. CAREY. Not in detail, perhaps. I could easily refresh my memory.

I would point out, however, if I may—and I would like to state—as I understand the bill, it is not so much guaranteeing the services as providing a method for payment of the services to be rendered.

Senator DONNELL. Well, as that is all it does, Mr. Carey, then I would—

Mr. CAREY. As a result of that, Senator, there will be greater freedom of choice on the part of the people, because some people have no choice at all now because there are not sufficient doctors or dentists or others to meet their needs and with the development of a broad-scale program in the field of health, it is certainly to be expected,

and their reasons for disappointment should this bill be enacted and it does not live up to its purposes.

I find nothing in the bill that would indicate that it would not. In fact, I have reason to believe that there is a great deal in the bill that does offer a promise of improvement in this field. I am quite certain, speaking again not as a doctor, but an organizer and administrator, that this bill as set forth is a glorious opportunity for the American people to have for the first time the benefits of the progress made in the field of medicine.

Senator DONNELL. That is one of the prime reasons for your support of the bill, that you sincerely believe that the bill will produce that?

Mr. CAREY. That is correct.

Senator DONNELL. And if the bill does not produce it, you are going to be greatly disappointed?

Mr. CAREY. Correct.

Senator DONNELL. On this matter of free choice of physicians, are you familiar with the fact that the bill permits, and in fact expects that doctors will have the right in the respective communities of the country to elect whether they will adopt a per capita basis of payment, with practitioner lists giving the numbers of persons, I take it, who will be on the list of the specific doctors. Are you familiar with that?

Mr. CAREY. Yes; it goes beyond that. It provides that if the majority of the doctors in an area decide on one basis and some do not care to go along, they do not have to become part of the program, or they can work out some other satisfactory arrangement. I think the bill has been very considerate, not only of the need of the patients or potential patients, but also of the medical profession.

Senator DONNELL. The bill, I take it, would not obligate any doctor to accept its terms or to adopt one of these practitioner lists?

Mr. CAREY. That is correct.

Senator DONNELL. And of course, if the doctor did not come under the bill, did not voluntarily avail himself of the right to come under the bill, there would be no way that you and I have, as taxpayers, to require him to give us his services under this bill. That is correct, is it not?

Mr. CAREY. There is no obligation on the part of the doctor except a moral obligation, the oath he takes in becoming a doctor, and the fact that the conditions are made extremely attractive for him, but still his right to strike—and there have been cases of that kind by professions—the right of opposition, the right to campaign against the proposals here are all fully adequately protected and I would say that the medical profession itself can continue—and I emphasize “continue,” to prevent the people from having their opportunity of their wishes being met under the system that is contained in S. 1320.

Senator DONNELL. You refer to the oath of a doctor. Is there any oath that a doctor takes to go into this system under S. 1320?

Mr. CAREY. I think there is an oath that a doctor takes to do the best possible job he can do in behalf of the health of the people, and I think that oath carries with it the expectation that he will look objectively, at S. 1320, and one reason why I say eventually the greatest champions of this proposal contained in S. 1320 will be the medical profession of this country.

Senator DONNELL. Of course, today you realize, as I do, do you not, that the American Medical Association, which comprises some 80 to 90 percent of the practicing physicians of the country, are opposed to this plan? Do you realize that?

Mr. CAREY. I believe they are. I am certain they are, but I believe there is less opposition within their ranks to S. 1320 than there was at this time last year.

Senator DONNELL. Well, I have not taken any poll and I am sure you have not, either, but that is your opinion. You are entitled to it.

Referring now to this matter of services I just started to ask you a little while ago about—

Senator MURRAY. Before you leave this subject you have just been talking about I would like to ask some questions.

Is it true that the medical profession has fought an effort to bring about a solution of this problem of medical care for the people of this country from the start? At first they said there was no need for it. Isn't that true? They claimed that every American, no matter how rich or how poor, could get the needed medical care and service in this country without the need of any legislation, so they opposed it. They took the stand there was no need for it. They opposed voluntary insurance and compulsory insurance both. Is not that a fact?

Mr. CAREY. That is right.

Senator MURRAY. When we were attacked at Pearl Harbor we found that we had no plan to fight the war, and we had to hurriedly prepare plans. Don't you think that now, inasmuch as we have recognized that there is a tremendous need in this country for some kind of medical care, that a country as great and rich, and possessed with such leadership as this country has ought to be able to work out a program if we want to work it out? It seems to me that the witnesses who come here to tell about the need for it are not the ones that should be required to lay out a blueprint that should be done by the medical profession, by administrators, and by the Congress. They are the ones to work that out, not the ordinary people who come here testifying as to the need for it. It seems to me that your testimony is the testimony of a citizen who comes here to tell us about the great need in this country, and not to attempt to lay out the program or the plan or the blue print by which we are going to bring medical care within the reach of all our people.

Mr. CAREY. I have been attempting, Senator, to follow that course. As I see it, the enactment of this legislation would be a long step in the right direction to meet the needs of the people. It is difficult to anticipate, just in detail, all the results that will flow out, any more than we could anticipate when the war would be over at the time we started our production for that purpose, or what we would be able to produce. We shot at it and we went far beyond our hopes at the time.

I have a notion that we will do the same thing here. The benefits that will flow out of the enactment of S. 1320 will be benefits that the medical profession will be proud of and the whole Nation, and one of the additional arguments that has been used by the medical profession in opposition to anything new to change the relationship that has been established between the patient and the doctor has been that in this country we have superior medical services rendered to the citizens. Why, certainly we have, and we should have. We have superior pro-

ductive ability on the part of the people. We have superior developed resources. There is no reason under the sun to stop just there. We have a path to follow, as I see it, and as we consider these matters we might also say that one reason for the reduced objections to the program contained in S. 1320 is the fact that there is more information now.

Since I have been testifying, for instance, the word "socialism" or "communism" has not been mentioned.

I think we can get down to the meat of the question and that is why I say it is well that we consider the need and consider the bill as to whether or not it is a framework and a mechanism in which the need can be met. I would say "Yes."

Senator DONNELL. Mr. Chairman, I wonder if the Senator would mind if I continued my examination. This sort of gets me off the track.

Senator MURRAY. I take up very little time in cross-examination, Senator. The Senator will find, as we analyze this record, when it is concluded, that my contribution in the form of questions or statements is very insignificant compared to the statements which have been incorporated in the record by others. I do not want you to feel that I am imposing on the committee the few times that I interpose any remarks.

Senator DONNELL. Mr. Chairman, I have no objection to the asking of any and all questions that the Senator very properly has a right to do. I am sure, though, that the Senator will not object to my having continuity in my examination.

Senator MURRAY. That is the reason I interposed there before you started, because I did not want to interrupt you after you had started the trend of questioning.

Senator DONNELL. I had been on the trend, attempting to get down to a further question. I would really like to proceed with the examination, if I may.

Senator SMITH. Proceed, Senator.

Senator DONNELL. Now, Mr. Carey, I had asked you some little time ago about whether you have examined the provisions of this bill to see what guaranty there is as to the quality of service that the bill does provide. You have examined the declaration of policy and the laudable purposes and the very high and noble objectives that are sought.

I am asking you whether you have examined the bill to see whether there is any guaranty of those things being carried out. Have you done that?

Mr. CAREY. Yes.

Senator DONNELL. I will ask you then as an illustration, what type of hospital service is guaranteed by the bill, if you recall?

Mr. CAREY. I think that as a result of the enactment of this bill and the application of this principle, we will have hospital provisions far superior to those in existence now.

Senator DONNELL. I will ask you what provision in the bill that is? Perhaps I did not state it as concretely as I should.

What provision in the bill is there that guarantees any particular type of hospital treatment or care or service? Do you have in mind the guaranty in this bill that a better service along hospital lines is

going to result from this bill? Is there any provision in the bill to that effect that you know of?

Mr. CAREY. There is no provision in the bill that I know of—rather that I would be qualified to testify on—regarding the technical analysis of the kind of medical treatment or hospital care that would be provided under the bill. The bill does set up a more orderly procedure than we have at the present time, or could have under S. 545 for the payment of the cost of the over-all medical-care program.

Senator DONNELL. May I call to your attention, Mr. Carey, the fact that section 218 (d) specifically takes up the question of the content of agreements for the furnishing of hospital services, and says, among other things this, line 20 and following, page 21:

Payments to hospitals shall be based on the least expensive multiple-bed accommodations available in the hospital unless the patient's condition makes the use of private accommodations essential for his proper medical care. An agreement made for furnishing such services shall not affect the right of the hospital or other person with whom the agreement is made to require payments from persons with respect to the additional cost of more expensive facilities occupied at the request of the patient, or with respect to services not included as benefits under this title.

Now, I have read that correctly, have I not?

Mr. CAREY. I did not follow it.

Senator DONNELL. That is a correct copy from line 20 and following on page 21.

Now, "multiple-bed accommodations", that, in just ordinary common parlance, means ward facilities, does it not?

Mr. CAREY. If I may interpose, I am certain you will find witnesses who are more able to respond to your question than I am able to, because it goes into a field that I just would hesitate, would be reluctant to make reply to a question of that nature. It is too technical for me.

Senator DONNELL. I do not think it is in any sense technical, from what I have read. I was asking you first what the declared objectives of the bill are, and they are high and noble and all that. Then I got down to the point of what study you had made to determine whether or not the bill contains a guaranty of the fact that those objectives will be attained, and I just asked you respecting that one simple illustration, and you observe from it that instead of giving the best, exclusive type of treatment—or, I should say, services—in hospitals, it says payments to hospitals shall be based on the less expensive, multiple-bed accommodations, and I interpreted that to mean wards, as distinguished from private rooms—

unless the patient's condition makes the use of private accommodations essential for his proper medical care—

and that then, instead of the patient being entitled to those more expensive accommodations, it says that—

An agreement made for furnishing such services shall not affect the right of the hospital or other person with whom the agreement is made to require payments from patients with respect to the additional cost of more expensive facilities occupied at the request of the patient, or with respect to services not included as benefits under this title.

The point I am making is perfectly obvious, I think, that this does not guarantee what you might expect, in view of the objectives set forth at the outset of the bill, but if a person wants to secure those

ultimate objectives, the hospital has the right to, distinctly reserved to it in the bill, require that the patient shall pay for the additional facilities over and above what the bill guarantees.

Senator MURRAY. May I interpose a question right there? Under existing conditions, many people in this country find it impossible even to get into a hospital where they could use those multiple-bed accommodations. In fact, they do not get in at all, and this bill certainly will make it possible for the people of the country to get hospitalization even though they occupy the less expensive bed.

Senator DONNELL. May I ask the Senator, Does this bill, S. 1320, provide for the construction of hospitals? We have the Ball-Burton bill for that purpose, and this bill, S. 1320, has nothing to do with the construction of hospitals?

Senator MURRAY. No; but it has to do with the support of the hospitals after they are constructed.

Senator DONNELL. But it contains the provisions I have read, does it not, Senator, with respect to the hospital facilities that are guaranteed in the bill?

Senator MURRAY. Oh, yes.

Senator DONNELL. Now, I would like to call attention further—I do not think this is ultratechnical—you have come here to give us your opinions about this bill and you have studied the bill, have you not? Have you read the bill from cover to cover?

Mr. CAREY. Yes, sir.

Senator DONNELL. If you do not mind turning to page 8, line 20 says this:

If the Board after consultation with the Advisory Council finds that the personnel or facilities or funds that are or can be made available are inadequate to insure the provision of all services included as dental, home-nursing, or auxiliary services under section 201 of this title, it may by regulation limit for a specified period the services which may be provided as limited or modify the extent to which, or the circumstances under which, they will be provided to eligible individuals. Any such restriction or limitation shall be reduced or withdrawn as rapidly as may be practicable and, in the case of dental services, priority in the reduction of withdrawal of any such restriction or limitation shall be given to children.

So we find, do we not, Mr. Carey, that you are not going to get just 100 percent under this bill, all kinds of medical services, hospital, home-nursing, auxiliary, and dental services, but the Board, if it finds there is not enough money in the sack, has the right to restrict and by regulation limit for a specified period—and I am quoting—“the services which may be provided as benefits” to be eligible. That is provided in the bill, is it not?

Mr. CAREY. I think that is a very fair statement. It does not hold forth any promises that cannot be accomplished. It tells the people just exactly what they can expect. It does not promise perfection or Utopia. It tells them that there might be shortcomings. It tells them that in the event shortcomings exist, fair steps will be taken in order to establish some system of priority that will give greater consideration to children. I think it is a splendid provision. I am pleased that those who prepared the legislation incorporated that in the bill. It is the kind of provision that all people can readily understand.

Senator DONNELL. It is not overtechnical, is it?

Mr. CAREY. No; it is a very fine statement.

Senator DONNELL. It is clear as to what it means, is it not?

Mr. CAREY. Certainly.

Senator DONNELL. And it does not guarantee?

Mr. CAREY. It is so clear, Senator, that I wonder why questions are raised on that paragraph.

Senator DONNELL. I tried to make that clear. Don't you understand that?

Mr. CAREY. I think it is clear to you, Senator. Certainly it is clear to me. I stated it was clear.

Senator DONNELL. I think it is perfectly clear.

Mr. CAREY. Can we proceed now to some other portion of the bill?

Senator DONNELL. Now, we will proceed in a few minutes, Mr. Carey—don't get in too much of a hurry here.

Mr. CAREY. May I tell you why? I do have to take a 1:40 plane and unfortunately, it will be necessary that I take it or make other arrangements.

Senator DONNELL. Well, we will endeavor to speed up as much as we can, Mr. Carey; however, you have come here to testify, and we thought you could stay until we got through with the testimony. We will proceed as rapidly as we can.

You referred here to the medical profession, and I want to ask you whether or not you have yourself studied the question as to how the plan of compulsion insurance from pay-roll taxes and the provision of doctors through the means similar to this bill over in England, how that has affected the quality of medical services over there? Have you studied that question?

Mr. CAREY. I have had conversations with the leaders of their government on this question in England just a matter of a few weeks ago.

Senator DONNELL. Do you mind telling us what particular leaders you discussed that with?

Mr. CAREY. I would mind.

Senator DONNELL. You would prefer not to tell us?

Mr. CAREY. I would prefer not to.

Senator DONNELL. Have you examined any of the officials?

Mr. CAREY. I was going to say, as well as in other countries within—well, as recently as 30 days, in Czechoslovakia.

Senator DONNELL. Do you mind giving us the names of those leaders whom you talked to?

Mr. CAREY. No; I could tell you their position.

Senator DONNELL. Would you mind doing that?

Mr. CAREY. I have no objection to doing that.

Senator DONNELL. That is as to Czechoslovakia? You prefer not to as to England?

Mr. CAREY. I just could not at the time give you—I just do not recall all of them and I would not be certain of the correct pronunciation of some of their names, but I could get the information for you, Senator.

Senator DONNELL. Very well.

Mr. CAREY. In Czechoslovakia it was people in charge of the program, such as the minister in charge of labor and social activities; members of the staff. I do not have readily available their names in detail.

And I have also talked with other people in the same capacity in other countries including the Soviet Union.

Senator DONNELL. How about New Zealand? Did you talk to anyone in that country?

Mr. CAREY. I have some of them, but not as much as I have in some of these European countries, and not nearly as recently.

(Subsequently Mr. Carey addressed the clerk of the committee as follows:)

CONGRESS OF INDUSTRIAL ORGANIZATIONS,
Washington 6, D. C., September 3, 1947.

Mr. PHILIP R. RODGERS,
*Committee Clerk, Labor and Public Welfare Committee,
United States Senate, Washington, D. C.*

DEAR MR. RODGERS: I wish to acknowledge receipt of your recent letter requesting the names of the foreign officials with whom I discussed the effects of compulsory insurance upon the standards of medical care.

I am attaching a list of names so that you may include it in the official publication of the hearings. Most of these people participated in the several discussions in varying degrees.

Sincerely yours,

JAMES B. CAREY, *Secretary-Treasurer.*

Union of Soviet Socialist Republics.—M. P. Tarasov, Mme. N. V. Popova.

Great Britain.—V. Tewson, A. Deakin.

France.—B. Frachon, L. Jouhaux, G. Monmousseau.

Mexico.—V. Lombardo Toledano.

China.—H. F. Chu.

Australia.—E. Monk, E. Thornton.

India and Ceylon.—S. A. Dange, V. B. Karnik.

Belgium.—E. Kupers.

Italy.—G. DiVittorio.

Czechoslovakia.—A. Zapotocky.

Africa.—B. Goodwin.

Senator DONNELL. Do you like the Soviet plan, concerning which you have had discussion with people from Russia?

Mr. CAREY. I would not use that model. I prefer to keep on S. 1320, if I may.

Senator DONNELL. Have you read any official reports or articles, by commentators, of any nature in regard to the success or failure, or intermediate ground between success and failure, of Great Britain's experience, particularly as it reflects itself in the quality of medical service that has occurred?

Have you read any such reports or comments?

Mr. CAREY. Yes; I have. And I might say at this moment that I am here to testify on behalf of a great number of other people. I cannot detail the kind of reading they have engaged in in this field, but they express pretty firm opinions with regard to many of these questions, and when Senator Murray and I raised the question about the kind of opposition that the principles contained in S. 1320 received, I did admit that a lot of argument was developed on the basis that in this country we have superior medical services rendered the people, and that I readily grant, but as to saying that we cannot improve our medical services, I would say there is a great deal of room for improvement, based on my personal experience, what I have read and what others have had in terms of experience, and in terms of the needs of the people I represent.

Senator DONNELL. I am wondering, Mr. Carey, if you can tell us of any specific article, booklet, pamphlet, document, that you have

read in regard to the effect of Great Britain's system on the quality of medical service in that country?

Mr. CAREY. No, sir—that is, as to making a comparison.

Senator DONNELL. Maybe I did not make that clear. What I mean is, have you read anything at all, any report, whether official or unofficial, book, document, pamphlet, newspaper article—anything that you have read in regard to the effect on the quality of the service of a medical nature in Great Britain which has resulted from the existing compulsory health-insurance plan in England?

Mr. CAREY. I have read a great deal, but I could not state names of pamphlets, or booklets, or authors.

Senator DONNELL. Can you give us the name of any one of them?

Mr. CAREY. No, sir.

Senator DONNELL. Now, you speak here of the fact, as you say, that there is no compulsion, and you make quite a point of that, I think. You say one of the outstanding attributes of S. 1320 is that it would impose no compulsion on anybody. I will ask you to state if one of the outstanding attributes of S. 1320 is that it contemplates the collection of a tax from the people who are subject to that tax under the terms of S. 1320?

Mr. CAREY. I made reference here to the fact that no one is required under this law to accept treatment or to become part of this program in terms of rendering service.

Senator DONNELL. Of course, there is nothing that requires a person, after paying his taxes, to avail himself of the benefits. He can waive those, of course, if he wants to.

Mr. CAREY. That is what I make reference to here.

Senator DONNELL. In other words, you mean then, I take it, with respect to compulsion, that after you and all the others who are subject to this tax—and all of us because a large amount or some part of the expense is going to be derived from general revenues—I take it you agree to that?

Mr. CAREY. Yes, sir.

Senator DONNELL. I say now that after we have all paid in our taxes, in one form or another, to set this scheme up under S. 1320 you mean by saying there is no compulsion, as I understand it, that there is no obligation on the part of any one of us to avail ourselves of the benefits of it?

Mr. CAREY. There is an obligation, very definitely.

Senator DONNELL. There is?

Mr. CAREY. There is an obligation on the part of every citizen of this country to avail himself of the opportunity of being healthy. You cannot walk around the streets of our community here diseased. There is an obligation on the part of all the citizens to conform to the needs of society, as I mentioned later in the course of my testimony. There is certainly an obligation on the part of the American Congress to give consideration to the needs of the people. There is an obligation to do that on this subcommittee. There is an obligation on people to work and avail themselves of the opportunity of employment, but that does not necessarily mean that they are compelled to do it. They may not avail themselves of the opportunity.

I do not care to get into a discussion of the meaning of the word "compulsion," but, if you will point out where S. 1320 does exercise

compulsion on anyone, I am sure we could save a considerable amount of time.

Senator DONNELL. I have always understood that the assessment of taxes involves an element of compulsion and I still think so, notwithstanding your argument that this bill is free from compulsion.

Mr. CAREY. By "compulsion," I mean no compulsion other than that which a citizen is obliged to do, to maintain citizenship and good standing in a community. There are certain things that a citizen is required to do, it is true, and I say there is nothing in this bill where the people are compelled to do things against their will, for their benefit.

Senator DONNELL. Even after we have paid the taxes, then, this bill does not compel us to accept any benefits under it? That is what you mean?

Mr. CAREY. That is correct. And there is compulsion in this sense that a person, even though he has no children, is compelled to pay taxes to support these schools. I think they get benefit from that. There have been people, citizens, that pay their taxes and send their children to private schools. They are compelled to support the instrumentalities of society for the education of the children generally. So, in that sense it might be considered that there is compulsion. Certainly there is.

Senator DONNELL. You referred earlier, Mr. Carey, this morning to the fact that you and the A. F. of L. representatives, and possibly you mentioned someone else, would all agree, generally speaking, and you referred a while ago that there had been no collaboration in the preparation of the material that has been presented here to the committee; that you could all agree on the principles that you have presented here?

Mr. CAREY. Yes, sir; I stated that after listening to the representative of the American Federation of Labor, Mr. Cruikshank, and I am quite certain if you put, not the words, or the thought contained in it, but the principles in the testimony he presented and the testimony that I, as a representative of the CIO present here, you will find they are very consistent; or if you take the statement that was presented for the record by Mr. Potofsky, you will find that they are consistent with these.

Senator DONNELL. In fact there is a very striking similarity, is there not, Mr. Carey, in a great many of the statements that have been presented to this committee? They take up, for instance, the American Medical Association's finding and with respect to medical indigents; they refer to the "charity" nature of the Taft bill; they go into the numerous questions in which there is a very striking similarity in the statement, is there not? There is no question about that?

Mr. CAREY. There is no question but that there is a striking similarity in the positions they take; yes, sir. I might say, Senator, that that is not surprising because this is a matter that has been thoroughly discussed. I do not think there was any collaboration between the members of the Resolutions Committee of the A. F. of L. in their meetings or the meetings of the CIO Resolutions Committee in their meetings, and yet their resolution adopted on the subject contains the same general ideas, and especially on this question with regard to whether we should take the principles contained in S. 545 or the approach contained in S. 1320, and I think that in each instance, and

without any subversive agents from any other institutions directing our activities in that respect, I assure you the CIO took its position on an independent basis, and that there were no agents of any other organization that helped us in the preparation of this statement that I presented to you here today.

Senator DONNELL. The statement was prepared by you?

Mr. CAREY. By James B. Carey.

Senator DONNELL. Personally?

Mr. CAREY. Personally, and without any assistance from any of the people you named when you raised questions with the previous witness.

Senator DONNELL. Mr. Carey, I want to ask you—you are familiar with the fact that there was a conference on labor research held on December 10 and December 11 of last year, and that a publication has occurred by the Federal Security Agency, and Social Security Administration, Bureau of Research and Statistics, which was presided over by Mr. Falk, and that that conference was attended by union representatives representing some 37 unions. You recall that; do you not?

Mr. CAREY. I have heard of that.

Senator DONNELL. For instance, Miss Katherine Elickson, who, I think, is your assistant director of research, CIO?

Mr. CAREY. Yes, sir.

Senator DONNELL. Has she been in attendance at these hearings right along; do you know?

Mr. CAREY. I do not know. I do not believe so.

Senator DONNELL. This is the first time she has come?

Mr. CAREY. I do not know. I returned on Monday of this week.

Senator DONNELL. That is not material, but she is here this morning and she was present at the research conference conducted under the auspices of the Bureau of Research and Statistics, over which Mr. Falk presided?

Mr. CAREY. May I ask you a basic question? Merely because that conference expressed some of the business views contained in the resolution adopted by the CIO, that does not mean that Katherine Elickson, representing the CIO, imposed the judgment of the CIO on that conference.

Senator DONNELL. I did not mean to leave any such impression at all. In fact, this conference was presided over by Mr. Falk—Chairman I. S. Falk—who opened the conference and made extensive statements from time to time, including one with respect to the Wagner-Murray-Dingell bill and the Taft bill, part of which reads in this way:

I want to take only a minute or two to draw certain contrasts between the two major pieces of legislation, the Wagner-Murray-Dingell bill and the Taft bill. As against the Wagner-Murray-Dingell bill as contributory insurance, the Taft bill approaches the problem of providing medical care through selective public charity—

and so forth.

By the way, I pause to refer to that “contributory insurance taxation.” You regard that as a matter of contribution or as a matter of law and compulsion?

Mr. CAREY. Taxation?

Senator DONNELL. Yes.

Mr. CAREY. I think even Republicans ought to pay income taxes and other taxes during a Democratic administration.

Senator DONNELL. I think so. You do not regard taxation laws as a matter of contribution, do you?

Mr. CAREY. It is contributions but some people can do it voluntarily, but those that do not care to do it in a voluntary manner ought to be required to do it.

Senator DONNELL. But at any rate, taxation as imposed by law?

Mr. CAREY. That is correct, sir.

Senator DONNELL. At this meeting held, over which Mr. Falk presided, and in which he made these observations—others that I shall not take the time to read—there was present Henry Bookbinder, assistant director of research, Amalgamated Clothing Workers, CIO, is he not?

Mr. CAREY. I believe he is; I am not certain.

Senator DONNELL. Well, you know Mr. Bookbinder, do you not?

Mr. CAREY. Not too well. The Amalgamated Clothing Workers are part of the CIO.

Senator DONNELL. I will ask you—do you know whether Miss Elickson was there?

Mr. CAREY. I suppose she was there. If she was not, she should have been. I will say that.

Senator DONNELL. I have a number of other persons that are listed as having been there: Miss Diana Farnham, United Office and Professional Workers of America; Mr. William Glasser, International Longshoremen and Warehousemen's Union, CIO; Mr. Godwin, United Automobile Workers, CIO; Mr. Clayton E. Johnson, director of unemployment compensation department, United Automobile Workers, CIO; Miss Eleanor Kahn, research analyst; L. E. Caslo, research director, Rubber, Linoleum, and Plastic Workers, CIO; Miss Ailene Link, research associates, American Federation of Hosiery Workers, CIO; Miss Esther Peterson, whom I know and who was here in the room, and now is legislative representative of the Amalgamated Clothing Workers, CIO; Mr. R. Shulman, research director, Marine Shipbuilding Workers, CIO; Miss Jean Weinstein, director, American Newspaper Guild, CIO; Mabel M. Weir, research director, Oil Workers International Union; A. L. Wuidaman, office of the president, United Automobile Workers, CIO.

Those are all listed as having been present at that meeting, and I assume the listing is correct.

Senator MURRAY. Miss Peterson is not in the room now.

Senator DONNELL. She was. I saw her a while ago. We will have the record clear. No objection to that.

Now, Mr. Carey, just one further question: Have you made any examination as to what expenses will be incurred after the year 1955 under S. 1320?

Mr. CAREY. No, sir.

Senator DONNELL. You referred to certain limitations in the bill in the early years of its operation. You have not made any study of it, have you?

Mr. CAREY. I said after a period of time. I think I specified about 6 years, Congress—and I say "Congress"—can give consideration to extending and taking care of other—taking other steps to extend the services to be rendered to the people of this country in the light of their experience. I am not using exact words, but the general notion. But, frankly, I would think that was a little too far to look forward to at this time, because the bill has not yet been enacted.

Senator DONNELL. That is the point I am getting at, that you are not able at this time to say what would be your estimate at all as to the ultimate expenditures under this bill after, say, 7 or 8 years of elapsed time.

Mr. CAREY. I would not say that, Senator.

Senator DONNELL. Can you give us an estimate, then, at this time, of what it would be?

Mr. CAREY. I think the expenditures will be reasonably in keeping with the services that will be rendered.

Senator DONNELL. Do you have any idea how much?

Mr. CAREY. I have confidence in the American Government and I think it will be within reason. I think the people, if they are not satisfied, will express themselves just as they have now expressed themselves as being in support of S. 1320, and would like to have an opportunity of reviewing it 6 years following its adoption.

Senator DONNELL. You say the people of this country have expressed themselves in favor of S. 1320?

Mr. CAREY. I think so.

Senator DONNELL. On what do you base that conclusion?

Mr. CAREY. On the unanimity within the ranks of labor.

Senator DONNELL. I am talking about, generally speaking, the people of the United States. Have you seen any poll on that subject? Do you know of a poll being taken on it?

Mr. CAREY. As you will recall, Senator, I might point out now because I am concerned that you might think this policy is not our own, it is. I think the people that attended those meetings indicated the interest and the interest of the people they represent in this case. You will recall the testimony that I presented to your committee a little over a year ago, and we discussed that question of poll. Could we save time by just inserting in the record of this committee the same condition we had regarding polls, its meaning and its purposes?

Senator DONNELL. Mr. Chairman, I may say the witness is not really a member of this committee, and we will probably determine what should go into this record. I am asking if you have taken any poll—I will ask it that way—as to the people—

Mr. CAREY. Yes, sir.

Senator DONNELL. Let me complete my question—as to the opinion of the people of the United States on the subject of S. 1320? Have you taken any poll, or have you seen any poll on that question?

Mr. CAREY. No, sir.

Senator DONNELL. That is all.

Mr. CAREY. And I would like to add to that answer that in the rank of the people I represent, discussion has taken place on the provisions of Senate bill 1320. We find they are overwhelmingly in support of S. 1320 and overwhelmingly in opposition to the provisions in 545, and there is no opposition whatsoever within our ranks to that position. It is unusual, I admit, but it indicates, I think, the overwhelming interest in this question, and also the solidarity of the thinking of the people on this subject.

Senator DONNELL. The CIO has 6,000,000 members, has it not?

Mr. CAREY. It has 6,338,000 dues-paying members, but I use the term 6,000,000 members because I do not think it is very significant whether it is 6,000,000 or 6,338,000.

Senator DONNELL. Has there been a poll taken of those members?

Mr. CAREY. Yes, sir.

Senator DONNELL. When was that poll taken?

Mr. CAREY. The poll was conducted in the orderly processes of our organization. I mention in my testimony, in the national convention of the CIO, and the national convention of the affiliated organizations and the State organizations and in the committee organizations and in the local union bodies and in the district council; I am trying to anticipate your question as to whether or not we sent out post cards. My answer is "No."

Senator DONNELL. In other words, there has been no poll of each of the individual 6,338,000 members of your union as to their opinion on S. 1320? That is correct, is it not?

Mr. CAREY. In our processes we consider that is the way of telling their opinion, by having it from the local union.

Senator DONNELL. I might just ask you again: Has there been anything sent directly to each of the 6,338,000 people?

Mr. CAREY. No, sir.

Senator DONNELL. That is all.

Senator SMITH. I might remind the subcommittee that this witness would like to get a certain plane, at what time?

Mr. CAREY. At 1:40.

Senator MURRAY. I would like to ask just a few questions.

Mr. CAREY. I will be delighted to return at some other time, at the need of the committee.

Senator MURRAY. We appreciate that but I hope it will not be necessary to bring you back here again.

ou feel that if this bill is put into operation there will be eventually a great improvement in the health of the American people?

Mr. CAREY. Yes, sir.

Senator MURRAY. And that, in turn, would tend to decrease the cost of the operation of the plan?

Mr. CAREY. Yes, sir.

Senator MURRAY. It would result also in a great increase in the members of the medical profession?

Mr. CAREY. It would result in an increase.

Senator MURRAY. And in nurses. So that, as a result of the combined operation of the bill, the health of the Nation would be greatly advanced, and thereby the cost of the complete operation of the bill would be greatly reduced?

Mr. CAREY. May I add on the other side, there would be a tremendous saving in what can now be considered a wasteful method of operation, measured in terms of loss of production by illness and other things.

Senator MURRAY. I put into the record here, the other day, statistics showing the great losses that this country suffers as a result of ill health. Industry, for instance, annually loses many millions of dollars as the result of ill health of its workers. Improvement in that country would be a great advantage to business and industry in this country?

Mr. CAREY. Yes; it would.

Senator MURRAY. There being great need for a program of this kind, you feel that the working out of the provisions of the bill is

something for experts to do, not for the witnesses that come here to tell us about the actual conditions in the country with reference to the need? For instance we have had heretofore people come from way out in the agricultural sections of the Nation to tell us about the failure properly to distribute medical care in those sections of the country. The same kind of witnesses have come here from the South. You do not feel that those witnesses should be the ones to lay out a blueprint for the American people? That is something that should be done by the Congress when the problem is laid before the Congress? It is the duty of Congress to work out a bill here that will accomplish the purposes that the people of this country demand?

Mr. CAREY. Correct.

Senator MURRAY. And that is all we are trying to do here. But we have had other witnesses testifying on this line—for instance, we had Dr. Parran here yesterday and he explained in some detail how this bill would be put into operation, how the different steps would be staggered so that we would finally get into complete, harmonious operation, and that is a problem, as I say, for experts. But you came here to tell us about the need from the standpoint of American workers, and you feel that the American workers are a unit on this proposition that we need some compulsion system of financing medical care in this country?

Mr. CAREY. And I say not only the workers, but I may say I have seven sisters and three brothers, all of them married, living in Senator Smith's State, and they too, as well as the members of the CIO, and their dependents as well, feel that way about it.

Senator MURRAY. S. 545 has been talked about here. It provides an appropriation of \$200,000,000, to be duplicated by the States. If that sum of \$200,000,000 was fully duplicated by the States, it would not go very far in meeting the needs of the country, would it?

Mr. CAREY. No, sir; and it would not be immediate. There would be some delay in the terms of the application.

Senator MURRAY. In order to get the care that that bill would undertake to provide, a person would have to sign an affidavit, or submit proof he was a pauper or was unable to pay for some reason or another?

Mr. CAREY. That is as I read the bill. That is my understanding.

Senator SMITH. It is not quite that. That is not provided in the bill.

Senator MURRAY. I am glad to be corrected. The bill provides that the people who are not able to pay—

Mr. CAREY. In whole or in part.

Senator SMITH. You have got the two questions presented: Whether you are going to have an over-all coverage under which everybody gets free medical care, even without paying the tax, or whether to let those pay that can pay and take care of the other people that cannot. That is another approach.

Senator MURRAY. Under S. 545 the people that get medical care do not have to pay anything. It is completely a Government program.

Senator SMITH. No; they have to pay—it provides that they pay part or all.

Mr. CAREY. No; they would pay for it, but not directly.

Senator MURRAY. Well, if that bill were carried fully into effect and expanded and we should undertake to have it applied to the

country as a whole, to meet the entire problem in this country, we then would have a system of really socialized medicine, would we not?

Senator DONNELL. You are not in favor of socialized medicine, I take it, Senator?

Senator MURRAY. I do not care what kind of medicine you call it. We should have medical care for all.

Mr. CAREY. I am going to answer that by stating I would not know.

Senator MURRAY. You would not know what the effect of that bill would be?

Well, anyway, you think that S. 1320 more adequately meets the needs of the country than S. 545?

Mr. CAREY. Yes, sir. That is why we are so wholeheartedly in support of S. 1320.

Senator PEPPER. I am aware of your time limitation, Mr. Carey, and I am just going to ask you this: As I see it, the core of S. 1320 is simply to provide a method by which the masses of the people of this country can pay for the medical care that they need. Now, the doctors, except in the sense that they also are taxpayers are not going to be the great payers of these fees that this law will require, because there are only a couple of hundred thousand doctors in the country, but what impresses me is that Mr. Cruikshank came here, appearing for 7½ million members of the A. F. of L., of the working people of this country, and you come here appearing for over 6,000,000 working people of this country. They are the ones that will be getting wages on the pay rolls of the country. They are the ones who will have to pay the tax, and you come here to say that "we, who are the ones that will bear the burden of the tax, want to pay the tax because it is the way we can budget our medical care," and you say that "the doctors, who will get the money that we pay in, have no right to block us before the American Congress from the the right to pay the taxes that will give us a way to meet the budget to pay the medical needs of the family."

Is that not about the gist of it?

Mr. CAREY. That is correct. I do not say that that is the position that will always be held by the doctors, the position of opposition. I would say that that is changing. Certainly it is not changing rapidly enough to cause the medical profession today to understand the provisions of Senate bill 1320 sufficiently to be here testifying as the champions in support of it. I do not look upon it as anything in the form of WPA for the medical profession, but I think there is a moral obligation on their part to support this bill.

Senator PEPPER. One other thing. Not only is it true that you are going to have to pay your part of the tax as workers, but it contemplates a tax on the employer, which will add to the cost of the goods, and the workers will have to pay or bear their share of that, too. So that the principal burden of these taxes that S. 1320 contemplates will be on the working people of the country, yet you are the ones who are here asking that you be permitted to pay those taxes.

Mr. CAREY. That is correct.

Senator DONNELL. The Senator does not at all contend that the pay-roll taxes will pay the whole expense of it?

Senator MURRAY. Every technician who has appeared here has certainly indicated that it would pay the majority of it.

Senator DONNELL. I say, though, the Senator does not contend that the pay-roll taxes will pay all the expenses.

Senator MURRAY. No, we do not know how much this may have to be, and we frankly confess that there may have to be an appropriation to supplement it. But that will have to be worked out in Congress, as to whether we want to raise the tax or whether we want to resort more to your method of subsidizing out of the Federal Treasury.

Senator DONNELL. That would be payment out of the Federal Treasury.

Senator MURRAY. But the principal approach to the payment of these services is through the pay-roll tax from the employer.

Mr. CAREY. Yes, sir.

Senator SMITH. Thank you, Mr. Carey. We appreciate very much your coming here to testify this morning.

Senator MURRAY. I assume Mr. Potofsky's statement will be included in the record?

Senator SMITH. Mr. Potofsky's statement will be put in following Mr. Carey's testimony. Now, we will recess until 2:30 this afternoon. (Mr. Potofsky's brief is as follows:)

STATEMENT OF JACOB S. POTOFSKY, GENERAL PRESIDENT OF THE AMALGAMATED CLOTHING WORKERS OF AMERICA AND MEMBER OF THE EXECUTIVE BOARD OF THE CONGRESS OF INDUSTRIAL ORGANIZATIONS, ON BEHALF OF THE CONGRESS OF INDUSTRIAL ORGANIZATIONS IN SUPPORT OF THE NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH ACT OF 1947

I am here today to speak not only for the 325,000 members of the Amalgamated Clothing Workers of America, of which I am the general president, but also for the more than 6,000,000 members of the Congress of Industrial Organizations.

The Amalgamated Clothing Workers of America is a union which was born in the sweatshops. Its members have for more than 30 years been actively improving their working and living conditions. As long ago as 1923, the Amalgamated instituted an insurance program which has since developed into an extensive system of benefits providing its members with substantial protection.

As part of the Congress of Industrial Organizations we have been in the forefront of the campaign for higher minimum wages and shorter hours and for old age, health, and other social insurance not only for our own members but for all the American people. We have done this because we believe that the problems of economic and social security are not divisible and must be met on a national level.

The opportunity to enjoy good health and protection from the economic effects of illness is a cornerstone of the basic American rights of freedom from fear and freedom from want. The health and well-being of the people are essential to maintenance of a high level of production and full contribution to the Nation's economy.

The poor state of the Nation's health was made shockingly apparent by our wartime experience. At a time when the national defense required the greatest utilization of our manpower, the Selective Service System found a very high proportion of our young men unfit for military service. Almost 5,000,000 young men between the ages of 18 and 37—30 percent of all those examined—had been rejected for military service by April 1945. Yet, despite this "weeding out," an additional 3,000,000 were discharged or treated for disabilities which had existed before their induction. These figures were tragically significant for our military mobilization. I mention them now because they are no less indicative of the inability of the American people to meet the demands of normal, peacetime living.

What are the facts about our Nation's health today? Our experts tell us that 1 out of every 20 are disabled by sickness on any average day. And these 7,000,000 who are incapacitated are by no means all suffering from minor or temporary ailments. More than half have been sick for 6 months or longer. These figures represent pain and personal suffering. And they also represent a great loss to

our productive capacity. At least half of the 7,000,000 disabled on an average day are in the labor force and would ordinarily be employed or looking for work. Illness or accident was responsible for the loss of 500,000,000 workdays or about 3 or 4 billion dollars in wages during 1942, when our need for war production was critical.

The simple truth is that our country's health facilities are insufficient and that those most in need of medical care are least able to afford it. Compared with other countries, our medical standards are high. But those health and medical resources which we have are so unevenly distributed that the areas and groups in greatest need have the least service. In spite of the tremendous strides made recently by our public health and maternal and child care programs, there are still 40,000,000 Americans living in communities without full time, local public health services. When one realizes that it would take more than 100 years to cover the whole Nation with public-health services on the present basis, the hopelessness of attempting to provide satisfactory health services without a comprehensive national health program becomes brutally clear.

Present insufficiencies of service are at least equalled by the financial inability of those families most urgently needing medical care. Illness most often strikes those least able to afford it. The medical histories of low-income families are records of premature death and longer and more frequent illness. Yet, although low-income families have greater medical needs than those with higher incomes, they actually receive far less medical attention.

Facts on our insufficient, badly distributed, and poorly organized health facilities and on the inability of large sections of the American people to pay for even a minimum of medical care have been testified to in detail by medical and public-health experts. I shall not linger over them. We believe that the National Government should act to improve the situation just as it has moved ahead to help build roads, improve forestry practices, help the farmers raise healthy animals, and in many other ways develop the Nation's resources. Surely, our people are our greatest resource.

Before the war, about \$4,000,000,000 a year was spent for medical care. Three-fourths of this was spent by patients and their families; one-fifth by Federal, State, and local governments; and the rest by industry and philanthropy. The costs of medical care can be fairly well predicted for large groups, and the distribution of risks and costs can, therefore, be spread to provide medical care for those least able to pay for it themselves. There is nothing new about this idea. Our educational system is based on the same principle.

To a certain extent, various insurance plans have been attempting to do this for years. The insurance program of the Amalgamated Clothing Workers of America had its origin in the establishment of an unemployment insurance fund in Chicago in 1923. After the enactment of the Social Security Act in 1935, it was converted, by agreement with the employers, into a life and health insurance plan which went into effect in 1940. The Amalgamated, which had pioneered in the field of unemployment compensation, then embarked on a program to protect its members against the financial burdens of death and disability. At the present time, almost 300,000 of the 325,000 members of the Amalgamated are entitled to benefits. These include death, accident, illness, maternity, and hospitalization benefits. And—parenthetically—I should like to remark that men's clothing workers receive, in addition, retirement benefits. That this insurance is answering a long-needed want on the part of our own members is best shown by the fact that up to March 1946, in almost half the deaths, the Amalgamated policy was the only insurance left by the member.

But, industry-supported plans cover relatively few workers. More extensive in coverage, although still not meeting actual needs, are the voluntary insurance plans, such as the Blue Cross plans. These now cover about 13,000,000 people—less than one-tenth of the entire population. But, although the success of these plans demonstrates the possibility of insuring middle-income families against hospital expenses, their costs are so high that they cannot be extended to the low-income families most in need. And, although these plans help make existing facilities available to those who can meet the costs, they do not touch upon the vital fields of medical care other than hospital care. Even our own Amalgamated insurance program does not provide medical service as such, but helps defray the expenses of such care, and then only partially.

The essentials of a good national health program are simple to formulate. The cardinal purpose of such a program is, above all, to place satisfactory medical and hospital care within the reach of all the people. More hospitals and more doctors must be available to those groups and in those areas of the country

where they are needed. More public health services, including maternal and child care services, must be provided. Medical education must be expanded to train the personnel needed to carry out the program. And, additional medical research should be made possible to aid in the prevention of the many painful and costly diseases which now take such a heavy toll among us.

We are opposed to the Taft bill, S. 545, as an ineffectual substitute for a national health program. It allows too little money for too few people on too limited a basis to be acceptable to the American people. The Taft bill is intended to give medical and dental care in the form of medical charity, a method abhorrent to the dignity of the American people. But, it is not only that small fraction of desperately poor Americans who so urgently require medical and dental care, but he great majority of self-supporting Americans who are not in a position to meet the unexpected costs of illness. The Federal funds authorized for medical service under the bill are insufficient, and the provisions for matching funds by the States are too indefinite. It is estimated that, at the most, less than 10 percent of the people would be covered by the program. Furthermore, the administration of the plan is unsound. It does not provide for adequate public representation on the national advisory councils, and, in fact, places the supervision of almost all federally supported civilian health and medical services under an agency controlled by organized medicine. It sets up no proper standards for the allocation of public funds to private voluntary organizations. And, although some aspects of the bill, such as provision for physical examinations for children and for cancer clinics, are desirable, taken as a whole, the Taft bill amounts to Federal underwriting of a poorly administered program of medical charity, which will benefit too few people.

The National Health Insurance and Public Health Act, S. 1320, however, would establish a workable national health program which, although not complete, would be comprehensive enough to be effective. By providing hospital care and all needed preventive, diagnostic, and curative services by a family physician of the patient's choice to all employed and self-employed persons, this bill lays a firm basis for insuring the Nation's health. Federal grants-in-aid to States will enable expansion of public-health services. The financing of the program primarily through a pay-roll tax to be borne equally by workers and employers will provide sufficient funds for a plan of the required scope and magnitude. It is a method which has been tried and proved in our already existing system of old-age insurance. Doctors would be free to enter or stay out of the program and could choose their method of payment. Administration by local committees of lay as well as professional representatives operating under a Federal administrative board and a set of national standards allows for local flexibility within the framework of proper safeguards.

The Congress of Industrial Organizations urges this committee to recommend adoption of the National Health Insurance and Public Health Act of 1947. The program proposed in this act is an extension and a proper implementation of our already existing system of social security. The laboring people of this country do not want charity. They want a positive and effective program to safeguard their health. By providing for a Nation-wide system of prepaid personal health service benefits and Federal grants for expansion of health services, this bill would establish the core of an effective national-health program. We urge enactment of this bill so that the American people will have protection from the economic effects of illness, an opportunity to enjoy good health, and the ability to make a maximum contribution to our Nation's economic well-being.

(Whereupon, at 1:10 p. m., the subcommittee recessed until 2:30 p. m. this day.)

AFTER RECESS

(The subcommittee reassembled at 2:30 p. m. pursuant to recess.)

Senator SMITH. The committee will please come to order. Is Mr. Michael M. Davis here today?

(No response.)

Mr. Davis and Mr. Louchheim are not here today. Is Mr. Horace Hansen here, general counsel of the Cooperative Health Federation of America?

Mr. HANSEN. Yes, sir.

Senator SMITH. Before you begin your testimony, Mr. Hansen, I want to read for the record, because I want to stress these points—I will postpone that for a moment.

Mr. Hansen, we will be very glad to hear you. Will you tell us just who you are, what is your job, and how you qualify as a witness here?

STATEMENT OF HORACE R. HANSEN, GENERAL COUNSEL, CO-OPERATIVE HEALTH FEDERATION OF AMERICA, ST. PAUL, MINN.

Mr. HANSEN. Mr. Chairman and gentlemen, my name is Horace R. Hansen. I am a practicing attorney in St. Paul, Minn. I am counsel for the Cooperative Health Federation of America, and appear here by their specific request.

Senator SMITH. That is not the same organization that is the Committee for the Nation's Health?

Mr. HANSEN. No; it is not. We are not affiliated with the Committee for the Nation's Health.

Senator SMITH. Could you give us a little statement of what the Cooperative Health Federation of America is?

Mr. HANSEN. Yes; I intend to do that in my statement.

Senator SMITH. Then proceed in your own way, Mr. Hansen. We will be very glad to hear you.

Mr. HANSEN. I am also here to represent the Cooperative League of the United States.

Senator SMITH. Does that mean the so-called cooperative movement in the United States?

Mr. HANSEN. Yes, sir.

Senator SMITH. Farmers' cooperatives and any other cooperatives?

Mr. HANSEN. All of the cooperatives who are affiliated with the Cooperative League of the United States and by their specific authority in the resolution passed unanimously in the cooperative held at Columbus, Ohio, in September of 1946, and by recent action of their board of directors I appear here and testify.

Senator DONNELL. That is action taken by the Cooperative League?

Mr. HANSEN. The Cooperative League of the United States with headquarters at 343 South Dearborn Avenue, Chicago.

Senator SMITH. You are not counsel for that league? You are just representing them for this purpose?

Mr. HANSEN. I am representing them for this purpose. That is correct.

Senator SMITH. Are you a member of that Cooperative League?

Mr. HANSEN. The Cooperative Health Federation of America is an affiliate of the Cooperative League of the United States.

Senator SMITH. What is the over-all membership of the Cooperative League, which I take it is a parent body—what is the membership of that?

Mr. HANSEN. The membership roughly is 2½ million American families, approximately 10,000,000 people.

Senator SMITH. The Cooperative Health Federation—how large an organization is that?

Mr. HANSEN. That has about 150,000 memberships.

Senator SMITH. Is that a branch of the Cooperative League you are interested in as general counsel?

Mr. HANSEN. I am counsel for them but I am not especially interested in that. I am representing them alone or representing the viewpoint of the Cooperative League of the United States.

Senator SMITH. Very well, proceed, Mr. Hansen.

Mr. HANSEN. We wish to submit for study by the subcommittee, and for the record, copies of two statements which are, of course, official documents and policy statements of the Cooperative Health Federation of America and have been widely distributed through our membership.

At this point I would like to insert in the record the resolution that I have numbered "1" which was passed by the conference held at Two Harbors, Minn., in August of 1946.

Senator DONNELL. Is that what is called one of the health workshops?

Mr. HANSEN. It was a national conference on health problems.

Senator DONNELL. It was what is called generally, though, one of the workshops, is it not?

Mr. HANSEN. It was a conference of—

Senator DONNELL. I say it is called that, though. That is what it is generally referred to as, is it not?

Mr. HANSEN. No; I believe not. While it concerns the specific problem, it concerns the whole general problem of health. I would like to have that inserted in the record as an official document for the Cooperative Health Federation, and also the statement containing opposition on any national health legislation which was adopted by the board of directors of the Cooperative Health Federation of America in their meeting on November 16, 1946, which I have numbered "2."

I would also like to insert in the record a letter signed by Mr. Jerry Voorhis, former Congressman, who is at present executive secretary of the Cooperative League of the United States and which letter authorizes me to speak for the league. I have numbered that "3."

I would also like to insert in the record the resolution adopted unanimously by the Cooperative League of the United States of America in their cooperative congress held in Columbus, Ohio, on September 9 to 11, 1946, which is numbered "3-A."

(The papers referred to follow:)

RESOLUTIONS CONCERNING NATIONAL HEALTH PROGRAM

Resolved, That the conference approve the principle of public responsibility for assuring the availability of health and medical services for all the people, without economic or other barriers, and therefore support proposals for larger grants to the States for public health purposes; and Nation-wide health insurance under public auspices, provided:

1. That all services provided through Government should be available to all the people on a democratic basis regardless of race, creed, residence, or economic status;

2. That any public-insurance proposal to receive our support must assure:

(a) Continuation and expansion of the voluntary health and medical-service agencies on a basis that will permit consumer control of administrative and organization policies;

(b) Freedom to establish new medical-service groups with consumer determination of policies;

(c) That as a condition for State participation in the national health program there shall be no State policies, legal or otherwise, that restrict the free development of consumer-sponsored medical-service plans;

(d) That programs of preventive medicine and public health, including services for mothers and children, will be broadly conceived and administered;

(e) That Government will share responsibility for a more favorable distribution of medical personnel and facilities;

(f) That provision be made in legislation that will assure to all the right to free choice of physician and freedom to designate the plan with which they wish to be associated;

(g) That Federal, regional, State, and local administrative and policy-making councils, boards, or committees provide for a majority or equal representation from organized consumer groups;

(h) That there be a maximum decentralization of administration and local control.

3. That in all legislation in the health and medical-care field the interests of consumers be protected through consumer representation on policy-making councils, boards, or committees;

4. That legislation be sought, through new bills or through amendments to existing legislation, for grants and/or loans to consumer-sponsored organizations for capital expenditures or purposes of establishing new facilities or expanding and enlarging existing facilities including health centers and hospitals;

5. That the new national organization of voluntary plans be instructed to further the above policies by public education and other appropriate means; and be it further

Resolved, That any association or federation which is organized at this conference be requested to set up, and provide a budget for, a committee of well-qualified persons whose duties it shall be to:

1. Study ways and means of carrying out these principles;
2. Cooperate with other groups in efforts to achieve those aims;
3. Analyze any proposed legislation relating to the achievement of these aims;
4. Make recommendations to the members of such association or federation with regard to action on any such proposed legislation; and
5. Carry out any other related activities as may be determined by the board or the membership.

SPECIFIC PROVISIONS THAT MUST BE INCORPORATED IN NATIONAL HEALTH LEGISLATION IF SUPPORTED BY CONSUMER-SPONSORED VOLUNTARY-PREPAYMENT ORGANIZATIONS * * *

National health legislation, to receive the support of the Cooperative Health Federation of America, must contain assurances that when voluntary organizations are operating in the public interest and are providing services to consumers of medical care, such organizations will not be discriminated against. Now existing voluntary-prepayment plans want, also, assurance that they will be free to compete, on an equal basis, with each other and with other types of organizations for medical services or with physicians practicing individually. Organizations established for the purpose of providing a medical service to their members must be free to expand their programs and membership and not be forced to change the basic character of their plan for medical services because of the existence of a national-health program. There must not be anything in the law that will prohibit or unnecessarily impede the establishment of new voluntary medical-service organizations.

To assure these objectives the following circumstances must be provided for in Federal legislation receiving the unqualified support of consumer-sponsored health-medical-care plans:

1. That any national-health program intended to improve the health status of the American people through removing existing economic barriers to necessary care and through making professional personnel and health facilities uniformly available throughout the country shall be based on the principle of medical service benefits to the individual and not cash benefits, providing, however, that disability insurance for income maintenance should be paid in cash benefits.

2. That organizations providing a medical service may negotiate contracts with Government to provide services to beneficiaries who select the particular plan by free-will designation, the terms of such contracts to be not less favorable than those contracts negotiated by Government with other organizations or individual providers of services for the same type of benefits.

3. That Government will be prohibited from granting exclusive rights to any corporation or organization of consumers or providers, or a combination of con-

sumers and providers, or groups of providers, whether direct or indirect providers, to act: (a) in any specific geographic area; (b) for any group or class of consumers of medical services; or (c) for providers of benefits under the program.

4. That Government will be prohibited from making a contract or entering into an agreement with any organization or corporation, whatever the type of sponsorship, that enjoys a monopoly under State law, Executive order, or regulation, or otherwise, for operation of a medical-service plan or for representing providers of services in negotiation with Government or rates of payment, and other related matters, in any geographic area or for any given group or class of consumers of medical services; except that this provision shall not apply to agencies of State government or its local political subdivisions.

5. That Government will be prohibited from making a contract with any professional association or corporation, State or local, for the provision of medical services if any provider currently licensed to practice his profession is excluded from participation in the program for any reason other than his professional competence or willingness to accept the conditions of the contract between the association and Government.

6. That Government be prohibited from:

(a) Requiring providers of services to be members of any voluntary association or organization, or to designate any specific agent to represent them in relations with Government for: (1) Negotiating rates of payment, (2) to act for them in submission of claims for payment; or (3) to receive money for benefits rendered to beneficiaries of the program; and (b) Negotiating with any agent of providers that requires membership in the providers' organization by withholding any professional privilege if such organization is not designated by a particular provider of services.

7. That Government be prohibited from the use of any type of voluntary agency as its agent in the performance of such administrative functions as (a) Disbursement of tax funds for payment to individual providers rendering services to individual beneficiaries; (b) determination for Government of the amount to be paid by Government to individual providers of services for benefits rendered by them; (c) determination of the conditions of the contract between Government and the individual provider of services, including such provisions as rates of payment, standards with respect to quantity and quality, use of special consultants, methods and procedures for participation in the program with reference to such items as home calls, office visits, and care in hospitals.

8. That coverage under a national health program shall be universal for all members of the population with no exclusion no exceptions for economic, racial, geographic, or other reasons.

(NOTE.—Circumstances shall not exist which recognize, insofar as the consumer of medical services in concerned, two systems of medical care—one for those who contribute through a special or general tax and one for those who are in the lowest income groups and who do not, therefore, contribute through some form of taxation.)

9. That Federal operation of the program is not provided for except in those instances in which State agencies do not properly exercise their responsibility or refuse to do so and that the maximum amount of decentralization of administration is provided for with administration through official State and local health and medical-care agencies.

10. That policy-making boards shall be required for all public or nonpublic agencies with responsibility for performing administrative or executive responsibilities and that such boards shall have representatives of the public interest and the consumers of medical services—to serve with the representatives of the professions—in an effective majority.

11. That allocation of funds by the Federal agency to State and localities be made in accordance with methods which will assure a Nation-wide uniformity of services with respect to kind, extent, and quality in not longer than a 10-year period.

12. That the Government be responsible for an equitable and Nation-wide distribution of professional personnel and facilities and for maintenance of standards of care.

13. That, since there is an insufficient number of all types of professional health personnel, including administrative, that the Government in the expansion of health and medical-care programs, recognize its responsibility for provision of public funds to expand facilities for training and to enable individuals to obtain training.

Adopted by the board of directors, Cooperative Health Federation of America, in meeting November 16, 1946.

THE COOPERATIVE LEAGUE OF THE UNITED STATES OF AMERICA,
 NATIONAL FEDERATION OF CONSUMER COOPERATIVES,
Chicago 4, Ill., July 1, 1947.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: The Cooperative League of the United States appreciates very much this opportunity to present before this committee testimony regarding the health problems of the American people. The cooperative league includes in its membership some 2½ million American families from all walks of life joined together by their mutual belief in the benefits to themselves and their country which flow from the application of cooperative methods and principles to the people's problems.

The cooperative league includes as one of its affiliates the Cooperative Health Federation of America, along with other cooperators operating in other fields of social and economic activity. It is logical, therefore, that testimony on health legislation should be presented for both the Cooperative League and the Cooperative Health Federation by the person designated by the board of directors of the Cooperative Health Federation. I regret that it is impossible for me to be present personally to introduce Mr. Horace Hansen to the committee, since he has been so designated.

Mr. Hansen will speak to the committee for the cooperative league generally and for the Cooperative Health Federation of America specifically. In connection with problems involving improvement of health services, enabling people to pay for the preventive and curative services they need, and presenting the viewpoint of the people as consumers of health services, the cooperative league logically takes the position that the health federation should make the specific decisions and determine and set forth the policy of the cooperative movement as a whole.

H. JERRY VOORHIS,
*Executive Secretary, Cooperative League, United States of
 America, and Cooperative Health Federation of America.*

RESOLUTION UNANIMOUSLY ADOPTED BY FIFTEENTH BIENNIAL CONGRESS, COOPERATIVE LEAGUE OF THE UNITED STATES OF AMERICA, COLUMBUS, OHIO, SEPTEMBER 9-11, 1946

Millions of people still suffer needlessly from inadequate distribution of medical care in spite of the outstanding progress of medical science.

This Congress commends the medical professions for their signal contributions to the scientific developments which now make possible the wider and more effective distribution of medical care.

This congress commends the medical cooperatives and group health associations for their pioneering efforts in enabling consumers to obtain fuller use of medical services through various types of prepayment plans. It further commends them for their recent action in organizing the Cooperative Health Federation of America.

The Cooperative League has consistently supported and encouraged the development of such voluntary health plans. It gave encouragement and assistance to the meeting which resulted in the incorporation of the Cooperative Health Federation of America. It now urges all cooperatives affiliated with the league to sponsor the establishment of organizations through which the people in their respective areas can obtain medical, hospital, and other health services on a cooperative prepayment basis. It further urges that such organizations will affiliate with the Cooperative Health Federation of America and assist in the distribution of health and medical care on a cooperative basis.

This congress recognizes that efforts of the cooperative movement alone cannot insure in the near future the distribution of adequate health care to all of the people in the United States. For this reason it approves the principle of public responsibility for assuring the availability of health and medical services for all the people without economic or other barriers. To this end it supports:

1. The making of larger grants by the Federal Government to the States for public-health purposes.

2. Nation-wide health insurance under public auspices provided that any proposed Government action in this field—

(a) Provided for the continued expansion of volunteer cooperative health and medical care plans on a basis that will permit consumer control of administrative and organizational policies.

(b) Provide for local control through maximum decentralization of administration.

(c) The making of Federal loans to consumer-sponsored agencies for hospitals, clinics, and equipment.

(d) Provide as a condition for State participation in a national health program that there shall be no State policies which restrict the free development of consumer-sponsored medical-care plans.

Mr. HANSEN. We wish to present the American consumers' viewpoint on national-health legislation now pending before this committee. Our interest is a social and economic one. We leave to the medical and allied professions questions in the field of medicine, how to treat diseases and maintain health.

Because the members of this subcommittee and others interested in the testimony presented to the subcommittee may not be entirely familiar with the purpose and work of the federation, we wish to state briefly what and why we are organized.

Realizing that consumer sponsored medical service prepayment plans throughout the country have common interests and problems; that groups of consumers wishing to establish prepayment medical-service plans are in need of technical assistance, the national conference of such groups was held in Two Harbors, Minn. in August; out of this conference the Cooperative Health Federation of America was formed. A board of incorporators was elected by this conference and the federation was formally established and officially elected at Columbus, Ohio, in September 1946.

Senator SMITH. Have you the names of the directors, the officials?

Mr. HANSEN. Yes, sir; I have. The incorporators and directors are as follows:

Michael Shadid, Elk City, Okla.;
Harry Becker, Washington, D. C.;
Elmer Richman, St. Louis, Mo.;
Cecil Crews, third vice president and director, Kansas City, Mo.;
George W. Jacobson, secretary-treasurer and director, St. Paul, Minn.;
Ludwig Anderson, director, Washington, D. C.;
Winslow Carlton, New York City;
E. J. Loehr, director, Saskatchewan, Canada;
James L. Monroe, director, Hale Center, Tex.;
Addison Shoudy, director, Seattle, Wash.;
Charles Wilkinson, director, Two Harbors, Minn.

The purpose of the federation, incorporated under the District of Columbia laws, as stated in the statement of bylaws adopted in September 1946, is as follows:

The purpose of this Federation shall be to engage in activities for the promotion of the health and well-being of its members and of the public; to provide facilities for improving the physical, mental, and moral condition of mankind; and to aid and assist its members and other persons, groups, associations, corporations, and institutions now engaged in furthering any of the purposes above named.

In order that this subcommittee may know the types of organizations which are members of the Federation, I wish to quote from the bylaws the statement of membership eligibility and I quote:

A regular member shall be any person, any incorporated or unincorporated group, association, cooperative, or corporation acceptable to the board of directors or executive committee and agreeing to abide by these articles, the bylaws and other rules of this association. Minimum qualifications for membership shall be:

(a) The furnishing, providing, securing, or arranging for medical or hospital services, or services allied thereto, on a prepayment basis, and the maintaining of satisfactory quality in such services.

(b) Effective control by users of the services in matters pertaining to policy;

(c) Operation on a cooperative or nonprofit basis;

(d) Ownership, leasehold, or management of the facilities resident in the users of the services, unless such ownership, leasehold, or management by others does not mitigate control by users of the services in matters pertaining to policy; and

(e) Such other qualifications as may be prescribed in the bylaws.

The Cooperative Health Federation of America now represents the majority of the consumers of medical services in the United States who have organized themselves through community, voluntary prepayment medical-care plans for the purpose of removing economic barriers to necessary medical care that exist today for the overwhelming majority of American people.

Not only are these consumer groups organized for the purpose of removing the economic barriers to necessary medical care but they are also organized to establish medical-care facilities for group medical practice.

We believe that it is only through group medical practice that the best interests of the public can be protected.

The federation believes from its own experience—that is to say, the experience of its member associations, some of which have been in existence for as long as 20 years—that health and medical-care services are not generally available for the majority of American people on a basis that they can afford, at standards of care, made available at the teaching hospitals and other hospitals of organized group medical practice, and benefit fully only an exceedingly small fraction of our total population.

Expert medical testimony presented to this subcommittee substantiates that position. We believe that it is only through mobilization of consumer effort and utilization of all the instruments of our Government, Federal, State, and local, that modern medicine can be brought within the reach of all the people.

We would like also to insert as part of the record for the subcommittee's reference our letter to the editor of the *Journal of American Medical Association*, which was published in that journal in the November 1946 issue. We have marked that as our "Exhibit 4."

(The letter referred to, dated October 9, 1946, follows.)

OCTOBER 9, 1946.

DR. MORRIS FISHBEIN,
Editor, Journal of the AMA,
Chicago, Ill.

DEAR SIR: The board of directors of the newly organized Cooperative Health Federation of America, whose inauguration was featured by an editorial in the *Journal of the American Medical Association* of August 31, wish to set before your readers a statement of the federation's principles and aims. We trust that you will publish this letter in full, because we feel that your editorial did not accurately report our position.

The first principle upon which our federation is based is that patients have the right voluntarily to organize for the purpose of securing medical attention for themselves and their families.

Free association for any purpose not inconsistent with the public interest lies at the root of our liberties. Does the American Medical Association hold that the organization of consumers to obtain physicians' services is "inconsistent with the public interest?" We cannot believe that it does. Yet, we find its constituent societies in a number of States sponsoring and supporting legislation that pro-

hibits patients from organizing plans for medical care without the express permission of the doctors. In many States, where such laws have been enacted, medical societies have set up prepayment plans; since the societies have the power to prevent the formation of other plans, their plans are clearly monopolies.

A major aim of the federation is to rectify the fundamental injustice of these laws. We have no wish to debar the doctors' plans; we wish merely to give consumers equal opportunity and thus restore in every State the liberty anciently permitted under the common law.

Our federation's second principle is that consumer-organized medical-care plans are an instrument for bringing the art and science of medicine more effectively to more people.

When consumers organize to provide themselves with services or goods, they do so to obtain more and better services and goods. In the case of medical care, the consumer's interest must first be in quality. The members of this federation understand that comprehensive medical services of high quality require well-trained physicians and competent auxiliary personnel, adequate facilities and equipment, and the development of a personal relationship between a patient and his doctor. To achieve these conditions requires rational organization of the doctors and allied professional personnel. It further demands close cooperation and thorough organization between those who render and those who receive the services. Group practice, developed by physicians from the needs of their science, is, in our view, the answer for professional collaboration. It has, in fact, been successfully utilized by the majority of our members. In combination with prepayment and consumer organization, group practice has demonstrated its ability to deliver a high quality of care.

There is no such thing as consumer control of medical practice. In plans sponsored by consumers, doctors are free agents, free to accept or reject the proffered compensation, free to render the kind of medical service their knowledge dictates and the profession's code of ethics demands.

In support of our statement that consumer-organized plans wish to improve the effectiveness of medical care, we point to our member plans in comparison with the inadequacy of medical-society-sponsored plans. Only a fraction of the medical-society plans have advanced beyond a minimum coverage of surgical operations. Their contracts are laden with restrictions and exclusions. The consumer-sponsored groups, in contrast, all show broader scopes of service and most of them place particular emphasis on personal preventive medicine.

Our member plans provide for medical services in contradistinction to cash indemnities. They seek to develop medical centers rather than sell insurance policies. Their intent is to broaden the scope and enhance the quality of medical care at the same time as they give financial protection.

For these reasons, the federation stands without equivocation for consumer-organized medical-care plans. It does not seek any exclusive rights for consumers, but believes that the right of free association and competition will bring about progressive improvement in the distribution and quality of medical care.

Our third principle is that the public has a responsibility for assuring the availability of health and medical services for all the people without economic or other barriers.

From our work in organizing and conducting local prepayment plans we are acutely aware that there are all too many American people who cannot pay for an adequate standard of modern medical care. To provide them with such care as a matter of charity is, we conceive, neither consistent with good medicine nor with fundamental social justice. We therefore support the view that public funds should be used to provide for medical care in such a way that everyone may receive equal service on an equal basis.

Because medical care is essentially a personal service and by its very nature requires an understanding of the community as well as of the individual patient, we stand for decentralization of any program of public health or health insurance. The disparity of means between States makes participation by the National Government imperative, but we believe that a maximum of local administration and control is essential.

In conformity with our first two principles, we also stand for freedom for every person in the selection of his or her source of medical care, for consumer representatives on boards and committees, and for the continued encouragement of voluntary associations of consumers. Application of these principles, we believe, effectively protects the American people against mechanical and impersonal medical services.

In summary, the Cooperative Health Federation of America believes that medical service is as proper an object for organization by patients as by doctors. We do not claim perfection for our plans, nor do we think that change in the method of paying for medical care will automatically and of itself alone immediately usher in the millennium. We have had wide practical experience in the organization of health plans and do not look for miracles. But we are intent on improving the distribution of the medical arts and sciences, and we believe that we have found one valid answer to the problem in voluntary consumer organization.

Sincerely,

COOPERATIVE HEALTH FEDERATION OF AMERICA,
GEO. W. JACOBSON, *Secretary-Treasurer.*

Mr. HANSEN. This is a companion statement of the statement of the things that the federation stands for in relation to the health and medical care program of the needs of medical services. It is a statement of the things that we believe in, and it is out of this belief that we have formulated our policy statement on standards for national health legislation.

While some of our member plans—speaking now of the Cooperative Health Federation—have been in operation for going on 20 years, by and large, the voluntary approach to a distribution of medical care on the prepayment basis is in the pioneering stage. While the prepayment method of obtaining medical care has been eminently successful in many parts of the country, we realize that voluntary action alone cannot solve the crying health needs of the whole population in any reasonable period of time.

Historically, all cooperatives favor voluntary over Government action; however, good health for every citizen is a matter of domestic security. The huge problem of making modern medicine available to all the people at a price they can afford to pay, and equalizing that cost, can be solved only by the Federal Government in a plan which has universal application. The Cooperative Health Federation, therefore, favors a national plan of health insurance, provided that voluntary plans are adequately protected and encouraged.

This position was not arrived at lately. How to obtain more and better health services has been a topic of serious discussion in cooperative meetings throughout the country for many years past.

Cooperatives are organizations of people in all occupations, farmers, factory workers, clerks, professional people, and from every income bracket. They represent both producers and consumers in the rural and urban areas of America. We know all too well that city workers with their fixed incomes are not prepared to meet unpredictable costs of serious illness in their families.

Farmers and people in small rural communities have a far more serious problem. There have been all too few physicians available in rural areas, and to make the problem worse, there has been a trend in recent years for physicians to move away from rural areas into the urban centers. For example, a recent study of the situation in Minnesota reveals an increasingly steady flow of physicians away from rural areas into the four large medical centers. By the end of 1946, over two-thirds of all the licensed physicians in Minnesota were located in these four cities, Minneapolis, St. Paul, Duluth, and Rochester, whose population is far less than one-half of the entire State.

Minnesota is considered a medically rich State. It has an excellent medical school integrated with the Mayo Clinic, and modern medicine at its best is available to that chosen population of the State which is

physically located in these 4 centers, yet only these 4 centers have the safe ratio of 1 physician to 1,000 population or less. Of the remaining 83 counties, 45 exceed the ratio of 1 to 1,000; 19 exceed 1 to 2,000; and 20 exceed 1 to 3,000.

This acute lack of medical service in rural areas was the subject of a rural health institute held in March 1946 at the University of Minnesota Medical Center for continuation study, where it was declared the judgment of the graduate school of medicine that the situation could be corrected only by (1), providing modern medical centers in rural areas and (2) assuring adequate and sustained incomes for physicians; both in order to induce physicians who are graduates of our medical schools to relocate in rural areas.

It was pointed out in this institute that modern medicine requires modern facilities, equipment, and laboratories and that physicians today will not practice out of the little black bag. Further, it was pointed out that the rise and fall of farm income over the years produces uncertainty in a physician's income. Moreover, a greater number of physicians today are going into specialties. Many of those who served in the war are returning to take 3-year courses under the GI bill in order to qualify for a specialty, with the intention of locating in large cities where the practice is more lucrative. The sum total of this trend is that rural areas in Minnesota will continue more and more to suffer from lack of adequate medical care unless something is done to correct the situation. In hearings conducted in the health committees of the State legislature in the last session, farm organization leaders, clergy, cooperative leaders, and farmers came in large numbers to tell of countless cases of extreme suffering and hardship and even unnecessary death because of the lack of health facilities and physicians in rural areas.

The situation is not peculiar to Minnesota but is common in all of the agricultural States of the country. In February 1947, the American Medical Association sponsored its second national conference on rural health problems. Many farm organizations and many public health officials were present to tell of this general situation in farm areas. It was declared by many well-informed people at this conference that their studies of possible solutions to the problem of better distribution of medical care inevitably led them to the conclusion that only voluntary effort on the community level would solve the problem. Only this method would provide the means of setting up the necessary health facilities and would assure adequate and sustained incomes to the needed physicians. It was stated that in recent years three annual meetings of the house of delegates of the American Medical Association had passed resolutions in favor of experiments in voluntary plans of prepayment medical care.

In the matter then of solving the problem of distributing medical care in rural areas, it is self-evident that voluntary action must be protected and encouraged in any national health plans.

To emphasize this point one need only consider alternative methods. One might be persuasion within the medical profession to encourage physicians moving to rural areas where they are needed. But, even if the medical associations were willing to attempt such persuasion, it would be fruitless until the causes for medical poverty in rural areas are effectively removed; namely, lack of facilities and assured income.

Another alternative might be direct Government compulsion upon the physicians themselves, but this suggestion is as abhorrent to co-operatives as to physicians.

To correct the rural dilemma, then, voluntary action must be preserved in any national health insurance system. We stress one point in this connection. Truly voluntary plans should be defined and administratively considered as those in which persons in a rural community may freely set up, finance, and control the needed facilities and with which physicians may freely associate themselves upon terms mutually agreeable. This is the American way and the only way by which rural people will be encouraged to work together to solve their common problem.

Recent experience in many parts of the country shows that, now that the problem is understood, rural people are enthusiastically seeking ways in which to provide themselves with modern medical facilities. I might say in that connection that some 25 or 30 communities, without any encouragement or incentive furnished by anyone, have studied to form voluntary health plans in their communities in Minnesota.

A national health insurance plan which will make its funds available to such a voluntary organization would provide an effective means to sustain its facilities and thus bring the blessings of modern medicine to our rural people. Any national plan which designates a single agency, group, or organization through which the funds must flow would stifle and foreclose such voluntary action.

To reemphasize this point, if any national plan gives over the control of the funds to medical associations or to commissions or agencies, the majority of whose governing body is required to be composed of physicians, it would fail to protect consumer-sponsored voluntary plans now in existence and would discourage the formation of new plans. Bitter experience has demonstrated to us—I am talking about the experiences of our member associations in the federation—beyond any doubt that where medical men are given effective or exclusive control they tend to give primary consideration to their proprietary interest. Take, for example, the fact that of all of the proprietary hospitals in Minnesota, 24 in number, not one meets the standards or has the approval of the American College of Surgeons.

On the other hand, nearly all of the voluntarily supported, nonprofit hospitals and community hospitals comply with the requirements of the American College of Surgeons, and have the approval.

In some States medical associations have obtained legislation giving organized medicine control over all prepayment plans.

Senator DONNELL. Did you strike out the words "exclusive and monopolistic"?

Mr. HANSEN. Yes, that is not true in all cases. I do not wish to make that statement all-inclusive. I want to say that in some States medical associations have obtained legislation giving organized medicine control over prepayment plans. There are different types of control. Others require a majority of the Government board to be composed of physicians, and some require at least 51 percent of the physicians in the area to be participants. Over one-third of our States now have such laws enacted by efforts of the medical associations. In those States where medic-controlled plans are in operation we have seen two things demonstrated: (1) Only very limited, catastrophic-type pro-

tection is offered, and (2) the plans, being essentially of the indemnity type, do nothing to encourage physicians to move to rural areas.

Senator DONNELL. Pardon me. May I interrupt you just a moment? In regard to the elimination of those words "exclusive and monopolistic" from your prepared statement, let me ask you for an illustration. Take what was referred to here by Mr. Biemiller in his testimony the other day as the "medical fence" bill in Wisconsin—are you familiar with that bill?

Mr. HANSEN. Yes, sir.

Senator DONNELL. Do you regard that as exclusive and monopolistic?

Mr. HANSEN. I do not. The one in Illinois, however, is. That says no one but physicians can sponsor or control any kind of prepayment voluntary plan.

Senator DONNELL. But you do not regard that medical fence bill, so-called, in Wisconsin as exclusive, as investing in organized medicine an exclusive and monopolistic control over prepayment plans?

Mr. HANSEN. No, sir. As a matter of fact, it is simply a permissive enabling act for medical associations, should they choose to set up these plans, and the session of the legislature in Wisconsin has just last week passed unanimously, in both the assembly and the senate, a bill giving consumers the right to set up voluntary plans.

Senator DONNELL. That bill went to the Governor. Has it been acted on yet, do you know?

Mr. HANSEN. It might have been, I have not heard. But I think the Governor will sign it. He said he would.

Senator DONNELL. Your testimony, I think, is quite important in regard to your construction of the so-called medical fence bill in view of the testimony given here the other day by Mr. Biemiller. I would not undertake to quote him with exactness, but my general recollection is that he regarded that bill as being a monopolistic bill in its nature.

Mr. HANSEN. It is simply permissive to the medical societies to set up their own plan. Thus, experience has demonstrated that when the voluntary field of prepayment medicine is controlled by medical organizations, (1) only limited, curative medicine is offered and usually only to low-income groups, (2) there is no incentive to offer preventive medicine, (3) medicine is not brought to rural people, (4) there is no incentive among the people to associate and form a common pool of funds to provide needed facilities, and (5) specialist services and other advantages of modern medicine are not made available equitably among the population. On the other hand, our experience in consumer-sponsored plans shows that when the people have a free hand they demand and organize to obtain comprehensive health service.

This is not to say that consumer-sponsored voluntary plans of the type conceived in the cooperative movement should have the exclusive privileges under any national plan. Rather it is to say that all types of voluntary prepayment plans must be free to compete on an equal basis with each other and with other types of organizations for medical services, or with physicians practicing individually. No one can make a blueprint or strike a pattern in a free America for any type of voluntary plan which will be acceptable to all people in all sections of the country. There has not been enough experience. The geog-

raphy of a section, its economic make-up, and the temperament of its people, as well as the extent of willingness of physicians in a section to cooperate, all together will determine the type or types of voluntary plans which most of the people in that section will support. The cooperative movement therefore insists that in any scheme of national health legislation the type of voluntary plans must be left open for free determination by consumers on the local level and will require that to receive its support any bill must give full assurance on this vital point. Further, the cooperative movement will insist that there be protection for the participating physician from discrimination against him by organized medicine for any reason except professional incompetence and unwillingness to accept the conditions of the contract between the voluntary plan and the Government.

In the past there has been repeated discrimination against competent licensed physicians who chose, against the wishes of their local medical societies, to participate in a voluntary plan. In many sections of the country such physicians were ousted from the society, with the drastic result that they were denied admittance for their patients in hospitals and denied access to consultative services. The criminal conviction of the American Medical Association in 1943 by the United States Supreme Court—that is, the affirmation of the conviction—for such discriminatory practices has not been entirely effective and it still continues. If voluntary plans are to be protected and encouraged, the law itself must protect the physician who participates against unwarranted and often capricious discrimination by a governing board in a medical society. Experience dictates the urgent necessity of such a provision.

Any national plan, to have the support of the cooperative movement, must provide for decentralization of administration in order to bring the administrative agency as close as possible to the people receiving the benefits. Administrative stopping at the State level cannot adequately know and deal with peculiarly local problems.

It is with all of these foregoing considerations that we have come to the study of the so-called Taft bill, S. 545, and the so-called Wagner bill, S. 1320.

The two bills now under consideration are widely divergent in aim and method. The Taft bill is designed primarily to aid the States to establish medical care programs for families and individuals having insufficient income to pay the whole cost of hospital and professional service, and dental care programs for children of the same income group. At the outset we dislike a purely charity bill. We cannot see the justification of segregating American people in the provision of medical care according to their income status. Income certainly has nothing to do with the incidents of disease or accident.

Senator SMITH. For the purpose of ready reference, I assume the case you refer to above is the case of the *American Medical Association v. The United States*, 317 United States, page 519 and following, decided January 8, 1943?

Mr. HANSEN. That is correct.

Although we believe that Federal funds for grants to State health agencies are necessary if persons in the so-called medical indigent group are to receive necessary services, and we support this principle, we are opposed to S. 545. It is not a comprehensive national health program, universally available to all persons everywhere. The federa-

tion believes that the consumers of medical services desire a public health program on a Nation-wide basis similar in scope and purpose to S. 1320, and in keeping with President Truman's health message delivered to Congress on November 15, 1946, and May 19, 1947. S. 545 is only a small fraction of what would constitute such a national health program.

If the means test provisions were removed from the Taft bill, it would, of course, embrace the whole population. The federation is opposed to the application of a means test as a condition for receiving medical care, to be paid from public-tax funds. If tax funds can be utilized for the payment of services to one group of the population, the federation believes that all persons taxed in accordance with ability to pay should be able to pay for their medical care on the same basis.

If it is right for the low-income groups to pay for medical care from taxation, and to receive tax-supported health and medical services, it is equally right for the other income groups to do likewise.

We have adopted the social-security principle in relation to workmen's compensation, unemployment insurance, old-age and survivors insurance, and it is time, we believe, to adopt this principle in relation to costs of keeping well and costs of sickness, as well as loss of wages during periods of disability.

If this bill—that is, S. 545—is offered as a solution to the health needs of the American people, it denies the evidence so amply available that millions of moderate and low-income people urgently need a method of providing themselves with adequate medical and hospital care when and where they require it.

Senator DONNELL. For purposes of easy identification, when I question you a little later, would you mind designating the insert that you just gave to the reporter as page 5 or 6, whatever it might be, so I can readily ask you to produce it when I refer to it?

Mr. HANSEN. I have it marked.

Furthermore, we feel that the passage of such a bill would delay and frustrate a solution of the whole problem and will do absolutely nothing to distribute medical care among rural people in whom we are primarily concerned. This bill would perpetuate the abomination of poor-law medicine. The requirement of signing a pauper's oath before receiving medical care would discourage, not encourage, these unfortunates in seeking timely treatment.

Senator DONNELL. Mr. Hansen, is there anything in the Taft bill that says anything about the pauper's oath?

Mr. HANSEN. One would have to establish that he did not have the means to pay, in order to receive the benefits, as I understand it.

Senator DONNELL. So you are drawing the conclusion that a pauper's oath would be the means of enforcing and applying that provision?

Mr. HANSEN. I assume that if a person were not able to pay from his own means, he would have to prove, under the Taft bill before he could receive the service, that he did not have the money to pay for it, and if I have used the term "pauper's oath" as something connoting a legal phrase, I did not mean it that way.

Senator DONNELL. You figure that he would have to make absolute proof that he was needy?

Mr. HANSEN. That is what I mean.

Senator DONNELL. There is no wording in the Taft bill that uses the expression "pauper's oath."

Mr. HANSEN. That is true.

Senator MURRAY. The expression comes down from ancient times, when a person who was poor was considered not a proper citizen, and was disregarded almost entirely. The entire concept of a person's having to come in and prove by taking an oath that he belonged to that class became very odious, hence the reference to it as the "pauper's oath."

It was well established, well known in many countries what the pauper's oath meant.

Senator DONNELL. The point I am getting at, Mr. Hansen, is that there is no mention in the Taft bill of the pauper's oath.

Mr. HANSEN. That phrase is not used in the bill, that is true. It would seem that in such a personal matter as medical care, we can be big enough as a nation to treat all Americans equal.

Another objection to the Taft bill is that it invites giving to the payees of moneys in the funds the control over expenditures. It seems to us elementary that this is not sound financial policy. It would be like giving control of Federal Highway Aid Funds to road contractors.

Specifically, we are opposed to legislative language which would permit, as we believe the Taft bill does, a State to contract with a medical society or other type of plan for the payment from Federal funds of insurance premiums to cover the cost of care of persons who, when ill, had agreed to seek care from the physician who will be paid from an insurance fund maintained under such voluntary agency auspices. We are opposed to subsidies from Federal funds in the guise of insurance premiums, and we are opposed to nonpublic agencies having responsibility under a Government contract to act for the Government in organizing and providing services to any group of individuals. Under S. 545 there is real danger of Federal funds being used as a subsidy to voluntary prepayment plans, sponsored by medical societies, since the bill provides for payment of such "insurance premiums" and the State Advisory Council set up in the bill would be composed largely of representatives of organized medicine.

Senator SMITH. Just a minute—a little earlier in your statement, on page 2, you stress very strongly your belief that a voluntary effort in the community level should be maintained in favor of experiments in voluntary plans of prepayment medical care. I do not quite see how you would keep those up under any plan you might favor, unless you did the very thing you are criticizing here.

Mr. HANSEN. The Taft bill invites and permits a contract to be made with the State Medical Association to administer and handle and expend the funds, and what I am saying here is that it is possible, under the Taft bill—in fact, we think it invites this procedure.

Senator SMITH. We invite the States to set up an over-all medical control, a State-Government affair, and take the responsibility.

You speak here of the Federal highway fund going to the road contractors. The same principle applies when we have our highway aid funds that clear through the State highway set-up. I mean it is the relation of a Federal-State affair. It is not the State medical association.

Mr. HANSEN. No; but I say that the Taft bill would, in effect, if it were to be put into practice, give the control of it to the medical society.

Senator DONNELL. Does the witness have any objection to telling us where the language is in the Taft bill? I am interested in that.

Mr. HANSEN. I wonder if that question could be held until I complete my statement?

Senator SMITH. Very well.

Mr. HANSEN. In addition the sponsors of this bill have said it was intended to encourage and assist such voluntary agency care plans.

Senator DONNELL. That reference to medical aid associations is in your insert No. 5?

Mr. HANSEN. Yes, sir; we feel that medical science is a heritage of the people. Medical students pay in tuition only a slight amount of the cost to society of giving them the knowledge of the science and the qualifications for practicing it. Starting before our present Federal Government the American people through taxes and private donations have supported, accumulated, and maintained the science of medicine. Those who are privileged to practice the science upon the bodies and minds of the American people under the licensing laws are merely present-day custodians of the science. The people, acting through their Government—that is, the State Government—wisely retain the right to grant or revoke a license in order to protect the public health and safety. How is it then consistent to say that these licensed custodians of medical science shall have the exclusive and omnipotent power to control the availability of medicine by controlling the funds?

We feel that the Wagner bill is a reasonable and intelligent approach to the entire problem. It recognizes the fundamentally sound proposition that it is prudent and wise to budget against unpredictable medical costs, which often mean individual financial disaster, and to spread the risk equally among the entire population. It recognizes that compulsory financial participation is necessary to make any such plan actually workable. It notices the fact that only a tiny fraction of the population has voluntarily insured itself against such unpredictable costs. It provides a systematic, self-respecting method of paying for a vitally essential need which cannot be neglected. It takes down the economic barrier which stands between a patient and the doctor he needs, permitting him to obtain more of modern medicine without the financial inhibition which exists today for most American people. It concerns itself only with the method of paying for health services and does not interfere with the science of practicing medicine; rather it encourages advancement of medical science by removing for physicians economic influences which affect the application of the science.

Moreover, and of special interest to us, S. 1320 provides for participation in the funds by voluntary plans. The bill does not provide all of the assurances we should like to see in order adequately to protect and encourage consumer-sponsored plans; especially it does not adequately protect a participating physician from discrimination by his organized society. We appreciate that full and adequate protection of consumer-sponsored plans would require accommodating State enabling acts and that is a matter for the State legislatures. With the

slight reservations we have indicated, S. 1320 is acceptable to the cooperative movement. We support and urge the passage of S. 1320.

Senator SMITH. The question I want to ask at the moment is the way you contemplate working in the voluntary plans, while at the same time you criticize the control of the voluntary plans by whoever may set them up. Do you mean by this that you do not want any contract with group cooperative plans, for example?

Mr. HANSEN. No; I did not say that.

Senator SMITH. No; I did not think you meant that. I am asking.

Mr. HANSEN. No. I did not mean that. We think, as I said, that the type of voluntary plan should be left to the citizens on a local level, leave it wide open. We are willing to compete fairly and openly with any plans that any medical society may inaugurate and operate.

Senator SMITH. Of course, that is perfectly possible under S. 545 as well.

Mr. HANSEN. There would not be any funds for people who are not indigent. In other words, I have put the emphasis in my statement on the shockingly poor distribution of medical care in rural areas, specifically because the overwhelming majority of the 10,000,000 people who are in the movement in the United States are in rural areas, and in order for those people to get decent medical attention they must have, first, a modern medical workshop to invite a doctor, to induce him to come there and practice modern medicine?

Senator SMITH. You mean like a hospital?

Mr. HANSEN. Or medical center; it might have 5 or 10 beds and a couple of doctors.

Senator SMITH. That was contemplated in the legislation passed last year, the so-called hospital bill that was contemplated to advance aid and have the State develop medical centers, hospitals.

Mr. HANSEN. But that is inadequate, from a financial standpoint.

Senator SMITH. These things have to grow. You cannot make a full-blown rose all at once. You have got to plant the seed and grow the plant. It was not contemplated that the hospital bill would cover all these needs at once, but it was a step in the direction, feeling out what we needed and how to do it.

Mr. HANSEN. It is a fine law and a great help. I did not mean to say it was not.

To finish my point, in order for rural people to have medical care, modern medical care, they have got to have some incentive to set up a modern medical facility. They will do it, and they will do it enthusiastically, as they did in Minnesota, without encouragement in the 25 or 30 communities, like mushrooms coming out of the ground. They just started into it in their own community, formed an association, subscribed the funds to build a hospital. Some of them have not even heard of the Ball-Hill-Burton Act, and if those people can furnish themselves with that modern medical workshop through their own cooperative community effort, and if S. 1320 were passed and tax funds were available to sustain the operation of that health facility through good times and bad in the rural communities, we will have made tremendous progress in the whole field of distributing medical care to the American people. The most neglected people are certainly the rural people.

Senator SMITH. I do not quarrel with you as to the need of the rural people.

Mr. HANSEN. The Taft bill does nothing for the rural people.

Senator SMITH. Oh yes, it does. The Taft bill contemplates setting up in the States a medical health program at the State level. The State takes the responsibility of inventing the ways and means to carry on. We do not leave the rural people out at all.

Mr. HANSEN. The farmers are not indigent today in Minnesota. Our farmers are well off, but—

Senator SMITH. I think any State that sets up an over-all health plan would be granted aid by the Federal Government for the entire population. Some people can pay, and why should not they pay for their health needs? You are advocating a plan of an over-all tax so that everybody gets free medical care, and that is not the approach under 545. I am not quarreling with it. I am just saying that is the approach you advocate in the S. 1320 program, as distinguished from the trial-and-error program in S. 545.

Mr. HANSEN. What I have said is that the cooperative movement has the unanimous support of the Cooperative Health Federation. Its position is that voluntary plans should be encouraged and protected, which S. 1320 does and for that reason we support it wholeheartedly and we are opposed to S. 545 because, to speak in plain language, in solving this problem, it is simply a sop, as we think, and that it will delay and frustrate the movement of the entire health problem of this country.

Furthermore, talking about trial-and-error methods and experimentation, we are fully aware that we are still experimenting in this whole field, both on the voluntary level and on the insurance level, and that if S. 1320 is passed, there will have to be a great deal of experimentation and trial and error. No one, we believe, in the country is qualified to make an absolute blueprint to tell us how it will work from year to year for the next 10 years. So we have to solve this problem. It is a crying social need, and we have got to be bold enough and daring enough to strike out and attempt to solve it.

For example, in Minnesota we attempted to work out this problem ourselves, and set up an insurance mutual. We started in 1938. I was counsel for that association from the beginning. We now have nearly 100,000 members.

Senator DONNELL. What is that association?

Mr. HANSEN. The Group Health Mutual. It turned into a business of some \$1,000,000 a year. We did not know where we were going at the time we started that mutual. We went along on the best actuarial basis we could obtain at that time as to the cost of medical and hospital care, and we evolved the thing year by year by putting to the task all of our business judgment, and watching it carefully. Today it is highly successful. The same thing that was done on that small scale could be done throughout the United States.

We think there is no question about it, because we know the secret of insurance is to get widespread risks. That is why it must be so it must have a sound actuarial basis to insure success.

So that eventually you have reduced an unknown cost to a known cost, and that cannot be done in any insurance company or under any national health legislation in any short period of time. It has to be done by trial and error.

But to say it is difficult, and no one has a blueprint is no reason for not attempting to do it.

Senator SMITH. I am not saying that. I am just presenting the differences in our approach. You would make an over-all tax now, tax everybody to deliver services that could not be delivered for some years. That is the question that troubles me. I think the State approach by grants-in-aid is the more practical, and in my judgment the quicker method. But that is a matter of opinion, of course.

Mr. HANSEN. My opinion is exactly the opposite, and for reasons which I think can be proved in the history of insurance companies. I think if you will look at the history of insurance companies generally, their early history, you will find that they have had tough sledding for about the first 3 years. They needed subsidies in the way of contributed surplus by their stockholders and so on, and after they got risks set out broad enough they became solvent and actuarially sound. The same logic must apply to national health insurance. It would apply, of necessity. So, if it is spread throughout the whole population on a tax basis we are sure, as far as we can be sure, that it will be actuarially sound and will work.

Senator SMITH. Have you any data on how it has worked in foreign countries on that basis, where we have a practicable demonstration of how it works, both as to the recipient and the physician? I would be interested in any data along that line.

Mr. HANSEN. I have not studied the plan in other countries.

Senator SMITH. I have said right along, and that is in S. 545—I have no objection to any State, the State of California, for example, that would like to try it. I would like to see California try it or any State try it and see how it works and come back to us and tell us to start with that. An over-all national tax which is a reduction to pay roll—I think we would be going a little fast with the data available. I have not seen data that convinces me that it would work.

Mr. HANSEN. I think, for instance, if you will consider that with the different types of regions we have in the United States, the financially wealthy section in the Northeast, the comparatively wealthy section in the north-central part of the country, some parts of the West—those areas might well carry on the successful plan State by State, but we are here before Congress because we are thinking of the United States from border to border, and many Southern States simply do not have an economy which will support it. Their State taxation, with the Federal taxation as it could, comes to quite a burden for those Southern States, and the risk has to be spread from coast to coast all over the country and all of our people have to be included in order for the thing to be successful, and I think the State-by-State idea is unsound for that reason.

Senator SMITH. Well, in both our educational program, which we are considering now, and also in S. 545, I think we are contemplating the very thing you are talking about. There are some areas of the country that need special help and differences in their favor in the way of funds. That has been the understanding from the beginning of the program for the distribution of funds. That is a fundamental of the formula. That can be regulated, of course. I am having a special study made of that now, a distribution basis as between the wealthier States and the poorer States. I am not denying that difference, but I feel that the State approach, to begin with, is the right way to go at it, to see what we can do with it—challenge the States to set up their health organization to meet this need that we

all recognize for taking care of our people on some basis. That is the only question that I raise. I am not drawing the conclusion that it necessarily is going to work. I cannot quite follow you on that, but that is a matter of opinion, I admit. You will probably admit that before you impose the tax you will have to have some preliminary work done to organize your country to get the necessary number of physicians trained and necessary hospitals and medical institutions built. Your whole set-up has to come before you are justified in asking people to pay the taxes for it. You have to put in Federal funds for 4 or 5 years before you can adopt the thing.

Mr. HANSEN. I am not here, Senator, as an expert on the actuarial basis of this thing. I do know that we need more physicians in this country.

Senator SMITH. We all agree to that.

Mr. HANSEN. But I would say that those who do not want to see this kind of extension of our social security in the United States could find excuses like that, and many more for not studying it.

Senator SMITH. I object again to being charged with making excuses. We do want to see it. We are just as sincere in wanting to see it as you are, but it is just a question of what is the best way to get results. That is what we are discussing here. We are not actuarial experts either, but we have the responsibility as legislators of putting our name to a law and voting for a law that we really believe will work. That is our problem.

Senator MURRAY. I don't think the witness intended that. He should have used the word "reasons". I do not think he intended to offer any offense.

Senator SMITH. But this witness has constantly said that if we raise a question against one piece of legislation, S. 1320, and in favor of S. 545, we are necessarily against accomplishing the results desired. But that does not go down with me.

Mr. HANSEN. It is a difference of opinion and approach.

Senator SMITH. There is very substantial and very intelligent difference of opinion as to how this thing can best be accomplished.

Mr. HANSEN. I think, however, that when our organization, representing some 10,000,000 of our population, together with the members and including the families of organized labor and other farm organizations, come to the Congress of the United States, with unanimity of opinion such as they have expressed in these hearings, and in favor of S. 1320, that the fact that those people who are willing to tax themselves for this kind of legislation, cannot be denied—they should be given opportunity to have this kind of plan.

Senator MURRAY. I am very glad to see you quickly resent any insinuation, Senator, as to your sincerity and honesty in this matter. I wish that I could get some sympathy along that line myself.

Senator SMITH. I have always said that, Senator Murray.

Senator MURRAY. I just got a clipping from the Chicago Tribune the other day in which they referred to this testimony that we had the other day, when I asked the witness whether or not he was a Communist, and the article goes on to assume that I was a friend and collaborator of his. They have been reading so much of the propaganda that goes out from this committee's office and from the Senate Office Building they are beginning to assume that I am in full league.

and cooperation with the Communists and Socialists and every other subversive movement in the United States. I don't think they are having any real success with it. It makes little difference to me. It does not hurt me a bit, but I think that is very unfair and very unjust for this committee to maintain a person here in this building who will send out stuff like that.

I did not think the Senate of the United States would ever fall so low as that.

I will join with you any time in resenting any remark here imputing evil intentions to your ideas or thoughts or your proposed legislation. I think that we, too—the minority here—should have some sympathy, some help and some protection from that sort of thing.

I think we are running into great danger in this country. It is becoming so that anyone who sponsors or proposes a measure for the benefit of the people of this country is immediately jumped upon and accused of being a Communist. Are people to be led to think that all sound, liberal, or solid legislation that is being proposed in this country is communistic—because they read in papers that it is espoused by Communists and Socialists? I think that is very unfortunate.

Senator PEPPER. Especially this health plan, the doctors themselves call it socialized medicine instead of applying to it its true description. They call "propaganda" of course, anything that anybody says that had any part in it, that he was a collaborationist. It would be just as accurate to charge the sponsors of the other bill with being fascists. Nobody would welcome that. We do not want to make such a statement, so I think the chairman has set a good example that might go out all over the country. We are all trying to find the best method of getting health care.

Senator SMITH. We have tried to do that all the way through. We are trying to get results, and I am one of those who do not approve of name-calling anyway.

Senator MURRAY. Mr. Hansen, a few moments ago you were speaking about certain favored sections of the country being in a better position to sponsor and make effective the voluntary plan. Of course, that is very obvious. The eastern section of the country, for instance, New Jersey, New York, Pennsylvania—these other sections of the East—in fact, all industrial sections—have been subsidized in this country for many years, and in fact, for almost our entire history from the Civil War on.

They have had advantages that have been denied to other sections of the country. Other sections of the country have been exploited by them, have been drained of their wealth. In the depression period we had to bring hundreds of millions of dollars into my State that had been drained out through our economic system because of the subsidy that is enjoyed by the eastern sections. They have the tariff system which has protected them and allowed them often to charge excessive prices to the farmers of the country. They have drained the Western States of their wealth so we were unable to establish industry of any kind and thus to develop a balanced economy. They maintain that system still.

Now they expect those sections of the country to get along without any satisfactory health program. It seems to me we should think about that phase of American economic life. There is where most of

the objection comes from, from the big, favored sections of the country where they have these high-income doctors who make two to three hundred thousands dollars a year.

If this bill were put into effect the medical profession all over the United States would benefit. The doctors in the country that do not earn a decent living now would earn fair incomes if this bill were put into operation and the more economically successful ones in the big centers would still be able to get along pretty well, too.

So I think there is a lot of merit in what you have said during your testimony, and I want to thank you for coming here and giving us the assistance that you have.

Senator DONNELL. I understand you are appearing here today as the general counsel to the Cooperative Health Federation of America?

Mr. HANSEN. Yes.

Senator DONNELL. In that capacity I assume you have many duties and study many different subjects, is that right?

Mr. HANSEN. I handle their legal work.

Senator DONNELL. You do not centralize your attention solely upon the subject of compulsory health insurance?

Mr. HANSEN. I do not. I am in private practice in St. Paul.

Senator DONNELL. And the Cooperative Health Federation of America is just one of your clients?

Mr. HANSEN. That is true.

Senator DONNELL. And are you also general counsel for the Cooperative League of the United States?

Mr. HANSEN. I am not. I came here today designated specially to speak in favor of S. 1320 and that is all.

Senator DONNELL. Your letter of designation from Mr. Voorhis is the authority which you have filed with the committee to that effect?

Mr. HANSEN. That plus the resolution passed unanimously in September of 1946.

Senator DONNELL. Does that mention your name, that resolution? I am talking about your authority to appear.

Mr. HANSEN. No; that just indicates their position.

Senator DONNELL. I was referring particularly to your authority to appear here today. That is derived from the letter from Mr. H. Jerry Voorhis, executive secretary of the Cooperative League?

Mr. HANSEN. Yes; and action of the board of directors, I believe, in May 1947.

Senator DONNELL. Now, Mr. Hansen, the Cooperative League—I am very much surprised and interested in the fact that Mr. Voorhis' letter and your testimony indicate that that includes in its membership some two and one-half million American families. Have you yourself gone into the verification of that, as to the accuracy of it, whether or not the Cooperative League has 2,500,000 families that are members of it?

Mr. HANSEN. I asked the office in Chicago on my way here to prepare for me a break-down of the number of members in each of their affiliated organizations, and I have that and will read it for the record:

Eastern Cooperatives, Inc., New York City, 50,000; Pennsylvania Farm Bureau Cooperative Association, Pennsylvania, 36,000.

Senator DONNELL. Is that that many individual persons? Or is that families?

Mr. HANSEN. That is families.

Senator DONNELL. You deal now with families when you give us these figures?

Mr. HANSEN. Correct.

Farm Bureau Cooperative Association of Ohio, 52,000.

Senator DONNELL. When you started in, the first figure was 50,000?

Mr. HANSEN. Yes.

Senator DONNELL. That is the eastern part of the country there. What were those first two?

Mr. HANSEN. 36,000 and 52,000.

Central States Cooperative of Chicago, 25,000.—

that is the fourth figure.

Midland Cooperative Wholesale, Minneapolis, 200,000; Central Cooperative Wholesale, Wisconsin, 55,000; Consumers Cooperative Association, Kansas City, 160,000; Associated Cooperatives of California, 60,000; Pacific Supply Cooperative, Washington, 70,000; American Farmers Mutual of St. Paul and the Farm Bureau Mutual of Ohio—

together, 1,000,000 is the way they give it to me on the list.

Senator DONNELL. An even 1,000,000?

Mr. HANSEN. Yes; they write insurance, cooperative insurance.

Senator DONNELL. Where is that located?

Mr. HANSEN. The American Farmers Mutual is located in St. Paul, Minn., and the Farm Bureau Mutual is in Columbus, Ohio.

Senator DONNELL. A million families?

Mr. HANSEN. Yes; insured with those two large cooperative mutuals, operating in several States I might say, outside of those.

Senator MURRAY. That goes into the State of Montana?

Mr. HANSEN. Yes, sir; it goes through there, also in part of the East.

Then we have as an affiliated fraternal member the Credit Union National Association, with a membership of 3½ million families. They were in attendance and an affiliated member at the Cooperative Congress last September, but I am not prepared to say that their organization has carefully considered or passed individually or separately upon this bill, so they should not be included.

Then we have in the Cooperative Health Federation approximately—you want all the list?

Senator DONNELL. Yes.

Mr. HANSEN. Group Health Association, St. Paul, Minn., 83,000, I believe; yes, 83,000.

Community Hospital, Elk City, Okla., 7,200; Group Health Association of St. Louis, 400; The Two Harbors Community Health Center—

Senator DONNELL. What State is that?

Mr. HANSEN. Minnesota—

3,800.

Group Health Cooperative of Puget Sound, 1,200; Labor Health Institute, St. Louis, Mo.—

they have an approximate figure on this because they have just enlarged in membership—an approximate membership of about 5,000.

Senator DONNELL. Do you know where their office is in St. Louis, by any chance?

Mr. HANSEN. No, I do not, but I will be glad to get it for you, Senator [continues reading]:

Hale County Cooperative Hospital, Hale City, Tex., 1,992. Cooperative Health Association, Superior, Wis., 1,332; Cooperative Health Association of Kansas City, 2,453; Group Health Insurance, New York, 19,000; Pacific Medical Center, Chicago, 2,000; Community Hospital, Sand Point, Idaho, 2,800; Group Health Association, of Washington, D. C., 11,000; Hospital Benefit Association of Phoenix, Ariz., 3,266; Greenbelt Health Association, Greenbelt, Md., 1,000.

Senator DONNELL. Is that all?

Mr. HANSEN. Yes.

Senator DONNELL. I do not think that adds up to 2½ million, Mr. Hansen, by quite a considerable amount, even including the 1,000,000 which obviously is a round figure, which you gave with respect to the Minnesota and Ohio Insurance Cooperatives.

Mr. HANSEN. There are some more. There is the Farmers Union Center Exchange, St. Paul, Minn., 100,000.

Senator DONNELL. Just stop there. I notice so many of these are in round figures, 200,000 in one of them, 400,000, 160,000, 100,000. Are these just approximations?

Mr. HANSEN. Conservative estimates based on last year's figures, the end of 1946. They are all estimates. I do not intend to say that gives us every last member, but I think they are conservative.

Farmers Union Cooperative, Omaha, Nebr., 20,000; Farmers Cooperative Services, Raleigh, N. C., 20,000; Consumer Cooperatives Associated, Amarillo, Tex., about 50,000.

Senator DONNELL. Is that all?

Mr. HANSEN. Those are the figures they gave us. I left Chicago yesterday and Mr. Borden gave me the figure, 2½ million which he stated is a conservative figure of the membership of these affiliates. I asked the clerk in his office to give me the list of the affiliates, and what I have given you is as far as I have gotten. I know that there are not complete.

I will furnish it to the Senator by tomorrow morning.

Senator DONNELL. That will be fine, as some of these are estimates, though some indicate they are not, I judge, by being extended figures like 1,992, 1,332, and so forth.

At any rate this Cooperative League of the United States has, as you say, a very large membership.

Now, as to the Cooperative Health Federation of America, is that a subordinate organization to the league?

Mr. HANSEN. Yes; it is one of the affiliates.

Senator DONNELL. Earlier this afternoon you gave the committee a list of gentlemen who constitute the board of one of these organizations, some 11 persons, starting with Ludwig Anderson in Washington. What board is that?

Mr. HANSEN. I have the list here.

Senator DONNELL. Is that the Board of the Cooperative Health Association of America?

Mr. HANSEN. Yes, sir. If the Senator wishes, I will put this in evidence.

Senator DONNELL. We will appreciate it if you will. I was going to ask you for one of these before we got through so it will be offered and placed in the record, with your approval, Mr. Chairman, at this point.

(Articles of incorporation and bylaws, Cooperative Health Federation of America, follow:)

COOPERATIVE HEALTH FEDERATION OF AMERICA—ARTICLES OF INCORPORATION AND BYLAWS

ARTICLES OF INCORPORATION OF COOPERATIVE HEALTH FEDERATION OF AMERICA

We, the undersigned, for the purpose of forming a cooperative association under and pursuant to chapter 397 adopted June 19, 1940, by the Seventy-sixth Congress of the United States, do hereby associate ourselves as a body corporate and do hereby execute and adopt the following articles of incorporation:

ARTICLE I. NAME

The name of this association shall be the Cooperative Health Federation of America.

ARTICLE II. PURPOSE AND NATURE

The purpose of this association shall be to engage in activities for the promotion of the health and well-being of its members and of the public; to provide facilities for improving the physical, mental, and moral condition of mankind, to aid and assist its members and other persons, groups, associations, corporations, and institutions now or hereafter engaged in furthering any of the purposes above named, and to aid and assist with its own means, or as agent, trustee, or representative of others, any such persons, groups, associations, corporations, and institutions in any such purposes.

The general nature of its activities and business shall be to provide, furnish, or arrange for educational material and facilities, promotional and organizational advice and services, technical and management advice and services, and such supplies, commodities, and equipment as may be desired or necessary; to engage in public relations; to conduct research; and to engage in any lawful activity related to any of the purposes named above.

For these purposes it shall have power:

(a) To acquire, purchase, hold, lease, encumber, manage, and sell any real or personal property necessary in or incident to its activities.

(b) To borrow money or property and to execute the necessary instruments therefor, and to receive gifts, endowments, bequests, and Government grants and assistance.

(c) To own, hold, and transfer membership in and share capital, bonds, and obligations of other associations and corporations, and while owner or holder thereof to exercise all the rights therein.

(d) To make necessary or desirable contracts, instruments, or obligations.

(e) To do and perform every act and thing necessary to the conduct of its activities and business for the promotion and accomplishment of the purposes set forth herein or permitted by the District of Columbia Cooperative Association Act, amendments thereto, or any other applicable laws.

ARTICLE III. PRINCIPAL OFFICE

The principal office of this association shall be in the city of St. Paul, Minn.; provided that its location may be changed when deemed necessary by the board of directors. John Carson, or his successor in office, at 726 Jackson Place NW., Washington, D. C., is hereby designated as agent for service of any legal process upon this association.

ARTICLE IV. DURATION

The time for the commencement of this association shall be the 1st day of October 1946 and its duration shall be continuous and perpetual.

ARTICLE V. MEMBERSHIP

SECTION 1. The association shall consist of memberships without stock and shall be operated on a nonprofit basis.

SEC. 2. The membership shall be divided into two classes—regular and associate members.

SEC. 3. A regular member shall be any person, any incorporated or unincorporated group, association, cooperative, or corporation acceptable to the board of directors or executive committee and agreeing to abide by these articles, the bylaws, and other rules of this association. Minimum qualifications for membership shall be—

(a) The furnishing, providing, securing, or arranging for medical or hospital services, or services allied thereto, on a prepayment basis, and the maintaining of satisfactory quality in such services;

(b) Effective control by users of the services in matters pertaining to policy;

(c) Operation on a cooperative or nonprofit basis;

(d) Ownership, leasehold, or management of the facilities resident in the users of the services, unless such ownership, leasehold, or management by others does not mitigate control by users of the services in matters pertaining to policy; and

(e) Such other qualifications as may be prescribed in the bylaws.

SEC. 4. A regular member shall pay a fee of \$50 regardless of date of entry into membership. Payment of said fee of \$50 shall constitute one membership share for which a certificate as provided by law shall be issued. The bylaws may provide for the payment of additional fees to constitute the total annual membership fees, provided that such additional fees shall be on a fair, proportionate, and uniform basis throughout the regular membership.

SEC. 5. An associate member shall be any person, cooperative, association, or nonprofit group, or public or private agency interested in furthering the purposes of this association, which is acceptable to the board of directors or executive committee. Further qualifications and the amount of membership fees for such associate members may be provided in the bylaws.

SEC. 6. Six regular memberships have been subscribed for.

ARTICLE VI. MEETINGS

SECTION 1. The first annual meeting shall be held before the end of the year 1947 and thereafter a regular meeting of members shall be held one in each calendar year at a time and place, within or without the District of Columbia, and upon such notice as prescribed in the bylaws.

SEC. 2. Special meetings of the members may be held as provided in the bylaws.

SEC. 3. The bylaws may provide for holding of meetings of the members by groups or districts and for a method of transmitting the votes there cast to the central meeting, or for a method of representation by delegates to the central meeting, or for a combination of both methods.

ARTICLE VII. VOTING RIGHTS

SECTION 1. Only regular members shall be entitled to vote.

SEC. 2. In the first and second annual meetings of the association each regular member shall be entitled to one and only one vote, regardless of the number of membership certificates held. Thereafter, in any annual or special meeting each regular member shall be entitled to one basic vote and in addition thereto a number of votes determined on a fair, proportionate and uniform basis as may be provided in the bylaws.

SEC. 3. Voting by mail may be permitted as provided in the bylaws, but there shall be no voting by proxy.

ARTICLE VIII. OFFICERS, DIRECTORS AND ELECTIONS

SECTION 1. The first officers and directors of this association shall be—
Michael Shadid, president and director. Address: Elk City, Okla.

Harry Becker, first vice president and director. Address: 1328 Eye Street NW., Washington, D. C.

Elmer Richman, second vice president and director. Address: 1127 Pine Street, St. Louis, Mo.

Cecil Crews, third vice president and director. Address: 318 East Tenth Street, Kansas City, Mo.

George W. Jacobson, secretary-treasurer and director. Address: 180 North Snelling Avenue, St. Paul, Minn.

Ludwig Anderson, director. Address: 726 Jackson Place NW., Washington, D. C.

Winslow Carlton, director. Address: 70 West Wall Street, New York City, N. Y.

E. J. Loehr, director. Address: Saskatoon, Saskatchewan, Canada.

James L. Monroe, Jr., director. Address: Hale Center, Tex.

Address Shoudy, director. Address: Seattle, Wash.

Charles Wilkinson, director. Address: Two Harbors, Minn.

All of the above-named officers and directors shall hold their respective offices and manage the affairs of this association until the first annual meeting, at which time not less than 11 directors, as provided in the bylaws, shall be elected. The first board of directors so elected shall divide itself by lot into two classes as nearly equal in number as may be, the term of the first class to be 2 years and the term of the second class to be 1 year; thereafter in succeeding annual meetings directors shall be elected for terms of 2 years.

SEC. 2. The first and succeeding elected board of directors shall, within 30 days following each annual meeting, elect from its membership a president, first, second, and third vice presidents and a secretary-treasurer, each of whom shall hold office for a term of 1 year or until successors are elected.

SEC. 3. The executive committee shall consist of the above-named officers plus such additional directors as the bylaws may prescribe. The board of directors may delegate any part of its authority to the executive committee. Any member of the executive committee who is unable to attend a meeting thereof may name an alternate director to serve in his stead with full authority in such meeting.

ARTICLE IX. BYLAWS

The first bylaws of this association shall be adopted by the above-named board of directors and may be amended in any special or annual meeting by majority vote of the members voting.

ARTICLE X. DISSOLUTION

This association shall be dissolved according to law; provided that after fulfilling the requirements of the law any surplus shall be distributed as a gift to one or more nonprofit groups, associations, or corporations having purposes similar to this association, as determined by the board of directors.

ARTICLE XI. AMENDMENTS

Amendments to these articles may be adopted by a two-third's vote of the members voting in any annual or special meeting.

In testimony whereof, we, the said incorporators, have hereunto set our hands this 8th day of September 1946.

In presence of Horace R. Hansen, Charles Marlies, M. Shadid, Elmer Richman, James L. Monroe, Jr., Charles M. Wilkinson, Cecil R. Crews, H. W. Culbreth, Dean A. Clark, Ludwig Anderson, Harry A. Becker, George W. Jacobson.

STATE OF OHIO,

County of Franklin, ss:

On this 8th day of September 1946, before me, a notary public within and for said county, personally appeared M. Shadid, Elmer Richman, James L. Monroe, Jr., Charles M. Wilkinson, Cecil R. Crews, H. W. Culbreth, Dean A. Clark, Ludwig Anderson, Harry A. Becker, George W. Jacobson, to me personally known who, being by me first duly sworn, acknowledged that they executed the foregoing articles of incorporation as their free act and deed, for the uses and purposes therein expressed.

R. STEVENSON,

Notary Public, Franklin County, Ohio.

My commission expires February 1, 1949.

BYLAWS OF COOPERATIVE HEALTH FEDERATION OF AMERICA

ARTICLE I. MEMBERSHIP

SECTION 1. Qualifications for membership as set forth in the articles of incorporation shall be determined by majority vote of the quorum of the board of directors or executive committee. In addition to minimum qualifications for membership stated in the articles, these bylaws may provide for further qualifications.

SEC. 2. In addition to the initial membership fee as provided in the articles, a regular member shall pay fees in each fiscal year based upon the number of persons who are users of its services (as hereinafter defined) according to the following schedule: 1 to 1,000 persons, \$50; 1,001 to 2,000 persons, \$100; 2,001 to 4,000 persons, \$150; 4,001 to 8,000 persons, \$200; 8,001 to 16,000 persons, \$250; 16,001 to 32,000 persons, \$300; 32,001 to 64,000, \$350; and so on, in like geometric ratio.

"Users of the services" as used in these bylaws shall mean persons who are covered in any plan providing hospital or medical services, services allied thereto, or indemnities therefor, on a prepayment or premium basis and shall include dependents and other persons so covered whether or not they are designated as "members" by any such plan.

SEC. 3. An associate member shall pay an initial membership fee of \$25, for which a nonvoting associate membership certificate shall be issued. In addition such member shall pay a fee of \$25 in each fiscal year.

SEC. 4. Any regular or associate member may contribute or donate funds to the association in addition to the annual membership fees, at any time in any amount. If such additional amount totaling more than \$500 is contributed or donated, the fact that the member is also a sustaining member shall be noted upon the membership certificate issued.

SEC. 5. Regular membership certificates shall, as required by law, contain a statement of voting rights, that no proxy voting is permitted, and the rights of the member upon withdrawal from the association. No certificates shall bear interest and no certificate shall be issued until paid in full.

SEC. 6. No certificates shall be transferable without express consent given by a majority vote of a quorum of the board of directors.

SEC. 7. Upon cessation or withdrawal of a member from the association, the board of directors shall have the power, but shall not be required, to purchase the holdings in membership certificates of such member and may thereupon reissue or cancel such certificates. A majority vote of the members voting at a regular or special meeting may order the board of directors to exercise this power to purchase such certificates.

SEC. 8. A regular or associate member may be expelled by a majority vote of the members voting at a regular or special meeting provided that such member is given at least 10 days' notice in advance of the meeting and an opportunity to be heard at the meeting. On decision to expel, the board of directors shall purchase the member's holdings at par value if sufficient reserve funds are available.

ARTICLE II. MEETINGS

SECTION 1. Annual meetings of the membership shall be held once in each calendar year, commencing in 1947, at a time and place, within or without the District of Columbia, as may be determined by the board of directors.

SEC. 2. Special meetings of the membership may be held at any time and place, within or without the District of Columbia, and shall be held at a time and place demanded by a majority of the directors or by written petition of 25 percent of the regular membership. Upon either such demand, the secretary-treasurer shall issue notices to all members promptly so that the meeting shall take place within 30 days after the demand.

SEC. 3. The secretary-treasurer, or any other officer designated by the board, shall give notice of the time and place of each meeting by sending a notice thereof to each member at its last-known address not less than 20 days in advance of the meeting. In case of a special meeting, the notice shall specify the purpose for which the meeting is called.

SEC. 4. A quorum for any annual or special meeting of the membership shall be 30 percent of the membership in good standing, but in no case less than six

members, in attendance thereat; provided, that when mail votes are counted a quorum shall be 51 percent. Mail votes may be included in the quorum total only on matters noticed in the meeting call; on all other matters, a quorum of 30 percent of the membership in attendance shall be required.

ARTICLE III. VOTING RIGHTS

SECTION 1. Only regular members in good standing shall be entitled to vote in any meeting. Associate members shall be entitled to a voice in any meeting of the membership but shall not be entitled to propose any action to engage in any parliamentary procedure, or to vote upon any issue or election.

SEC. 2. Commencing with the third annual meeting of the membership, regular members, in addition to one basic vote, each shall be entitled to additional votes in geometric ratio to the total number of its membership who are users of the services as defined in the articles of incorporation and these bylaws according to the following schedule: Between 1,000 to 2,000 persons, one vote; 2,001 to 4,000, two votes; 4,001 to 8,000, three votes; 8,001 to 16,000, four votes; 16,001 to 32,000, five votes; 32,001 to 64,000, six votes; and so on, in like geometric ratio. The total number of votes thus allotted to each member may be cast in any meeting by one or more accredited delegates, or by mail as hereinafter provided. A member shall be entitled to its full number of votes only when its membership fees then due are paid in full; except that if a member has paid at least \$50 of its annual fee, it shall be entitled to one vote.

SEC. 3. Voting by mail shall be conducted in the following manner: The secretary-treasurer or any other designated officer shall send to the regular members a copy of any proposal, and a list of nominees for directorships, if applicable, to be offered at any meeting, together with a notice of the meeting at least 20 days prior to the date thereof. The mail votes cast by the members shall be counted together with those cast at the meeting only if such mail votes are placed in the hands of the secretary-treasurer at least 3 days before the meeting. Upon decision of a majority of a quorum in attendance at any meeting, any proposal may be submitted to members absent from the meeting for mail vote. In such case, the secretary-treasurer or any other designated officer shall forthwith mail to each such absent member an exact copy of the proposal acted upon with instructions that the ballot shall be returned within 15 days to be counted. The returned mail votes shall be counted with others cast at the meeting in determining the quorum provided in section 4 of article II, and the result of the voting.

SEC. 4. Any provision in the articles of incorporation or these bylaws referring to votes cast shall include those cast by mail: Providing, that if a member has designated delegates and has transmitted their credentials to the secretary-treasurer as hereinafter provided, such member shall not be entitled to vote by mail in that meeting.

SEC. 5. Before each annual or special meeting of the membership, a member should elect whether it will cast its votes in the meeting by delegates who will be present at the meeting, or by mail. If a member elects to vote by delegates, it shall send the credentials for its delegates to the secretary-treasurer at least 7 days before the meeting. In no case may delegates themselves vote by mail.

ARTICLE IV. DIRECTORS

SECTION 1. At least 7 days before the first and each succeeding annual meeting each member desiring so to do may place in the hands of the secretary-treasurer nominees for directorships. This plan of nomination of directors shall continue until at any annual meeting the total regular membership exceeds 35 in number. At such annual meeting, the members shall elect a committee of 3 persons other than directors; who shall make a study of the membership area for the purpose of proposing to the next annual meeting a plan of geographical districts, formed in such manner that the size of the membership organizations for each district is approximately equal. At the annual meeting in which such district plan is reported and proposed by said committee, the matter shall be placed near the head of the agenda for consideration. If adopted, the members shall then caucus and decide upon nominees for directors in such manner that nominations from one district shall not exceed that of any other by more than one, and the total does not exceed the number to be elected. In addition to nominations so made, nominations may be proposed from the floor and the members shall then proceed by secret ballot to elect a board of directors.

SEC. 2. At the first and each succeeding annual meeting the members shall elect by secret ballot not less than 11, nor more than 17 directors, as they may determine. Not more than 2 directors shall be elected from any member organization. If any membership is terminated, the director, if any, from such terminated member organization shall be automatically removed from the board of directors. If and when the board is increased from 11 members, the newly elected members shall be divided into classes of 1- and 2-year terms in like manner as the first selected board, so that half (meaning 1 member more or less of that number) of the total membership of the board shall be elected in each annual meeting, it being the intention that terms of members of the board be staggered.

SEC. 3. The board of directors shall have the general control of the business and the affairs of the association, may make all necessary rules and regulations not inconsistent with law, the articles or these bylaws for the guidance of officers, employees, and agents of the association and shall have power to employ and dismiss an executive secretary and other employees of the association and to determine their duties and fix their compensation.

SEC. 4. The board of directors shall elect from its membership a president, first, second, and third vice president and a secretary-treasurer each for a term of 1 year as provided in the articles, having due regard for the duties of such officers, the geographical location of each and the necessity for their meeting together as an executive committee. The board may replace any officer during his term for lack of attention to duties or action inimicable to the best interest of the association upon two-thirds' vote, after 10 days' notice and with opportunity to be heard.

SEC. 5. Any officer or director who is absent without reasonable excuse for two successive meetings of the board of directors or executive committee shall be replaced.

SEC. 6. The board of directors shall have power at any time to fill the vacancy, occurring for whatever reason, of any officer or director, for the balance of the term of such officer or director.

SEC. 7. The five named officers shall constitute the executive committee. This committee shall have all the power and authority invested in the board of directors between meetings of the board. The actions of the executive committee shall be subject to review and to approval or reversal by the board of directors at any time.

SEC. 8. The president or any vice president, with the secretary-treasurer, may call a meeting of the board of directors at any time upon 15 days' notice in advance, but meetings may be held on waiver of such notice.

SEC. 9. The president or secretary-treasurer may call a meeting of the executive committee upon 7 days notice in advance, but meetings may be held on waiver of such notice.

SEC. 10. Meetings of the board of directors or executive committee may be demanded at any time upon request of a majority of the members thereof.

SEC. 11. A quorum for the meetings of either the board of directors or the executive committee shall be a majority of the members thereof. If any member of the executive committee is unable to attend a meeting, he may designate a director as an alternate in his stead, and the presence of such alternate shall be included in determining the quorum.

SEC. 12. The board of directors shall appoint an executive secretary to serve as manager of the affairs of the association. The executive secretary shall serve at the pleasure of the board and shall not be entitled to a vote in meetings of the board or executive committee. The executive secretary shall have the exclusive duty and responsibility of engaging employees of the association within the budget and the classification of positions determined by the board of directors or the executive committee, but no person shall be employed to whose employment a majority of the board or executive committee object. Generally, the board and executive committee shall act as a policy-making authority while the executive secretary shall be solely responsible for the execution of the determined policies. Individual directors shall not interfere in executive functions, nor shall the executive secretary attempt to influence individual directors. The executive secretary shall be answerable to the board or executive committee at all times for the proper function of the association office.

SEC. 13. Any employee handling over \$1,000 in any year shall be covered by an adequate bond as determined by the board and at the expense of the association.

SEC. 14. The board of directors may create and appoint such standing com-

mittees and councils as it deems necessary. All such committees shall be responsible to the board of directors. Nominees of associate members of this association may be appointed on such standing committees with full authority and vote. A majority of any standing committee shall constitute a quorum thereof and decisions may be made by majority vote of the quorum.

SEC. 15. Meetings of the board of directors, executive committee, and any standing committee may be held at any place within or without the District of Columbia.

SEC. 16. No officer or director for his duties as such shall be entitled to compensation, except actual expenses, unless upon vote of the members in any annual or special meeting.

SEC. 17. The board of directors shall cause an audit of the books and records of the association to be made at the end of each fiscal year and report the findings of such audit, together with a statement of the financial condition of the association, at each annual meeting. If the amount received by the association in any fiscal year is less than \$10,000, such audit may be made by a committee of three persons appointed by the board of directors or executive committee who shall not be officers, directors, or employees. If the receipts exceed said sum, such audit shall be made by an experienced accountant. Within 60 days after each fiscal period a report of the financial condition of the association, sworn to by the president and secretary-treasurer, shall be filed with the Recorder of Deeds for the District of Columbia as required by law.

SEC. 18. A referendum on any action by the board of directors shall be conducted in the following manner: The board may refer any action to the membership for approval or disapproval by mail vote, provided that the action is referred within 10 days of the time thereof; and the board shall so refer an action on majority vote of the directors or on petition of 10 percent of the membership, provided, that the rights of third parties which have vested between the time of the action and the referendum shall not be impaired thereby.

ARTICLE V. OFFICERS

SECTION 1. The principal duties of the president shall be to preside at all meetings of the association, the board of directors, and the executive committee, and sign all contracts and other instruments.

SEC. 2. The first, second, and third vice presidents, in order, shall succeed to the office of president in case of death or disability of the president and shall discharge the duties of the president in his absence.

SEC. 3. The principal duties of the secretary-treasurer shall be to have general charge of the keeping of proper records of the proceedings in the meetings of the association, the board of directors, and the executive committee. He shall have the general custody of the books, records, papers, and moneys of the association and shall provide for the safekeeping thereof, provided that such of these duties as may be authorized by the board of directors or executive committee may be delegated to the executive secretary, provided that the secretary-treasurer retains supervision of the methods employed in the discharge of these duties.

ARTICLE VI. FISCAL YEAR

The fiscal year of this association shall be from July 1 to June 30.

ARTICLE VII. AMENDMENTS

SECTION 1. Amendments of the articles of incorporation may be proposed by a two-thirds vote of the board of directors or by petition of 10 percent of the association members. Notice of the meeting to consider such amendment shall be sent by the secretary-treasurer at least 30 days in advance thereof to each member, accompanied by a full text of the proposal and by that part of the articles to be amended.

SEC. 2. These bylaws may be amended, with or without notice, at any annual or special meeting by a majority vote of the members voting.

The bylaws as above were duly adopted by the first board of directors of the Cooperative Health Federation of America in meeting on this 8th day of September 1946.

GEORGE W. JACOBSON, *Secretary-Treasurer.*

Senator DONNELL. Now I will ask you also, in addition to this board you have given us a list of, which as I see it is a list of the officers and directors of the association—that is to say, of the Cooperative Health Federation of America—there is another board, is there not, a smaller board than that?

Mr. HANSEN. It is the executive committee.

Senator DONNELL. Does that consist in part of Mr. Carey, who testified here this morning from the CIO?

Mr. HANSEN. No; Mr. Carey's organization cannot be a member of this federation.

Senator DONNELL. Is Mr. Carey on a board connected with the Cooperative Health Federation of America?

Mr. HANSEN. No; he is not.

Senator DONNELL. Is he on a board connected with the Cooperative League of the United States?

Mr. HANSEN. He is not.

Senator DONNELL. Do you know of any board connected with either of those organizations that has as its members the following persons:

Mr. Carey, CIO;

Mr. Cruikshank—

Mr. HANSEN. Our federation?

Senator DONNELL. Yes. Mr. Cruikshank, A. F. of L., who testified here this morning; Dean Clark of the United States Public Health Service; Mr. Harry—I am not quite sure of this name—Calbreth, apparently, Ohio Farm Bureau—

Mr. HANSEN. Culbreth.

Senator DONNELL. You know him?

Mr. HANSEN. Yes, sir.

Senator DONNELL. Dr. John Lawrence—possibly Dr. John Lawrence of St. Louis and Gladys Edwards of the Farmers Union. Do you know the board constituted of those persons? Isn't that an advisory board of the Cooperative Health Federation of America?

Mr. HANSEN. I would like to check my record to see. I have a list of the committees here. I have here the official committees as of July 1, 1947, and I will read them into the record, or give this letter to the clerk.

Senator DONNELL. Will you do that? Just give it to the clerk and save time unless—may I see it?

Mr. HANSEN. This is a letter of July 1 on the letterhead of the Cooperative Health Federation.

Senator DONNELL. Do you know of any committee composed, or board composed, of those six persons whose names I gave you, beginning with Mr. Carey and ending with Gladys Edwards?

Mr. HANSEN. No; I am not familiar with that board.

Senator DONNELL. You do not know what that would be?

Mr. HANSEN. No; I do not.

Senator DONNELL. You spoke of knowing Mr. Culbreth. Mr. Culbreth is one of the incorporators of the Cooperative Health Federation, is he not?

Mr. HANSEN. Yes; he is.

Senator DONNELL. He is one of the six persons that I mentioned. You also mentioned Dr. Dean Clark of the United States Public Health

Service in that list of six persons. He is also one of the incorporators of the cooperative, is he not?

Mr. HANSEN. Yes, sir.

Senator DONNELL. In that list of directors that you mentioned, was Mr. Harry Becker, Washington, D. C. He is first vice president and director of Cooperative Health Federation of America?

Mr. HANSEN. Yes, sir.

Senator DONNELL. Is he still an officer and director of that federation?

Mr. HANSEN. So far as I know, he is.

Senator DONNELL. Do you know him also to be with the Children's Bureau in the Social Security Agency of the United States Government?

Mr. HANSEN. I believe that is the department he is in.

Senator DONNELL. And he was also the president—and possibly still is—I am not sure—of group health here in Washington, D. C., is that right?

Mr. HANSEN. Yes, and it is in that capacity that he is on the board of directors.

Senator DONNELL. Group Health is the organization that is mentioned in the opinion of the Supreme Court of the United States in this case of *American Medical Association v. The United States* (317 U. S., 519)?

Mr. HANSEN. Yes, sir. I do not think Mr. Becker was an officer at that time, however.

Senator DONNELL. I am not sure whether he was, but he has been, possibly still is; I do not know about his now being, but he was at one time at any rate president of Group Health in Washington?

Mr. HANSEN. I think he still is.

Senator DONNELL. Who is the Washington representative of the Cooperative League of the United States?

Mr. HANSEN. Mr. John Carson, 726 Jackson Place NW., Washington, D. C.

Senator DONNELL. That is the address, 726 Jackson Place NW., Washington, D. C.?

Mr. HANSEN. Yes.

Senator DONNELL. Mr. Voorhis is the executive secretary of the organization, Cooperative Health Federation of America, a dual position?

Mr. HANSEN. Yes, sir.

Senator DONNELL. Was Mr. Voorhis at one time a Member of Congress?

Mr. HANSEN. That is true.

Senator DONNELL. From what State?

Mr. HANSEN. California.

Senator DONNELL. I think you indicated—I do not recall whether you said it in so many words, but I got the idea that you are not undertaking to appear here today as an expert in the subject of compulsory health insurance; is that correct?

Mr. HANSEN. That is true.

Senator DONNELL. You are a lawyer and you are representing your clients, and you are presenting the views of your clients—they may be your own views; I am not questioning that in any degree—but the point I am making is that you are not appearing here as a witness to

testify as an expert on compulsory health insurance? Is that right?

Mr. HANSEN. That is correct.

Senator DONNELL. And in that connection—I mean by these questions no offense—have you studied at all the history of compulsory health insurance, we will say, first in Germany?

Mr. HANSEN. I have read something on compulsory health plans throughout the world in a rather sketchy fashion. I have attempted to make no profound study of it.

Senator DONNELL. Do you recall the names of any of the articles that you have read, or books, if they be books, on the history of compulsory health insurance in Germany?

Mr. HANSEN. No, not at the moment.

Senator DONNELL. And I ask you the same question as to whether you recall any specific book or pamphlets or other literature which you have read on the history of compulsory health insurance in Great Britain?

Mr. HANSEN. No.

Senator DONNELL. Or France?

Mr. HANSEN. No.

Senator DONNELL. The Scandinavian countries, any of them?

Mr. HANSEN. No other countries.

Senator DONNELL. Or New Zealand?

Mr. HANSEN. No, sir. I do not pretend to be an expert witness.

Senator DONNELL. And you are not testifying as to the cost of placing into effect S. 1320?

Mr. HANSEN. I am not; I am here to say that regardless of the cost the health of the American people is so necessary that it should be put high in priority upon the accomplishments of this Congress and the appropriation that this Congress makes. I think the health of the people is the most important thing that we have got to consider.

Senator DONNELL. I appreciate your comments on that, but I want it clear that you are not undertaking to testify here today, and do not profess to have examined into the question as to the ultimate financial cost of putting into effect the system under S. 1320. That is correct, is it?

Mr. HANSEN. That is right.

Senator DONNELL. You mentioned, I think, in general terms—I did not take it down in shorthand because I am not a shorthand reporter, but I think you said substantially that in order that this plan under S. 1320 may be actuarially sound, it must be compulsory. You said that, did you not, in substance?

Mr. HANSEN. I did.

Senator DONNELL. I take it you feel that S. 1320 is to be actuarially sound. Right?

Mr. HANSEN. I do not see how that question could be answered because the bill does not contain any provisions for financing.

Senator DONNELL. You recognize that it does involve compulsory features, does it not?

Mr. HANSEN. Certainly.

Senator DONNELL. You would not share, I take it, the view that is set forth in this sentence of Mr. Carey's testimony: "One of the outstanding attributes of S. 1320 is that it would impose no compulsion on anybody." You would agree with that statement?

Mr. HANSEN. That is not literally true, because all taxes are compulsory.

Senator DONNELL. That is what I pointed out in the course of my interrogation of Mr. Carey this morning; that is, that S. 1320 does, in your judgment, involve both a pay-roll tax and ultimately the resort to general taxation to provide any deficit remaining unpaid from the pay-roll tax?

Mr. HANSEN. I understand such a financial policy must be considered.

Senator DONNELL. And in favoring S. 1320 you are doing so on that theory?

Mr. HANSEN. Yes, sir.

Senator DONNELL. You referred to the Southern States, as to the burden that you feel they are not able to handle, as I understood it. I take it you are speaking as a matter of general knowledge, without specific, detailed economic study of those States; right?

Mr. HANSEN. That is correct.

Senator DONNELL. Now, your own State, Minnesota, has a very fine illustration of the success of medicine and surgery in this country, has it not, in the Mayo Hospital to which you referred?

Mr. HANSEN. That is right.

Senator DONNELL. One of the outstanding, if not the outstanding institution of its kind in this Nation. That is correct, is it not?

Mr. HANSEN. I think so.

Senator DONNELL. And, generally speaking, do you concur with the views of some of the witnesses, possibly all of them, that the medical profession has made an outstanding achievement in this Nation along lines of scientific advancement?

Mr. HANSEN. There is no question about it.

Senator DONNELL. I wanted to ask you very briefly about two of those inserts, if you could let me have them, please. One of them was No. 5; the other was the one just before that. I do not know whether you numbered it 4 or not.

Mr. HANSEN. No. 6.

Senator DONNELL. I take it these inserts were prepared subsequent to the preparation of your original statement?

Mr. HANSEN. Well, the statement was prepared by me in collaboration with members of a committee designated by the board of directors, in line with the resolution and statement previously adopted, so that we have the insert that I neglected to put into my statement, that was called to my attention.

Senator DONNELL. Do you have any objection to telling us how large a committee that was?

Mr. HANSEN. No, sir. I believe it was a committee of five.

Senator DONNELL. Scattered, from various sections of the country?

Mr. HANSEN. Yes.

Senator DONNELL. Were those individuals persons who had specialized in the study of compulsory health insurance, so far as you know?

Mr. HANSEN. That was Michael Shadid, of Elk City, Okla., and Winslow Carlton, of New York, George Jacobson, of St. Paul, myself, and Miss Gwen Goodrich, of the office in Chicago.

Senator DONNELL. Is Mr. Shadid a physician?

Mr. HANSEN. Yes; he is.

Senator DONNELL. He is in Elk City, Okla.?

Mr. HANSEN. Yes.

Senator DONNELL. Mr. Carlton, he is a physician?

Mr. HANSEN. No; but he has been in the field of voluntary medical-care services for a period of about 10 years in New York City.

Senator DONNELL. Have you learned in any way what study, if any, he has given to the history of compulsory health-insurance operations throughout the world?

Mr. HANSEN. I would be inclined to think that Winston probably made a rather thorough study.

Senator DONNELL. That would be your best judgment?

Mr. HANSEN. I think he has.

Senator DONNELL. I take it you are giving us just your judgment, not actual conclusive knowledge on that point?

Mr. HANSEN. That is right.

Senator DONNELL. Mr. Jacobson, is he an officer?

Mr. HANSEN. He is manager of Group Health Mutual in Minnesota.

Senator DONNELL. Do you know whether or not he has made any special study of the history of health insurance, compulsory health insurance, in other nations?

Mr. HANSEN. I know he has read a great deal of the subject. As to exactly what he has read, I do not know.

Senator DONNELL. And the other party was Goodrich. Where is she?

Mr. HANSEN. In the office of the federation in Chicago.

Senator DONNELL. What is her educational background, if you know?

Mr. HANSEN. I think she is a graduate of the University of Ohio.

Senator DONNELL. Do you know whether or not she has made any special study of the subject of health insurance in other nations?

Mr. HANSEN. I do not know whether she has or not.

Senator DONNELL. Now these inserts; insert 5 specifies your opposition to legislative language which was to permit a State to contract with the medical society for the payment of funds for insurance premiums. You say you are opposed to subsidy from Federal funds. I would like in that connection to ask you to answer at this time the question to which I have referred, where in S. 545 is the language under which you think the medical associations would have control of the administration of the plan under S. 545?

Mr. HANSEN. The bill does not state so specifically, but makes it possible. The bill does not preclude the possibility, which to me is an important thing.

That is in contrast with the provisions, the wise provisions in S. 1320, that no agreement shall be made with any group or association to the total exclusion of any other group or association. The Taft bill, as I am saying, is wide open on that and would permit the State to make an exclusive contract with the medical association, and I have pointed out the danger in that, because in some States it is only possible under existing laws for the State medical association to initiate and operate voluntary plans.

Senator DONNELL. Now, Mr. Hansen, I am sure you are trying to give us your very best recollection and judgment, and I personally

want to express my appreciation of your very courteous responses to the questions and your willingness to answer that.

I am wondering if you have observed on page 17 of S. 545, in connection with this whole subject of medical-care services this language beginning at line 4:

Any State desiring to take advantage of this title may submit a State plan for carrying out its purposes. Such plan must (1) designate a single State agency—notice that “State agency” —

as the sole agency of the plan or designate such agency as the sole agency for supervisory administration of the plan, providing that on or before 1949 such agency shall be the State health agency.

Mr. HANSEN. I have read that.

Senator DONNELL. Doesn't that indicate that the State agency, as for illustration, the bureau of health, the department of health, whatever may be the name, is contemplated, on or before 1949 to be the single State agency which shall, quoting the language of the bill, “be sole agency for supervising the administration of the plan”?

Mr. HANSEN. Well, that is during and after 1949. There is nothing in this bill to prohibit the State, under section 712, the one which we have been reading, to designate the State medical association as the single agency. It is for that reason we make our objection to this provision.

Senator DONNELL. I am not quite clear as to your point there. Do you mean that there is ambiguity as regards the “before 1949,” or do you regard it as leaving it open until 1949?

Mr. HANSEN. Leaving it open after 1949.

Senator DONNELL. After 1949?

Mr. HANSEN. Yes.

Senator DONNELL. You construe this language to make it obligatory that the agency “shall be the State health agency”—you construe that to be applicable only prior to 1949? Is that your construction?

Mr. HANSEN. Yes, sir.

Senator DONNELL. I am glad to get your comment on that, and I may say to you in all frankness that I had previously observed myself that there was some ambiguity in my mind as to that language, and it is confirmed by your observation there. I may be wrong on this, but the interpretation I would put on it was that the intention was that by that time the agency “shall be the State health agency,” that thereafter it shall be the State health agency. There may be some room for question as to the wording, and if that should be clarified, I should certainly be pleased to have it clarified.

You think that this simply means that up until 1949 it must be the State health agency, and after that time it may be any agency.

Mr. HANSEN. Yes, sir.

Senator DONNELL. And you base your view in large part—your view that the medical society could obtain control of this plan in a given State, the State medical association, upon your interpretation of that language in lines 10 and 11 on page 17?

Is that right?

Mr. HANSEN. Yes, sir. I want to make one further statement in connection with that and that is—

Senator PEPPER. What page is that on?

Senator DONNELL. Page 17, line 10.

Senator SMITH. If these words were in there, it would cover your objection, I imagine—

providing that on or before 1949 and thereafter, such agency shall be the State health agency.

Senator DONNELL. I ask the chairman's pardon. I was conversing here with Dr. Shearon and I did not hear that.

Senator SMITH. I was just trying to see what language would make clear to Mr. HANSEN—I share his view that it might mean only until 1949, and I would not be in favor of that.

Would this language meet your point: "Provided, That on or before 1949 and thereafter, such agency shall be the State health agency"? That is, somewhere between now and 1949 we expect this thing to move into the State health agency and that would be the medium through which the system would be administered hereafter.

Mr. HANSEN. There would be no particular reason for having the year 1949 in the provision if that were to be the intent of the legislation.

Senator SMITH. Otherwise, it could be argued that they could drift along until 1950 or 1970, unless they have got to do it by 1949, and thereafter keep it up. That was my thought, and that is what I thought the language meant when I read this bill originally.

Senator DONNELL. That has been my interpretation, though I can quite readily see the ambiguity.

Senator SMITH. I think it should be amended. I think the language should be clarified to show, or should be changed.

Mr. HANSEN. I have another objection to designating the State health agency, although perhaps that is the best that could be devised here in this bill the way it is set up. I would like to see a committee where a majority of the committee are the users of the service, on the theory that I have already expressed, that the payees of any Federal money should not control its expenditure. It is a fact in our State, and I think in a great many States, that the State health agency is controlled by the State medical association. You will find almost invariably that nominations are made by the State medical association to those positions, and if there is not a direct tie with the State association, they are appointed by the governor with the approval and advice and consent of the State medical association. There is a fealty between the State health agency and the State medical association which cannot be denied and if the State health agencies would be responsible to the wishes and to the policies laid down by the State medical association, by simply saying "State health agency" is not enough because you will find that their doctors of medicine are members of the State association.

Senator DONNELL. You know of no State, do you, in which the statute provides that the State medical association shall have the power to designate who shall be the head of the State health agency?

Mr. HANSEN. No; but I say it is usual for the State medical association to make nominations of candidates for appointment to the State health agency.

Senator DONNELL. I can quite understand how the governor of a State would be very much inclined to confer with medical associations, because the State medical association, being the official spokesman in large part for organized medicine, would be the group from

which the governor would probably expect to obtain—certainly the power of appointment of the State health agency ultimately resides, does it not, in every case that I know of, in the appointive power of the State, which ordinarily is the governor by and with the advice of the Senate. Is not that true?

Mr. HANSEN. That is true, and I can agree with you that the governor, the executive head of the State, would want to have medical men in the State health agency.

However, it is not necessary, in my opinion, to have the health agency of the State in exclusive control of licensed physicians who are members of State associations.

Senator DONNELL. You would not advise that Federal funds be administered by a group of private citizens who are not under oath of office of any kind, would you? Would you not advise that the administration of Federal funds which are distributed throughout the Nation should be in the hands of some officials who are not ordinarily under bond but are under official oath, rather than those funds be administered by private citizens who may be under neither bond nor oath?

Mr. HANSEN. I agree with that.

Senator DONNELL. I very much appreciate your responses, and thank you very much.

That is all.

Senator PEPPER. Mr. Hansen, I believe the last time I saw you was in Mannheim in the United States Army of Occupation. What was your position there?

Mr. HANSEN. I was chief prosecutor of the War Crimes Branch.

Senator PEPPER. How long were you in the Army?

Mr. HANSEN. Three years and five months.

Senator PEPPER. Now, I agree with what the Senator has so generously said about other Senators here and we are all indebted to you for the very fair statement you have given us about this matter, both in your prepared statement and orally. Your analysis of the bill has been very penetrative and very clear. On the last point, have you noticed any difference between the kind of contract which would be made under voluntary prepayment plans, and their administration under the two bills?

Mr. HANSEN. Yes.

Senator PEPPER. Do you find—would you tell us under which there is the greater possibility that, for example, the American Medical Association or subsidiaries of that association might be chosen as the exclusive group to render medical service?

Mr. HANSEN. S. 545 provides—at least, makes it possible for control by State medical associations over the administration of expenditure of funds—leaves it open to that.

S. 1320 provides that no agreement shall be made exclusively with any group.

Senator PEPPER. In S. 545 I find the provision on page 18, beginning in line 16:

such program may also provide for the furnishing of such services to such families and individuals by means of payments (in the nature of premiums or partial premiums or reimbursement of expenses or otherwise) by the State to any voluntary health, medical, or hospital insurance fund, or other fund, operated not

for profit, in behalf of those families and individuals unable to pay the whole cost of such services, or insurance therefor.

And in S. 1320 I find subparagraph (c) reading:

No agreement made under this part shall confer upon any individual or other person, or any group or other organization, the right of furnishing or providing personal health services as benefits, to the exclusion in whole or in part of other individuals, persons, groups, or organizations qualified to furnish or provide such service.

Mr. HANSEN. We like that. We think it more democratic, more American. Also S. 1320 provides that a majority of the advisory council shall be laymen, and we agree with that wholeheartedly.

Senator PEPPER. Now, how long have you had knowledge of this Cooperative Health Federation of America, in behalf of which you have appeared here?

Mr. HANSEN. I attended the incorporation meeting and have been counsel since its inception.

Senator PEPPER. And when did you say the incorporation occurred?

Mr. HANSEN. September 1946.

Senator PEPPER. What did you say was the principal purpose of that organization?

Mr. HANSEN. I quoted it for the record. It is stated in our articles of incorporation. Do you wish me to repeat it?

Senator PEPPER. Did you give it in your previous testimony?

Mr. HANSEN. Yes, sir.

Senator PEPPER. Just summarize it in a general way.

Mr. HANSEN. In a practical way it is to furnish a place for the exchange of information and knowledge among our member associations, to assist them with technical information and assist them in making their plan to work better and to assist in the formation of voluntary plans anywhere in the United States or the country.

Senator PEPPER. What led to the formation of this organization?

Mr. HANSEN. It was because of the cooperative movement in the whole field of health. It is rare to go to any meeting of cooperatives where health is not discussed. It is one of the leading topics of conversation in the country among cooperatives, because it is one of the most crying needs. Rural people are suffering from a shockingly poor distribution of medicine. I could tell this committee of many, many cases, sworn testimony of people before our State legislature when they attempted to get an enabling act in the last session of this year. The medical association fought it bitterly, and in 1945 they attempted to get an exclusive law and it was only by the pressure of all of organized labor, cooperatives, credit unions, and other civic groups that the State association was prevented from getting an exclusive, monopolistic bill in Minnesota. They stopped us from getting a plan, the enabling act that was passed in Minnesota in the last session, and we felt that if in a national health plan the doors were open for truly voluntary plans it would help the States to see that they could gain something by coming into this sort of thing, and it would encourage the people in the local level to organize plans for themselves, because then they would have a means of sustaining the organization they had set up.

Senator PEPPER. You say you encountered the opposition of the medical associations in your organization?

Mr. HANSEN. We encountered what I would describe or have described publicly as vicious opposition.

Senator PEPPER. In what way did they express opposition?

Mr. HANSEN. We asked the legislature in Minnesota simply to put on the books an enabling statute which would permit persons to form membership associations under the nonprofit laws of the State.

Senator PEPPER. Voluntary associations?

Mr. HANSEN. Voluntary associations, in which each member would have one vote, regardless of the amount of contribution, which would be fairly democratic and cooperative, and permit that association to arrange with doctors for medical services on any basis mutually agreeable between the physician and the association, and set up health facilities that they needed, like they are now setting up hospitals, the same way in which we attempted to include this amendment. The medical association in Minnesota put a great deal of political pressure on the members of the health committee time after time when we came there with witnesses from various parts of the State, who traveled great distances, but the health committee was unable to obtain a quorum.

I remember one case in particular when I had some witnesses prepared to testify from the State Grange, the State Farmers Union, and ministers and others, and we were scheduled so that we had a difficult time getting there, and we could not get a quorum, and I went out in the hall and found three members who should have been there and provided a quorum, and each of them told me that the medical association, the hospitals in their area, and even the druggists, had put such pressure on them to stay away from voting on this bill that they said "if we go up there in that committee and you make us vote on it, we will have to vote for it, and if we do we are sunk politically."

That is what we ran into in both house and senate, and for that reason it was most difficult to report it out of the committee.

Senator PEPPER. You say you encountered that opposition really, which you describe as "vicious" opposition. You said "vicious"?

Mr. HANSEN. Yes.

Senator PEPPER. Notwithstanding the fact that the plan that you people proposed for the State of Minnesota was a voluntary plan?

Mr. HANSEN. It involved no Government funds whatever.

Senator PEPPER. It involved no Government funds and notwithstanding the fact that you proposed to make mutually agreeable contracts with the doctors and hospitals?

Mr. HANSEN. Yes.

There was no compulsion in any of it.

Senator SMITH. What reason did they give for opposing it? I think the proposal was a reasonable one, the kind of thing I thought we could get groups together to work out voluntary plans that we are talking about.

Mr. HANSEN. Frankly, Senator, they could not meet us logically upon the provisions of the bill at all, and they chose to use the tactics I have described.

Senator SMITH. I am wondering what attitude physicians of the standing of Dr. Mayo would have. Was he a party to that opposition?

Mr. HANSEN. Dr. Mayo did not appear one way or the other. I can tell you this, however, Mutual Health went to the Mayo Clinic in 1940—I was there—and talked with Mr. Howarton, the manager, and

he said that if and when we could get a law in Minnesota which would enable these plans to operate, the Mayo Clinic would not only serve the people of Rochester and the surrounding area with prepayment medicine on a very reasonable basis, but would take all the reference work from other plans which we might have in other parts of the State.

So we considered the Mayo Clinic was working with us, but unfortunately we had the same old common-law prohibition existing in Minnesota as obtains in so many States, that there is a so-called corporate practice involved, therefore violation of the licensing law, and for that reason we must have an enabling act on the books.

Senator SMITH. The reason I was raising the question of whether a person of the caliber of Dr. Mayo would oppose the reasonable proposal which you made—I would think not. I would think the Mayos are big enough men to see that they had to work this thing out and cooperate with it. Many of my friends in the medical profession today are cooperating 100 percent on thinking through with us some of these problems. I correspond with them every day on how to perfect the thing, how to work out the best way to do it.

Mr. HANSEN. A great many doctors in our State are perfectly willing and happy to cooperate, but the problem is this: That because it is not lawful under the laws of the State—it happens to be common law in our State—because it is not lawful, therefore it becomes unethical, and if a doctor voluntarily cooperates, participates in a plan with a group of these people, he is guilty of committing an unethical act and he is ousted from the State society, which immediately entails his being barred from using any hospital or obtaining consultative services.

So the great pressure that can be put upon him is just inestimable.

Senator PEPPER. That is why you had to have that act?

Mr. HANSEN. That is one reason we did. That is one reason we like to have a provision added to any bill that doctors shall be free to participate in and shall be protected against discrimination. We think that this bill, S. 1320, would encourage some of these States to see, some of these medical associations to see the light.

Senator SMITH. That had nothing to do with the compulsory insurance or voluntary plan. They both have the same effect. I mean what you are arguing is to have recognition of the group-insurance plan, which I heartily agree with. I think we must get some kind of group plan of medicine; it is just a question of how to work it out. Do you have any comments on that?

Am I correct in that statement, that what you are arguing for now is not necessarily compulsory health insurance plan but you are arguing for recognition of the group approach? You are not arguing for the compulsory plan?

Mr. HANSEN. No; I should not like to leave that impression.

Senator MURRAY. You are trying to break down the medical monopoly; is that it?

Senator SMITH. If I may interject there—in the light of Senator Murray's suggestion, as to the American medical monopoly, it so happens that I was raised in a medical family, the son of a doctor, and any idea of a medical monopoly would be just as abhorrent to me as to Senator Murray. I do not think there is a medical monopoly.

I think there are in certain areas some individuals, but I do not think, generally speaking, that there is a medical monopoly in America.

Senator MURRAY. I had reference to the Minnesota situation.

Senator SMITH. It may be locally, but I do not know anything about that, and taking your statement, there is no sense in the medical group trying to oppose it. I think what you are attempting to get is the group plan in effect.

Senator MURRAY. Are you familiar with the Medical Fence Act?

Mr. HANSEN. That is it; yes.

Senator MURRAY. You are familiar with that situation?

Mr. HANSEN. Yes; in Wisconsin.

Senator DONNELL. He has already testified, Senator—I do not know whether you were here at the time—that the Medical Fence Act does not create a monopoly, as Mr. Biemiller was under the impression it did when he testified the other day.

Mr. Hansen, I think correctly stated that the so-called Medical Fence Act was merely a permissive granting to the State society an authority, not the creation of a monopoly. Am I correctly stating it?

Mr. HANSEN. Yes, sir. It is quite easy to become confused on that point, and I could see how a layman could get confused upon it.

Senator MURRAY. This gentleman who was testifying here the other day was an expert in this field, had devoted 10 or 15 years of his life to it, was a member of the State legislature out there and was connected with all of the activities there that were involved in that Medical Fence Act. And he was formerly a Member of Congress here.

Mr. HANSEN. Yes; I know Andy very well. What that act did was to permit medical societies—and it said only “medical societies”—to set up voluntary plans and to operate them. It was a permissive enabling act for the medical society, but it did not specifically state that consumer plans would be unlawful. However, it amounted to that because the common law prohibition against corporate practice which violates the licensing laws would bar it anyway. So the consumers had to go in this session and obtain an enabling act for themselves, which they did, and I believe by this time it has been signed by the Governor.

Senator DONNELL. You made it clear, however, earlier in your testimony—I think you mean the same thing now—that the so-called Medical Fence Act did not create a monopoly; it still left the way open for the legislature to grant to anybody else the privileges that the legislature might want to grant.

All it did was grant permission to this society.

Mr. HANSEN. Yes.

Senator MURRAY. But the State legislature had not taken action along that line.

Senator DONNELL. It has now.

Mr. HANSEN. It has now—a couple of weeks ago.

Senator MURRAY. So at that time the Medical Fence Act had the effect of giving exclusive control of the situation in that State.

Mr. HANSEN. In the manner in which I have stated. It had that practical effect.

Senator DONNELL. Just a minute; I respectfully disagree that it had that effect. What it did was grant permission to one society which it had not granted to others, and subsequently granted to others.

Mr. HANSEN. You must remember, Senator, that the common-law prohibition still stood in the way and formed an insuperable obstacle to the consumer-sponsored organization, and until that was cleared away by the session in Wisconsin now going on—just passed a couple of weeks ago—there was no way in which consumers could form a plan, an organization of their own.

Senator DONNELL. I think we all mean pretty much the same thing. I may be expressing it a little differently, but I take it that under the general law the corporation has only such powers as are conferred upon it by the legislative body, and that the legislative body in the so-called Medical Fence Act conferred those powers upon the State medical society and did not confer them on anybody else; neither did it say nobody else should have them.

Subsequently, in the meantime, as you have indicated, not having conferred them, the cooperatives did not have the power, and subsequently, by act of the legislature a few weeks ago—even less than that, maybe—there has been similar authority conferred upon cooperatives.

Mr. HANSEN. That is a very good statement.

Senator DONNELL. Now, Mr. Hansen, I want to ask you—not to trespass but just a moment here—I am very greatly interested in this matter that you mentioned in Minnesota and I am wondering whether it was the medical society that opposed your bill?

Mr. HANSEN. Yes, sir.

Senator DONNELL. The State medical society? Who was president of that society at that time, do you know, and where did he live?

Mr. HANSEN. Dr. Edson and Dr. Berger were the men who were particularly in the leadership of the fight against us.

Senator DONNELL. Do you know his initials?

Mr. HANSEN. No, sir; I do not.

Senator DONNELL. He is with the Mayo Clinic, is he not?

Mr. HANSEN. Yes, sir; the Mayo Clinic. And the Mayo Clinic wanted it understood that he there spoke as an individual, not for the clinic.

Senator DONNELL. He was one of the men who opposed your bill?

Mr. HANSEN. And Dr. Sohlberg. I forget his first name, and town, and Dr. Sogge, Windom, Minn.—all three of whom are members of the State council, the governing body of the medical association.

Senator DONNELL. They were the active legislative opponents of your bill and acting, as you understood it, in behalf of the State medical society?

Mr. HANSEN. The Minnesota State Medical Association.

Senator PEPPER. Mr. Chairman, at this time, and in connection with assertions about monopolistic practices, I wish to offer in the record a letter from Mr. Thurman Arnold to Dr. Channing Frothingham, chairman of the Committee for the Nation's Health, Inc., dated July 2, 1947, commenting on the two questions:

What monopolistic practices and tendencies exist today on the part of the American Medical Association and the State and county medical societies which, taken together, constitute "organized medicine"?

Would the Taft bill promote or restrict such monopolistic practices and tendencies?

Also I would like to introduce into the record a statement by Alma Vessels, executive secretary of the National Association of Colored

Graduate Nurses, Inc., addressed to Senator James E. Murray, dated July 1, 1947, endorsing—containing a resolution adopted by the National Association of Colored Nurses endorsing S. 1320.

Senator SMITH. I might ask the Senator if he will yield just a moment, because, apparently, it was anticipated that the Frothingham letter was to be introduced today sometime and I have a letter from the secretary and general manager of the A. M. A., Chicago, as follows:

It has come to my attention that a letter from Thurman Arnold, Esq., to Dr. Channing Frothingham, chairman, Committee for the Nation's Health, Inc., 1790 Broadway, New York 19, N. Y., dated July 2, 1947, has been introduced as part of the record of the hearings on S. 545 now being held before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. That letter undertakes to call into question the good faith of the American Medical Association in its efforts to promote the health of the people of the United States. I respectfully request that this communication also be made a part of the record.

The American Medical Association, now 100 years old, was organized "to promote the science and art of medicine and the betterment of public health." It has endeavored to do so to the best of its ability by stimulating progress in medical education, by efforts to assure the purity and potency of medicinal preparations and the therapeutic value of apparatus, by exposing quack remedies and charlatans, by promoting national medical research, and by many other methods, including fostering and development of prepaid voluntary medical-care plans.

I respectfully request that this communication be introduced in connection with the other letters offered by the Senator from Florida. (The letters referred to follow:)

ARNOLD, FORTAS & PORTER,
Washington 5, D. C., July 2, 1947.

DR. CHANNING FROTHINGHAM,
Chairman, Committee for the Nation's Health Inc.,
New York 19, N. Y.

DEAR DOCTOR FROTHINGHAM: Your letter of June 27, 1947, asked me for my comments on the Taft health bill, S. 545, with particular reference to its "restraint of trade and monopolistic implications." In answering your request, I am not writing as the former Assistant Attorney General who prosecuted the case against the American Medical Association, but as one who has always fought monopoly and monopolistic tendencies to such an extent that I am still referred to as "the trust buster."

I would like to break down your inquiry into two specific questions:

I. What monopolistic practices and tendencies exist today on the part of the American Medical Association and the State and county medical societies which, taken together, constitute "organized medicine"?

II. Would the Taft bill promote or restrict such monopolistic practices and tendencies?

I. As to the first question:

(a) I have long felt that organized medicine has utilized agreements, boycotts, blacklists, suspensions, and expulsions to prevent or impede physicians from participating in plans which would make medical services more widely available at less cost to patients. Under the Code of Ethics of the A. M. A., a county medical society may discipline and even expel a doctor who has entered into economic arrangements which the society considers "contrary to sound public policy." The medical society sets itself up as the judge of what is "sound public policy."

Expulsion or even suspension from a medical society is a severe penalty, especially since it ordinarily deprives a physician of staff membership in any hospital. In the case of a surgeon, this may destroy his practice. Thus the medical societies have assumed power over the practice of a profession licensed by the State, and over the civil rights of American citizens. Such a power goes far beyond that of a private club to control its own membership. In my opinion, such power is an exercise of a public function and should be subject to public scrutiny and, when necessary, to court review.

A physician may be brought up for discipline before a committee of doctors that might include his chief competitors in his private practice. In our civil

or criminal courts we would not tolerate a situation in which the judges might profit financially as a result of the verdict they rendered. We should not permit such a situation to exist in medicine.

(b) In spite of the decision in the case of *American Medical Association v. United States*, organized medicine has continued to put obstacles in the way of the establishment and operation of nonprofit voluntary medical care plans sponsored by other than medical societies. In 17 States, the State medical societies have obtained the passage of legislation which practically gives control over prepayment medical care plans to these societies and prevents farmers, industrial workers, and other consumers from organizing prepayment plans under their own auspices.

Prepayment plans are not the practice of medicine, but are methods of financing medical costs. The people who pay the bills, not the doctors who are paid by these people, should certainly have the right to organize such plans for their own benefit. Such monopolistic laws seem to me an unwarranted interference with private enterprise and experimentation in new ways of financing medical service.

(c) Recently the American Medical Association has begun to use a white list to promote prepayment plans sponsored by medical societies. Its council on medical service, which spent over \$100,000 during 1946, grants the A. M. A. seal of acceptance to voluntary prepayment medical plans which meet its requirements. In order to qualify, a plan must have the approval of the medical society of the State and the county in which it operates. Up to date, the A. M. A. has granted its seal of acceptance to 52 plans, all of which have medical-society sponsorship. So far as I am aware, the A. M. A. has not granted its seal of acceptance to any one of nearly 200 existing prepayment plans which have been sponsored by industries, unions, farmers, cooperatives, and other groups besides medical societies.

II. Would the Taft bill promote or restrict these present monopolistic tendencies?

My opinion is that this bill would substantially increase the powers and the monopolistic control of organized medicine. My reasons for this belief are as follows:

(a) The form of administration prescribed in S. 545 would give substantial control over the policies for expending the Federal funds appropriated under this bill to officials who would be the creatures of organized medicine and to councils a majority of whose members would owe their allegiance to medicine rather than to the public.

(b) Such control would not apply to the Federal health agency set up by this bill, but, what is still more important, on the State level also. Under the bill, Federal powers are limited and most of the administrative responsibility is vested in State organizations. The State agencies, as outlined in this bill, would be practically controlled by State and local medical societies. The monopolistic powers and tendencies now exercised by these societies would be greatly increased because the new State agencies would control the expenditure of public funds to care for certain persons and to aid voluntary prepayment plans. The State administrators under this bill could grant funds to medical-society-sponsored plans, and refuse such funds to other plans. The bill does not limit administrative powers in this respect. It does not, for example, prohibit an exclusive contract with a single private prepayment plan.

For these and other reasons which could be spelled out in more detail if space permitted, I believe the Taft bill, S. 545, to be decidedly undesirable.

Very truly yours,

THURMAN ARNOLD.

NATIONAL ASSOCIATION OF COLORED GRADUATE NURSES, INC.,

New York 19, N. Y., July 1, 1947.

Senator JAMES A. MURRAY,
Senate Chamber, Washington, D. C.

MY DEAR SENATOR MURRAY: At the first postwar biennial convention of the National Association of Colored Graduate Nurses just concluded in Atlanta, Ga., it was unanimously voted by the 400 delegates representing 26 States that we send you the following resolution:

"Whereas the National Association of Colored Graduate Nurses has always been vitally concerned with the health of all the people, and whereas the health

of the Nation's largest minority, the Negro people should be of particular concern to the entire country, be it therefore

"Resolved, That we strongly urge the passage of 'The National Health Insurance and Public Health Act of 1947,' S. 1320, without discrimination as to race, creed, or color."

We respectfully urge its inclusion in the record of the Senate Subcommittee on Health.

We wish to express our sincere appreciation for your efforts in behalf of legislation which will insure greater health benefits for all of the people of our Nation.

Respectfully yours,

ALMA VESSELS, R. N.,
Executive Secretary.

AMERICAN MEDICAL ASSOCIATION,
Chicago 10, July 9, 1947.

Hon. H. ALEXANDER SMITH,
United States Senate Building, Washington, D. C.

DEAR SENATOR SMITH: It has come to my attention that a letter from Thurman Arnold, Esq., to Dr. Channing Frothingham, chairman, Committee for the Nation's Health, Inc., 1790 Broadway, New York 19, N. Y., dated July 2, 1947, has been introduced as part of the record of the hearings on S. 545 now being held before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. That letter undertakes to call into question the good faith of the American Medical Association in its efforts to promote the health of the people of the United States. I respectfully request that this communication also be made a part of the record.

The American Medical Association, now 100 years old, was organized "to promote the science and art of medicine and the betterment of public health." It has endeavored to do so to the best of its ability by stimulating progress in medical education, by efforts to assure the purity and potency of medicinal preparations and the therapeutic value of apparatus, by exposing quack remedies and charlatans, by promoting rational medical research and by many other methods, including fostering the development of prepaid voluntary medical care plans.

The intimation, implicit in Mr. Arnold's letter, that in those efforts the association, or any of its constituent or component units, have been motivated by a selfish or improper interest or that they have not had as an impelling objective the betterment of the health of the people, stems either from a lack of obtainable knowledge or from a disregard of knowledge actually possessed.

Mr. Arnold is quite correct that the council on medical service of the association has established "standards of acceptance for medical care plans" and that it has granted its seal of approval to a number of such plans sponsored by medical societies that have met the standards so established. Plans developed by other groups must meet the standards established by the council if they are to receive its seal of approval and a study of such other plans is now under way.

As to whether or not the enactment of S. 545 would tend to "increase the powers and the monopolistic control of organized medicine," which Mr. Arnold asserts it would do, the association has sufficient confidence in the integrity of the sponsors of the bill and in their sincere desire to promote the public well-being to be convinced that no such result is intended nor will any such result ensue if the bill is enacted. Mr. Arnold is simply seeing implications in the bill not warranted by its provisions.

Sincerely yours,

GEORGE F. LULL.

Senator DONNELL. With the Senator's consent, at this point, while this citation is already in the record, I think it will be well, for convenient reference, to again insert it, with reference to the case to which Mr. Arnold refers, namely, the *American Medical Association v. the United States*, being (317 U. S. 519).

Senator PEPPER. Yes; I think we should have it. I ask to insert in the record an article entitled, "Health Means Plans and Dollars" with

the subtitle "We must find a way to meet our challenging national medical problem," in the April 1947 issue of Kiplinger's Magazine. That is put out by the well-known author of the Kiplinger letter. That contains some very interesting material on this subject, among which is:

This country had higher infant death rates than seven other countries, higher cancer, heart, nervous, and mental disease rates. The average life expectancy at birth was higher in four countries; at 20 years it was higher in each country; at age 40 in 11; and at age 60 in 12.

And so on.

Senator SMITH. Are you offering this entire document, this magazine?

Senator PEPPER. I will offer it for the record, just a couple of pages.

Senator SMITH. Very well.

(The article Health Means Plans and Dollars follows:)

HEALTH MEANS PLANS AND DOLLARS—WE MUST FIND A WAY TO MEET OUR CHALLENGING NATIONAL MEDICAL PROBLEM

United States medicine, which has devised brilliant treatments for many of our ills, is having a hard time prescribing for its most acute problem—how to make medical services available for all who need them.

There is wide agreement on the diagnosis—our medical facilities are badly organized and too expensive for most people. There is no general agreement on the right treatment, despite the universal interest in working out some solution. We are all potential consumers of medical services, and we are all affected by the health of our community. And our overburdened doctors need relief from a system under which they can't take care of all the sick, even with charity treatments.

Although the Nation's health cannot be put on a dollars-and-cents basis, employers should be concerned with the terrific inroads, largely preventable, which illness makes on production. Before the war between four and five hundred million work-days were lost annually from sickness—about 40 times the number lost through strikes. The loss of consumption power may be even greater.

Here is what's wrong in the judgment of the American Medical Association, individual doctors, lay experts, and Government officials:

The traditional fee system of payment for medical services is too costly. Most people can afford emergency pills and treatment, but not preventive medicine or prolonged, catastrophic illness. Some estimates say that about 20 percent of the population can't pay even for minimum medical needs.

There are not enough doctors, especially in rural regions, slums, and small communities. Many doctors are underpaid. Few have time to keep up with developments.

Hospitals and other facilities are too few, poorly distributed, often antiquated. Medical research is haphazard. We spend a hundred dollars for research on infantile paralysis, which afflicts relatively few, for every 25 cents spent on mental disease, which afflicts millions and fills more than half the Nation's hospital beds. Many people, particularly if they have no trouble meeting their own medical bills and deal exclusively with comfortably established city physicians, find it hard to accept so sweeping a diagnosis. But the clinical facts are disturbing.

According to the AMA in 1940, most individuals and families with incomes under \$3,000 needed help in meeting medical bills. That amounted to well over 75 percent of the population. People who borrow from small-loan companies need the money most often to pay medical bills.

For many an ailing individual the high cost of sickness poses the question of how much medical attention he can do without, and for how long. The grim consequences of such enforced self-denial showed up in prewar medical statistics, which brutally dispose of the notion that the United States is the healthiest Nation on earth.

This country had higher infant death rates than seven other countries; higher cancer, heart, nervous, and mental disease rates. The average life expectancy at birth was higher in 4 countries; at 20 years it was higher in 8 countries; at age 40 in 11; and at age 60 in 12. The subsequent revelation that about 40 percent of

young Americans were unfit for military service for medical reasons has hushed our big talk about national health standards.

It's not primarily the doctor's fault that protracted illness and preventive medicine are so expensive, although it is a fact that organized medicine, through the American Medical Association, has demonstrated a minimum of social awareness in facing the mounting medical crisis.

But the individual practitioner usually is too busy with his never-ending responsibilities to think about broader medical issues. He carries an appalling load. In most cases the family doctor has fully earned the respect and affection which millions of Americans have for him. He has a habit of quietly scaling down bills for needy patients and carrying a load of charity cases without talking about it.

So many doctors have concentrated in the cities that demands on country and small-town doctors are proportionately higher. These small community doctors are often the ones with poorest facilities, largest practices, and lowest incomes.

The main effort to bridge the economic gap between patient and doctor has been through voluntary group insurance plans as a substitute for the fee system of payment. During the last two decades many Americans have got partial coverage against sickness through one of these plans.

But they have three fatal defects: They don't offer adequate coverage; they have proved too expensive for lower-income groups; and they don't include enough people.

Like most commercial health insurance policies, group insurance plans tend to restrict services and to neglect thorough treatment. Some group plans provide only hospitalization for limited periods, but over half our medical bills are for treatment given outside of hospitals. Less than 5.4 percent of the population has insurance for physicians' services, and about 2.5 percent have complete home, office, and hospital coverage. Only 1 American out of 4 has any kind of health insurance at all.

Many of people who have had experience administering group health plans say that these are only a necessary stopgap in the absence of a national health plan.

There are signs that the tide is setting in the direction of such a national program as a logical extension of social security. Opinion polls show a majority in favor of pay-roll deductions to provide national health insurance. And in the last Congress Republicans and Democrats joined to provide Federal funds for the construction of more hospitals and clinics, and for treatment and research in mental health and other fields.

Congress hasn't acted on the problem of providing medical services for those who can't afford them. But it may do so during the present session. Senator Robert A. Taft (Republican), Ohio, has revised his health bill, and reintroduced it, with the support of the AMA. Given the Senator's influence and the Republican desire to win votes from those who would benefit by the measure's provisions, chances for this bill look pretty good. Its main provisions:

Coordination of civilian Federal health functions in a new Federal health agency.

Appropriation of \$200,000,000 yearly to assist States in providing medical care and hospital services for individuals and families unable to pay for them.

Cash contributions by States at least equal to the sum advanced from the Federal Treasury.

Approval of State programs by the Surgeon General, with appeal to a national health council in event of disagreement.

Enactment of the bill, according to its proponents, would probably make some basic medical services available to the poorest 20 to 25 percent of the population; opponents say only 10 percent.

Critics of the bill object strongly to a provision that applicants would have to prove their inability to pay. Too many States require a means test as proof of this inability to pay. This is a throw-back from the concept of social security to that of public charity. It seems needlessly humiliating, say the critics, that sick people should have either to exhaust their savings or stigmatize themselves as paupers to obtain emergency medical care.

The Taft bill also minimizes basic public interest in good health for everyone. We do not maintain schools only for those who are too poor to go to private schools, nor libraries for those who are too poor to buy books. Why offer medical care to the indigent, and exclude middle-income families for whom, also, medical services are too expensive?

Another criticism is that the Taft bill, by providing only emergency relief, forestalls any attempt to combat disease on a Nation-wide scale. Some doctors

think tuberculosis could be wiped out in the United States within a generation, syphilis within a shorter time. But this could be done only through a Nationwide campaign, with services readily available to everybody.

One major political force interested in going beyond the provisions of the Taft bill is United States labor. With hopes of big wage boosts collapsing, union negotiators are now going down the line for fuller health coverage as well as cash benefits paid for by employers. Management will be hard put to refuse this demand altogether.

In the next few years an estimated 8,000,000 workers are likely to get new or increased health protection as a result.

Senator Taft's prescription, limited coverage for bottom-income groups, differs of course from the unions' proposal—full coverage for all union labor. But by one of the ironies of politics, both efforts may have the same long-run effect.

Once you provide basic medical care for 35,000,000 citizens under the Taft bill and for additional millions of industrial workers under union contracts, the objection to going the whole hog diminishes. The cost would be much cheaper if it were spread over the whole population. And coverage would be more complete. The financial and administrative burden of health and welfare clauses would be taken off private enterprises and placed on official agencies.

One proposal for such a program has been embodied in the administration-sponsored Wagner-Murray-Dingell bill. It is expected to be financed by a 3 percent pay-roll levy divided between employees and employers, plus a general appropriation for research and training.

Payments from this fund would be entrusted for disbursement to the Surgeon General, who would also set standards. But day-to-day administration would be left to States, local communities, and existing medical groups. Doctors would continue, if they preferred, to practice on the present fee system, with payments made to them out of the insurance fund. Doctors who wished to practice on a full or partial salary basis could do so. Those who wished to remain completely outside the system would be free to do so.

Patients could go to any general practitioner in the system. The doctor also would be free to accept or reject patients.

It's worth noting that the British Medical Association once fought a national health system based on compulsory health insurance just as stubbornly as the AMA does now. After a Conservative government set one up anyway, the British Medical Association swung to support. One reason: doctors' incomes went up.

Like a number of distinguished medical men, some United States business leaders have come to regard a national health program as a desirable extension of our present social-security laws. Executives like Charles Luckman, president of Lever Bros.; Gerard Swope, president of General Electric; and David Sarnoff, of RCA, feel this way.

Total cost of a national health program has been set at \$4,000,000,000 yearly. That's about what we pay now, in doctors' bills, taxation for public health service, etc., for such medical care as we get. Socially and economically, it would seem sensible to organize medical services for faster progress toward the goal of medical science, which is not just care in sickness, but positive health for the individual and for the entire community.

Senator PEPPER. Mr. Hansen, you do feel then, that the organization of this Cooperative Health Federation of America for which you speak, and the sentiments that you have here expressed by the rural people and people who might be considered of average intelligence does represent a growing demand on the part of the American people that there may be some plan worked out by which adequate medical care, including all phases of medical care, may be made available and accessible to the whole American people?

Mr. HANSEN. There is no question about it.

Senator PEPPER. Thank you very much.

Senator SMITH. Members of the committee, before we recess, and in order to emphasize the point, which I think we are very much interested in, that we are not discussing partisan matters now, because the so-called Taft bill, S. 545, and the so-called Wagner-Murray bill that

Senator Murray introduced here, S. 1320, and Senator Murray is a Democrat and Senator Taft a Republican, but I can state there are differences of opinion in my own Republican Party on the questions concerned, and I know there are in the Democratic Party, but I have here given to me by a friend of mine a copy of a letter from Dr. R. B. Robins, Camden, Ark., which he suggested that I insert in the record to show his view at least. This letter is addressed to Mr. Gael Sullivan, executive director of the Democratic National Committee.

Dr. Robins is a member of the Democratic National Committee, the national committeeman from Arkansas, and he writes under date of July 2, 1947:

DEAR MR. SULLIVAN—

I have your bulletin of June 21, 1947, in which you continue to urge the idea of compulsory health-insurance legislation. To me and the people in my section of the country, this is a very repulsive project of the Democratic Party.

It is very well known that this is the brain-child of such radical social reformers as Michael Davis and Isidore Falk, who would like to see our democratic system transformed into a totalitarian system.

It seems to me that it is high time for the Democratic Party to stop pushing the philosophy of bureaucracy in our country. The present program seems to have as its ultimate object the destruction of the principal of self-reliance of the American citizen and making him more and more dependent upon the central Government. This leads to the loss of freedom as it has in all of the nations which have tried it.

The tax gatherer this year will take more than one-fourth of our national income. Yet, our party continues to try to push programs that will increase this. The national health program which you are advocating is a compulsory program. There is no choice. It would build one of the greatest bureaus in the history of the world—a multi-billion-dollar bureaucracy.

I would like to see the Democratic Party get away from the philosophy of Government paternalism and get back to the basic principles that made this Nation great.

I am looking forward to seeing you next Wednesday.

Sincerely yours,

R. B. ROBINS, M. D., *National Committeeman.*

Senator SMITH. I am merely offering this because of the suggestion sometimes made that all the criticism of this approach comes from the Republican Party, and I just want it to appear that there is a difference of opinion among Democrats as well as Republicans, and this evidence is from a member of the Democratic National Committee, addressed to the executive director of the Democratic National Committee by Dr. R. B. Robins, Democratic national committeeman for Arkansas, Camden, Ark.

So it appears that we are approaching the subject, I might say, from a bipartisan standpoint, and we are trying to solve the problem, and we have different points of view in both parties.

Senator PEPPER. I guess we will probably find that a lot of Democratic doctors are against S. 1320 and a lot of Republican workers and farmers are for it.

Senator SMITH. Mr. Hansen, we appreciate very much your coming and thank you again for the fair way in which you have presented the matter.

Mr. HANSEN. I appreciate the attention, the courtesy, and good humor of the committee.

Senator SMITH. I understand that Mr. Joseph Louchheim and Michael Davis, who were to be here today, will be here tomorrow morning.

Senator MURRAY. At the conclusion of the meeting yesterday I talked to you about it, Senator, and as a result of my conversation then I believe I told Michael Davis and the other gentlemen that they would not have to be here tomorrow. I will have to check into that and see whether I can get them here.

Senator SMITH. We have on our list Mr. Lasker, I believe, and various Senators who will speak on the bill.

(Whereupon, at 5 p. m., the subcommittee adjourned until 9:30 a. m., Friday, July 11, 1947.)

NATIONAL HEALTH PROGRAM

FRIDAY, JULY 11, 1947

UNITED STATES SENATE,
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE
ON LABOR AND PUBLIC WELFARE,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 9:30 a. m., in the committee room, Capitol Building, Senator Forrest C. Donnell presiding.

Present: Senators Donnell (presiding), Murray, and Pepper.

Senator DONNELL. The committee will please be in order.

At the request of Senator Smith, I am presiding this morning since it became necessary for him to be present at a meeting of the Committee on Foreign Relations, and I state he regrets very much his inability to be here this morning, as he was very anxious to attend and it is only because of the meeting of the other committee at which he finds it necessary to be present that he is not here.

Is Mr. Albert D. Lasker present?

Mr. LASKER. Yes, sir.

STATEMENT OF ALBERT D. LASKER, NEW YORK, N. Y.

Senator DONNELL. Mr. Lasker, will you please state your name, your address, and business and whether or not you are appearing for some organization or yourself?

Mr. LASKER. My name is Albert D. Lasker. My address is 3313 Chrysler Building, New York, N. Y.

I am president of the Albert and Mary Lasker Foundation.

I am appearing for myself.

Senator DONNELL. Mr. Lasker, would you tell us, please, also what business you have been in for a number of years?

Mr. LASKER. I was for 45 years, most of the time, the head and owner of a large advertising agency of America.

Senator DONNELL. What was that?

Mr. LASKER. Lord & Thomas—it went out of business when I went out of business.

Senator DONNELL. Yes.

Mr. LASKER. I was also part owner and helped run several other businesses, such as Pepsodent, Kotex, and Kleenex, and other packaged goods businesses, and I had clients in many others in which I had an interest, many of the largest manufacturing firms in America.

Senator DONNELL. Yes.

Mr. LASKER. I would say I was owner or part owner or adviser to businesses that ran into the billions during the years.

Senator DONNELL. Will you proceed, Mr. Lasker?

Senator MURRAY. I might add, Mr. Lasker, for many years you have been interested in the health problems of the Nation, have you not?

Mr. LASKER. I have been interested in the general health problem, having been attracted to that humanitarian problem through facing health problems not only in my own life but in my own family.

Senator MURRAY. And you are appearing at the personal request of the sponsors of this legislation?

Mr. LASKER. Oh, yes; I had no idea of appearing until I was asked to.

Senator MURRAY. All right.

Senator DONNELL. Proceed, Mr. Lasker.

Mr. LASKER. When first invited by members of your committee to testify on the various national health bills which you are now considering, I was hesitant to accept because, although I have long been deeply interested in these measures, I could not quite see where I qualified as an expert. While my presence here today evidences my own judgment that I do so qualify, I think it is important that I outline to you the reasoning which brought me to that judgment and the limitations of my "expertness."

Certainly, I cannot qualify as an expert on the technical, clinical, or scientific phases of medical practice. In that respect, it may be we are all in the same boat. Yet I think I do qualify on a number of other grounds. First, I am an expert sufferer, and thus qualified to plead the cause of others who, in their own persons or in the illness of family and close relations, have learned at first hand the agony of severe illness and the manner in which financial difficulties accentuated and sharpened that agony. In this sense, I am in no way unique. I am certain that all of you here can, in some way, match the experience I want to tell you, ever so briefly, about.

As a young man of very modest means, I married. A short time later my wife was taken with a grave illness—an illness that continued intermittently for 34 years, till her death. Within the first year of that illness, medical bills completely wiped out the small savings upon which we had so boldly ventured into matrimony. The blow was a staggering one to me. To my sick wife, it was an added burden; a constant worry and concern that no ill person should be asked to bear. I was fortunate in that my business ventures were successful. I was able to stay one jump ahead of the onrushing bills. As a young man in business in a period of economic expansion, I got by. But I know and you know that many millions of others, working on fixed salaries or struggling to make a go of small shops, farms, or limited small businesses, have inevitably gone under when subjected to the same devastating strain. It was only good fortune that saved me from being overwhelmed by the cost of a major medical disaster. Yet I know even then that I was among the very few so situated.

In speaking as one who has had to meet the bills, I am sure I speak of an experience common to us all. Certainly most of you, no matter how well off you may be today, have at some time and in some degree faced this same problem. It is this very knowledge, that we all are and have been sufferers from the inadequacy of provisions for meeting the cost of medical care, that inspires my great confidence in the members of this committee. No matter how strongly I may feel

that one of the bills before you offers a solution and that another does not, I would be sadly lacking in judgment if I did not fully recognize the fact that both these bills come from men whose minds have met and agreed on one great principle, namely—and I here quote from the preamble of S. 545—

That it (should be) the policy of the United States to aid the States to make available medical, hospital, dental, and public health services to every individual regardless of race or economic status.

When disagreement exists as to method and means of achieving an end, it often happens that the basic agreement as to the end itself is overlooked. If I could make no other point today, I would want to hammer home the all-important fact that in the very act of writing these bills, there has been a meeting of minds as to purpose. You Senators, who are so busy with untold numbers of pressing matters, which require speedy decision, have earned the gratitude of countless citizens by taking the time and effort to hold these hearings and to seek to frame a final bill that will, in the best possible manner and in the American tradition, carry out this great aim upon which all of you are obviously agreed.

While, as a sufferer, I may be qualified to speak emotionally on the need for implementing this splendid statement of purpose and policy, one would need further to qualify as an expert to justify taking your time on a discussion of method and means. I believe I do so qualify as a voter, citizen, and taxpayer, in which latter capacity I have been privileged—thanks to our democratic system and the vast opportunities which America offers its sons—to pay, for a long term of years, taxes running into large figures. Whichever of these bills you pass or whatever the compromise you eventually arrive at, I shall be privileged—and I mean privileged—to pay some portion of the ultimate cost for administration and for direct aid, through my taxes.

I think I qualify, too, as an expert because I have spent all of my life in business, in fairly big business. The businesses I have owned or advised or been a part owner in have employed and still employ tens of thousands of people. Just as you must plan for the welfare of all the people, I have played a part in planning for the welfare of these employees—and that, in many instances, involved their health and the health of their families. Like most other businessmen, I have long been aware of the fact, you can't miss it if you are in business, that productivity, the key to the prosperity of employer and employee alike, falls whenever sickness strikes.

American industry lost about 600,000,000 man-days of productivity last year because of sickness. Certainly if we worry about reducing the economic losses of strikes, we must worry quite as much if not more, about such staggering losses from sickness.

Even when our employees are not themselves sick, illness of others may take a cut out of their productivity. Let any member of the family fall ill, let even the threat of illness, the worry about maybe falling ill, strike any of us and our productivity falls off.

As a businessman, I have specialized in distribution and merchandising. And, of course, that is exactly the problem you are facing up to when you write or rewrite these health bills. You've got to find a way of distributing medical care more widely. The product itself is a universal demand. But 97,000,000 of our citizens can't afford a

serious illness. They can't afford enough medical care, nor can they afford to do without it. We can't afford to let them do without it.

I have heard the statistics as to the health of selectees explained away by very learned gentlemen. But all their wit has not been enough to erase the shock which all of us suffered when it was discovered that millions of our supposedly most healthy young men were in so poor a physical or mental state that they could not serve their country. Certainly, in the interest of the national security if not in the interest of the common welfare, we must make certain that the next generation does not suffer, when medicine can prevent it, from any such an overwhelming percentage of poor physical or psychological condition.

Now then, how can we do this? How can we achieve the purpose stated in S. 545's preamble? We seem to be in agreement on purpose and policy. But when it comes to method, we have two bills that seem to be at opposite poles. One proposes to utilize the democratic principle, to make it possible for all to pay for medical care by accumulating a pool of prepayments. The other proposes to allot Federal money, plus State money, to meet the bills of those unable to pay.

Now, it is generally accepted that our present national medical care totals some 4 to 6 billion dollars a year—no one knows the exact figures in view of inflation, but let's accept the 5-billion figure, for the moment. The bill, S. 545, for Federal subsidy of those unable to pay calls for \$200,000,000 a year from the Federal Treasury; just about enough to take care of the medical needs of 5 percent of the people. If we allow for State matching to any degree and for partial payments for border-line cases, we will find we will be spending far more than \$200,000,000, and we will still not take care of the problem of more than 10 percent of the people. Yet, in 1945, 69 percent of all American families earned less than \$3,000 a year—97,000,000 people. And these people are the very backbone of a liberal and democratic state.

Way back in 1939, when \$3,000 was a whale of a lot more than it is today, the American Medical Association published a chart which stated that families with incomes under \$3,000 per year need help in varying degree to meet the cost of serious illness.

The first thing we'll have to face is the fact that \$200,000,000 just won't do the job for those who can't afford to pay for medical care. It can serve 5, at most 10, percent of our people. It cannot begin to serve 69 percent, or two-thirds of our people. People with incomes between three and five thousand dollars simply can't afford serious illness. The average cancer case costs \$1,000 a year.

As a businessman, it seems to me the purpose expressed in S. 545, "To aid the States to make available hospital, dental, and public-health service to every individual regardless of race or economic status," is not remotely covered by the appropriation provided for in the bill. If the stated purpose of the bill is carried out, certainly according to the American Medical Association's chart, those who would have to be helped in some degree with medical aid would expand the cost to many times the contemplated appropriation. Unless sufficient funds are appropriated to carry out the stated purpose of the bill, then the statement is but a mockery.

But suppose, even so, you decide to limit aid to the bottom 5 or 10 percent. What then? You'll take care, largely, of the chronically indigent—those, who, by and large, can never contribute much to our

general productivity. You will not begin to do anything for the vast lower middle class, the people who pay taxes, grow our food, make our cars, operate our factories, run our offices. They will still, most times, have to defer going to the doctor for fear of the bad news they will get when he examines them. They still will have to go to loan sharks, sell their few bonds, hock their car, and worry themselves doubly sick as a punishment, one might think, for being a shade above the subsistence and relief and indigence level.

Now the other bill before you, S. 1320, calls for prepaid medical care, for buying medical care on the installment plan, with an insurance pool to which all would contribute and from which all would draw when the need arose. I hear that called socialized medicine, but then, in my day, I've heard a lot of other things we all now accept, called socialistic.

When I was a boy, the first law was passed creating the Interstate Commerce Commission, and most solid citizens felt, honestly, that the ICC spelled the end of private enterprise. We had the same sort of opposition to the Federal Reserve bill and the SEC and the Federal Trade Commission—all were opposed by some as the end of private enterprise. Even the Pure Food and Drug Act was so opposed, and it is to the everlasting credit of the American Medical Association that the association wasn't stopped by the cries of "socialism." but fought and fought until it convinced Congress and the country that we needed such a bill, with teeth in it. I was on the opposite side of the fence on that pure-food bill. I had many food and drug connections, and I shared their fears that this would unfairly injure the food and drug industries. I've since learned to be grateful for that act, and in the process, I've learned that socialism is often a word used to scare us when argument cannot convince.

Frankly, gentlemen, I don't think insurance, for any purpose, is socialism. It's as American as corn or apple pie. That's why Congress has passed a dozen or more Federal-insurance programs—crop insurance, work-risk insurance, unemployment insurance, old-age insurance, and so on down the line. If you adopt the insurance principle to provide medical care for all, you will merely be following an accepted American practice, doing in medicine what most of you have long since voted to do in other fields.

But more than that, you will be putting a premium on self-help. Instead of providing medical care as a dole for the indigent, you'll be making it the bought-and-paid-for right of free men and women; you will administer an insurance pool, but the people will pay their own way.

No swarms of investigators will have to check up on whether our fellow Americans are really indigent enough to deserve a Government hand-out; no citizen will have to undergo the shame of public pauperization to secure medical care for a sick child. The insurance principle is certainly the democratic way of solving this problem, because it will use the State to serve the people rather than to master and regiment and police them.

But will it work? Well, as to cost, we are told that it will cost from 4 to 6 billion dollars a year. Frankly, I think it may cost more, at least at first. Because you will not only have to provide for the insufficient medical care our people now get; you will also

have to provide for additional care—the care the people need but cannot now afford, for lack of the means to pay.

The carrying out of the purposes of the national health-insurance bill won't cost the people, through the Federal Government, anything remotely like 4 or 6 billion dollars, added money. True, the people, all the people, will pay taxes to the Federal Government to cover the cost of the insurance. But much of that money will come right from where it now comes, from the people who meet the medical bills today.

It has been said that there will be some time lag, after we begin collecting the tax for medical care insurance, before adequate medical care will become available to all people at all places. Obviously, removing the financial barriers which now dam up the public demand for medical care will not cause a shortage but will bring to light the shortage of physicians and medical care facilities which now exists in some areas. But surely it has never been the American way to refuse to march forward to a better and more expansive life because we have to face obstacles on the way.

But before not too long, I think we will find our cost of sickness insurance falling. Because people will be going to their doctors early. Consider cancer. It has been reliably calculated that 17,000,000 Americans now living will die of this disease if we do not find new or better ways of curing it. Before they die, they will suffer many months, often many years, of ceaseless torture and incredible expense. But many types of cancer, caught early, are curable. If we can make it possible for people to detect and treat cancer in its early stages, we can not only save the lives of nearly half who now die—important as that will be—but we can also save the expense of their chronic, long-drawn-out illness.

The same is true of heart disease in many cases and of a score of other illnesses. Prepaid insurance will put a premium on preventive medicine, and that will hold costs down while vastly increasing the well-being and the productivity of millions of people.

I think that we have now covered the essential difference between these two bills. S. 1320 proposes to help the people to pay for their own medical care. Not so with S. 545. We already have one tremendous group of our citizens, the veterans, properly covered by a system of socialized medical care, paid for entirely out of general Federal Treasury funds. But do we want to extend that system of subsidy from the general Treasury funds to millions more, without responsibility and without contributions from the people? If times of stress, such as we experienced in 1932, ever come again, the beneficiaries under S. 545 would multiply beyond any present concept, and constitute a burden on the Treasury when the Treasury could least afford it.

I have stressed the so-called practical side of these bills at length. But a far more important side, as I see it, can be tersely covered. I want to bring my remarks to a conclusion with a plea that this committee report out at this session, and that this Congress at this session pass a bill truly providing for prepaid medical insurance; a bill which will guarantee medical care to all, with patients choosing their own doctors and doctors choosing their own patients.

I plead for this on the basis of good business, good democracy, and true humanity. I plead with you to help America go forward medi-

cally, just as we have in our long history gone forward, to make new world records in political freedom, human welfare, and industrial accomplishments. Let us be true to our America.

Senator DONNELL. Senator Murray, do you desire to question Mr. Lasker?

Senator MURRAY. No, but I desire to thank Mr. Lasker, and he has made a very forceful statement, and I appreciate your coming here, Mr. Lasker, and thank you very much.

Senator DONNELL. Senator Pepper?

Senator PEPPER. Mr. Lasker, I apologize for my lateness, since I desired you to come here and let the committee have the benefit of your views and also to let the public have the benefit of your views.

I know of no private citizen in this country, than you, assisted by your fine, lovely wife, so interested in the cause of public health, and I do not know of any American citizen who has been as generous with his time and money and personal efforts to alleviate the suffering of his fellow citizens.

I know you have been a successful businessman and that the people have the confidence to know that you would not recommend anything contrary to free Americanism.

Mr. Lasker, as one member of this committee, I want to express a very deep appreciation to you. As I understand you feel this S. 1320 will enable a large number of people of this country to have a part in providing for their medical care in probably the most adequate way that has yet been suggested.

Mr. LASKER. I do.

Senator PEPPER. And you feel that S. 1320 approaches this health subject in a broad manner, providing for the training of doctors and technicians, which of course is imperative if we are to have health for our people; providing for preventive medicine by our Public Health Service and extending and contributing more to the prevention of disease, and providing means by which the people may acquire and have access to medical service and treatment available to them.

Mr. LASKER. In broad principle, I do.

Senator PEPPER. And you set down in your statement that S. 545 with a Federal contribution of \$200,000,000 contemplated cannot, in your opinion, afford to the people of this country the medical care that they require?

Mr. LASKER. I feel S. 545 has very little relationship to what I am pleading for. Mind you, I would rather see inadequate medical care than nothing at all, and I am not appearing against S. 545. I am appearing for S. 1320.

I feel S. 545, as I said in my statement, would carry medical care to at the utmost 5 or 10 percent of our people and as those are really indigent, it would all be paid for out of the Treasury; it is a very socialistic expenditure.

I am not opposing that, because we have a large area of socialistic medicine in the Veterans' Bureau which I am enthusiastically for. The progress made under General Bradley and General Hawley is amazing to anyone that follows it, but in times of stress, under S. 545, I see such a great area of our whole people coming under socialized medicine that it would be a burden on the Treasury that I do not believe the Treasury could afford. For that reason I cannot be for S. 545.

Senator PEPPER. In other words, being a champion of free enterprise in this country, you say if the term "socialistic" is to be applied to S. 545 or S. 1320, it would be more appropriately applied to S. 545?

Mr. LASKER. That is right, but I want to define the manner in which I use the word "socialistic." I am not a Socialist. I am for the American system. I am opposed to socialism as a political creed. I am talking about socialism in its broad aspect. I do not want to use the word as "group baiting" or something like that. I am for public schools. Those are socialistic.

Senator PEPPER. In a sense it is a service contract by the State without any direct contribution by the beneficiary?

Mr. LASKER. That is right.

Senator PEPPER. For example, that same distinction would exist in our method of old-age assistance, which is paid for out of the Federal Treasury to the old people without the beneficiary paying anything directly back for it, as contrasted with our old-age and survivors insurance under which the worker would get the benefit, contributing directly out of every month's pay-roll check?

Mr. LASKER. That is right. I am not in favor of socialized medicine, except in limited fields, such as the socialized medicine we have for the veterans. The increasing cost for the veterans is in a way—and may be ultimately in a very large way—a burden on the Treasury, which was never contemplated when the first bill was passed.

Senator PEPPER. Mr. Lasker, I do not want to ask you anything that would make you feel that you were required to speak immodestly of what you have done in any field, but it has been the practice here for the committee to inquire something about the background of the witnesses who appear here as having some bearing on the weight of their testimony to be given by the committee, and I do not believe you made such a statement at the beginning of your testimony.

Would you be good enough to sketch for us what has been your own business and public-service background, and next what has been your association in health?

Mr. LASKER. Senator Donnell asked my business background.

Senator DONNELL. I think we would like to have it amplified.

I would like to have a statement where you were born, and what your early education was, and your experience.

Senator PEPPER. It is personal and business.

Mr. LASKER. When it comes to the story of where I was born, catch your breath, and wait until I finish. I was born in Germany. I had seven brothers and sisters, two born before me and five after me, all seven born in Galveston. My parents were American citizens. My mother was born in Rochester, N. Y. My mother was ill of another sickness when I was on the way, and they had taken her to a hospital at Freiburg, Germany, to be sure I would be delivered in good shape.

I am a natural citizen of the United States, really born in Galveston, Tex., as far as I am concerned, but insofar as the Kaiser is concerned, I was born in Germany because when I was 18 years old he came to the place where my mother had stayed after my birth, he did not come in person but sent his emissaries.

Senator DONNELL. *Persona per alia* and not *persona per se*.

Mr. LASKER. Yes; to see whether I would serve my term in the Germany Army.

Senator PEPPER. You did not serve.

Mr. LASKER. No. The German system at all times was abhorrent to me. I mean, whether it is called the kaiser system or the Hitler system, just as the Russian system is abhorrent to me; it is the same system whether it is called the czar system or the communistic system. It is absolutism and state police control. One of the types of thing I fear is that in the course of years, as the years go by, we will under S. 545, without its sponsors meaning it, run a big chance of having state medicine in fact, which I, throughout my whole life's philosophy have opposed in every possible way.

You wanted to know my business experience. Will you pardon me while I modestly proceed to boast.

Senator DONNELL. Would you mind first telling us where you had your schooling?

Mr. LASKER. Two or three weeks ago, I found I was much more of an expert on medicine in those days than now.

I was educated in the kindergarten, grammar school, and high schools of Galveston, Tex. I started our high school paper, which I believe is still published.

Recently I was looking over some old papers and came across a copy of the Ball High School Reporter of April 1892. I was its editor, I started it, I made myself editor. I moved right in.

The leading editorial was signed as written by me, and at that early precocious age I had acquired the modesty which ever since has mantled me.

The title of the editorial was "Athletics in the High School" and the first sentence began this way: "Even the ancient Romans agreed with me when they said 'In a healthy body resides a healthy mind.'"

Now I appear here on the basis of that statement.

Senator DONNELL. That reminds me about that story of an after dinner speaker that said "Demosthenes is dead; Cicero is dead; and I am not feeling well myself."

Mr. LASKER. I am not feeling well myself either, because I was warned you might cross-examine me on phases I might not know about. What I do not know I am going to say I do not know. It is hard—

Senator DONNELL. It is very interesting indeed, Mr. Lasker.

Mr. LASKER. As to my business experience, you do not want my life's story?

Senator DONNELL. Just use your best judgment.

Mr. LASKER. I worked on the morning paper in Galveston; I was then 16, and had a position offered me by the old United Press in New York.

Galveston was at the end of the line in those days and newspapermen in that period were marked by how much they could drink.

Being at the end of the line our island on the Gulf of Mexico, Galveston got many trying to make drinking records. My father was fearful because I seemed to show some sympathetic cooperation along that line. He was fearful that I might, if I kept to reporting, become a candidate for Alcoholics Anonymous. Many years before he had done a great favor for the advertising firm of Lord & Thomas of Chicago, which then and until its dissolution was one of the three largest in the world, at times the largest but always among the three. The three leading firms alternated. He had done them a great favor.

Now mind you, you brought this up. He asked them if they would give me a chance to learn advertising. My father did not know in those days that to a man on the reportorial end that was like asking him to be a pickpocket. They wrote back they would take me, they having the intention to keep me for 3 months at \$10 a week, which would have cost them \$125 and which would have liquidated the obligation.

I had a notion, I was not proud, that if I went to Chicago and then went on to New York at the end of 3 months—my mind and Lord & Thomas' had already met you see—I could get a little aid from my father, because I was not to get a very great salary. But I had a reportorial state of mind. In Chicago I asked for a definition of what advertising was so I would know at least what I had gotten into. In those days there was no one who could define it. There may have been 12 or 14 firms in the business at that time. I doubt if any of them did as much as \$1,500,000 business, whereas, you know today advertising is one of the great industries of the country.

So I stayed on longer than the 3 months, seeking to find out what advertising was. It is a long story, but the definition was given me one day, or night, rather, by a man who had been a Canadian mounted policeman.

I was in my employer's office, Mr. Thomas, about 6 o'clock in the evening. At that time every building had a saloon in the corner. We did not know them then by the name of taverns. They were saloons. We worked from 8 to 6, including Saturdays, those days.

Senator DONNELL. The newspaper fraternity is pricking up its ears at this point.

Mr. LASKER. I forgot about the newspapers being present.

Senator DONNELL. Go ahead.

Mr. LASKER. I was sitting with my employer when a note was handed to him, which he read and passed to me and which read:

I am in the saloon below. You do not know what advertising is. I do. If you want to know, tell the messenger who brings this note to come down and tell me to come up.

My employer threw it over and said, "There is a crank." All this was about 7 o'clock in the evening. Often we would stay overtime. Nobody paid us anything for this, but we liked our work.

By that time I liked it too, because I was in it as a reporter to find out what advertising was.

I said, "Do you mind if I see this man?" and he said "No." So the man, John E. Kennedy, the father of all modern advertising, came up and stayed until 2 or 3 o'clock in the morning.

Today there is no great impact in Galileo's theory—that the world is round. Nor in Newton's theory of gravity. But in their times, these ideas worked vast changes in men's minds. So it was with what unfolded to me that night.

He defined advertising as "salesmanship in print." Before that it was just thought of as keeping your name before the public.

As a result of that, although I came to stay only 90 days, I was like the man who came to dinner. I stayed with the firm 45 years, and I kept Kennedy to teach me, and I got others for him to teach, and from our office emanated the basic principles of the techniques of advertising copy for we published everything he told us.

We thought it was too big a thing for us to keep to ourselves. Every paper, I believe, and every magazine in America ran a series of advertisements on these principles, which he wrote for us.

That brought me then into the early days of merchandising, because you must remember this was in 1902. Thus I was brought into the early days of modern packaged goods, advertising and merchandising, into the early days of the automobile industry, into the early days of the tire industry. In fact, with few exceptions, we did much of the pioneer advertising of those lines.

I subsequently became part owner of some firms in these fields, established some of them, and thereby had a wide experience in the development of modern methods of distribution.

In fact, I might as well say it, until the time of my retirement, no man living had had an opportunity to have quite as wide experience, because I was the sole owner of my business, and in total had probably personally supervised more advertising than any other one in the line.

Senator PEPPER. What was the business, Mr. Lasker?

Senator DONNELL. Lord & Thomas.

Senator PEPPER. I see. Lord & Thomas.

Mr. LASKER. When I retired in December 1942 I could have maybe sold my firm name. But then, I would not have been retired, because the people would have thought they were entitled to consult me. So I got out entirely. I left all the advertising accounts in which I had any direct ownership with the people who worked for me. They are still running business under their own names, and are among the largest in the world. Shortly thereafter I sold almost all my interests in all the other businesses with which I had been connected.

Senator PEPPER. Now, Mr. Lasker, would you tell about what public service you have had?

Mr. LASKER. Well, the first is, and it will not please you so much, I was assistant chairman of the Republican National Committee under Will Hays for 2 years. I also, with Harold Ickes, was campaign manager for Hiram Johnson when he ran for the Presidential nomination in 1920. I am today what you would call a Vandenberg Republican.

Senator DONNELL. We will convey that information to Senator Vandenberg.

Mr. LASKER. I was for many years a trustee of the University of Chicago, from which I resigned when I moved from Chicago to New York, for I do not believe in being trustee on anything where you are not able to serve.

I think absentee trusteeship even worse than absentee ownership because in absentee ownership you are at least neglecting only what you own yourself.

I was for 2 years, in the early twenties, chairman of the United States Shipping Board.

Senator PEPPER. Was that under President Harding?

Mr. LASKER. Yes; I do not know whether you call this public service, but until about 1926 I was one of the controlling owners of the Chicago Cubs. It was a fight I initiated that put Judge Landis in charge of baseball. That is one of the public services, of which I am most proud, because baseball means so much in our national life to

our youth. We had such terrible scandals in baseball I thought it was utterly essential that baseball be put out of the control of owners and independently controlled.

I have been on hospital boards, community boards, like the Red Cross. I will put the rest in as et cetera.

Senator PEPPER. Now if I may ask you, you have been active in aiding private research?

Mr. LASKER. Yes. I retired from business for that purpose. I have a belief that after one has had as fine a life for one's self as one wants, that what one made by serving the people, should, in a large measure, return to the people.

Senator PEPPER. I would not ask you to name the amount of your contributions, but would you just indicate whether you contributed sums that might be regarded as large sums of money to private research in the country?

Mr. LASKER. Oh, yes; some millions of dollars. That is my only business. Our foundation largely expends its money on medical research.

Senator PEPPER. What is the name of the foundation?

Mr. LASKER. The Albert and Mary Lasker Foundation, one of the smaller ones. We are very small. We do not have much money, and we have to look for bargains in medicine. We have to look for things that offer great promise in that way.

Mrs. Lasker and I, through the foundation, approached a very small society that has been in existence for 30 years, and to which, 25 years before my sisters and I had given \$50,000—the American Society for the Prevention of Cancer—and 3 years ago we went to them and proposed if they would nominate lay control for the executive board and change the name to the American Cancer Society, we would provide moneys for a national campaign of fund raising. It takes added funds for a national campaign, and we would have to have a campaign of national education on the subject of cancer. However, that cost comparatively little money. From having been in publicity myself and my wife also having been in related fields, with one of the young men that had once worked for me, we devised a campaign of publicity that caught the imagination of the Nation. Now in its third year the American Cancer Society has raised its goal of \$12,000,000. Until we came into it, it raised only small sums, only once approaching a million.

Last year in its second year they raised \$10,000,000, but more than that, they have awakened the country to cancer and what can be done about cancer.

Senator PEPPER. Mr. Lasker, what has been the total sum received from the public by the American Cancer Society since you have been connected with it?

Mr. LASKER. They have had three campaigns. I am not now connected with the society. My health being bad, I had to resign from the board, though I advise with them much as I did with clients in the advertising business. My wife took my place on the board, and in 2½ years they have raised \$26,000,000, of which 40 percent has gone to research.

It would be interesting for this committee to know how we came to this great study.

My wife went to see Dr. Gregg, the head of the Rockefeller Foundation, and she told him that we were going into medical research in

our foundation, as a life occupation for both of us, but that we had comparatively little funds, I mean as compared to the Rockefellers or Carnegies or these rich oilmen.

Senator DONNELL. Or the Montana gentlemen.

Senator MURRAY. I think you are thinking of Missouri. Montana is an impoverished State, impoverished by the industrial East.

Mr. LASKER. Senators, I ask you to let me add that if Montana is impoverished I think New York State will contribute money to help Montana not be an impoverished State, just a small sum.

Senator DONNELL. You were talking about cancer work and that would be interesting.

Mr. LASKER. So she went to Dr. Gregg and told him we had to find good bargains. Undoubtedly during the course of years various things have come to the Rockefeller Foundation, they considered as worthy, but which did not happen to fit in their over-all program. Not even the Government has money enough to cover all the programs that should be covered, or that might well be covered.

Dr. Gregg was very cooperative and at the end of 2 months we received a letter covering 14 various projects. There was some talk on one project, namely, cancer research. My wife and I felt that so many people suffered from cancer our foundation would make a survey of the amount of private money given from foundations and all other sources for cancer research.

I thought that for cancer there were many millions spent annually. This is 5 years ago. Those whom I spoke to felt there were many millions, but we found that the total amount for research on cancer, a disease so dreadful that the mere thought of it is devastating, and which reaches into every life and every home, the entire amount of private money then being spent on research was less than \$600,000 annually and the Government spent about \$500,000.

Here is the Department of Agriculture, and I am for it, spending \$9,000,000 that they gave to Mexico for the hoof-and-mouth disease alone.

The Department of Agriculture spends in a similar kind of work, in studies of plant and animal life, \$50,000,000 a year, and yet the total money spent on medical education in the United States is, at a maximum estimate, \$25,000,000 a year.

How can we in this great expanding country ever fully utilize medicine, until we have more medical education?

It is for that reason among others, you are all agreed, that there is a shortage of medical care. The people want doctors and will use the doctors if they can get them and pay them.

I did not go into that in my testimony, but the basis of everything should and has to be the extension of the medical schools.

If Missouri does not have money enough or Montana does not have money enough for the extension of medical education, since disease knows no boundaries or State borders, but can come and touch us all alike, that is one place where I believe the Federal Treasury can get the biggest bargain ever offered it by doing everything to aid the extension of medical education.

I do not think there has ever been a bargain offered our country, since it was established, such as this.

Senator DONNELL. Senator Pepper, is there anything further?

Senator PEPPER. That is the story I wanted you to tell, Mr. Lasker, because it shows the breadth of your background and understanding of your interest.

Mr. LASKER. I did not cover other things we are interested in. We are interested in supporting research both abroad and here in varying places.

Most of the grants our foundation gives, I presume 80 percent, are not to people who appeal to us because we feel people who have the initiative to appeal will find someone who will give them assistance. Rather, we look for fields where there is a lapse of work and give money to those we approach who we feel can do it.

Senator PEPPER. It is broad experience and intensive interest, which you have manifested with your time and money, that leads you to support a bill like S. 1320, which contemplates first doing a great deal in the field of preventive medicine, second, provides for increasing the number of doctors and technicians, and third, plans to aid the people under the Hill-Burton bill. Because you think S. 1320 approaches this great common objective is the reason you come to give your support to it?

Mr. LASKER. That is right, Senator. I think these is one other thing that leads me to be for this bill, and that is the amount of suffering I have seen among people who could not afford medical care.

I could recite one case after another that touches you and every one of us, cases where the sick do not go to the doctor in time either because they fear the expense or because of other strains and stresses, with the result, I think, we have more absenteeism in industries from sickness than we have from strikes. Yet, we get all "het" up about strikes, front-page news, but it is not front-page news about absenteeism through sickness. I do not know that I will do it, because I have not been well, but I am really thinking of starting a league of sufferers throughout the United States. I mean it, because that is the only term that expresses it.

I am just as sure that ultimately Congress will pass a bill like this as I am sitting here. They will pass it from the great unspoken upsurge of the people wanting an opportunity for health.

Then too, my concept is we will have better medicine; doctors will be more prosperous; and we will have a more productive Nation. I do not want to be coy, but if we are going to have to face an unfriendly nation of 250,000,000 people, and we have only 140,000,000, and they always keep ahead of us in population, our main hope of preserving ourselves is in the health of the people we have.

Senator PEPPER. Well, thank you very much, Mr. Lasker, for coming here. As one who happens to temporarily hold public office, and from whatever right that gives me to speak for the public, I want to thank you.

Mr. LASKER. Proper medical care for all means everything to all of us. I am not one of those who claim they do not get anything out of this struggle. I want to make this clear. I am not a professional "do gooder." I get much personal satisfaction out of sharing in this struggle. I have been impelled to action in this matter, in medical research and health, because of my belief that health is the very cornerstone in a strong democracy, such as ours. For ours is a liberal democracy, which is not only political, but is also a way of life inclusive of the economic and social aspects of our society.

Senator DONNELL. Is there anything further, Senators?

Senator PEPPER. That is all.

Senator MURRAY. I have no questions.

Senator DONNELL. Mr. Lasker, I am sure your service to our country has been very great indeed, and I congratulate you for the very fine strides you and your wife have shown in your very fine philanthropic and public efforts.

Mr. LASKER. I am a little embarrassed that came up.

Senator DONNELL. We asked for it.

Mr. LASKER. It is like having the door opened on you while you are shaving without your clothes on.

Senator DONNELL. That is expressing it rather well.

Mr. LASKER. I do not want it to seem as if I think it was unpleasant. It has not been unpleasant.

Senator DONNELL. We acquit you of any intent—

Senator PEPPER. We opened the door.

Senator DONNELL. I would like to ask you some questions, Mr. Lasker, too.

In the first place I judge from your broad experience, and particularly from your work in advertising alone, you are thoroughly convinced of the great importance of publicity in setting forth the merits or demerits of any proposition. That is correct, is it not?

Mr. LASKER. I think the very cornerstone of our American society, the very cornerstone of our democracy, is that differences between us can be discussed.

Senator DONNELL. And in that connection bringing to the attention of the public through the customary forms of publicity is of course of high importance in developing public opinion.

Mr. LASKER. I would like to see a lot of discussion on the floor of the Senate on any point that can be raised.

Senator DONNELL. In commercial articles, the developing through advertising or knowledge on the part of the public of various commodities, is of course of prime importance in marketing this commodity.

Mr. LASKER. In many cases.

Senator DONNELL. In many cases.

Mr. LASKER. Yes, sir.

Senator DONNELL. It is likewise true in the matter of legislation, in the matter of health legislation, regardless of which bill we favor, the matter of publicity is very important.

Mr. LASKER. We differ very much between commercial publicity and free discussion of things that touch the welfare of the people. It is like two men called doctors. One is a veterinarian and the other is a medical man. I want to make that distinction. I am not an expert in propaganda.

Senator DONNELL. There is some difference in the analogy, but nevertheless publicity is essential in these days to acquaint the public with the merits or demerits of any proposition.

We would all agree to that, would we not?

Mr. LASKER. No; I think certain types of publicity are hurtful.

Senator DONNELL. Yes.

Mr. LASKER. In public discussions I am willing to agree to free discussion, agree that free discussion in pamphlet form, on the air, or in the press, reaching the public is very valuable.

Senator DONNELL. May I give you an illustration?

Mr. LASKER. But I am not such a great believer—

Senator DONNELL. I want to illustrate the point.

Mr. LASKER. Yes.

Senator DONNELL. You referred to Dr. Gregg of the Rockefeller Foundation. You, that is, the Albert and Mary Lasker fund, have jointly financed the Committee on Research and Medical Economy, have you not, Mr. Lasker?

Mr. LASKER. That was done. I am just over a sickness of 2 years, which kept me 7 months in the hospital, and I am not fully acquainted with that. My wife attended to that.

Senator DONNELL. Without going into the details of it, you know as a matter of fact there was a collaboration between the Rockefeller Foundation and the Mary and Albert Lasker Foundation?

Mr. LASKER. In several things. I believe so.

Senator DONNELL. The importance of publicity was recognized, I take it, by that organization, the Committee on Research and Medical Economics, by the issuance of the report in evidence, entitled "Principles of Nation-wide Health Program," printed by the Committee on Research and Medical Economics, Report of Health Program Conference.

Have you seen that publication?

Mr. LASKER. No, sir.

Senator DONNELL. I call to your attention the fact that copies of this report are stated to be obtainable from this Committee on Research in Medical Economics at 1719 Broadway, New York.

Do you know whether Mr. Michael M. Davis is chairman of that Committee on Research in Medical Economics?

Mr. LASKER. I believe he is.

Senator DONNELL. Do you know whether or not Dr. Channing Frothingham is one of the members of that committee?

Mr. LASKER. Yes, sir.

Senator DONNELL. You know Dr. Frothingham?

Mr. LASKER. I only met him once casually.

Senator DONNELL. You know of the fact that Mrs. Lasker has been very active, and properly so, in the matter of health and related subjects, and is a member of the board of directors of another organization known as the Committee for the Nation's Health?

Mr. LASKER. Yes, sir.

Senator DONNELL. Do you know that Dr. Channing Frothingham is or has been until recently chairman of that committee?

Mr. LASKER. Yes, sir.

Senator DONNELL. I ask you if you know Dr. Ernst P. Boas?

Mr. LASKER. No; my wife does.

I said I was appearing as an individual. I am not appearing as a representative of the Albert and Mary Lasker Foundation.

Senator DONNELL. I understand.

Mr. LASKER. My wife's interest in this is in a very different area than mine. She is active technically. I have devoted myself in the last 2½ years to cancer and to the crystallization of opinion. Thus, I am not in close touch with that end.

Senator DONNELL. Mrs. Lasker, as you mentioned, is on the cancer board.

Mr. LASKER. About 4 months ago my doctors demanded that I not work for a year. In fact they protested when I came today. She is taking my place for that time.

Senator DONNELL. I was inquiring whether or not you knew Dr. Boas who appears upon the letterhead of the Committee for the Nation's Health as a member of the board?

Mr. LASKER. Yes, sir.

Senator DONNELL. I take it you are familiar with that. Your wife, Mrs. Lasker, is also a member of the board?

Mr. LASKER. That is right.

Senator DONNELL. Do you know Michael M. Davis?

Mr. LASKER. Oh, yes; I know him.

Senator DONNELL. You know he is a member of the board of directors of the committee?

Mr. LASKER. Yes, sir.

Senator DONNELL. That committee is a corporation with offices in Washington at 914 G Place NW.?

Mr. LASKER. Yes, sir.

Senator DONNELL. I have in my hand at this moment a press release which was given out by the Committee for the Nation's Health, Inc., for release, entitled "Thurman Arnold Charges American Medical Association With Monopolistic Practices."

I may say that charge which was made by Mr. Arnold was referred to in a letter which was read into the record yesterday.

Do you know whether Miss Margaret J. Stein is the Washington representative for the Committee on the Nation's Health?

Mr. LASKER. Yes, sir.

Senator DONNELL. That is the same Miss Stein who sits in the room now?

Mr. LASKER. Yes, sir.

Senator DONNELL. You also know, Mr. Lasker, that among the members is a law partner of Mr. Arnold; namely, Mr. Abe Fortas. You knew that?

Mr. LASKER. No. Maybe I did.

Senator DONNELL. His name appears upon the letterhead.

Mr. LASKER. Yes; I think I did.

Senator DONNELL. Among other members, I think I mentioned Dr. Frothingham. I know I mentioned Dr. Boas.

Is Mr. Matthew Woll, of the American Federation of Labor, in whose behalf Mr. Cruikshank appeared yesterday, a member?

Mr. LASKER. Probably. I do not know.

Senator DONNELL. You referred to Mr. Kennedy as having given the definition of advertising as being salesmanship in print. That was in 1903?

Mr. LASKER. Yes, sir; or thereabouts.

Senator DONNELL. Since that time advertising has expanded so that today, not only in print but radio and through the movie business, there is a very effective means of advertising in this country. That is correct?

Mr. LASKER. Yes. Except advertising, did you say in the movies?

Senator DONNELL. Yes.

Mr. LASKER. Movies to a limited extent, but the press and radio, certainly.

Senator DONNELL. A film got out by someone for circulation through the motion-picture theaters, if it is a good film, and people are interested, attracts attention and has great influence?

Mr. LASKER. I do not know how much influence it has.

I wish the film people would do more on it on things of general interest. My quarrel is they do too little.

Senator DONNELL. I take it you would regard that type of publicity as having a real value in national affairs?

Mr. LASKER. In our national discussions here?

Senator DONNELL. Yes.

Mr. LASKER. If I were to go and ask one of the film companies, not that they would do it because I asked it, but because a private citizen asked it, to have a film on national health, I would be very careful to ask them to present both sides. I am always willing to be convinced myself. I always like to have both sides presented because I try to be on the side that will gain by the other side being discussed.

I feel if we could get a discussion on a wide basis on these two bills, there would be a great national upsurge for our bill, for the bill in which I concur.

Senator DONNELL. You say "our" bill.

Mr. LASKER. I know, but I never wrote it.

Senator DONNELL. Yet, have you not called it "our bill"?

Mr. LASKER. A Freudian error.

Senator DONNELL. Have you been rather closely in touch with the authors of the bill?

Mr. LASKER. No, sir. So that there is nothing hidden, I sat at a dinner one night in my whole life with some of the authors of the bill. Other than that I have not met with anyone in connection with it.

Senator DONNELL. The dinner to which you refer, Mr. Lasker, was here in Washington or in New York?

Mr. LASKER. Here in Washington.

Senator DONNELL. Was it recently given?

Mr. LASKER. Yes, sir.

Senator DONNELL. How recent?

Mr. LASKER. That is how I came up here.

Senator DONNELL. That is fine. I wish I had been there too. It was a good dinner, I presume?

Mr. LASKER. Yes; the Statler did very well by us.

Senator DONNELL. When was that dinner held, Mr. Lasker?

Mr. LASKER. I think maybe 3 weeks ago. I will give you the whole dark conspiracy, right in the limelight.

Senator DONNELL. That is what I want. Go right ahead.

Mr. LASKER. My wife at the present time is, and has been since that dinner, quite ill and in bed with jaundice. I do not mean to say that the dinner gave her jaundice. I want to make no admissions.

Senator DONNELL. Make no admissions. You may want to file a suit.

Mr. LASKER. I thank you for the guidance.

Senator DONNELL. All right, go ahead.

Mr. LASKER. I was very disturbed. I knew something was brewing and she was coming down to the meeting of the executive committee of the National Health—

Senator DONNELL. The Committee for the Nation's Health?

Mr. LASKER. The Committee for the Nation's Health. They were to have a meeting afterward with the sponsors of this legislation.

Senator DONNELL. Of S. 1320?

Mr. LASKER. Yes. I cannot remember the number.

Senator DONNELL. Yes.

Mr. LASKER. S. 1320.

Senator DONNELL. The Committee for the Nation's Health, Inc.?

Mr. LASKER. Yes, sir.

Senator DONNELL. Was to have a conference between its representatives and sponsors of S. 1320.

Mr. LASKER. Yes, to encourage them to keep on.

Senator DONNELL. Encourage whom?

Mr. LASKER. The sponsors.

Senator DONNELL. The sponsors?

Mr. LASKER. To let them know, to the extent of 10 or 12 laymen there, they had public support.

Senator DONNELL. Mrs. Lasker, was she one of the laymen present at that meeting?

Mr. LASKER. Yes. She was on that committee. I was fearful of her health because I saw she was not well. So, I came down to check that she did not overdo herself.

It was for that reason only, and as long as I was here she said "Come to the dinner. They will be glad to have you."

Senator DONNELL. And you and Mrs. Lasker attended the dinner?

Mr. LASKER. Yes, sir.

Senator DONNELL. Do you recall, Mr. Lasker, how many were there?

Mr. LASKER. Eighteen or twenty, I think.

Senator DONNELL. Do you mind telling which of the sponsors of the bill were there, S. 1320?

Mr. LASKER. I hate to tell such a thing, to admit that they have been seen in public with us, with these terrible people, out for the health of the Nation. This is bad.

I would say Senator McGrath, Senator Murray, and Senator Pepper were there, and furthermore, I am going to tell on them. Senator Taylor would have been there, but his mother-in-law was ill. That is about all.

Senator MURRAY. I object to any further questions tending to incriminate the Senators.

Mr. LASKER. I want to say it would have been an awful good thing if you had been there. You would have become convinced. I really do think we could have had a meeting of minds. I am not joking.

Senator DONNELL. At this dinner to which you are referring, I presume three or four discussions were had quite sympathetic to the sponsors' plan in regard to it?

Mr. LASKER. You know how those dinners are. Everybody was convinced on the same viewpoint, and they all agreed what a good viewpoint they had.

Senator DONNELL. They were all convinced of that before they got there, and did not discuss it.

Mr. LASKER. Cocktails and highballs were served and all added to the enthusiasm.

Senator DONNELL. Now, Mr. Lasker, in your discussion this morning—

Senator PEPPER. Before we leave the dinner, because that is one of the occasions we are always reluctant to leave, I recall the delightful company. Mr. Lasker was there just as a casual observer and spectator. He participated in no way in our discussions. He sat around and did not say anything until just at the close somebody said, We have a very distinguished visitor here, very observant and attentive, and he has not said much, let us ask his views.

Well, Mr. Lasker was in a group of people that felt they knew something about the subject. In fact, some of them thought they were really experts.

Senator DONNELL. Naturally Mr. Lasker made the best speech.

Senator PEPPER. He made such a moving speech that the sponsors drafted him to be a witness here and to give the Senator from Missouri an opportunity to hear him, and the next time we will invite you.

Mr. LASKER. I am sure they will never get me to another dinner unless you are present, and I am counting on your saving me from having to go.

Senator DONNELL. I think Mr. Lasker has given a most colorful and very powerful expression of his views. I can well understand how his views, as expressed, were very, very moving and impressive.

Do you remember whether Mr. Michael M. Davis was present?

Mr. LASKER. Yes, sir.

Senator DONNELL. Was Dr. Frothingham there?

Mr. LASKER. Oh, yes.

Senator DONNELL. The board of directors were there, or most of them?

Mr. LASKER. I do not even know, frankly. The heads of this committee were there.

Senator DONNELL. Yes.

Mr. LASKER. It was a dinner held after their respective meetings.

Senator DONNELL. Yes. Was Mr. Abe Fortas there?

Mr. LASKER. I think yes. I just got a nod that he was there.

Senator DONNELL. Now Mr. Lasker, I was going to ask you something about one or two of your observations in your statement this morning.

Mr. LASKER. Yes, sir.

Senator DONNELL. You mentioned at the outset "I cannot qualify as an expert on the technical or clinical or scientific phases of medical practice." I want to say I cannot either.

I want to ask you this, you mentioned in recent years your organization, your foundation, the Mary and Albert Lasker Foundation, has conducted research abroad?

Mr. LASKER. Where is that?

Senator DONNELL. I took a note of that. You stated—

Mr. LASKER. I stated that we had grants.

Senator DONNELL. What?

Mr. LASKER. Grants.

Senator DONNELL. What is that?

Mr. LASKER. Grants is where you give money to an individual or institution to do a particular piece of research.

Senator DONNELL. Perhaps I misunderstood. I thought in response to a question asked by Senator Pepper or Senator Murray you had said that.

Mr. LASKER. Had given grants. We conduct nothing.

Senator DONNELL. Have any of those grants abroad studied the history of compulsory health insurance?

Mr. LASKER. No; these are grants for scientific research.

Senator DONNELL. There has been no study otherwise.

Mr. LASKER. The statement says exactly what I am expert on. I am expert as a man who has suffered all his life and has seen sufferers, and as a man whose life has been spent in the distribution of merchandise.

I have no expert knowledge beyond that.

Senator DONNELL. I was not inquiring about you personally.

Mr. LASKER. We made no such study abroad.

Senator DONNELL. This means some repetition and maybe it is, but I would like to ask you if you yourself at any time made any study of the history of compulsory health insurance in any other nation of the world?

Mr. LASKER. To dignify what I know by the word "study" would be an affront to that word.

I never have pretended to be an expert witness or even undergo an examination, but I have a deep conviction that it is working in most of the countries of Europe. I do not include England, but in most countries of Europe it is an accepted practice.

Senator DONNELL. I understand you have not made a study of the subject of compulsory health insurance?

Mr. LASKER. It would be an affront for me to try to illumine you on that.

Senator DONNELL. You referred earlier in your testimony to something to that effect.

Mr. LASKER. That I first saw the light of day in Germany?

Senator DONNELL. No; that was not it. The particular memorandum I have, I am afraid I have misplaced. You said something about German system. You were not talking about the compulsory health insurance system. You said the German system was abhorrent to you.

Mr. LASKER. I was talking about their political system. Although I hold the view, if the German system included the health insurance paid for by the people, to that extent, within the German system, I would feel they had done a democratic thing.

Senator DONNELL. I get your point exactly. However, you have not, just to repeat, given study to the history of compulsory health insurance in Germany?

Mr. LASKER. No; I know about it from having been there and in the Scandinavian countries.

Senator DONNELL. You do not know from personal study what the opinion of well-informed people is on the other side as to the effect of compulsory medical insurance in either Germany, France, or England, on the quality of medical service in any of those nations. You do not know that, do you?

Mr. LASKER. I believe regardless of whether it is insurance, or whether it is under our system, that there is better medicine in the United States today than anywhere in the world.

Senator DONNELL. That has been your observation?

Mr. LASKER. Yes; and that medicine has come through assistance from private and State sources.

Senator DONNELL. Yes.

Mr. LASKER. In our medical schools and so on, but I have seen and been enough with American medicine to know it is the best in the world, though it is far from being what it can achieve, and I believe that more medical schools and more medical experts will make American medicine what it should be.

Compared to the rest of the world it is No. 1, but compared with what America can do I am impatient with it.

Senator DONNELL. You do think, compared with other nations, American medicine is superior?

Mr. LASKER. Not as is within the reach of most of the people; no.

I am differentiating between the practice of medicine and the ability to take advantage of it.

I think I can illustrate it this way. A few years ago I heard some doctors referring to their practice as business. On a few occasions I heard doctors say, "My business is driving me mad," or "I have too much business."

After I thought it over, I realized I should not be questioning that as the proper term. Medicine is both a profession and a business. Any operation where money comes in and goes out is a business.

So then I got to really contemplating the business end of medicine and I am convinced the business end of medicine, the distribution of the merchandise, is very very backward.

I do not quarrel with the medical profession. They are so busy rendering service, most of them at a great sacrifice to themselves, as evidenced by the fact a bigger percentage of doctors die from heart disease than any other group, they are so busy they do not have time to think of the question of distribution of medical care, and like all of us, if we are overworked, and we are in a vested situation, we shrink from anything new.

I think I covered that by my own reaction to the Pure Food and Drug Act. I now think that this act has, in a large measure, benefited the consumer of medicine.

In the United States there are 160,000 to 180,000 doctors, but there are 140,000,000 consumers. Now it is almost the only transaction where the consumer is considered out of turn if he says something about how the trade should be made. I am making bold to speak for those 140,000,000 consumers of medical care.

Senator DONNELL. Mr. Lasker, what I particularly had reference to, and the question was whether or not you have studied yourself the effect which the German, the French, or the British system of handling health-insurance matters has had on the quality of medical service rendered.

Have you made any study of that?

Mr. LASKER. I could not dignify it by the word "study."

I think I am an informed man, and I must limit myself to the area in which I want to testify because it is only in that way I am competent.

On these other questions your committee will find witnesses, pro and con, or both, who will testify much better. I disqualify myself to answer your question.

Senator DONNELL. Well, I take it that you did not assert, from what you have said this morning a number of times, that you have studied the effect of those various systems in those nations, and I

might add New Zealand and the Scandinavian countries, on the quality of medical service rendered. You have not studied that?

Mr. LASKER. I have to reassert that the quality of medicine in the United States for many reasons will be better than any offered anywhere, regardless of the system of its distribution. We cannot compare the quality of service under any system with that of any other country. I think it is acknowledged in all countries, that we are the first in the art of medicine.

I want to answer that question of yours directly. That much I do know.

Senator DONNELL. I am glad to have you so state and I think that is the general consensus of the evidence we have had.

Mr. LASKER. Therefore it would not be the type of medical care that made medicine less good in the countries you named?

Senator DONNELL. What I wanted to get at is whether or not there is any evidence you are giving this morning or intend to give that you have personally made any study of the system in those countries?

Mr. LASKER. Senator, because I do not want to keep you too long, let you and me join in disqualifying me to answer that question.

Senator DONNELL. You referred to the American Medical Association 1939 chart.

Mr. LASKER. Yes, sir.

Senator DONNELL. Have you seen that chart recently?

Mr. LASKER. The 1939 chart?

Senator DONNELL. Yes.

Mr. LASKER. Yes.

Senator DONNELL. Do you recall when you first saw it and by whom it was called to your attention?

Mr. LASKER. Yes; the young ladies who attend to the statistical work in our foundation.

Senator DONNELL. In your foundation?

Mr. LASKER. Yes. We have our own copy. I wish I had brought it here to back up my evidence.

I shall be very glad if you wish to send you a photostat of the chart itself.

Senator DONNELL. We will be glad to have it. I think we have the chart already.

Mr. LASKER. I would have to see the chart.

Senator DONNELL. Is that the chart?

Mr. LASKER. That would be it.

Senator DONNELL. The edition we have is 1940.

Mr. LASKER. No; I had 1939. They may have in the office 1940 and others. I just picked up one. I thought there was only one.

Senator DONNELL. I might mention we have had quite a number of witnesses that have referred to this particular chart.

Mr. LASKER. I am sorry I referred to it.

Senator DONNELL. It is perfectly all right. I was wondering how it came to your attention as it has come to the attention of a number of other witnesses.

Mr. LASKER. In our foundation we keep very closely in touch with all medical publications of every kind.

Senator DONNELL. Now, Mr. Lasker, you have been very patient and I shall ask you about only a few other matters.

In regard to the provision of service, you say in your statement, under the other bill before you, S. 1320, it calls for prepaid medical care, for buying medical care on the installment plan, with an insurance pool to which all would contribute and from which all would draw when the need arose.

Is it your understanding that S. 1320 enables all the people of the United States to draw these medical services?

Mr. LASKER. Well, up to a certain extent.

Senator DONNELL. Then everybody in the United States, you think, is covered by that bill up to a certain amount of service. Is that right?

Mr. LASKER. If they are within the group that pays in.

Senator DONNELL. You think it is only the group that pays in.

Mr. LASKER. Again I was testifying on the proposal. I have read them, but find both bills very difficult to understand. There were sections which if I were to reread them several times I still could not get clear. I read both bills and I may be clouded on some detail, but by and large the answer is "Yes."

Senator DONNELL. Yes what?

Mr. LASKER. By and large, yes, what I stated.

Senator DONNELL. That this is an insurance bill to which all would contribute and from which all would draw when the need arose.

Mr. LASKER. From your question, do you say I am assuming there may be some few exceptions?

Senator DONNELL. I might say, Mr. Lasker, there is some misunderstanding.

Mr. LASKER. I would be very glad if you would tell me.

Senator DONNELL. I am not qualified to state the exact percentage of persons who would contribute, or the actual percentage of those who would draw benefits.

It is my general understanding, and I am sure that either Senator Murray or Senator Pepper will correct me if I am grossly in error, but it is my understanding the bill contemplates about 85 percent of the public receiving benefits thereunder.

Am I approximately correct on that?

Senator MURRAY. It covers a lot, but the State may be able to cover in by contribution all those who are wholly indigent and unable to make any contribution whatever.

Mr. LASKER. Oh, no. I meant by saying that, people like myself might not be covered. I was speaking, if you noticed in the \$3,000 group. I meant all within that group.

You took it out of the context and you might get a little off base.

Senator DONNELL. As I understand S. 1320, even though a man may have a fortune of a million dollars he pays in on the \$3,000 income?

Mr. LASKER. That is right, but he might want further medical care than he would get under the bill. I would think it would cover the medical care of practically all the people up to the minimum amount.

Senator DONNELL. You had some difficulty in understanding this bill and the other bill?

Mr. LASKER. I have never read a bill in the Congress that I understood fully if it was more than 2 pages long.

When I was in public office I had great trouble with men who drew bills for me understanding their own drafts. Sixty days later they asked me what I had in mind in regard to several paragraphs they had drawn for me.

Senator DONNELL. What I am getting at, you are not asserting this bill, S. 1320, does cover 100 percent of the population of the United States?

Mr. LASKER. No; I am asserting by and large it will 100 percent cover the needs of the people of the United States.

Senator DONNELL. In that connection I wish to call attention to the fact that there is a provision in the bill in section 205 (a), provision for benefits for noninsured and needy and other individuals.

Mr. LASKER. Yes.

Senator DONNELL. The reason I mentioned that there has been a great deal of comment about S. 545 not being satisfactory on the ground it is a dole, and I call your attention to the fact that S. 1320, about 85 percent contribute.

Mr. LASKER. I would think that.

Senator DONNELL. And about 85 percent are expected to derive benefits as a matter of fact or right, but in addition you have the others.

Mr. LASKER. I do not get your question. I do not quite understand your question.

Senator DONNELL. But in addition there may be provision made for persons ineligible under the early provision, persons who are needy to derive benefits under S. 1320?

Mr. LASKER. I told you I was not in particular instances against what they call socialized medicine. I am for the Veterans' Administration and I am for S. 545 if it will accomplish the purpose, although I hold S. 545 will not anywhere near do the job.

I am not against what is in S. 545 if it is included in S. 1320.

The point I make, if you will read over my statement, is that S. 545 puts a premium on being indigent, and confines itself to what is called socialized medicine.

Senator DONNELL. Now, Mr. Lasker, I think in your comments on S. 545 that you referred to the sections in which are set forth certain findings of Congress, and one of the findings that has been frequently mentioned in this evidence by persons opposed to S. 545 is on page 2, as follows:

That it is the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public health services to every individual regardless of race or economic status.

In fact, you quoted that in your statement this morning.

Mr. LASKER. Yes.

Senator DONNELL. I want to make this mention in the record. I do not think that means at all that it is contemplated that S. 545, plus the money authorized to be appropriated, plus the money from the States, will provide service of this nature to every individual in the United States.

Mr. LASKER. Oh, no.

Senator DONNELL. The idea in S. 545 is that it is the policy of the United States to aid the State to make available these services to every individual.

In other words, where you have individuals that are able to take care of themselves, this bill obviously, by the amount involved in the bill, does not contemplate payment to anybody, and that is amplified and corroborated by the language of the bill and a little later on where it is stated at page 18 of the bill therein envisaged will—

Set forth a stabilized program designed and calculated to provide within 5 years—

(a) hospital services, surgical services, and medical services for all those families and individuals in the State having insufficient income to pay the whole cost of such; and

(b) periodic physical examinations for all children in elementary and secondary schools in the State.

The point I am making is I do not think the view \$400,000,000 is not enough to take care of everybody justifies criticism of S. 545, because it does not contemplate that.

Mr. LASKER. In all good will, I now have to speak at a little length. Senator DONNELL. Fine.

Mr. LASKER. I want to reiterate what I said in the statement, I am for every Senator interested in health. If we differ, we differ through differences of philosophy, but there can be no differences on facts and financing.

Senator DONNELL. Very well.

Mr. LASKER. If that paragraph means only what you say, I want to be so bold as to say the paragraph is a mockery.

Senator DONNELL. That is what you have said.

Mr. LASKER. That is what I have said.

Senator DONNELL. You do not understand S. 545 contemplates providing services to everybody in the United States?

Mr. LASKER. No.

Senator DONNELL. Indeed, you recall, as I have just read from the bill, page 18, the programs are to be designed for persons having insufficient income.

Mr. LASKER. My prime quarrel, if I may use the expression in good nature—

Senator DONNELL. Certainly.

Mr. LASKER. In S. 545 that the paragraph or declaration of its purposes is not at one with the rest of the bill, and I really think the sponsors ought to withdraw that paragraph to make the issue clear so it can be really discussed.

That paragraph expresses much better and in fundamental words, and in fewer words than I, as I am a rather longwinded man, what I should like to see covered. Bill S. 545 does not provide for that, because two-thirds of our people who cannot afford proper medical care are not covered by S. 545. Two-thirds of our people have their lives blighted because they cannot have preventive medicine. Two-thirds of our people are psychically upset, either because they do not know how they will get medical care or do not know how they will pay the bills when they get through, and while I favor the declaration of purpose in S. 545, only S. 1320 carries it out.

Senator DONNELL. I get your point, and I think your point is one that should be very carefully considered by the sponsors of S. 545, because if there is an ambiguity derivable from page 2 it should be removed.

Mr. LASKER. I would not say ambiguity. One of the things I cannot understand about S. 545 is that its statement of purpose made it implicit that the things I am forwarding in my own little way as to medical care would happen, and then when I read the bill I found the bill has nowhere any provision to cover such statement of purpose.

The only quarrel I have with the bill is if you want that kind of bill. I do not want that kind of bill, but I do quarrel with that paragraph on purpose.

Senator DONNELL. I think your view is wrong. I am not prepared to admit that you are correct. The bill does what I have stated, does it not?

Mr. LASKER. Yes. Naturally the bill does not do what you have stated. The bill provides the Government provide socialized medicine to the indigent and puts a penalty on the worker, who is two-thirds of our population.

Let me tell you a little story. Within the last 4 years, we have had in our home two cooks who have had cancer. By coincidence one followed the other.

The first cook was afraid and she would not tell us. She could not afford to be sick. So she kept on working, and then thinking there was some shame about cancer, two weeks later she died.

The other cook did tell us.

My wife and I sent her to a hospital and paid her bill for 4 months, but she was so far gone she did not live.

Neither of those women were indigent. Both of those women were self-respecting, the finest type of citizen and both of those women knew they ought to go to a doctor but they were afraid of the bills.

Another instance, I was very sick in the Presbyterian Hospital in New York. I have had a barber for many years and he came there three times a week to shave me. He looked so ill one day I had the old thought of saying "roll over, you should be in bed."

He looked much sicker than I felt. He said he had not slept for nights; and doctors had told him he had heart trouble. I said "You should not be on your feet and you should not shave me." Fortunately an interne came in and I told him about it. If the man had not been in the hospital they could not have taken him in because the hospital was full.

As it was they arranged to take him in the emergency part where they have a few beds.

That man is raising a family of children. He is of Italian extraction; the children are first-generation Americans. In his desire to educate them, Senator, he has no money saved and he is always working on the next day's receipts.

He is really one of the finest men I ever knew, as far as character is concerned. The net result was that he was in that hospital 4 months. He was there 4 months, and is still under medical care. If I hadn't paid his expenses the man would have worried so much as to what would happen to his family—and I also advanced money for the family to live on—that he never would have gotten well.

Now, had there been general insurance for these three cases that I have told you about—these cases which have touched me personally recently—the two cancer cases might have been saved, and the man who was ill with ulcers, largely a psychological sickness due to his wor-

ries over his economic condition, would have gone to the doctor earlier and had himself taken care of.

It is for those people that I speak. I do not call them the little people, as the phrase is very often used, because they are not the little people. They are the big people of this country. A country that has not got a middle class, and a large middle class, particularly in the lower-income group, will never remain a democracy. I am firmly convinced of that. Those are the people who are the heart of this democracy. And unless we give them health and an opportunity to pay their way to health, we are not strengthening our democracy, at a place and at a time when there is a crying need for it, not only domestically but vis-à-vis our world relations.

Senator DONNELL. Mr. Lasker, do you think the bill should provide for treatment for a person afflicted, let us say, with tuberculosis?

Mr. LASKER. How is that?

Senator DONNELL. Do you think S. 1320 should cover treatment for a person afflicted with that disease, tuberculosis?

Mr. LASKER. Surely.

Senator DONNELL. Do you understand that this bill, S. 1320, does so provide?

Mr. LASKER. I have read the bill, you understand, but I have not deposited all provisions of it in my memory. Vaguely, I think it does. I can say this, Senator: there was nothing that either bill provides that I wasn't for. May I say that to you, because I want to emphasize it: there is nothing that S. 545 provides that I am not for. I am merely opposed to it on the basis of the statement of purpose, and that it does not carry out the statement of purpose. It is too little, to too few people, and in too few right places.

Senator DONNELL. Do you regard hospitalization as frequently being of great importance in the treatment of tuberculosis?

Mr. LASKER. You are getting into a field with which I am not too familiar.

Senator DONNELL. I mean aside from any technical aspects, you and I agree that it is important to have hospitalization for tuberculosis in many instances; is that correct?

Mr. LASKER. In many instances; yes.

Senator DONNELL. Now, I want to say first, in regard to your cancer illustration—

Mr. LASKER. Pardon the interruption, Senator, I am not quarreling with what is in S. 545.

Senator DONNELL. I am not talking about S. 545. I am talking about S. 1320.

Mr. LASKER. Yes, sir.

Senator DONNELL. What I want to understand or find out is whether it is your understanding that S. 1320, with respect to tuberculosis, provides for hospitalization. As you analyze the bill, does S. 1320 provide for hospitalization of persons suffering from tuberculosis?

Mr. LASKER. I do not remember that detail. I would not be able to speak expertly on it. I'm afraid I am not competent to testify with respect to that. Please don't embarrass me by asking me to.

Senator PEPPER. May I call Mr. Lasker's attention to a provision of S. 1320?

Senator DONNELL. Yes.

Senator PEPPER. I would like to call your attention to page 68 where, under "Grants to States for health services," it states that one of the purposes for which grants are to be made to the States, under subparagraph (3), at line 18, is to—

establish and maintain adequate health services for the early detection, prevention, treatment, and control of tuberculosis, venereal diseases, mental disorders, cancer, heart and degenerative diseases, dental disorders, nutritional deficiency diseases, or other diseases or conditions which have a high morbidity or mortality incidence or which require extensive care or specialized therapy.

You see, mentioned in there is tuberculosis.

Senator DONNELL. Yes. I am glad you mentioned that, Senator. I want to comment on that for a moment, and ask Mr. Lasker about that.

In the first place, Mr. Lasker, with respect to your statement about not understanding all of the bill, I do not contend that I understand all of this bill. As a matter of fact I haven't read all of S. 1320. It is a long, long bill, and I have not studied it all. I know the general principle of it, but I want to say this with respect to S. 1320, however, that there is a very distinct limitation—at least that is my understanding—on the hospitalization for tuberculosis, mental diseases, and nervous diseases, and I respectfully call your attention to the following language at page 6:

Hospital services consist of hospitalization, including necessary nursing services, and such physician, laboratory, ambulance, and other services in connection with hospitalization as the National Health Insurance Board (hereinafter referred to as the "Board"), after consultation with the National Advisory Medical Policy Council (hereinafter referred to as the "Advisory Council"), by regulation designates as essential to good hospital care, for a maximum of sixty days in any benefit year; but hospital services shall not include hospitalization in a mental or nervous disease or tuberculosis hospital or institution, or hospitalization for any day more than thirty days following the diagnosis of tuberculosis or a psychosis.

Now, when I call that to your attention I also call to your attention the fact that at page 9 of the bill, under the subheading "Availability of benefits," there is a duty cast upon the Board, to which I have referred, to study and make recommendations as to needed service and facilities for the care of the chronic sick afflicted with physical ailments, and for the care of individuals afflicted with mental or nervous diseases, and as to needed provisions for the prevention of chronic physical diseases and of mental or nervous diseases, and of making reports from time to time, with recommendations as to legislation. The point I am making, Mr. Lasker, is I think that while you have pointed out what you consider to be an inconsistency with respect to S. 545 and the subsequent provisions of that bill, you have also perhaps observed the very broad general statements in the declaration of purpose in S. 1320.

There has been previously developed in this testimony by other witnesses, I think you will find, that those broad statements in the declaration of purpose are limited very, very materially in various instances in subsequent provisions of the bill.

Now, I want to mention also—

Mr. LASKER. Pardon me for interrupting, Senator, but would you mark those two places that you were referring to, please?

Senator MURRAY. Would you permit him to comment on that?

Senator DONNELL. Yes.

Mr. LASKER. Yes; I remember that very distinctly. I want you to set me right.

Senator DONNELL. Yes, I will.

Mr. LASKER. Because I don't agree with your interpretation of what I think.

Senator DONNELL. If I could just finish this thought I am on now, Senator Pepper called attention to page 68, in connection with the provision under "Grants to States for health services." When it gets down to these matters of mental diseases, cancer, heart, and degenerative diseases, dental disorders, nutritional deficiency diseases, and so on, control of tuberculosis for some reason under S. 1320, as I see it, goes over into the theory of S. 545, and does two things.

In the first place it provides for a grant to States which is such as S. 545 does, and in the second place I think it provides for the administration of the States' grants somewhat along the general line of charity for needy persons who are chronically indigent, so to my mind it should be pointed out in connection with the comment made by Senator Pepper that title III, which is located at page 68, goes right directly into the theory of S. 545.

Now, Senator Murray was fearful that I might overlook some part of this. I will call your attention again to these earlier pages.

Mr. LASKER. I told you I have no quarrel with S. 545, save for one paragraph.

Senator DONNELL. That is the paragraph in the declaration of purpose?

Mr. LASKER. Yes. It is inherent that the things covered in S. 545 have to be covered in a comprehensive bill. My quarrel with S. 545 is that it is not comprehensive. It only looks after the needy and the indigent, and does not look after the tremendous two-thirds who have to be helped, not with money out of the Federal Treasury to pay for normal medical care, but given an opportunity to pay into an insurance fund.

Nor do I interpret those two paragraphs you have quoted in the way you do, though I want to say this: First, I never really studied the details of the bills carefully because I felt whenever a bill was going to finally be drafted it would be a compromise in detail, and done over, and I so state here, with respect to any final compromise you may arrive at.

Senator DONNELL. I understand.

Mr. LASKER. Don't you see?

Senator DONNELL. Yes.

Mr. LASKER. Consequently, I don't take them as a finished product.

Senator DONNELL. But if you will take those sections that I quoted.

Mr. LASKER. Will you give me those pages again?

Senator DONNELL. Pages 6 and 7.

Mr. LASKER. I didn't go through S. 1320 with a fine-tooth comb, but it undoubtedly is no perfect bill that should finally be passed by the Congress of the United States. I took it that there would be a lot of changes and I took it that these hearings are being conducted on the principle that there would be many changes. I took it that I was a witness on the principle, and I disqualified myself on the details.

Senator DONNELL. Now, the earlier portion to which I referred was pages 6 and 7, and page 9, beginning at the bottom of page 6.

Mr. LASKER. Beginning where at page 6?

Senator DONNELL. Down at the bottom, at subdivision (e).

Mr. LASKER. I see.

Senator DONNELL. Line 25. I was reading from that, running through to line 12 on page 7.

Mr. LASKER. Yes, sir.

Senator DONNELL. And then again on page 9, between lines 8 and 17, and then the page that Senator Pepper called attention to.

Mr. LASKER. What part of page 7 was that again?

Senator DONNELL. All of page 7 down through line 12.

Mr. LASKER. Just let me read that carefully.

Senator DONNELL. Yes, sir.

Mr. LASKER (after reading). Yes. Now, what was the next one, Senator?

Senator DONNELL. While you are looking at page 7, may I direct your attention to the fact that hospital services there are defined to consist of hospitalization, and so forth?

Mr. LASKER. Yes.

Senator DONNELL. That reads:

* * * hospitalization as the National Health Insurance Board, after consultation with the National Advisory Medical Policy Council, by regulation designates as essential to good hospital care, for a maximum of 60 days in any benefit year * * *

Mr. LASKER. Thirty days.

Senator DONNELL. Well, line 8 says 60 days. In other words, in your cancer case—

Mr. LASKER. I might say this.

Senator DONNELL. May I finish that sentence, please? As I see it, in your cancer case, the maximum that a person can have hospitalization under S. 1320 is 60 days in any benefit year, and then when you go down to tuberculosis, mental or nervous diseases, there is a further limitation to not more than 30 days.

Mr. LASKER. Yes; I see that.

Senator DONNELL. You would agree with that construction, would you not?

Mr. LASKER. Yes; I read that. Now, what is the other one?

Senator DONNELL. Now the question is—

Mr. LASKER. You read another.

Senator DONNELL. That was on page 9.

Mr. LASKER. I would like to take the two together.

Senator DONNELL. Lines 8 to 17.

Mr. LASKER. Yes. I will read that. [After reading.] Oh, yes; I remember distinctly those two paragraphs impressing me as something that I had to see. They are confusing. It may be that only the man who wrote it knows fully what is meant there.

Senator DONNELL. I wasn't so much confused by it, though there may be some difficulty in that, but the point I was getting at, if I might just finish, is to get your view after comments on the cancer case with respect to the bill inasmuch as it limits, in the cancer case, as I understand it, the hospitalization to 60 days, and then goes into tuberculosis and mental and nervous diseases and limits them to 30 days, and as I have read here from page 7—

Mr. LASKER. Yes. Now, if I just—

Senator DONNELL. If you will let me finish, please, I may say in all fairness I am not so clear myself as to the meaning of this next sentence on page 7. It says:

Whenever the Board, after consultation with the Advisory Council, finds that moneys in the account (established by section 271) are adequate and that facilities are available, it may by regulation increase the maximum days of hospitalization in any benefit year.

Mr. LASKER. Yes.

Senator DONNELL. Now, whether that is to limit it by these maxima up here, I would judge it will not. I would judge they would go further. That would be my opinion.

Mr. LASKER. I was going to ask you, would you read the other lines? I took it that there were reasons why it was that way, whether I agreed with it or not. You understand you cannot come into a full flowering in this kind of a venture the first day, the first month, the first year, or even the second year. There will be a lot of people paying into this fund who won't be able to get preventive medicine for a while. That is going to be a big obstacle.

Senator DONNELL. The time lag?

Mr. LASKER. The time lag, yes; and it was a detail that I did not bother to get myself informed about, though an important detail, I admit.

Senator MURRAY. At that point, Mr. Chairman, I would like to call attention to the fact that these provisions on pages 6 and 7 follow exactly the procedure that is followed in the overwhelming majority of hospitals in this country. A lay board decides which of the many suggested services are essential to good hospital care. American hospitals are considered the finest in the world, and we are following the practice that is followed in American hospitals.

Mr. LASKER. I took it that the heart of the matter was expressed from line 12, after the word "psychosis," and down to line 16, those lines inclusive.

Senator DONNELL. I would respectfully suggest, however, for your consideration, Mr. Lasker, the fact that the general rule apparently is laid down earlier, namely, that the maxima prescribed are 60 days and 30 days, and it is only when the Board, after consultation with the Advisory Council, finds that moneys in the account are adequate and facilities are available that there is any power to increase those maxima. In other words, you start out with the rule of 60 days, 30 days.

Mr. LASKER. Perhaps I ought to tell you what I took that to be.

Senator DONNELL. Yes.

Mr. LASKER. In the end it isn't always the length of the step that counts, but the direction. Do you gentlemen follow me?

Senator DONNELL. Yes.

Mr. LASKER. Now, my difficulty with S. 545 is not that it doesn't start at the right road, but it stops at the home of the indigent and does not proceed further on the road to the homes of the great working middle classes. We can't traverse the whole road immediately. Now, as to S. 1320, I took it that it was really a case of playing for time until there would be enough money in the general pool to permit of wider hospitalization, because hospitalization is where you run up into the great big money in medicine, and if that is not the purpose then it should be clarified to state what is the purpose.

I think, Senator Donnell, that you have brought out a very, very important point, that S. 1320 does not make completely clear—

Senator PEPPER. Mr. Chairman, let me interrupt just a minute. I think the record ought to show the pertinent provisions relative to this subject. The Senator from Missouri, the acting chairman, has asked a question as to whether S. 1320 does not provide limited hospitalization for patients who might have been diagnosed, who have had tuberculosis and cancer, for example. The Senator is correct that there is a limitation in the length of time that a patient may occupy a hospital with assurance under the insurance fund. As Mr. Lasker has pointed out, it does provide that the Board, after consultation with the Advisory Council, may find that the insurance fund is adequate to allow a longer period of residence in a hospital by, for example, a cancer patient or a tuberculosis patient.

Mr. LASKER. That is how I understood it.

Senator PEPPER. But it must be remembered that the part of the bill on page 6 and page 57 described the benefits of the insurance fund, and obviously the fund has its limitations. If you are going to give more services out of the fund you must increase the fund in some way or other.

However, in another part of the bill, as I pointed out, on page 68 there is a section that prescribes, to refer to the grants-in-aid to States, to expand its basic State and local public health organization and the basic services provided thereby; also to establish and maintain adequate maternal and child-health services, and particularly services for locating and caring for crippled or otherwise physically handicapped children; and also to establish and maintain adequate health services for the early detection, prevention, treatment, and control of tuberculosis, venereal diseases, mental disorders, cancer, heart and degenerative diseases, dental disorders, nutritional deficiency diseases, or other diseases or conditions which have a high morbidity or mortality incidence or which require extensive care or specialized therapy, and so on, and then in section 302 on page 69, under "Grants to States," it is provided:

To assist the States and the counties, health districts, and other political subdivisions of the States in carrying out the purposes set forth in section 301 of this title—

it is section 301 from which I just read—

there is hereby authorized to be appropriated for the fiscal year ending June 30, 1948, the sum of \$100,000,000; for the fiscal year ending June 30, 1949, the sum of \$150,000,000; for the fiscal year ending June 30, 1950, the sum of \$225,000,000—

and for each succeeding year a sum sufficient to carry out the purposes of that section, whereas S. 545 has no provision like that for grants-in-aid for the Public Health Service to try to carry out the purposes set out in section 301, except in respect to cancer.

On page 13 of S. 545, it says as follows:

(c) To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention and control of cancer, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention and control of such disease, including the provision of appropriate facilities for diagnosis and including the training of personnel for State and local health work, and to meet the cost of pay, allowances, and traveling expenses of com-

missioned officers and other personnel of the service detailed to assist in carrying out the purposes of this section with respect to cancer, and to administer this section with respect to such disease, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1948, and for each fiscal year thereafter, the sum of \$10,000,000.

Now, that is a desirable thing, yet if you will compare the two bills and what they do with respect to either the preventive stage or the diagnostic stage, you will find, I think, that the general over-all scheme as set out in S. 1320 is far more adequate.

Mr. LASKER. I took it that the general over-all plan of S. 1320 was this: To start a pool that would have money in it to insure that the people could have the services of physicians of their selection, and at the same time let the physicians have patients of their selection, and that then it was left largely to the development of how much money would be left in the pool as to how much further it could go in the way of hospitalization.

Senator PEPPER. And then it attempts to make specific provision for the chronic case.

Mr. LASKER. Of course, I believe in the course of a few years, Senator Donnell—

Senator DONNELL. Yes?

Mr. LASKER. That if we have national health insurance, in the course of not so many years we will find we need much less hospitalization than we need now.

Senator DONNELL. You feel that after a while we will need much less hospitalization?

Mr. LASKER. I am committed to that deeply. This is what I believe. I believe that on a 10-year operation of this bill the net to the country would be a money profit. That is my belief.

Senator DONNELL. I see.

Mr. LASKER. And that the doctors by and large would be better off financially.

Senator DONNELL. Mr. Lasker, might I make this observation at this point? I referred a little while ago to page 68, to which attention was directed by Senator Pepper, as being a portion of S. 1320 which follows the theory of S. 545 of grants to States. I think that is correct. I made a further observation to the effect that it was the theory of title III, pages 69 and following, to follow along the line of the provision of these services for the needy. I am not sure whether I am correct on that, and I want to make my statement subject to this correction, that I would like to study that portion of the bill further to determine whether I am correct in that statement.

Senator PEPPER. There is no means test, even under the title III part.

Mr. LASKER. Oh, no. In my testimony I so stated, that in S. 1320 there is no means test. And again to quote from myself, as well as I remember, there are no police to come around and pry into the private affairs of a citizen, or humiliate him.

Senator DONNELL. I think you are in error, however, if I might respectfully say so, in your statement that there is no provision for a means test or anything. I take it by that you mean there is nothing of that sort in S. 1320.

Mr. LASKER. That is right.

Senator DONNELL. At page 13, S. 1320 has the heading "Provision of benefits for noninsured needy and other individuals."

Mr. LASKER. Yes.

Senator DONNELL. I take it that the only way you can find out if a person is needy is by imposing some sort of a test in order to enable that determination to be made.

Mr. LASKER. Would you like to have me tell you what I meant?

Senator DONNELL. Yes, sir.

Mr. LASKER. Or at any rate the way it seems to me. You understand that now, and for the last hour—and I do not object to it—you have been asking me questions that at the beginning I disclaimed competency to answer, because I am not an expert, do you see? In the same way I am not an expert on foreign affairs, but nevertheless I can have very deep, philosophic convictions. I am not an expert on banking, but I can have very deep convictions with respect to banking, and how the country will make the most money. If, then, I am invited, if you want to invite me to be a Senator at large and draw this bill, I will promise to do the best job I know how. Do you see?

Senator DONNELL. Yes.

Mr. LASKER. But I wanted to make it clear that this is the way it seemed to me. Under S. 545 the offices where people would have to appear would be only for indigents; therefore, a man would be marked an indigent. Under S. 1320 there would be a place where the people would come generally at times and you could not tell who was the needy or who was not the needy. I don't think that in America we are going to put any man to the shame of letting the public know or let it publicly be known that he is an indigent. That is my feeling in the matter.

Senator DONNELL. I understand.

Mr. LASKER. You see, American citizenship to me is a franchise—a franchise to give decent treatment and to be given decent treatment.

Senator DONNELL. I would like to mention at this time the administration of the old-age insurance. Out in our State, for instance, we have a great many old people who receive money from the Government.

Mr. LASKER. Yes; I know.

Senator DONNELL. They receive money from the State and from the Federal Government. That is in the form of assistance and is given only to people who qualify for it under the State laws as being needy. I have forgotten the exact language of the statute.

Mr. LASKER. But old age is a different thing. We have throughout the ages, in all civilizations, respected the elders. That has been true all through the years. But it is a different thing when a young woman of 28 has to walk in. I am just looking at it in the way that human reactions are. Yes; it is a very different thing. I would not mind going for my old-age pension, but I would have difficulty, if I were a younger person, in going for anything else.

Senator DONNELL. Now?

Mr. LASKER. Oh, no.

Senator DONNELL. May I say this also, Mr. Lasker? This is not intended to interrogate you along matters that you very modestly state you are not too familiar with.

Mr. LASKER. It is not a case of modesty. I simply don't know.

Senator DONNELL. I do not want to ask you about these things which you claim to be no expert on. However, you did give the cancer case as an illustration this morning, a case taken right from your own house, and you have come advocating a specific bill very eloquently and very powerfully, S. 1320.

Mr. LASKER. Oh, not as eloquently or powerfully as I should like to have done.

Senator DONNELL. Let me complete this statement now, please.

Mr. LASKER. Yes, sir. I'm sorry.

Senator DONNELL. I think it was perfectly proper, and I know you are not criticizing us for doing so, for us to ask you, in view of your observations about the cancer matter, what you had to say in regard to these limitations of hospitalization under S. 1320.

Now, may I say this further—this is not a question, but for the record—that we already have in the Public Health Service, grants and services to States which cover venereal disease authorization, and I quote from the statute, “to be appropriated for each fiscal year a sum sufficient to carry out the purpose of this subsection,” and that subsection relates to the developing of more effective measures for the prevention, treatment, and control of individuals, and so on.

We likewise have in the same act, the Public Health Service Act, at 314 (b), a provision of like nature with respect to tuberculosis, and an authority for the appropriation of a sum for each fiscal year of 1945 sufficient to carry out the purposes of the subsection.

I want the record to show likewise that S. 545, at pages 12 and 13, contains a proposal to amend the Public Health Service Act by adding a new subsection, which is of a similar nature and is related, I think, to the venereal disease and tuberculosis sections of S. 1320. This amendment, contemplated and provided for in S. 545, relates to the control of cancer and provides likewise for an appropriation for the fiscal year ending June 30, 1948, and for each fiscal year thereafter, the sum of \$10,000,000 for that general purpose.

Now, Mr. Lasker, I want to say that I am almost finished with examining you, and yet we happen to have a statute at present in effect, or a rule in effect under statutory authority, requiring this committee not to sit when the buzzer buzzes without leave of the Senate, and therefore it is our custom when that buzzer buzzes to recess for a very few minutes pending the obtaining of that consent, so I am going to ask your indulgence, please, when the buzzer buzzes for a few minutes, and then I will not detain you any further.

Mr. LASKER. If I may be permitted to do so, I should like to catch a 1 o'clock train. I had no notion when I started that I would be talking so long. I thought I would be here about 20 minutes.

Senator DONNELL. The committee will be in recess for a few minutes.

Mr. LASKER. Thank you.

(A short recess was taken.)

Senator DONNELL. Mr. Lasker, we may resume now, if that is agreeable to you.

Mr. LASKER. Yes, sir.

Senator DONNELL. I had called your attention to certain language on page 7, and in the course of that language reference was made to the National Health Insurance Board. I am referring now to S. 1320.

Mr. LASKER. Yes, sir.

Senator DONNELL. The National Health Insurance Board. Are you familiar with the functions of the National Health Insurance Board, as set forth in S. 1320?

Mr. LASKER. I am, but I would have to read it over to refresh my memory. I am not positive of the bill in my mind.

Senator DONNELL. I understand, but you are familiar enough with it to be advocating the bill here before us this morning?

Mr. LASKER. Oh, yes; and I have read the bill, and I wrote my statement after reading it.

Senator DONNELL. I wanted to know if you had studied the functions of the National Health Insurance Board.

Mr. LASKER. Would you be specific?

Senator DONNELL. Have you studied anything at all with respect to the functions of the National Health Insurance Board in this bill?

Mr. LASKER. I have not made a profound study of either bill.

Senator DONNELL. Do you remember what the functions of the National Health Insurance Board are, from your reading of S. 1320?

Mr. LASKER. I read both bills.

Senator DONNELL. I am referring to page 38 of the bill, S. 1320.

Mr. LASKER. Yes.

Senator DONNELL. At line 22, where it says,

There is hereby established in the Federal Security Agency a National Health Insurance Board.

and so forth.

Mr. LASKER. You see, I know so very little. I mean I know so little of the technique that I am afraid to say yes to anything for fear that I will trap myself in something I don't know.

Senator DONNELL. We do not want to trap you at all, Mr. Lasker.

Mr. LASKER. I know you don't. I said "trap myself," and that is why I plead more ignorance than I really have until a thing is specifically pointed out.

Senator DONNELL. Beginning at line 22 on page 38, the language following makes provision for the establishment of a National Health Insurance Board. You observe that provision?

Mr. LASKER. Yes; and it is to be composed of five members, three of whom are to be appointed by the President by and with the advice of the Senate and the consent of the Senate, and two others.

Senator DONNELL. And those two are to be the Surgeon General of the Public Health Service and the Commissioner for Social Security, the other three, as you said, to be appointed.

Mr. LASKER. Yes, and each member is to receive a salary of \$12,000 a year.

Senator DONNELL. I wanted to ask you this question: Do you regard the creation of such a National Health Insurance Board to be an important feature of this bill, S. 1320?

Mr. LASKER. I really have not given that enough thought. I am here to advocate the general principles of the bill, especially with respect to the free choice of patients with respect to their doctors, and doctors with respect to their patients, through an insurance fund.

Senator DONNELL. Yes.

Mr. LASKER. And Senate bill 1320 does that. I am not prepared—I have not gotten enough of the pros and cons of the thing—to go into the techniques of it. I am not qualified to do so at the moment. If

I had time, and you wanted it, I could make a deep study of it, but I have not yet done so. I read it through only casually because I really did not think it was going to be passed this year, you see. I didn't feel we were up to that yet. I just thought that there are hearings every year, from the sum total of which nothing happens for a long time and then the bill finally passes.

Senator DONNELL. Now, Mr. Lasker—

Mr. LASKER. Although, of course, I would like to see it pass this year. I wish it had passed last year, or the year before.

Senator DONNELL. I would like to ask you this. You are a businessman. You have had wide experience. And this matter which is set forth in S. 1320, which bill you have read, involves a matter of great consequence and large expenditures of money. Do you regard it of importance that there be a National Health Insurance Board?

Mr. LASKER. Well, there has to be some administrative board. For instance, the people of the United States have a board which is called the Congress of the United States. There must be administrators for everything.

Senator DONNELL. There must be administrators.

Mr. LASKER. Yes.

Senator DONNELL. Do you have any feeling about that board having some functions and ultimate powers vested in it? Do you favor that idea?

Mr. LASKER. Yes; but I do not want to get into details on the general principle of all these kinds of things. I like to provide for lay representation.

Senator DONNELL. Yes; but that isn't what I was getting at. I wanted to find out whether you think it is of importance to have an administrative board to which you refer, with ultimate powers and functions vested by the bill providing for this plan.

Mr. LASKER. Well, some board, someone.

Senator DONNELL. All right; that leads up to what I want to get at. If you will pay special notice for just a moment to line 22 at the bottom of page 38, and going over to page 39, you will observe this language:

All functions of the Board—
that is this board we have been talking about—

shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

I want to pause at this point and ask you if in any of the business enterprises with which you have been connected the functions, all functions, of the board of directors of the company shall be administered under the direction of the president or any other official of the company under his direction?

Mr. LASKER. I don't get it.

Senator DONNELL. Well, here is what I mean. Take Lord and Thomas, or any other firm or corporation.

Mr. LASKER. Yes.

Senator DONNELL. There is a board of directors of six to nine men, we'll say.

Mr. LASKER. Yes.

Senator DONNELL. And it has a president.

Mr. LASKER. Yes.

Senator DONNELL. Then the question is this: Do you favor giving to the president of a corporation power superior to that of the board of directors?

Mr. LASKER. No, sir; and you will find that in connection with cancer last year I testified for quite the opposite, if anything was done for cancer, to what is provided in S. 1320 this year.

Senator DONNELL. Yes; in other words, this bill, S. 1320, would carry out the analogy, as I see it, of a board of directors of a company being subordinate to the president. You don't favor that, do you?

Mr. LASKER. No, sir; and in my testimony I didn't mean—I thought I would be here only half an hour, and I did not want to get into everything. On that part there I claim to be expert on what you ask, and if I gather your views, I agree with you.

Senator DONNELL. You do not agree with the provision of S. 1320?

Mr. LASKER. No, sir.

Senator DONNELL. You do not?

Mr. LASKER. No, sir; if a final bill was to be drawn, I would appear as a witness questioning that.

Senator DONNELL. In your opinion, the provision at line 22 of page 39 of S. 1320, that "All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator" is not a wise provision?

Mr. LASKER. Let me read that. "All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator." No, no; now, if that Board itself had a chairman, I would be for it. Do you follow me?

Senator DONNELL. You would not be in favor of the chairman having more power than the Board itself?

Mr. LASKER. No; but this is for the purpose of administering.

Senator DONNELL. And under the direction and supervision, it says, of the Federal Security Administrator.

Mr. LASKER. I think the Federal Security Administrator already has so much to do that this additional burden would be—

Senator DONNELL. Unwise?

Mr. LASKER. Would put it down so far that the Congress could never know who really was doing it.

Senator DONNELL. I was not addressing myself particularly to the volume of his work, but to the theory of having a board and—

Mr. LASKER. Well, I feel that—

Senator DONNELL. Pardon me, Mr. Lasker, I would like to complete this thought: and having one official who is superior to the Board and has the power of direction over the Board.

Mr. LASKER. Yes.

Senator DONNELL. Do you favor that?

Mr. LASKER. If it was an independent one, I would.

Senator DONNELL. If that was independent?

Mr. LASKER. Let's see. If it read something like this: "All functions of the Board shall be administered by the Board under the direction and supervision of the chairman." If the bill provided, you know, for an independent board.

Senator DONNELL. Let me ask you this. In the ordinary business affairs of any corporation, do you favor having a board of directors which is subordinate to the president?

Mr. LASKER. No.

Senator DONNELL. And subordinate to the direction of the president?

Mr. LASKER. Not in business affairs, but that is the best you can get in Government. I was the chairman of the Shipping Board, and I would have been a dead hen if they had not been under my direction and supervision. I could not have gotten anywhere because then comes in political pull, which you don't run into in business, and men from the Hill, associations, and all that, and goodness knows that each one is the representative of a certain district, and there finally has to be some head. You see, for instance, I'll take the Shipping Board when I was there. I could not do anything in principle without a vote of the members of the Board, and I had only one vote the same as the rest, but the minute they voted on anything it was under my direction and supervision.

Senator DONNELL. But that is not what this bill says. This bill says that all functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

Mr. LASKER. Then some of that wording would have to be very carefully studied. It would have to be gone over with a fine-tooth comb.

I would like to make clear for the record what I think, that if there was an independent board with a chairman, the board votes as a board, but then the board also—I know this to be a fact in many corporations, I know many corporations where it is that way—where the board consists of people who spend their whole time in the corporation, and then after the board meets and determines things these people become department heads. From that point on the president administers, directs, and supervises the work of everyone.

Senator DONNELL. Now, Mr. Lasker, may I ask you this?

Mr. LASKER. But I can see how this wording is ambiguous. You are right.

Senator PEPPER. Before you get away from that, I have a question.

Mr. LASKER. I think it is ambiguous.

Senator DONNELL. Senator Pepper has a question.

Senator PEPPER. I think Dr. Parran also testified in response to the inquiry from the Senator from Missouri on the same point, and he said if the language was construed to mean what the Senator from Missouri indicated it to mean, merely that the Federal Security Administrator could overrule the Board on everything, that he would thoroughly agree with you that it needs interpretation, but he interpreted the language to mean that in other sections there the Board was given the authority to lay down the rules.

Mr. LASKER. I definitely agree that it does need clarification.

Senator PEPPER. You feel it is desirable to clarify that?

Mr. LASKER. Oh, yes; it needs considerable clarification.

Senator DONNELL. I appreciate the fact that time is flying, and I will try to get through with you as quickly as possible.

Mr. LASKER. I can take the 2 o'clock train in case I can't leave by 1.

Senator DONNELL. We will be through with you in a very few minutes now.

Mr. LASKER. I just feel that I am getting to the stage where I am beginning to bore you because I have been talking so much.

Senator DONNELL. It is just the other way around. I don't want to do that.

Senator MURRAY. We are willing to stay here all afternoon if it is necessary.

Mr. LASKER. I will stay here this afternoon, all day tomorrow, all this week, and all next week if you will get me a room.

Senator DONNELL. Maybe we could give you one of those dinners.

Mr. LASKER. I think, after talking all this time, you ought to give me a dinner.

Senator DONNELL. Now, Mr. Lasker, may I refer to the concluding page of your statement where you plead that the committee report out a bill which will guarantee medical care to all and—and this is the part I am directing your attention to especially—"with patients choosing their own doctors and doctors choosing their own patients." Now, I take it that you construe S. 1320 to accomplish the result that patients will choose their own doctors and doctors will choose their own patients; is that not correct?

Mr. LASKER. Yes.

Senator DONNELL. I am wondering whether or not you have studied in that connection the provisions on page 20 of the bill S. 1320, particularly lines 7 to 9, which refer to a per capita basis of compensation and refer to a practitioner's list. Have you given thought to the effect of that?

Mr. LASKER. Where is that?

Senator DONNELL. That is line 7 to line 9, on page 20 of S. 1320.

Mr. LASKER. Line 7 to line 9?

Senator DONNELL. Yes, sir.

Mr. LASKER. Wait until I read it.

Senator DONNELL. Surely. Please do.

Mr. LASKER (after reading). Yes, I am very well acquainted with that. Now, of course, that does not include doctors who do not choose to go into the fund.

Senator DONNELL. No; that is not the point I had in mind. The point I have in mind is this: You speak here about the guaranty to patients to choose their own doctors.

Mr. LASKER. Yes.

Senator DONNELL. I take it you consider that to be an important guaranty in the bill, do you not?

Mr. LASKER. I consider that really to be part of the essence of the bill.

Senator DONNELL. You consider that to be part of the essence of the bill?

Mr. LASKER. Yes, sir.

Senator DONNELL. I will illustrate the point I am getting at in this way. Suppose we say—and I always have to get back to my State—well, let's take the town of Sedalia, Mo.

Mr. LASKER. No; you take it.

Senator DONNELL. How is that?

Mr. LASKER. You take it. [Laughter.]

I've got New York. That's enough.

Senator DONNELL. That's all right. I'll take Sedalia, Mo. Now, suppose in Sedalia that under the bill the doctors decide to adopt this per capita basis of compensation, and there is a doctor allotted to

take care of 500 persons. Let's call him Dr. Smith. Five hundred people go on his practitioner's list. Dr. Jones can also have 500 persons, and Dr. Williams can have 500. All right. Suppose Dr. Smith is generally considered to be the best doctor in Sedalia. I hope there isn't a Dr. Smith there, or I will be in trouble with the other doctors. But suppose he is generally considered to be the best doctor in Sedalia, and the people flock to the appropriate place to register in order to get on his list. Five hundred people come there in a hurry within the first few days and get on his list after this bill goes into effect. Then you and I, and Senator Pepper, and Senator Murray—we would like to have you come too—jointly go down and want to get on his list, but his list is already filled. Is there not there a limitation on the right of the patient to choose his doctor?

Mr. LASKER. No.

Senator DONNELL. Why not?

Mr. LASKER. No more than there is now. I have had the experience myself of wanting to get a doctor who is a specialist in something and he simply said to me, "I can't take you. I already have too many patients. I have too much to do as it is." And that is true right now, under our present system. Then he said, "However, I will give you the names of four men who are as good as I am." You know how I felt at that suggestion, don't you? I became angry and said, "You can turn me down if you want to, but don't try to tell me who is as good for me in your mind as I think you are." Now, if you can talk the doctor into taking you on in spite of everything, that's all right, but right today there are some doctors who cannot take on additional cases.

Senator DONNELL. Today, however, it is a matter for the determination on the part of the doctor and the patient together; if they can agree that he is going to take the case, and if he can take it, he will.

Mr. LASKER. It is a matter of determination on the part of the doctor and the patient as to whether or not he is going to take the case.

Senator DONNELL. I do not agree with you on this per capita basis where Dr. Smith has 500 patients on his list. As I understand it, that is the maximum number.

Mr. LASKER. Yes.

Senator DONNELL. In fact, there is some provision for that somewhere.

Mr. LASKER. But Dr. Smith can say that there are such-and-such names on the list that he doesn't want, so he has likewise had a right to choose his patients. Now I am in Sedalia; is that correct? I am back in Sedalia?

Senator DONNELL. Yes.

Mr. LASKER. My name is on Dr. Smith's list. I can say that I don't want to be on his list. Then they have to put me on another list.

Senator DONNELL. But, Mr. Lasker, suppose you want to get on the list and his list is full, you would agree that under this language there is no way for you to get on it. That is true; is it not?

Mr. LASKER. Well, of course; but that isn't that he has not had free choice and the doctor has had the freedom to say "no." Now, we don't want to have a police state of things. If we send him to the

doctor and say to the doctor, "You have to take him"—maybe the doctor isn't too busy, maybe the doctor just doesn't like him, and in that case then the doctor should not take him because he would not be a good doctor for the patient.

Senator DONNELL. I am anxious to get your idea on this matter, in connection with S. 1320. Dr. Smith has been given a list of 500, and I just want to insert here at this point that beginning at line 4, on page 24 of the bill, it says:

Any such limits shall take account of professional needs and practices, shall provide suitable exceptions for emergency and temporary situations, and shall not exceed maximum limits fixed by regulations made by the Board, after consultation with the Advisory Council.

Mr. LASKER. Will you let me see that, please?

Senator DONNELL. Yes; page 24.

Mr. LASKER. What lines?

Senator DONNELL. Beginning with line 4. And then the rest of that sentence reads—

which regulations may provide for nationally uniform limits or for limits varied to take account of relevant factors.

Now, the question I am asking you is when Mr. Smith, who we assume is generally considered to be the best doctor in Sedalia—when his list is full and the regulation has been set down that that is his number, and we four men come up there and want to get on his list, we would agree here today, would we not, you and I, under this bill, that we could not get on his list? That is true; is it not, Mr. Lasker?

Mr. LASKER. But we had a free right to choose to get on his list.

Senator DONNELL. We came there to get on his list, but we couldn't.

Mr. LASKER. That is inherent in life.

Senator DONNELL. But we agree that is the law that is being provided under this bill.

Mr. LASKER. I wouldn't agree with the interpretation that you put on it.

Senator DONNELL. I am asking you about the facts in the case, if Dr. Smith already has a list with the names of 500 persons.

Mr. LASKER. No; I wouldn't even agree to that, because I think—

Senator DONNELL. Just a minute. Dr. Smith already has 500 persons on his list, and we four walk up there and want to get on his list for extended treatment by that doctor. There is no way under this bill in which we would have a right to get on his list and be treated by the doctor of our choice. That is a true statement; is it not?

Mr. LASKER. You say "have a right"?

Senator DONNELL. Yes.

Mr. LASKER. Oh, no; there is no way, and that is why I am for this bill. There is no way in which anybody has a right to make a doctor look after him who, for any reason, says no. Now, I am going to hold out for the doctor on that part of it, even if they weaken on it.

Senator DONNELL. But that is what I am getting at.

Mr. LASKER. The reason I feel so deeply about that, sir, is because it is my firm belief that there is nothing to a doctor-patient relationship unless the doctor wants the patient. Do you understand?

Senator DONNELL. I understand that, but in the case I have cited, Mr. Lasker, from the illustration I have given I think it is clear that when a doctor has his list full, and it is prescribed that that is his maximum, as is provided here under this language I have read to you, he cannot take any more. That is what "maximum" means; is that not right?

Mr. LASKER. Let me say it another way.

Senator DONNELL. Is that not true?

Mr. LASKER. No.

Senator DONNELL. My statement is not true, Mr. Lasker?

Mr. LASKER. Well, no.

Senator DONNELL. Regardless of the interpretations.

Mr. LASKER. No; I don't like the inference of your statement.

Senator DONNELL. I have not put any inference on anything.

Mr. LASKER. Your statement is an inference.

Senator DONNELL. If there is a list of 500 persons, and it is filled, and then 10 more people come and want to get on that line, if the regulation says that 500 is all the doctor can take, 500 is the maximum, then those 10 men cannot get on that doctor's list. Is that true or not?

Mr. LASKER. I am talking about——

Senator DONNELL. Won't you please answer that question?

Mr. LASKER. No; I won't answer yes or not. That's like asking me to answer "yes" or "no" to the old question, "have you quit beating your wife?"

Senator DONNELL. No; it is not.

Mr. LASKER. Senator, I can see your viewpoint, and I can see that it is honestly fixed in your mind that way, and I am going to try to show you that it isn't that way.

Senator DONNELL. All right; go ahead.

Mr. LASKER. I see that it is honestly fixed in your mind. I think I can give you an illustration. In New York we have what is called the Blue Cross plan. You know, of course, all about the work of that organization.

Senator DONNELL. Well, not all about it.

Mr. LASKER. Now, I know of not only 1 or 10 or scores, but I know of hundreds of cases of people who have paid in advance for hospitalization under the Blue Cross insurance plan. Their doctor has certified that they should go into the hospital, and they have had to wait from 2 to 3 weeks or more before they could get in, and in some cases they couldn't even get into the hospital of their choice. The hospital simply was filled up. Now, that is happening in every city in America today under the Blue Cross plan, which is perhaps the largest and most successful medical-aid plan that we have today. Now, I think we can have a meeting of minds if I answer your question by giving the analogy of the Blue Cross plan.

Senator DONNELL. Mr. Lasker, I don't think you have answered my question. You have talked about a presently existing medical-aid plan. I am not going to ask you any more except this once.

Mr. LASKER. I am not trying to be fractious. I just don't want to testify to something that I don't see.

Senator DONNELL. I want you to see my point. If you don't agree, well and good, but I would like to ask you this question, which I think can be answered pretty easily. In the illustration I have used, Dr. Smith has been allowed a maximum of 500 patients.

Mr. LASKER. Yes.

Senator DONNELL. And he has already filled his list—that list has been completely filled, there are 500 persons on that list.

Mr. LASKER. Yes.

Senator DONNELL. And then 10 more people come along and say, "Dr. Smith, we want to get on your list." He looks at the number on his list and says there are already 500. Then he looks at the regulations and says that's all he can take. Does it not inevitably follow that he cannot take the other 10? That is true, is it not?

Mr. LASKER. You mean if he already had the maximum number of 500?

Senator DONNELL. Yes.

Mr. LASKER. I see. Maybe I did not understand your question. You mean he is limited to 500?

Senator DONNELL. Yes. He is limited to 500, and he has 500.

Mr. LASKER. And he has 500?

Senator DONNELL. Yes.

Mr. LASKER. And maybe he could take 10 more?

Senator DONNELL. I am not raising that. There is no question about maybe he could. The question I am putting to you is that here is a paper which contains a list of 500 persons.

Mr. LASKER. Yes.

Senator DONNELL. And here is a regulation issued under S. 1320 which says that 500 is all he can take. There are 500 names on that list—500 of them.

Mr. LASKER. Yes.

Senator DONNELL. And then more people come up 2 days after that list of 500 names has been completed. Let's say 10 more people come. Those 10 additional persons cannot get on the list under that statute. That's true, is it not?

Mr. LASKER. Well——

Senator DONNELL. Is that not true?

Mr. LASKER. I would say——

Senator DONNELL. You would agree on that, would you not?

Mr. LASKER. I would say that unless the doctor made room, or the local board—I am not going on the basis of the local board, you see.

Senator DONNELL. Mr. Lasker, won't you please just answer that question?

Mr. LASKER. I can't.

Senator DONNELL. If there are 500 people on the list, and the regulation says that the doctor cannot take more than 500 patients, then the 10 additional patients who come to that doctor could no get treatment from him, could they?

Senator PEPPER. What's the use in arguing that?

Mr. LASKER. What did you say?

Senator DONNELL. I want Mr. Lasker's idea on it.

Senator MURRAY. You have asked him.

Senator DONNELL. I know I have, and I would like to get a statement on it. That is one question on which I haven't been able to get an answer from him.

Now, Mr. Lasker, the list consists of 500 people. There it is—a list with the names of 500 people on it, right there in front of us. You also have a regulation under S. 1320 that 500 is all he can take. Ten more people come along and want to get on that doctor's list, but it is already filled up. Those 10 other people cannot get on that doctor's list, can they?

Mr. LASKER. I don't know about that 500. I think that is dangerous—that is dangerous medicine.

Senator DONNELL. You are not answering my question.

Mr. LASKER. I don't see how he is going to be able to look after 500 all at one time.

Senator DONNELL. All right. Make it 200 then. If the doctor has a list of 200, and the regulation says that 200 is all that Dr. Smith can take, but 10 more people want to get him to take care of them, they cannot get on his list; can they?

Mr. LASKER. If a doctor—

Senator DONNELL. They can't; can they?

Mr. LASKER. If a doctor has all the patients he can handle today under the present set-up, they can't get on his list.

Senator DONNELL. I am talking about the lists under the bill. If the list is already filled with 200 names, and the regulation says 200 is all he can take, and then 10 more come along and want to get on his list, can those 10 get on? What is your answer on that, "yes" or "no"?

Mr. LASKER. My answer would be that I don't know the bill well enough to answer "yes" or "no." But I have such faith in the American people that when it comes to be worked out it will be worked out as nearly practicable as human beings can do it.

Senator DONNELL. You still have not answered the question, Mr. Lasker.

Mr. LASKER. I have been disturbed about that. I have tried to answer all your questions, if I understood them.

Senator DONNELL. I think you could also answer that question, Mr. Lasker. When it comes right down to plain numbers, 510 is more than 500; isn't it? We do agree to that; do we not?

Mr. LASKER. What?

Senator DONNELL. We agree that 510 is more than 500? You do agree to that, don't you?

Mr. LASKER. Yes.

Senator DONNELL. And 210 is more than 200, you would agree to that?

Mr. LASKER. Yes. But don't ask me anything about algebra. I told you I only went to high school.

Senator MURRAY. Mr. Lasker, isn't it a fact that in the large cities of this country and in many of the medium-sized cities of this country people are not always able to get the doctor of their choice when they want him?

Mr. LASKER. That is the point I am making.

Senator MURRAY. Isn't it well known that sometimes people travel all across the continent here in order to go to a special surgeon at Johns Hopkins Hospital in Baltimore, let's say, and then when they get there they find that he is not available?

Mr. LASKER. That is the point that I have been trying to make.

Senator MURRAY. Now, isn't it true that in many cities a very insignificant proportion of the population choose a doctor that they don't know?

Mr. LASKER. I will answer you this way. If we can get back to Sedalia, I think I can answer you now. You know, this took me by surprise. I had not studied up on this. I think I could answer you now.

Senator DONNELL. All right. Go ahead.

Mr. LASKER. Under any system, including the best, certain doctors at some time will always have to turn away people.

Senator DONNELL. I don't know whether that is always true or not.

Senator MURRAY. That is true in barber shops, too, isn't it?

Mr. LASKER. Yes, sir. [Laughter.]

Oh, yes. Well, you must remember that barbers were the original surgeons, so you're not so far off when you make a comparison between the two.

Senator DONNELL. Mr. Lasker, I won't trespass but a moment longer. Referring to the pure-food bill, you are strongly in favor of it today, are you not?

Mr. LASKER. Yes.

Senator DONNELL. And you were strongly opposed to it when it was before Congress for enactment, is that not right?

Mr. LASKER. Yes; but if you are going to ask me what is in the pure-food bill today, I wouldn't be able to answer you.

Senator DONNELL. I did not ask you what is in it.

Mr. LASKER. I plead ignorance.

Senator DONNELL. But as you said in your statement—as I understand your statement—you are today strongly in favor of that bill?

Mr. LASKER. Yes.

Senator DONNELL. That is correct, isn't it?

Mr. LASKER. Yes.

Senator DONNELL. It was favored by the American Medical Association, was it not?

Mr. LASKER. Yes.

Senator DONNELL. And you were strongly opposed to it when it first came up for consideration by Congress?

Mr. LASKER. Well, you know—

Senator DONNELL. Isn't that right?

Mr. LASKER. Well, you know I am not always right.

Senator DONNELL. Is it true that you were strongly opposed to the pure-food bill when it was before Congress?

Mr. LASKER. I was within myself, but I did not do anything about it.

Senator DONNELL. Well, you said in your statement, "I was on the opposite side of the fence on that pure-food bill."

Mr. LASKER. That's right. . . But I did not do anything about it. I did nothing.

Senator DONNELL. But your judgment at that time was that it was a mistake and you were opposed to it; is that correct?

Mr. LASKER. Well, I guess that parts of it looked as if they would affect my interests. I was opposed to them.

Senator DONNELL. The question is, You were opposed to the bill?

Mr. LASKER. That's right.

Senator MURRAY. Was your position the same with respect to the stock brokers in New York?

Mr. LASKER. The point I make is that anyone with a vested interest cannot be objective, and my plea here is that I'm human too.

Senator MURRAY. So the security dealers of the country were very bitterly opposed to the Securities and Exchange Commission when it was first proposed, and now they wouldn't think of having the act that set the Securities and Exchange Commission up repealed, because it is protecting them.

Mr. LASKER. I wrote the sentence about those other bills in my prepared statement because I did not want to seem to criticize any doctors who were opposing this, because I do not criticize them. They are still among the noblest and most self-sacrificing of our people. They practice a priesthood that means much to all of us. I merely believe we can and must help them to multiply their help to us. That is all.

Senator MURRAY. Mr. Lasker, you say that you would like to see a broad public discussion of the problems involved in these bills.

Mr. LASKER. Yes.

Senator MURRAY. Are you familiar with the National Physicians' Committee, which has carried on propaganda against this measure?

Mr. LASKER. Yes; and I want to say that I have also heard that that committee, which is carrying on political propaganda, is tax deductible.

Senator MURRAY. Yes.

Mr. LASKER. Whereas the National Health Committee, to which I plead guilty of contributing, is not tax deductible, and I would like at this hearing to bring out why is not a lay movement entitled to the same privileges as a department of the American Medical Association.

Senator MURRAY. Of course, in reality the deductions of contributions to the National Physicians Committee are not deductible.

Mr. LASKER. I understood they were.

Senator MURRAY. But the management of that organization induced people to contribute to them on the basis that they could make deductions of those contributions, and I believe that doctors all over the country and other people who have contributed to that committee, have wrongfully made those deductions which they should not have made. I believe the committee should have been prosecuted for its misleading advertisement, and for its action in inducing people to violate the law by making contributions and then deducting them from their income-tax reports.

Mr. LASKER. I have made contributions to committees that were subject to the deduction privilege, Senator Murray, or which I thought were. I'd hate to be prosecuted.

Senator MURRAY. I don't mean to prosecute the individuals who make the contributions, but I think those who induced them to do it, who asked them to violate the law, should be prosecuted. They have used that deduction privilege illegally.

Mr. LASKER. Well, don't they have a tax-exemption certificate from the Treasury.

Senator MURRAY. No; they do not.

Mr. LASKER. Oh, I misunderstood. I withdraw the whole thing. Then it is a matter between those who have made the deductions and the Treasury.

Senator MURRAY. Now, you say that you would like to see a broad discussion of this subject in the public press?

Mr. LASKER. Yes.

Senator MURRAY. And you do not approve of the conduct of some who accuse us who sponsor this legislation of being in some manner connected up with Communists and Socialists?

Mr. LASKER. Senator, let me tell you a little story that will give you an illustration of my feeling on that phase of it. I once was playing bridge with a man, and I happened to make a bid that he didn't like. He was my partner at the time. He turned to me, and with great disgust, he said "Fascist."

I am unimpressed by sloganizing. The word "socialistic" can be given to S. 545, and in principle I am for everything, almost everything, that is in S. 545, so then to that extent I am for socialistic medicine. I merely say that there are some areas in which every society has to go socialistic. One is veterans' medicine, another is for the indigent. But I am in favor of having medicine and medical treatment made available to the two-thirds of the producing people who cannot afford it now.

Senator DONNELL. Any questions?

Senator PEPPER. No questions.

Senator MURRAY. No further questions.

Senator DONNELL. We are very appreciative of your attendance here today and your testimony. We hope you will be able to catch your train.

Senator MURRAY. Mr. Chairman.

Senator DONNELL. Yes.

Senator MURRAY. On behalf of the other Senators who have been associated with us on this bill I want to present some statements from them to be put in the record, and also the report that Senator Pepper and I put in last year, as a statement from us.

Senator DONNELL. I understand the statements are from Senator Wagner, of New York; Senator McGrath, of Rhode Island; Senator Taylor, of Idaho; Senator Chavez, of New Mexico; Senator Murray, of Montana; and Senator Pepper, of Florida.

Senator MURRAY. That is correct.

Senator DONNELL. They will be incorporated into the record, and I shall also offer, with your approval, for the record, a release by the Committee for the Nation's Health, Inc., for release Thursday, July 10, 1947, referring to the charges made by Mr. Thurman Arnold, being an exhibit to which I referred earlier in the testimony today.

Senator PEPPER. No objection.

Senator MURRAY. No objection.

(The document referred to follows:)

[For release Thursday, July 10, 1947]

THURMAN ARNOLD CHARGES AMA WITH MONOPOLISTIC PRACTICES

COMMITTEE FOR THE NATION'S HEALTH, INC.,

Washington 1, D. C.

Charging that medical societies "have assumed power over the practice of the profession, licensed by the State, and over the civil rights of American citizens," Thurman Arnold, former Assistant Attorney General, launched an attack on the Taft health bill.

Specifically referring to the health bill now sponsored by Senators Taft, Ball, Smith, and Donnell, the former trust buster declared that in his opinion "this bill would substantially increase the powers and monopolistic control of organized medicine."

He charged that the Taft bill would give "substantial control over the policies for expending Federal funds to officials who would be the creatures of organized medicine. * * *" He told the Committee for the Nation's Health, which is supporting the national-health insurance bill, S. 1320, that in his opinion the Taft bill would increase the "* * * monopolistic powers and tendencies now exercised by these State societies."

Arnold had been asked by the Committee for the Nation's Health for an opinion on the monopolistic implications, if any, of the Taft bill. The full text of the Arnold letter is attached.

(The Committee for the Nation's Health will testify before the Health Subcommittee of the Senate Committee on Labor and Public Welfare on July 10. Spokesmen will be Joseph Louchheim, executive director, and Dr. Michael Davis, chairman of the executive committee.)

Senator MURRAY. Senator Pepper and I have stated our own positions on the basic principles involved in S. 545 and S. 1320 during last year's hearings on S. 1606 and during the hearings before this subcommittee. It is not necessary to repeat them at this point.

We do ask, however, that report No. 5 of the Subcommittee on Health and Education to the Committee on Education and Labor, dated July 1946, be placed in the record of these hearings along with the statements of the cosponsors of S. 1320.

Senator Pepper and I believe it to be the most complete, concise, and accurate presentation of the need for national health insurance and of the inadequacies of current attempts to solve the problem before us.

(The document referred to and the statement of Senators Wagner, McGrath, Taylor, and Chavez follow in succession:)

HEALTH INSURANCE

[Pursuant to S. Res. 62]

REPORT TO THE SENATE COMMITTEE ON EDUCATION AND LABOR FROM THE SUBCOMMITTEE ON HEALTH AND EDUCATION

We have the honor to submit herewith the fifth interim report of the Subcommittee on Health and Education.

The subcommittee's third interim report, issued in January 1945, presented a series of facts showing the gravity of the Nation's health problem. Over 40 percent of the Nation's selectees were found unfit for military duty, and at least a sixth of these had defects which were remediable; many more had preventable defects.

In fact, more than 23,000,000 people in the country have some chronic disease or physical impairment. On any one day, at least 7,000,000 people in the United States are incapacitated by sickness or other disability, half of them for 6 months or more. Illness and accidents cause the average industrial worker to lose about 12 days from production a year, a loss of about 600,000,000 man-days annually. Sickness and accidents cost the Nation at least \$8,000,000,000 a year—half of this amount in wage loss and half in medical costs.

Preventive services are inadequate—40 percent of our counties do not have even a full-time local public health officer. Sanitation needs are great—846,000 rural homes do not have so much as even an outdoor privy. Hospitals are needed—40 percent of our counties, with an aggregate population of 15,000,000, do not have a single recognized general hospital. Doctor shortages are severe—in 1944, 553 counties had less than 1 active physician per 3,000 population, the "danger line," and 81 had no active doctor at all. Even in 1940, before many doctors were drawn off to war, 309 counties had less than 1 active physician for every 3,000 people, and 37 had no active doctor at all. Maternal and child-health services are inadequate—it is estimated that half the maternal and a third of the infant deaths could be prevented if known measures were fully applied. Seventy-five percent of our rural counties have no prenatal or well-baby clinics at all under the supervision of State health departments. State agencies had 15,000 children on their lists awaiting crippled children's care in early 1944. They do not even pretend to care for the half-million children with rheumatic fever (the most killing of all diseases for children between ages 5 and 15) or for the tens of thousands of cerebral palsypa("sstic paralysis") victims.

To meet such problems, the subcommittee recommended Federal action with regard to certain features of a national health program, including Federal grants for hospital and health center construction,

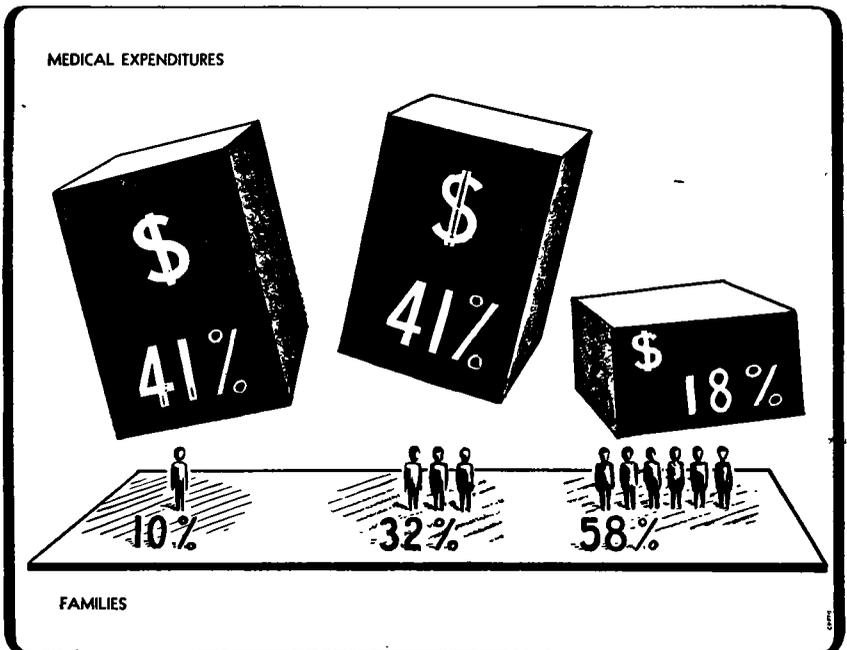
sanitation, public health, medical research, education, and medical care for the needy.

The report also expressed dissatisfaction with the prevailing "pay as you go" or fee-for-service method of payment for medical services but withheld judgment with regard to the claims that voluntary health insurance plans offer a satisfactory solution to the problem. This report summarizes the results of our further study of this subject and sets forth the conclusion we have reached.

THE COSTS OF MEDICAL CARE

The burdens of sickness and of medical care fall unevenly on the people. Illness strikes some families hard, while others may not be

FIGURE 1. THE COSTS OF MEDICAL CARE ARE UNEVENLY DISTRIBUTED



Source: Committee on the Costs of Medical Care.

touched. In any year, 47 percent of the people will have no serious illness at all, 51 percent will be sick one to three times, and 2 percent four or more times. The next year, some new families will be hit, while some of the same families will continue to suffer. The costs of medical care are also subject to wide variation. In any year, a tenth of the population has to bear four-tenths of the total burden of medical expenditures (fig. 1).

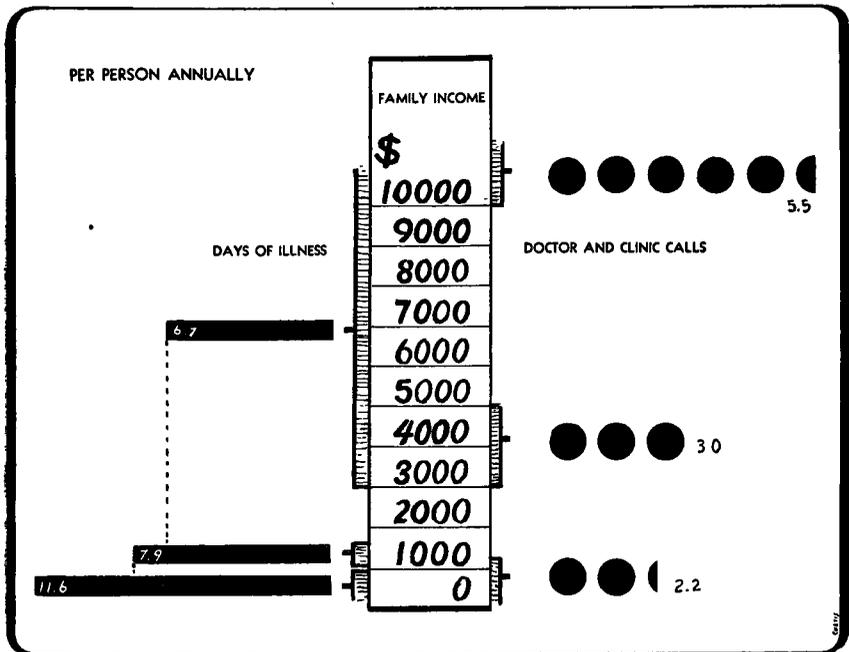
When sickness does hit hard, wage losses and medical costs may wipe out a family's entire savings and drive it into debt. Material in our files indicates that people borrow from small loan companies to meet medical expenses more frequently than for any other single reason. Illness is also the most frequent cause leading people to seek

help through charity except in periods of widespread and long-continued unemployment.

Even on the average, medical care has become increasingly costly. The average family reported an expenditure of \$100, or 4.6 percent of its income, for medical care in 1944.¹ No later national data are available, but a study conducted by the Bureau of Labor Statistics showed that the average medical care expenditure by urban families in 1944 was \$133; rural expenditures are known to be somewhat less.

There is an inverse relationship between the amount of sickness and the amount of medical care received by people in various income groups in our country at the present time. People with low incomes have more sickness and need more medical care, yet they receive less than those in the upper-income groups. (See fig. 2.)

FIGURE 2. THE LOWER THE INCOME, THE MORE SICKNESS AND THE LESS CARE



Index chosen to show amount of sickness is days of disabling illness annually, representing disabilities lasting 7 days or longer in age group 15 to 64. National Health Survey data.

Index chosen to show medical care received is doctor calls per person, including home, office, and clinic calls or visits, health examinations (including immunizations), well-baby clinic visits, and eye refractions per person annually. Committee on the Costs of Medical Care data.

Medical care is still, in the main, received in accordance with ability to pay rather than in accordance with need. It is often argued that this is not so—that no doctor will turn down a patient because he has no money, and that charity beds are available in hospitals for those who cannot afford to pay.

There is a modicum of truth in this. Most doctors spend part of their time giving care free to patients, and most hospitals have some beds for charity patients. But this tells only part of the story.

¹ Spending and Saving of the Nation's Families in Wartime. U. S. Department of Labor, Bull. No. 723, October 1942, p. 20.

Charity does not begin to take care of the need. Decent charity care is usually not available in small towns and rural areas, and even in large cities it is far from satisfactory. Table 1 shows that only a small percentage of those in the very lowest income group in rural areas get any free medical care, though many undoubtedly need it.

TABLE 1.—Percentage of families reporting any free medical care received, 1941

Net family money income	Place of residence		
	Rural farm	Rural nonfarm	Urban
0 to \$449.....	6.9	13.9	17.3
\$500 to \$999.....	8.8	12.4	22.9
\$1,000 to \$1,499.....	3.6	14.0	11.1
\$1,500 to \$1,999.....	4.9	6.8	11.6
\$2,000 to \$2,999.....	6.2	5.8	9.3
Over \$3,000.....	4.9	6.2	8.8
All incomes.....	6.4	11.2	12.5
Number of families answering.....	762	981	1,300

NOTE.—Adapted from data collected by Bureau of Human Nutrition and Home Economics and Bureau of Labor Statistics. Represents percentage of families stating that any family member had received free physician, hospital, clinic, dental, nursing, or eye care, drugs, or medical appliances, in the course of the year. For details of study, see U. S. Department of Agriculture, Miscellaneous Publication No. 520, June 1943.

While it is true that many doctors give their services free, no physician can estimate the number of people who do not come to him when they are in need. Except in emergencies, and sometimes even then, most people would rather do without care than “lower themselves” to ask for charity.

That there are actually a good many disabling illnesses for which no medical care is received and that these instances are most frequent in the lower income groups is shown by the following table:

TABLE 2.—Percentage of disabling illnesses lasting a week or longer for which no doctor care was received

Income group	Percentage of illnesses without doctor care
Under \$1,000.....	22
\$1,000 to \$2,000.....	18
\$2,000 to \$3,000.....	15
\$3,000 to \$5,000.....	13
\$5,000 and over.....	11
All incomes.....	19

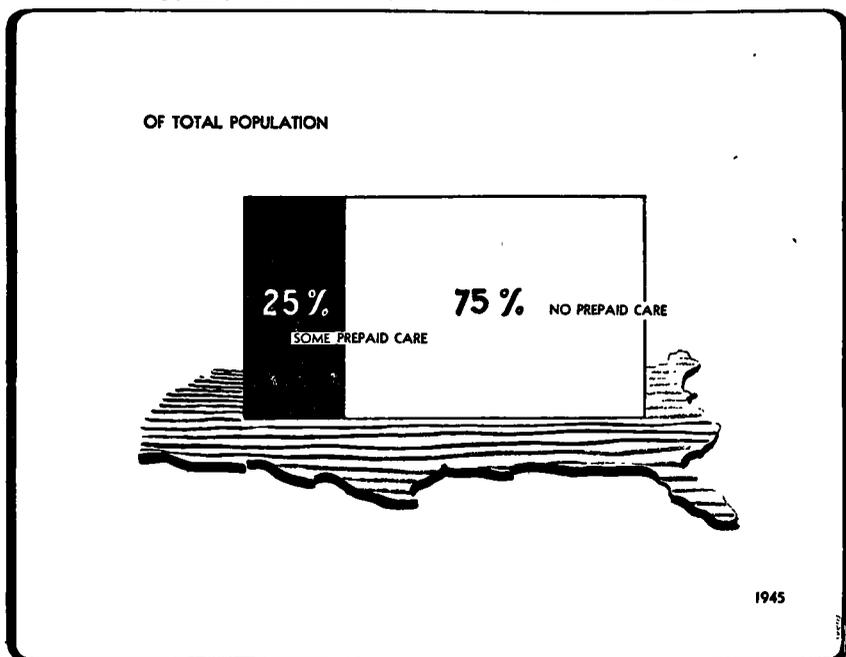
Source: National Health Survey data, 1935.

It was on the basis of facts such as these that the subcommittee voiced the opinion in its Interim Report No. 3 that the current “pay as you go” or fee-for-service system must be replaced by “some form of group financing which would make it possible to share the risks and distribute the costs more evenly.”

PREPAYING FOR MEDICAL SERVICES

The American people have been trying for over a hundred years to insure themselves against the uneven burden of medical care costs. Medical care prepayment plans started in the lumbering, mining, and railroad industries, usually for workers in isolated places, and spread later to the larger cities, particularly to industrial establishments. Disability benefit plans to compensate for loss of earnings during sickness were started at about the same time by fraternal organizations and have also continued to grow. The number of people protected,

FIGURE 3. PRESENT COVERAGE OF VOLUNTARY PLANS



Source: Estimates for 1945. They agree substantially with estimates by the Social Security Board and by Dr. Morris Fishbein, editor of the Journal of the American Medical Association.

however, is still comparatively small in proportion to the need, and the benefits offered are usually limited.

In 1945 approximately 75 percent of the population had no medical care insurance whatsoever, while 25 percent had insurance against one or more items of medical care costs. (See fig. 3.) Only about 2.5 percent of the population, however, are known to have had what might be called "comprehensive" coverage, i. e., at least doctor's care in hospital, home, and office, and hospital service for illnesses other than those usually excluded by insurance policies (such as mental disease and tuberculosis).

Another 10 percent of the population had part of their doctor's fees covered, usually the surgeon's or obstetrician's fees in hospitalized illness only. The other 12.5 percent of insured persons had only their

hospital bill covered, i. e., bed, board, nursing, operating room, laboratory fees, etc., while in the hospital. (See table 3 and fig. 4.) Relatively few people had any coverage of dental, home nursing, or preventive care costs, or regular health examinations. The figures may involve a good deal of overlap.

TABLE 3.—Number of people known to be covered by voluntary health insurance, 1945

Types of coverage	Number (in mil- lions)	Percent of popu- lation (1945) ¹
Comprehensive medical care ²	3.5	2.5
Partial physician or surgeon service (most with hospitalization).....	14.0	10.0
Hospital care only.....	17.5	12.6
Any item covered (physician, surgeon, general hospital, or dentist).....	35.0	25.0
No prepaid medical care.....	105.0	75.0

¹ U. S. Census Bureau estimate, 140,000,000.

² "Comprehensive" is used to mean at least relatively full physician's and surgeon's care in office, home, and hospital and general hospital care.

Principal sources: United States Chamber of Commerce Health Insurance Conference Proceedings, January 1945; Klem, Margaret, Prepayment Medical Care Organizations, Social Security Board Memorandum No. 55, June 1945; the Journal of the American Medical Association, vol. 128, p. 1173, 1945; Blue Cross Bulletin, vol. 8, No. 5, May 1945; letters to subcommittee from medical care insurance experts.

The 25 percent of the population with some kind of coverage subscribed to three main types of plans: Nonprofit hospitalization (Blue Cross), prepayment medical care organizations (sponsored by industry, medical societies, consumer organizations, private physicians' groups, or Government), and commercial health and accident insurance plans. (See fig. 5.)

WHAT THEY GET

More detailed data are available for the approximately 5,000,000 members of various kinds of prepayment medical care organizations. Table 4 indicates that the type of medical service offered varies considerably with the different types of organization. In general, the medical-society-sponsored plans, excluding those in the States of Washington and Oregon,² tend to offer more restricted services. Government-sponsored, industrial, private group, and consumer-sponsored plans tend to be more comprehensive.

SERVICE AND CASH

Medical care insurance is of two types—service and indemnity. The service type assures stipulated kinds of medical care, such as physician's, surgeon's, or hospital service, to the patient. The indemnity type pays the subscriber specified amounts of cash toward expenses incurred during illness or accident—so much for a particular operation, hospital stay, or day of disabling illness. In the case of the indemnity type the practitioner or hospital may or may not charge more than the amount of the cash benefit, and the patient may or may not use the money to pay his medical bills. Although the

¹ These plans differ from other medical society plans in their historical origins and relationships with the American Medical Association. They are listed separately by both the Social Security Board and the American Medical Association.

FIGURE 4. THE TWENTY-FIVE PERCENT: TYPE OF SERVICES RECEIVED

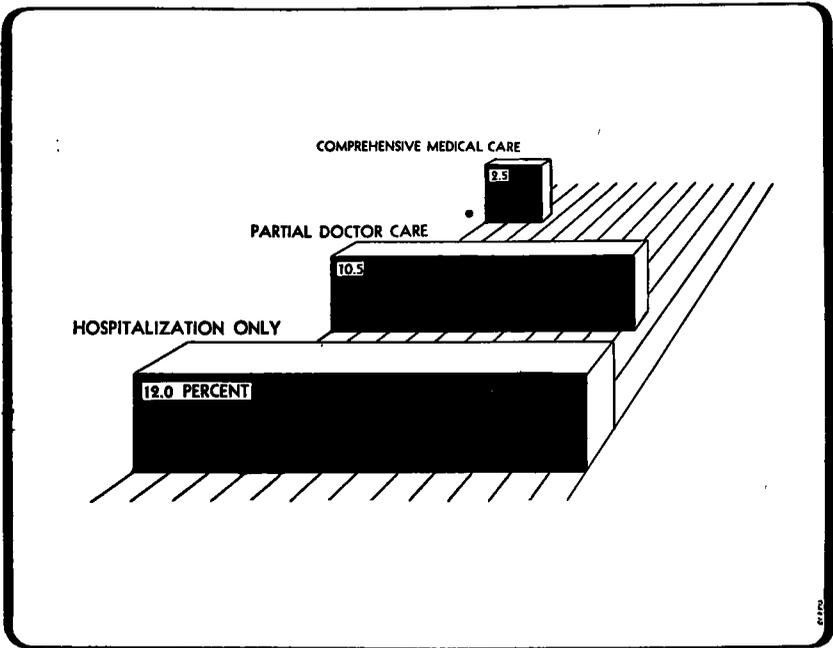
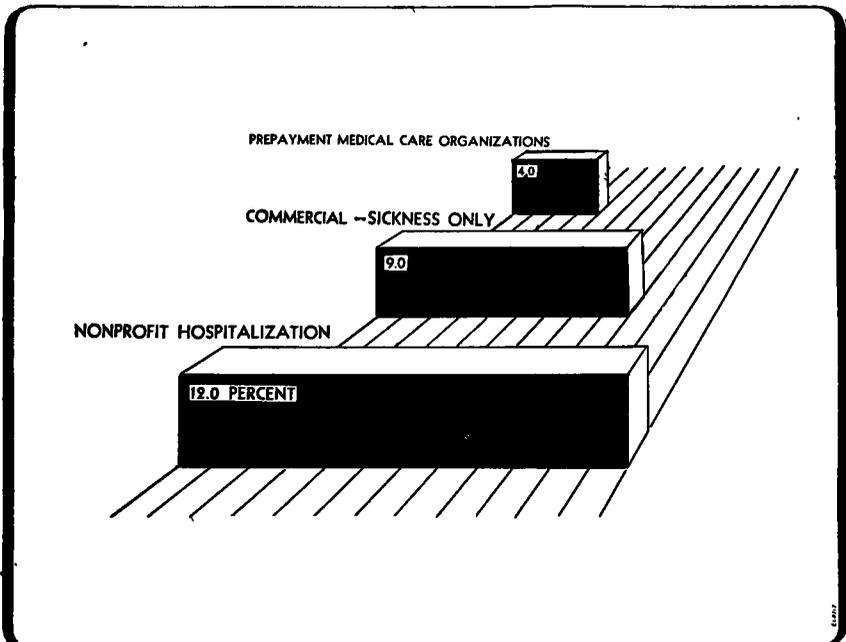


FIGURE 5. THE TWENTY-FIVE PERCENT: TYPE OF PLAN



Sources: Same as for table 3 and fig. 4.

indemnity type of insurance is common, it affords a less satisfactory type of protection from the health standpoint than do the service plans. It is not designed to guarantee medical service, especially for minor illness and prevention, but to fulfill certain economic functions. These are (1) replacement of wage loss, and (2) reimbursement for part or all of the expenses incurred during major disabling illnesses. The indemnity and service plans should be carefully differentiated; the latter is more accurately termed "medical care insurance" than the former.

TABLE 4.—Number of persons eligible for care under prepayment medical-care organizations and percent eligible for specified services, by type of organization, 1945

Type of organization	Number of persons eligible for care	Percentage distribution of persons eligible for physicians' services				Percent of persons eligible for—		
		Medical or surgical care in home, office, and in hospital	In home and office only	In hospital only		Hospitalization	Some type of dental service	Special-duty or visiting-nurse service, or both
				Medical and surgical cases	Surgical cases only			
Total.....	4,975,850	60.8	4.1	10.7	22.9	66.3	30.4	44.2
Industrial:								
Financed by employer.....	212,590	83.2	3.9	-----	12.9	95.4	30.4	45.6
Financed jointly by employer and employee.....	546,772	92.1	6.7	.1	1.1	88.5	77.9	70.9
Financed by employee.....	752,786	84.8	2.0	1.0	2.5	97.4	44.3	76.7
Medical society:								
Washington and Oregon.....	954,100	100.0	-----	-----	-----	100.0	29.1	84.6
Other States.....	1,640,256	7.9	-----	26.7	66.3	13.3	-----	-----
Private group clinic.....	406,353	80.7	-----	19.3	-----	92.3	57.1	39.6
Consumer-sponsored								
Financed partly by Department of Agriculture.....	23,553	100.0	-----	-----	-----	100.0	100.0	-----
Other.....	326,561	52.4	44.1	3.2	.3	59.4	12.6	9.6
Governmental:								
War Food Administration and cooperating agencies.....	97,300	100.0	-----	-----	-----	100.0	100.0	100.0
Other.....	15,602	100.0	-----	-----	-----	100.0	100.0	1.2

Source: Adapted from data in Klem, Margaret, Prepayment Medical Care Organizations; Social Security Board, Bureau Memorandum No. 55, third edition, June 1945.

BLUE CROSS

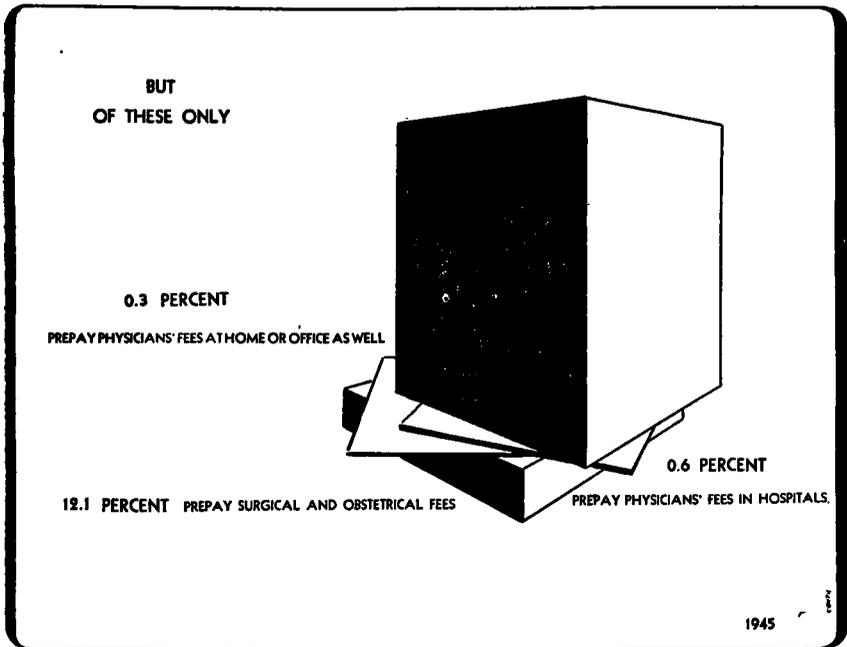
The largest of all voluntary health insurance organizations is the Blue Cross system. By October 1945, 18,400,000 people were reported to be covered by this type of plan.

The Blue Cross plans are semiautonomous nonprofit hospital service plans approved by the American Hospital Association. They cover the expenses that are ordinarily included in the general hospital bill (bed, board, operating room, ordinary hospital drugs, and nursing service) for a specified period of hospitalized illness, usually for 21 to 30 days. Partial payment for 60 days additional is common. Enrollment is mainly by employed groups. The cost for a family of four is usually about \$24 a year which may be partly or completely borne by the employer.

Of the total of 16,000,000 Blue Cross members in 1944, 13,400,000 had only their hospital bill covered. Some 2,000,000 also had their surgeon's and obstetrician's fees provided. About 100,000 had physician's care in hospitalized illness covered. Only 50,000 were entitled to physician's care in home and office as well as in the hospital. (See fig. 6.)

It should be noted that these plans usually cover only the hospital bill and do not cover doctor's or dentist's bills, home nursing, or other types of medical service. Hospital expenses comprise about one-seventh of all medical care costs, while physicians' and surgeons'

FIGURE 6. ALL BLUE CROSS MEMBERS GET HOSPITALIZATION



Source: Letter from director, Hospital Service Plan Commission, American Hospital Association, January, 1945.

services account for about three times as much. Important as these plans are to those having hospital expenses, which tend to be large when they are incurred, they do not cover most medical care, preventive or therapeutic.

MEDICAL CARE PREPAYMENT PLANS

A much smaller number of people have insurance for doctors' services. Physicians' and surgeons' services take 40 percent of the average medical dollar and are the most important single item in all medical care. It is early, high-quality doctor's care in home and office that the average person needs most, but current prepayment plans handle such service most inadequately.

The various types of medical care prepayment plans differ widely in the services they offer. (See fig. 7, pp. 14-15.)

GROUP PRACTICE PLANS

Most of the plans offering comprehensive prepaid medical care are group practice plans, sponsored by industrial firms, consumers, or physicians. In general, they offer services to groups of employed individuals and sometimes to their families. The doctors are usually on salary, full-time or part-time, and the service is given mainly in clinics rather than in the individual doctor's office or in the patient's home. The cost ranges from \$12 to \$36 a year per person and from \$36 to \$100 or more for a family of four. A typical cost is \$24 a year per person.

Certain data concerning a few of these plans are shown in table 5.

TABLE 5.—*Examples of group practice prepayment medical care plans which provide comprehensive service*

Name plan	Number of people covered	Number of doctors		Number of registered nurses employed	Charges per year	
		Full time	Part time		Individual	Family of 4
1. Ross-Loos Medical Group, Los Angeles, Calif.	26,890	92	0	101	\$30.00	(1)
2. Stanacola Employees Medical and Hospital Association, Baton Rouge, La.	19,200	8	3	1	\$36.00	\$36.00
3. Farmers' Union Hospital Association, Community Hospital, Elk City, Okla.	9,381	4	0	4	\$12.00	\$25.00
4. Group Health Association, Washington, D. C.	8,522	6	9	9	\$27.00	\$84.00
5. Trinity Hospital, Little Rock, Ark.	4,554	6	0	25	24.00	86.00
6. Endicott-Johnson Corp., Workers Medical and Relief Department, Johnson, N. Y.	42,000	12	15	30	\$48.00	\$90.00
7. Southern Permanente Foundation, Kaiser Co., Fontana Calif.	4,900	7	2	20	31.20	93.60

¹ Reduced fees for individual services to dependents; 73,000 dependents covered.

² Initial membership fee of \$20. Special assessments up to \$9 in any one year.

³ Initial membership fee of \$50. Extra charges; e. g., for home calls and hospitalization.

⁴ Initial membership fee of \$12. Certain extra charges.

⁵ Company pays all. Figures refer to cost to company in 1941. Includes sickness disability payments of \$12 per week for employee.

Principal source: Klem, Margaret, Prepayment Medical Care Organizations, Social Security Board Memorandum No. 55, third edition, June 1945; information as of 1945.

Forty percent of all members of prepayment medical care organizations obtain care through group practice. Over half of these, or 1.3 million people, are members of industrial type plans; the others are members of private group clinics or consumer sponsored plans.

In order to illustrate concretely what such plans offer, a summary description of one of the best-known plans is shown in table 6.

TABLE 6.—*Ross-Loos medical group (Los Angeles, Calif.)—Private group clinic*

COST		METHOD OF PRACTICE	
Individual:	Group, \$30 a year. Nongroup, \$36 a year.		
Family:	Reduced fees.		
Group, full time.		REQUIREMENTS	
Age and physical examination requirements if not in group.	(No income requirements.)		

TABLE 6.—*Ross-Loos medical group (Los Angeles, Calif.)—Private group clinic—Continued*

NUMBER OF PARTICIPANTS	
26,890 subscribers.	
73,000 dependents.	
PERSONNEL	
92 full-time doctors.	
101 registered nurses.	
SERVICES INCLUDED	
1. Medical care:	
General practitioner and specialist in clinic, home, hospital.	
Surgery.	
Maternity.	
2. Hospitalization, up to 90 days in any one year except for maternity.	
3. Preventive services and routine diagnostic procedures.	
SERVICES NOT INCLUDED OR INVOLVING EXTRA CHARGES	
1. Dental care.	
2. Services obtainable from public programs (tuberculosis, mental, workmen's compensation).	
3. Home nursing.	
4. Drugs and appliances.	

The number and membership of group practice prepayment plans are increasing gradually. Their popularity is rising among doctors, especially younger ones, as well as among the public. A poll of medical officers in the armed forces, sponsored by the American Medical Association showed that 53 percent of the doctors replying wanted to enter private group practice after their discharge.³ This popularity is undoubtedly based on sound reasons. There is evidence, both qualitative and quantitative, that well-organized group practice can offer better medical care than individual practice. The best utilization of specialists' knowledge and skills, of auxiliary personnel, and of complex modern laboratory facilities can be achieved through group practice. The cost of high-quality care under group practice seems to be considerably less than under individual practice. (See p. 13.)

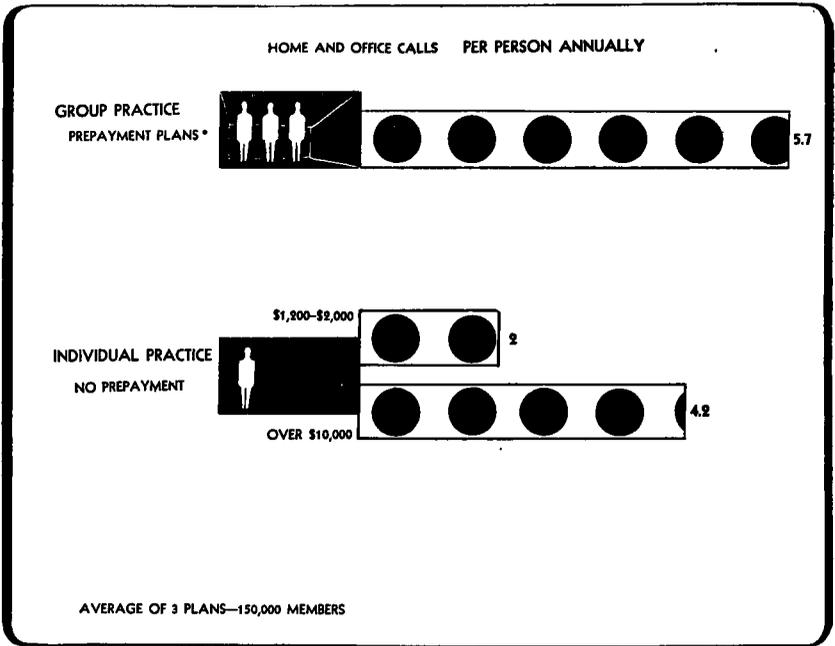
Study of the amount of medical care received by members of group practice plans indicates that they receive more service, on the average, than recipients of individual, fee-for-service care. A comparison of the services received by subscribers to three typical group practice plans having a total membership of 150,000 with a control group of similar size who received care on an individual practice basis appears to illustrate this point well. The control group lived in communities of similar geographic location, population, and per capita income. (See fig. 8.)

MEDICAL SOCIETY-SPONSORED PLANS

A more recent type of medical care prepayment plan is that sponsored by State or county medical societies. Until about 1939 almost all medical societies opposed prepayment plans, actively or passively. Many have now begun to offer plans covering certain limited types of services, which are usually confined to surgical care during so-called catastrophic (i. e., hospitalized) illness and to maternity service after a waiting period of about 9 months.

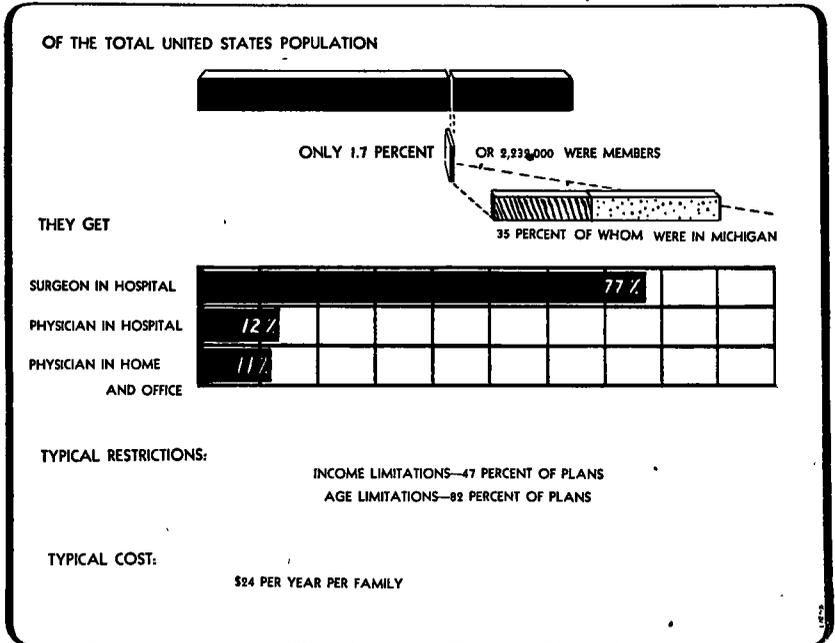
³ Based on data in *Journal of the American Medical Association*, vol. 125, p. 558, 1944.

FIGURE 8. MEDICAL SERVICES RECEIVED



The three plans were selected because their membership (with their families) comprised more or less a cross section of an employed population. See *The Experimental Health Plans of the United States* Department of Agriculture, Subcommittee Monograph I, January 1946, p. 33.

FIGURE 9. MEDICAL SOCIETY PLANS, 1945



Source: *The Journal of the American Medical Association*, vol. 124, p. 371, 1944; vol. 128, p. 1173, 1945

The typical cost for a family of four ranges from \$18 to \$36 a year. This is usually purchased together with Blue Cross hospitalization. Thus, for a total of about \$50 annually a family eligible to join may be assured relatively complete medical service for hospitalized illness during the period of hospitalization.

Data concerning some of the largest medical society plans are shown in table 7. Most medical society plans have group-enrollment and income-limit requirements.

When such plans were first started, several State medical societies (e. g., in Michigan, California, and New Jersey) offered comprehensive medical care coverage, including home and office service. However, all have withdrawn such contracts or are doing so now. Why is it that the group-practice prepayment plans are usually able to offer comprehensive medical service, whereas the medical society plans are not?

One reason is undoubtedly the difference in cost of furnishing services under the two types of plans. All the medical society plans pay individual doctor's fees for each service rendered, and none have any but the loosest professional organization and supervision. On the other hand, the doctors in the group-practice plans are on full- or part-time salary, under more or less integrated professional organization and supervision. It is interesting to note the estimates by two experts of the costs of comprehensive medical care under conditions of group practice and individual fee-for-service practice.

Whatever the explanation, the fact remains that almost no medical society plans offer comprehensive care. They do not cover the numerous illnesses that confine a patient to his home or take him to a doctor's office but are limited to hospitalized illness.⁴ The result is that they cannot possibly offer the member all needed preventive, diagnostic, and therapeutic services, i. e., complete high-quality medical care.

COMMERCIAL PLANS

Commercial health and accident insurance policies are of two main types—those with group and those with individual enrollment.

According to estimates of the companies, group commercial insurance covered about 8,000,000 people in 1944.⁵ Of these, over six million had hospitalization policies. Five of the eight million had surgical policies as well. Members are paid specified amounts of cash toward their expenses for different kinds of operations or toward their hospital bills. Some have, in addition, policies which pay specified amounts of cash during disabling illness. An illustration of the group type of plan is given in table 9.

No accurate information is available concerning the number of people covered by individual commercial health and accident policies.⁶ They vary widely, and generalizations are difficult to make concerning

⁴ The Washington and Oregon plans do not fit this and certain other generalizations true of other medical society plans. With the exception of maternity care, plans in these two States do provide comprehensive doctor and hospital service.

⁵ See E. Millman, Social Security in the United States. Proceedings of United States Chamber of Commerce Conference on Health Insurance, January 1945.

⁶ According to a national health and accident underwriters organization, 40,000,000 people were covered under group and individual policies for "substantial health benefits" in 1944. The validity of this is open to serious question. If the 8,000,000 people with group disability insurance are subtracted, this would leave 32,000,000 people with individual health and accident policies. Such policyholders received, in the aggregate, \$104,000,000 as benefits in 1944. Thus, the average benefit received by the policyholder could not have exceeded \$3.25. Of this the lion's share went to pay wage loss from disability; less than a fifth was paid as indemnity for any kind of medical service. This can certainly not have provided very "substantial health benefits"; the average individual's costs for sickness and wage loss comes to around \$60 annually. The benefits usually cover only a relatively small percent of the insured person's sickness costs.

TABLE 7.—*Examples of medical society plans—Descriptions in terms of family of 4*

Name	Year begun	Number of people covered (subscriber and dependents)	Requirements	Benefits	Cost to family of 4
Michigan Medical Service: Surgical benefit plan.	1940	777, 104	Group enrollment only; minimum number, 10; minimum percent of total group, 75; extra charges if income is over \$2,500 per year.	Surgery in office, home, and hospital; maternity care after 9 months' membership.	\$27. 00
California Physicians' Service: State-wide surgical plan.	1939	123, 000	Group enrollment; children under 1 month and over 19 years excluded; additional charges if income is over \$3,000 per year.	Surgical care; includes Caesarean sections and care for ectopic pregnancy.	36. 00
Colorado Medical Service: Surgical plan.	1942	65, 702	Group enrollment; children under 1 month and persons over 60 years not eligible. Additional charges if income is over \$2,400 per year for family of 4.	Surgical care in home, office, hospital; maternity care after 1 year membership.	24. 00
Delaware Medical Care Plan.....	1943	56, 341	Group enrollment; children under 1 month and over 18 years not eligible; maternity benefit, \$50; tonsillectomy after 1 year.	Surgery and 2 weeks aftercare up to \$150 in any one illness.	19. 80
Massachusetts Medical Service.....	1943	114, 656	Group enrollment; dependent children over 19 or married excluded; additional charges if income over \$2,500 a year.	Care for hospitalized illness; surgical benefits within specified limits; maternity care, 40 percent of cost after 9 months.	24. 00

NOTE.—Information relates to middle of 1945. Source: Same as fig. 9.

them. In general, they pay the insured person specified amounts of cash for disability due to accidents and, sometimes, sickness. The total premiums paid for individual accident and sickness insurance policies in 1944 amounted to some \$260,000,000.⁷ About 88 percent of the individual policy premiums were for accident and 12 percent for sickness policies.⁸ The sickness policies, in the vast majority of cases, pay specified amounts of cash toward hospital, surgical, and nursing expenses. They do not usually cover nonhospitalized illness causing less than 2 weeks' complete disability, nor do they provide regular health examinations or preventive services. They tend to have high "expense loadings," or administrative and promotional costs. Thus, only about 40 percent of all receipts from individual sickness and accident policyholders was paid out in 1943 as benefits to policyholders.⁸ Total benefit payments by individual health and accident companies amounted to 1.3 percent of the total national medical and wage loss bill in 1943.

TABLE 8.—Estimated annual cost of complete medical care for family of 4 under voluntary insurance

Type of practice	Without dental care	With dental care
Group practice, salary.....	\$103	\$147
Individual practice, fee for service.....	303	352

NOTE.—Based on data in S. Bradbury, *The Cost of Adequate Medical Care*, University of Chicago Press, 1937, and Michael M. Davis, *America Organizes Medicine*, 1941. Estimates for group practice from experience. Those for individual, fee-for-service practice derived by applying number of services needed to medical society standard fee schedule (used in workmen's compensation cases, etc.).

TABLE 9.—*Republic Aircraft Products group insurance plan (Travelers Insurance Co., Hartford, Conn.)*

[Commercial indemnity, group insurance type]

COST

Individual: \$36.60 a year.
 Family: Not eligible.

TYPE OF PRACTICE

Immaterial. Patient pays bills as usual.

REQUIREMENTS

Group enrollment, 75 percent of employees necessary.
 Pay-roll deduction.
 Employees only.
 No age, income, or physical restriction listed. There is a pre-employment physical examination.

BENEFITS—CASH INDEMNITY

1. Hospital expense: \$5 a day up to 31 days in any one illness, plus \$25 in any period of hospitalization for hospital "extra charges" such as operating room, anesthesia, X-rays, etc.
2. Surgical fee reimbursement up to \$150, according to standard fee schedules as listed.
3. Maternity indemnity up to \$5 a day for a maximum of 14 days for hospitalization in childbirth or miscarriage.
4. Sickness and accident indemnity of \$15 a week up to 13 weeks after fourth day of sickness disability and first day of accident disability.
5. Life insurance: \$1,500.
6. Accidental death or dismemberment: Up to \$150.

⁷ Insurance Economics Society of America leaflet, 1945.

⁸ Spectator Insurance Yearbook Reporting Service: Premium Losses, by States, of Casualty, Surety, and Miscellaneous Lines in 1943, p. 226, 1944.

TABLE 9.—*Republic Aircraft Products group insurance plan (Travelers Insurance Co., Hartford, Conn.)—Continued*

NOT INCLUDED

1. Medical care other than as specified above.
2. Full hospital care other than as specified above.
3. Maternity care other than as specified above.
4. Dental care unless surgical.
5. Routine preventive and diagnostic procedures.
6. Drugs and appliances.
7. Home nursing.
8. Services ordinarily obtainable from governmental agencies.

Source: Company booklet.

Table 10 summarizes the provisions of a common type of individual sickness policy. No claim is made that this is "the" typical policy. Variations in policies of this kind are so great that it would be impossible to pick any one as typical.

TABLE 10.—*Individual health policy (specimen)—Commercial indemnity, individual type*

COST ¹
Individual:
Men, \$65 annually.
Women, \$90 to \$180, depending on occupation.
TYPE OF PRACTICE
Immaterial. Patient pays bills as usual.
REQUIREMENTS
Benefits begin only after first 14 days of any period of disability. Disability due to accidents excluded.
BENEFITS—CASH INDEMNITY
1. Total disability: \$50 a week for up to 52 consecutive weeks in event of continuous complete disability, after waiting period of 2 weeks.
2. Hospital and/or nursing: \$25 a week up to 20 weeks in event of hospitalization or necessary attention by graduate nurse.
3. Surgical. Up to \$200 according to set fee schedule for operations.
Services not indemnified (other than as specified above):
1. Physician.
2. Maternity.
3. Dental.
4. Routine preventive and diagnostic services.
5. Drugs and appliances.
6. Services provided by government.

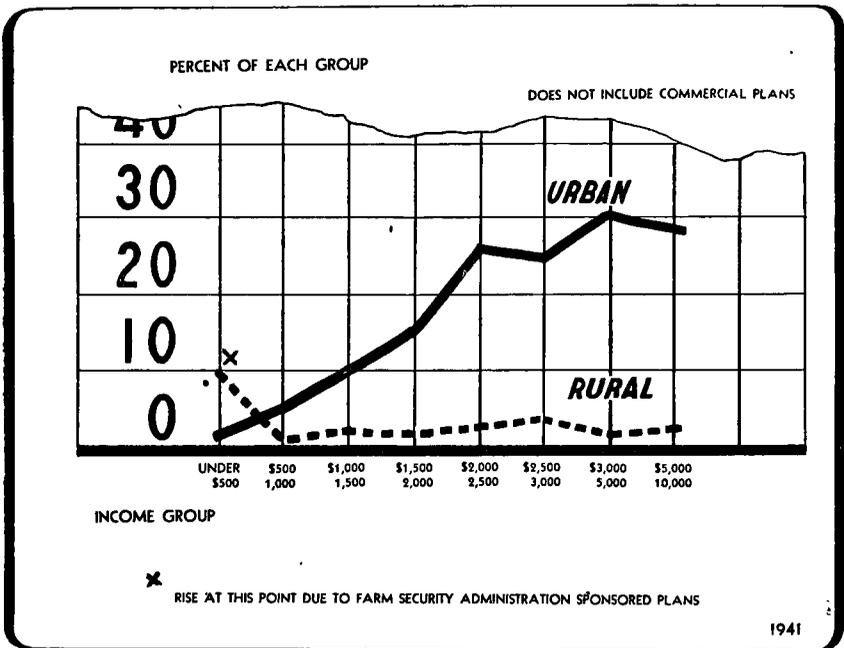
¹ Depends on weekly indemnity. Rates given here are for \$50 per week, a common type written. They are quoted by underwriters at multiples of \$5 per weekly indemnity; those given above are for 10 times the base rate. Premiums given are for age group 18-49. Extra charges are made for age group 50-54, age 55 and over excluded.

SHORTCOMINGS OF VOLUNTARY MEDICAL-CARE INSURANCE

Voluntary medical care insurance plans have run into numerous difficulties, and many have failed. As has been shown, only a small part of the population has any form of medical care insurance. The number of people eligible for medical care in prepayment medical-care organizations increased from 3,300,000 in 1943 to 4,980,000 in 1945, but most of this increase was in plans covering only "catastrophic illness."

Those who do belong to health insurance plans seem to be predominantly from the middle-income, urban part of the population. The last available break-down shows that while approximately 30 percent of the urban people in the most prosperous category had some form of prepaid medical or hospital care insurance, the proportion fell off rapidly as income decreased and membership was reduced nearly to the vanishing point among the low-income groups. Among rural people the situation was even less favorable; regardless of what the income level was, almost no one had any medical or hospital care insurance. Indeed, the highest proportion of coverage among rural people was in the very lowest income group, a phenomenon that is accounted for by the medical and hospital prepayment plans sponsored by the Farm Security Administration. (See fig. 10.)

FIGURE 10. WHO BUYS PREPAYMENT



Figures are for 1941 and refer to nonprofit prepayment plans, including group hospitalization plans, but excluding commercial health and accident insurance policies. The hump in the lowest income rural families is due to membership in Farm Security Administration sponsored prepayment plans. Adapted from G. Angle and J. Pennock, What Families Spend for Medical Care. United States Department of Agriculture, April 1944.

Since the time the data on which figure 10 is based were collected, the Blue Cross hospitalization plans have increased their rural membership somewhat to include at most 750,000 farm people. This is still less than 3 percent of the farm population. Prepayment plans which include medical care among the benefits have increased little, if any, in the rural parts of the country. Blue Cross has also increased its enrollment of employed industrial workers and their families since the time the survey was made.

Lack of money is not the only reason why more people do not belong to prepayment plans. The fact that enrollment is voluntary

means that a person may choose not to join, even if he can afford to do so. Experience shows that a substantial segment of the population believes that, regardless of the plans' merits, they do not need them.

A poll in Rochester, N. Y., showed that the two main reasons given for not having hospital insurance were: "Can't afford it" and "Don't need it." (See fig. 11.) These results are especially significant, because Rochester has a much larger proportion of its population covered by hospital insurance than most cities.

The question of how much people can actually afford to pay for medical-care insurance is, of course, a complex one. It is well to point out, however, that even in the prosperous year 1942, one-half the families in the United States had incomes of less than \$2,000. In that year such families spent an average of \$58, or somewhat over five percent of their income, for medical care. If we assume that they cannot pay more, it becomes clear that most of them cannot afford membership in existing medical-care prepayment plans which provide anything like comprehensive service. Membership in the limited-benefit plans is also out of the question as far as most of these people are concerned.

Employer contributions to some prepayment medical-care plans do, of course, ease the burden on such families, but they are not always forthcoming.

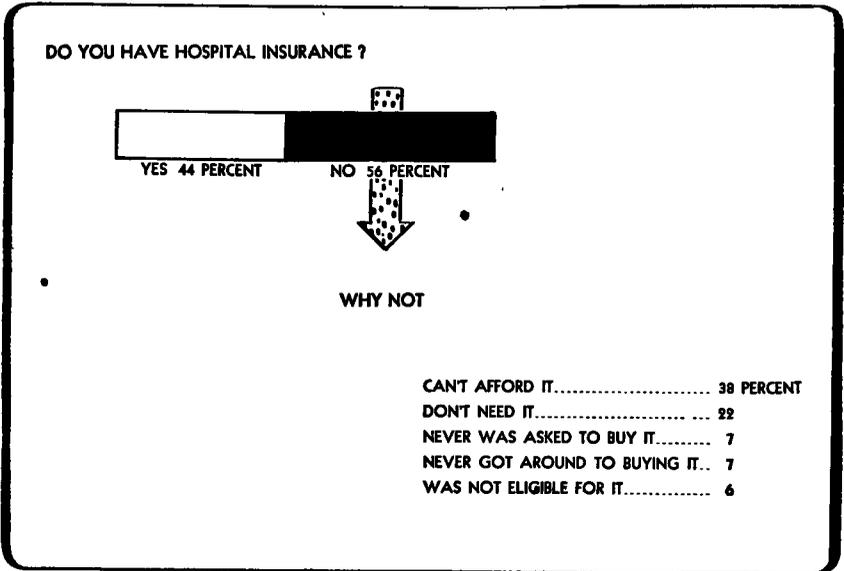
Turn-over of membership in voluntary plans is another serious shortcoming. Even the Blue Cross plans, which minimize this factor through such techniques as group enrollment, have a 25-percent annual turn-over in membership. Other types of plans have even greater difficulty in maintaining a stable membership. It is not uncommon to hear a person say, "We didn't have sickness in our family last year, so why should we join again?" The result is that the healthiest members tend to drop out, while the ones who are most often sick tend to stay in. As this process continues, the plan is required to pay out an increasing proportion of its funds for medical services, and eventually it may find itself approaching insolvency. The only remedy then is to increase the charge to members or reduce the benefits to which they are entitled. This has been the experience of several of the plans sponsored by medical societies; for example, those in Michigan, California, and New Jersey.

This characteristic feature of voluntary plans is illustrated in striking, if extreme, fashion by a study of membership turn-over in a Government-sponsored voluntary plan for low-income farmers in rural Ohio. (See fig. 13.)

After 3 years of operation only 24 percent of the original membership still belonged to the plan. The families who remained used the plan most, while those families which used it least tended to drop out.

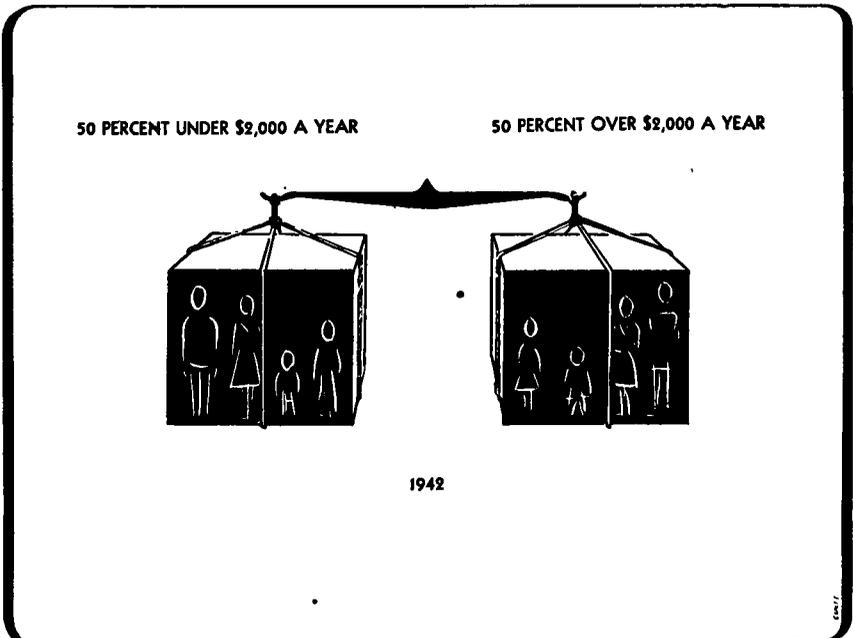
In the industrial plans, maintenance of membership is, of course, dependent upon continued employment. Even in normal or boom times this is a decided disadvantage, and in a period of depression protection is lost by a substantial proportion of the members at the very time when their need is greatest. In this connection it is interesting to consider the experience of the Permanente Foundation plans sponsored by the Kaiser Shipbuilding Co. on the west coast. At the peak of the war-production period, 76,000 of the 90,000 Kaiser employees belonged to one of the plans. By November 1945, however, when employment had fallen, only 7,500 shipyard members

FIGURE 11. HOSPITAL INSURANCE POLL, ROCHESTER, N. Y.



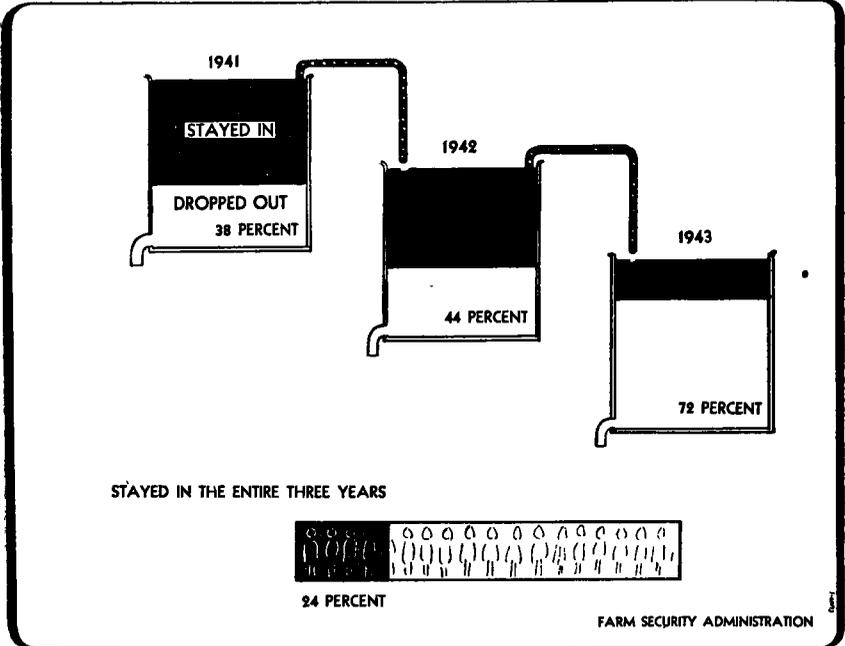
Source: W. Smillie, A Survey of the Facilities for the Care of the Sick of Rochester, N. Y., conducted for the survey committee of the Rochester Community Chest, Inc., 1941, p. 109.

FIGURE 12. AMERICAN FAMILY INCOMES



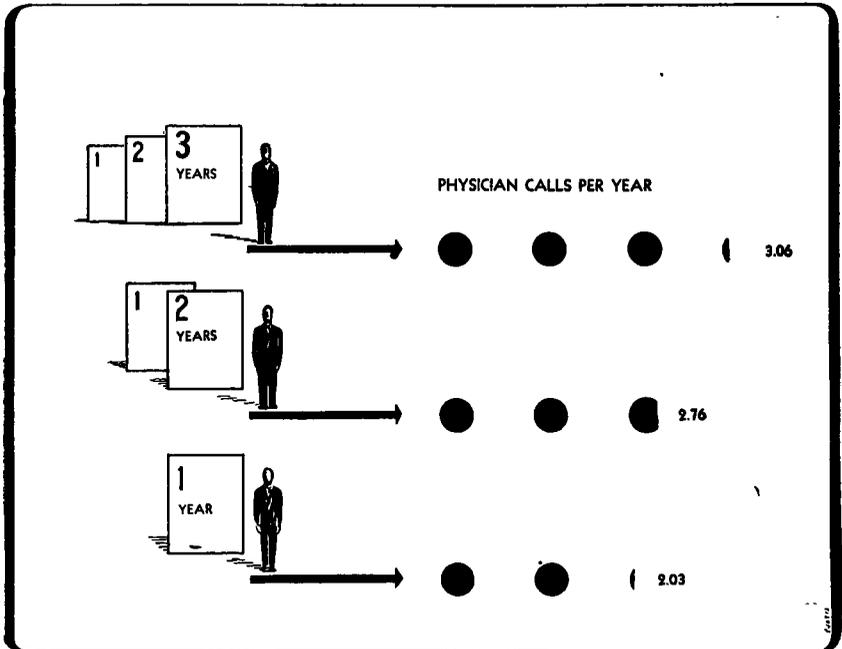
Source: Office of Price Administration.

FIGURE 13. TURN-OVER IN A VOLUNTARY MEDICAL CARE PLAN, RURAL OHIO



Source: McNamara, R. L., and Mangus, A. R., Prepayment Medical Care Plans for Low Income Farmers in Ohio. Agricultural Experiment Station, Worcester, Ohio, Bull. No. 653, October 1944, pp. 20-22.

FIGURE 14. THOSE WHO USED THE PLAN MOST REMAINED MEMBERS



Source: Same as fig. 13.

remained. Other groups in the community are now being added in an attempt to replace this loss.

In order to safeguard themselves against a preponderance of "poor risks," almost all voluntary plans have had to lay down rather rigid requirements for enrollment. The main requirement is usually group membership. This helps to obtain a "favorable selection," i. e., a substantial proportion of healthy people who will use the plan less. But it also rules out many people who do not belong to an eligible group.

"Adverse risks," such as the very young, the very old, and those with pre-existing physical handicaps, are usually excluded from voluntary plans. Many plans will accept members only from among those with incomes below a specified limit.

Other major disadvantages of voluntary medical care prepayment plans are: Spotty geographical coverage, a tendency toward high administrative and promotional costs (most marked in the commercial plans), unsuitability to the needs of an increasingly migrant population, and (with some exceptions) lack of consumer representation in policy making and management.

The result of all these limiting circumstances is that many people, even though they might desire it, are not able to procure even the limited type of protection offered by most voluntary plans.

There is much discussion about a national system of voluntary health insurance. It would seem from the foregoing that this is a contradiction in terms. No voluntary health insurance network can be national in the sense of reaching all communities and all people; conversely, no truly national system can be voluntary. To seek such a system appears to us to be chasing a rainbow.

TAX-ASSISTED VOLUNTARY HEALTH INSURANCE PLANS

Since it appears obvious that a large part of the population cannot afford to purchase comprehensive medical care through voluntary prepayment plans, it might be considered that tax assistance to such plans would afford a solution to the problem. The subcommittee has recently published a study⁹ of tax-assisted voluntary health insurance plans sponsored by the Department of Agriculture in six rural counties. We have been interested in the lessons of this study. While the tax assistance helped considerably, these plans also remained subject to what are the apparently inherent defects of voluntary health insurance.

Each plan took the form of a voluntary health association open to all farmers in the county. They offered relatively complete doctor, dentist, and hospital care, on a prepayment basis, within the limits of availability and quality prevailing in these counties. Although the total cost of the services averaged \$45 a year per family, Government subsidy reduced the family charge to \$20 annually (1943-44). The minimum family payment averaged \$13 a year in the six plans. Despite these low charges, only 40 percent of those eligible to belong actually joined. (See fig. 15.)

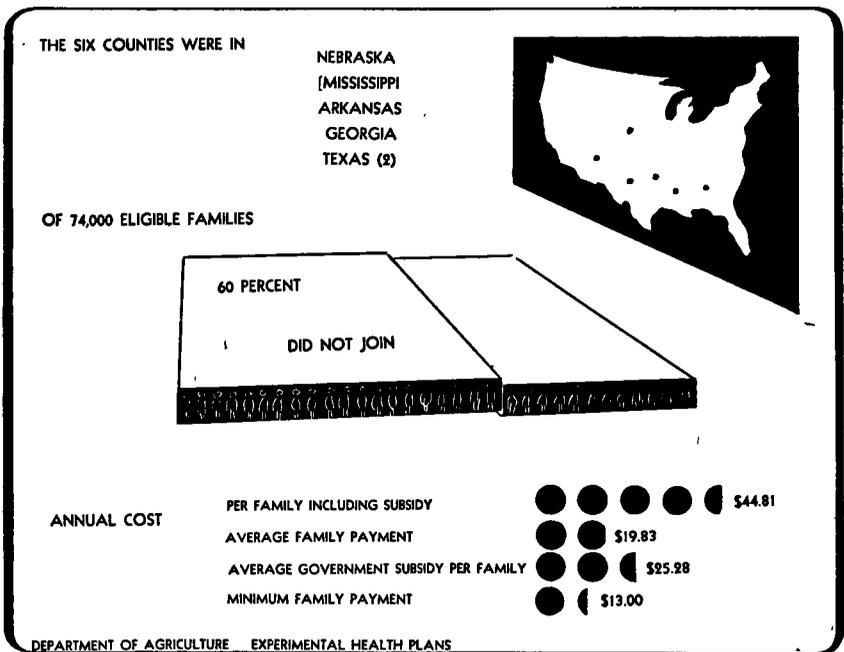
Some of the reasons for failure to maintain membership after joining the plans are indicated by a public opinion sample taken in one of the

⁹ The Experimental Health Program of the United States Department of Agriculture; a study made for the Subcommittee on Wartime Health of the Committee on Education and Labor, January, 1946.

counties. (See table 11.) Economic reasons ranked first. This might seem strange in view of the low cost of the plans to the farmers. The average family annual net cash income of association members, however, was only \$162 in 1942. (See table 12.) The county was a relatively poor one, with a "level of living index" of 82 on a "par" basis of 100, but there are many counties like it in the United States.

Neglect or disinterest was another major reason given by families for not retaining membership. There was almost no active antagonism to the plan, and a negligible percentage gave a dislike of Government help as their reason for leaving (or not joining). Yet this was in Texas, where a particularly rugged brand of individualism is supposed to prevail.

FIGURE 15. HOW TAX-SUBSIDIZED VOLUNTARY HEALTH INSURANCE WORKED IN SIX RURAL COUNTIES



Sources: Farm Security Administration and Bureau of Agricultural Economics. All figures refer to 1943-44, the second year of operation of the experimental health associations.

TABLE 11.—Reasons given for leaving Cass County (Tex.) Rural Health Association

Reasons given	Percentage
I. "Couldn't afford cost"-----	41.8
"Didn't have cash at time"-----	5.5
II. "Interested, but just neglected to rejoin"-----	23.6
"Just didn't rejoin"-----	5.4
III. "Doing nonfarm work and thus no longer eligible"-----	9.1
IV. "Don't like Government help"-----	1.8
V. Other reasons-----	12.8
Total-----	100.0

TABLE 12.—*Tax subsidized voluntary health insurance plans—Department of Agriculture sponsored experimental health associations—Summaries, by county*[1942-43 first year of operation] ¹

County	Eligibles belonging (percent)	Number persons belonging	Persons eligible (number) ²	Doctor services received per person ³	Level of living index ⁴	Average family net cash income	Average annual payment per family
Walton (Ga.).....	32. 2	4, 031	12, 510	2. 3	85	\$180	\$11 77
Hamilton (Nebr.).....	36. 8	2, 079	5, 646	4. 1	123	383	25. 47
Nevada (Ark.).....	48. 2	6, 350	13, 174	2. 0	78	114	7. 88
Cass (Tex.).....	49. 4	10, 337	20, 930	3. 3	82	162	9. 50
Newton (Miss.).....	51. 9	8, 958	17, 244	1. 8	84	78	6. 06
Wheeler (Tex.).....	74. 4	4, 072	5, 476	5. 5	110	360	21. 63
Total (or average).....	47. 8	35, 827	74, 980	2. 9	94	183	11. 02

¹ Number of members and percent of eligible membership fell the second year, and Hamilton County (Nebr.) discontinued operation.

² January 1942.

³ Per year (includes home, office, and hospital calls).

⁴ Rural Level of Living Indexes for Counties of the United States, 1940, by Margaret Jarman Hagood, U. S. Department of Agriculture, October 1943. Par is 100.

Source: Letters from Head, Division of Farm Population and Rural Welfare, Bureau of Agricultural Economics, Mar. 13, 1945, and Chief Medical Officer, Farm Security Administration, U. S. Department of Agriculture.

COMPULSORY HEALTH INSURANCE

The United States is one of the very few industrial nations in the world that does not have a system of prepayment for medical care as part of its social insurance system. This neither proves the method good nor bad, yet it is significant that no country has ever repealed such an arrangement once it has been established. Instead the trend has been toward increasing the number of people covered and the scope of the services offered. For example, the British health insurance law, first passed in 1912, originally provided general practitioner care only for certain categories of employed persons. It is now being expanded to give the whole population complete medical care. The British Medical Association, which is analagous to the American Medical Association, has approved the principles of the expanded program, as have practically all other interested groups in that country.

The United States was actually a pioneer in social insurance against the costs of medical care, though this fact is not widely known. In 1798 Congress enacted a law requiring all merchant seamen to contribute a certain amount monthly for the building and maintenance of marine hospitals. The first hospital was built with these funds in Norfolk, Va., in 1800. Merchant seamen have received medical care in them ever since, although they are now financed directly from Federal revenues. What has now become the United States Public Health Service was created as the Marine Hospital Service. As late as 1874 this plan was called "a peculiarly American institution." It is interesting to note that the marine hospitals have been in the forefront of medical progress. They were among the first to emphasize preventive medicine and to undertake clinical and laboratory medical research. They have made important recent research contributions, e. g., the use of penicillin in the treatment of syphilis. They have been singularly free of politics and regimentation and have provided high quality medical care.

EXISTING TAX-SUPPORTED MEDICAL SERVICES

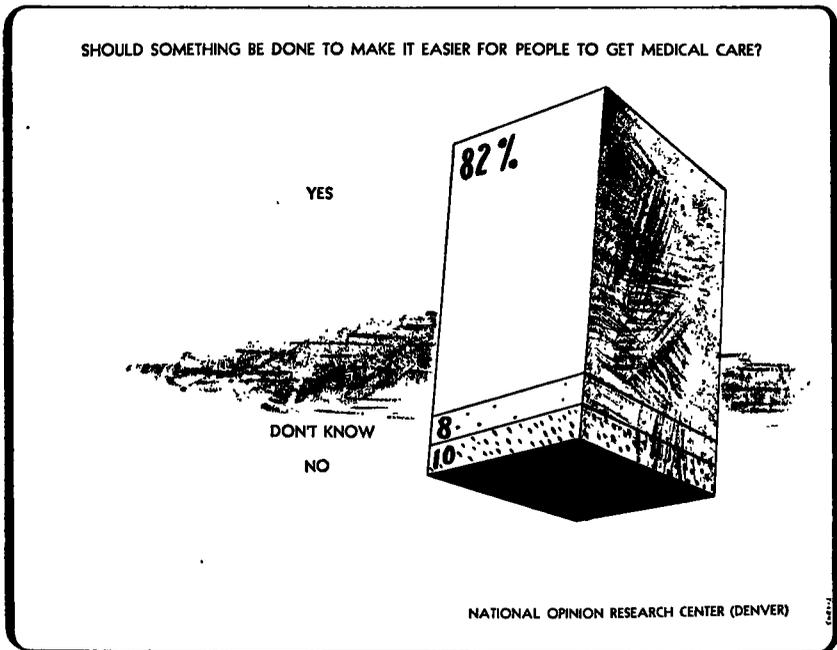
While most of our day-to-day medical care is not supported either by taxes or social insurance, enough of it is so that no one needs to be horrified if the American people decide that they want the amount of such care increased. Twenty percent of all medical expenditures, exclusive of those for the armed forces, are for tax-supported medical services. Veterans, merchant seamen, and Members of Congress are entitled to part or all of their medical care at Government expense. The agricultural workers' health associations of the War Food Administration and the Farm Security Administration-sponsored voluntary health associations for low-income farmers are examples of well-run Federal medical care programs. Over 70 percent of all hospital beds in the country are tax-supported, including general, tuberculosis, and mental beds. Public health departments, workmen's compensation, medical care for the needy, and school health activities are other examples of State or local tax-supported services.

PUBLIC OPINION

Various public opinion polls show that the public believes:

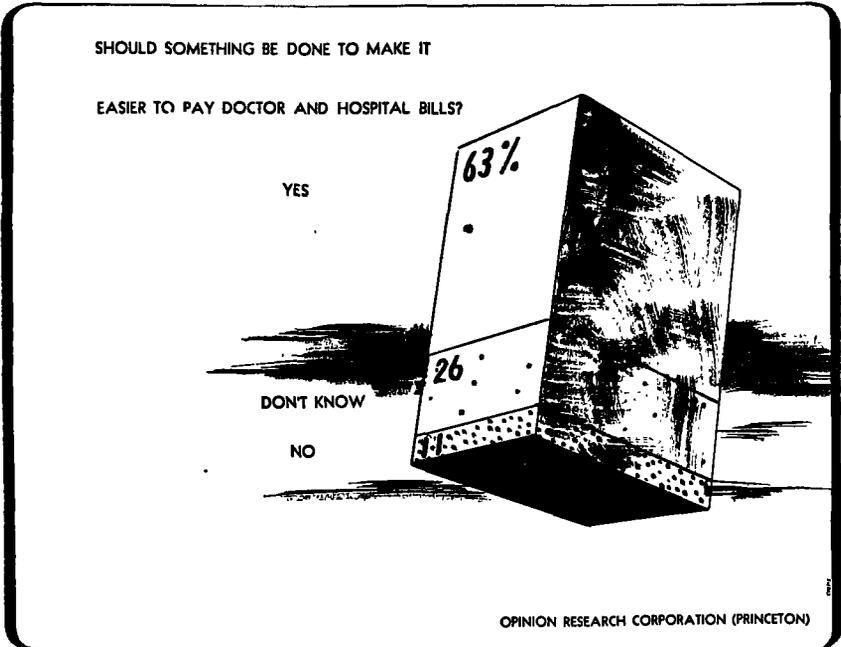
1. Something should be done to make it easier for people to get medical care when they need it. Eighty-two percent said, "Yes"; only 10 percent, "No." (See fig. 16.)

FIGURE 16. UNITED STATES OPINION ON COSTS OF MEDICAL CARE: I



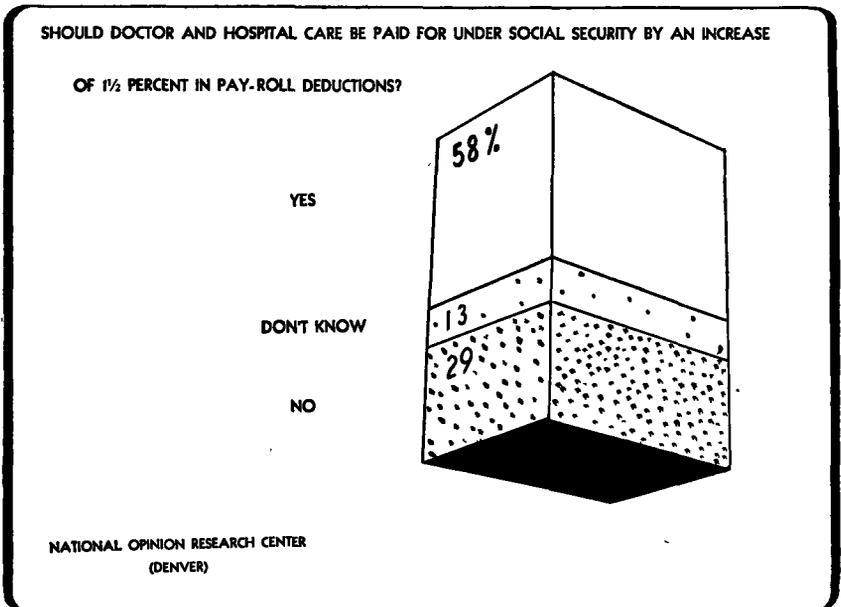
2. Something should be done to make it easier to pay doctor and hospital bills. Sixty-three percent said, "Yes"; only 11 percent, "No." (See fig. 17.)

FIGURE 17. UNITED STATES OPINION ON COSTS OF MEDICAL CARE: II



3. It would be a good idea if the social security law also provided for payment of doctor and hospital care, even if this meant an increase of 1½ percent taken out of people's pay checks; Fifty-eight percent said, "Good idea"; only 29 percent, "Bad idea." (See fig. 18.)

FIGURE 18. UNITED STATES OPINION ON COSTS OF MEDICAL CARE: III



CONCLUSION

Our health needs are urgent. Each day we fail to achieve the proper solution exacts its toll. We must resolve that the lessons of the selective service rejection rates will not be lost upon us, that never again will we allow sickness to cripple our people to the extent it now does. As a nation, we cannot afford to gamble with our health.

Some say that we are the healthiest nation in the world, and that therefore nothing need be done. There is little evidence that we are the healthiest country in the world. We do not rank at the head of the list in any of the major health indexes—crude or age-specific death rates, life-expectancy rates, infant and maternal mortality, or even of some of the comparable disease-incidence rates. But even if we were, it would not excuse our health failings.

Even before modern medicine had reached its present peak of complexity and specialization, the fee-for-service, individual practice method of providing medical care did not meet the Nation's health needs. Now it is a complete anachronism. It results in barriers to good health care which keep not only low-income people, but most middle-income families, from the fruits of modern medical science. It inhibits the full use of modern preventive medicine since it forces most people to wait until they are seriously ill before going to a doctor. And it leaves any family the prey of unexpected crippling costs from medical bills and wage loss. On top of the natural tragedy of illness may be heaped economic catastrophe.

The need for health insurance has become clear. The well-tried American way of meeting the hazards of life by spreading risks and by prepaying costs is applicable to health services.

For a century and a half the American people have experimented with various ways of insuring themselves against the costs of medical care. Voluntary group prepayment plans of various sorts have been devised for certain occupational or other selected groups, and for certain types of medical service. In the last 20 years, the growth of these plans has accelerated, but they still provide only 3 or 4 percent of the population with relatively complete medical services. Some say that since the voluntary plans are growing, ultimately they can meet the need. We do not deny that they are growing. Those who think as we do helped build them, against the opposition of the stand-patters who 15 years ago were attempting to block their growth and labeling even such voluntary systems "socialized medicine." We also agree that they have certain potentialities for further growth.

However, we are firmly convinced, for reasons we have given in this report, that they can never meet the total need.

* * * * *

In its third interim report this subcommittee stated:

In order to meet the requirements of the public and of the professional groups concerned, any method (of health insurance) which is evolved should offer complete medical care, should be reasonable but not "cut rate" in cost, should include substantially all of the people, should afford the highest quality of care, should permit free choice of physician or group of physicians, should allow democratic participation in policy making by consumers and producers of the service, should be adaptable to local conditions and needs, and should provide for continuous experimentation and improvement.

After careful study of existing voluntary plans, it is evident to us that none of them meets all of these requirements. Neither does it appear probable that any voluntary plan can be devised which will fulfill them.

The voluntary plans have served and are serving a valuable purpose, even though they do not provide any final answer to the problem of prepaid medical care for all the people. They have developed useful data on the prepayment of medical costs, and have educated large sections of the public on the value of medical care insurance. Furthermore, they have trained sizable numbers of medical and administrative personnel in the techniques of prepaid medical care. There is no reason why such plans should not continue to perform useful functions within the framework of a national health insurance system.

However, to cover everyone, the adverse as well as the good risks, the young and the old, the sick and the well, the rural and the city dwellers, the low- and the high-income groups, the poor and the rich areas, *all this takes a mechanism as representative and all-inclusive as a national health program, built around a system of prepaid medical care. It must be financed by required contributions to the social-security fund and by payments from general tax revenues.* Such a program will satisfy all the requirements set forth above, and will make possible the achievement in the foreseeable future of our goal of high quality health care for all.

The cost will not be greater than that of our present inefficient and wasteful fee-for-service system. According to leading experts the charge to the average family under a national health insurance program will actually be less than it pays now, partly because the employer and the Government will both contribute to the fund. It is noteworthy that the labor organizations, all of whose members are wage earners, are among the staunchest supporters of national health insurance.

Health insurance is often erroneously called "socialized medicine" or "State medicine." As President Truman pointed out in his health message, such a system is one in which the doctors are employed by the Government. We do not advocate this. National health insurance, which we do advocate, is simply a logical extension of private group health insurance plans to cover all the people. It is a joint national endeavor. It will guarantee free choice of doctor or group of doctors and free choice of hospital by the patient, and free choice of patient by the doctor. Indeed, free choice will be extended, because current financial barriers to the actual exercise of free choice will be broken down.

Some aspects of a national health insurance program are, of course, experimental. No legislative framework or administrative plan can be perfect at first. Shortcomings will undoubtedly be uncovered, but they will be overcome as we learn from experience. None of these shortcomings, however, will be anywhere near as costly as the toll of lives and health now being exacted by our failure to have a national health program providing good medical care for all. The need for it is urgent.

The concern of the Federal Government in this matter is clear. If only the national defense were involved, this would be reason

enough for the adoption of a national health program. The costly lessons of the selective service rejections and of the armed forces medical discharges have made this apparent.

Today America faces the challenge of world leadership. To a very large extent we bear the principal responsibility for the kind of world we are to live in. America can continue neither prosperous nor secure unless her people are healthy and full of strength. We owe it, therefore, to the Nation, and to every man, woman, and child in it, to open to every citizen the door to the marvels of modern medical care. Only thus unhindered by the heavy drag of sickness and ill health, can we make our full contribution to a free and happy world.

CLAUDE PEPPER.

ELBERT D. THOMAS.

JAMES E. MURRAY.

GEORGE D. AIKEN.

Senators Taft and Smith dissent from some of the findings and conclusions of the report.

Senators Hill, Tunnell and Morse, because of the pressure of other business, have not completed their study of the subject of this report.

STATEMENT OF SENATOR ROBERT F. WAGNER, NEW YORK

For the past several weeks this subcommittee has had the opportunity to obtain all the facts and shades of opinion on one of the fundamental long-range problems facing this Nation—how to protect and improve the health of our people.

You have come to know of the great need of our people, not only those of low incomes but the many millions in the middle-income groups, for adequate medical care and security against the economic drain of disease. As one of its sponsors I am convinced more than ever that the National Health Insurance and Public Health Act of 1947 provides the only practicable program to deal with the problem.

I shall not burden you with the detailed argument which you can find extensively spread in the testimony of the experts who have appeared before you. I want only to affirm with all the conviction that I can command that the national-health bill is deeply rooted in the rich soil of American democracy, both as to the objectives it seeks to achieve and in the methods it proposes to employ for their attainment.

We should not be unduly perturbed by the vicious attacks of its misanthropic enemies that the national-health bill is communistic and un-American. Every measure for social welfare to improve the lot of the people has been stigmatized with this accusation. In no other case is the charge more palpably false.

Individualism, no doubt, is basic to the American way of life. In some quarters, however, it has been distorted into a doctrine of jungle morality, echoing Cain's denial that he was his brother's keeper. I prefer to believe that the true concept of American individualism is expressed by the Judeo-Christian ethical precept of the worth of the individual and the sacredness of his life. A man's life and that of his wife and children are no less sacred and no less worth saving because he does not happen to be in the income brackets in which ade-

quate medical care and facilities can be provided. After these many years of destruction of human life, we should indeed experience joy bordering on ecstasy in dedicating our energies and resources to the alleviation of pain, fear, and suffering.

Equality of opportunity in the pursuit of happiness is a basic concept of our democracy. The widespread impaired health, evidenced by the high rejection rates of selective service during the year, constitutes a denial of the principle to millions of Americans.

Adequate medical services on the basis of need, not ability to pay, is a birthright of every American. It is a matter of right, not charity.

The present system of individual fee for service medical care is inadequate to secure this birthright to the mass of our people. It can be secured to them only through the established insurance principle of distribution of risks promulgated by Government cooperative effort. In the realm of health insurance, the national-health bill implements Lincoln's view that "the legitimate object of government is to do for a community of people whatever they need to have done but cannot do at all or cannot do so well in their separate and individual capacities."

The national-health bill is in the groove of American political tradition in establishing a Nation-wide system of prepaid personal health-service benefits and Federal grants to States for expanded health service. It retains the virtue of national planning and avoids the disadvantages of overcentralization by providing for State and local responsibility for operation. Disease is no respecter of social, local, or State boundaries. Sickness and its incidence are a national problem and can be treated effectively only on a national scale.

The patient-doctor relationship, too, is treated by the bill in the traditional spirit of American cooperation. It will not be regimented. Far from depriving the patient of his free choice of a physician, the national-health bill will enhance that freedom by making medical care responsive to need rather than to ability to pay. To the mass of our people, particularly in the rural areas, the free choice of a doctor is a mockery. Just as the right to a job is a reality only in an economy of full employment, so the free choice of a physician can have meaning only when the financial and other barriers to medical assistance are removed.

A corresponding increase will occur in the freedom of the physician. His economic position will improve in consequence of the greater demand for his services and the elimination of the many charity patients he now has to treat. Liberated from the limiting and irrelevant considerations of the patient's ability to pay, and given impetus by sufficient hospital and research facilities, the physician's art and science will reach yet-undreamed-of heights of achievement.

The harnessing of atomic energy and other wartime projects have shown what can be accomplished by freeing man's creative energies. If we can mobilize for purposes of destruction, why not to eliminate cancer and the other scourges that afflict mankind? There is enough idealism in the rank and file of the medical profession to welcome an era when they can truthfully say that they give of their best and serve not the few but all who are in need of their ministrations.

A nation's greatest asset is its people. To the preservation and improvement of this asset the national-health bill addresses itself in

the traditional American way of doing things. On the present world stage the eyes of the people everywhere are upon America to observe whether we can provide security, the new imperative of our age, within the framework of freedom and democracy. If we are to emerge successful in the titanic struggle of political ideas and systems, the national-health bill is a must.

Let us pass it without further delay.

STATEMENT OF SENATOR J. HOWARD McGRATH, RHODE ISLAND

Early in June 1947, Raymond Rich Associates, a firm of unquestioned standing and probity, submitted its resignation as public relations counsel of the American Medical Association. In so doing this firm took the unprecedented action of publicly announcing the reasons why it could no longer serve the AMA. These reasons were, in effect, that the AMA does not honestly represent the doctors of America and in fact refuses to carry out their instructions.

This incident, together with the testimony thus far presented during the hearings on S. 545, the Taft Act, and on S. 1320, the National Health Insurance Act, has greatly strengthened my support of S. 1320. The Rich incident brings to light the differences between our doctors and their official spokesmen; the hearings have brought out our great differences of opinion between our people and the representatives of the AMA.

The spokesmen for organized medicine and the spokesmen for lay organizations have consistently differed over the following issues:

1. Shall the Congress require as a matter of basic law that a national health program be run by a medical man?

The AMA and picked representatives of its affiliates who have appeared before this committee have said yes. Professional organizations of public health officials and social workers have said no. But the loudest "no" has come from spokesmen of organizations that represent just ordinary people—workers and farmers.

2. Shall the Congress postpone a far-reaching program until voluntary prepayment programs have had a chance to prove whether they can meet the need?

AMA spokesmen have said yes, but have spoken of voluntary programs only in reference to those programs that either were run by the doctors or approved by them. Other witnesses have consistently said that these programs were not adequate and could not be adequate.

3. Shall the Congress enact a national health program that will permit a State to divert Federal money to a single type of program or shall the Congress provide that all proper medical service organizations whether consumer, or farmer, or worker, or doctor owned be given equal opportunity?

AMA spokesmen who have differed on other sections of the Taft Act, evidently all agree on the provision which makes it possible for a State to designate one and only one prepayment plan as the recipient for Federal funds. Other witnesses have pointed to the antimonopolistic character of S. 1320, the National Health Insurance Act, and have indicated their desire to see continuing experimentation in the field of medical care organization.

Knowing the excellent relationships that exist between individual patients and doctors, I have been amazed at the conflict these hearings have revealed between the AMA as the organization of American doctors and organizations composed of patients of American doctors. There has hardly been a witness who has appeared against S. 545 and on behalf of S. 1320 who has not condemned the social and economic attitudes of the official spokesmen for organized medicine.

Representatives of organized labor from New Jersey have differed with the representatives of organized medicine from that State. This was true with the set of witnesses from New York State. I assume that the representative of organized labor from Kentucky—judging from the affidavits that he brought from the mine workers of his State—likewise differs with the official stand of organized medicine in his State.

The Farmers Union representative who came from North Dakota took time from her statement on this legislation to condemn the attitude of the secretary of the North Dakota State Medical Society before another committee of this Congress. And, the representatives of the powerful Grange organization differed drastically with the point of view of the AMA on the Taft Act.

Now, there has come to my attention a series of documents which explain much of this conflict—a series of documents which indicate to me that the officials of the AMA are not even willing to abide by decisions of the representative body of their own organization—the house of delegates. These documents tell the story of resistance to progress as well as of the undemocratic functioning of the national organization. These documents reveal the gap between the social and economic point of view of America's doctors and that publicly proclaimed by the officials of the AMA as revealed in the resignation of Raymond Rich Associates as public-relations counsel of the AMA.

The story of what now is known as the Rich episode indicates to me three things in regard to public responsibility of the Congress:

1. The undesirability of public bodies utilizing the AMA, or its subsidiaries, as agencies for the administration of public funds.
2. The absolute necessity of action by the Federal Government and the States to meet the medical-care needs of the American people without further reliance on the possibility that organized medicine in the immediate future will be able to furnish the necessary leadership for developing a national health program.
3. That the AMA no longer acts in the interest either of the people or the doctors in the field of medical economics and of the social aspects of medicine.

Raymond Rich Associates were engaged in February 1946 first to study the public relations of the AMA and then retained in September 1946 to carry out the recommendations which had been approved by the house of delegates. However, early in June 1947, Raymond Rich Associates resigned because their, and I quote—

* * * position had become professionally untenable.

For the record, I want to give a little background on this public relations firm whose position became so untenable that they resigned to maintain their professional integrity.

Raymond Rich Associates was formed 5 years ago as an organization unique in the field of public relations, in that it was to serve

solely the needs of nonprofit organizations whose principles and purposes were in the public interest. The experience of the senior associates prior to that time aggregate 17 years in commercial fields and 65 years in editorial and advertising work. The organization has served as counsel to groups as diverse as the New York Law Society, the Twentieth Century Fund, and the Council of State Governments. Its reputation and ability are unquestioned.

Let me tell the committee how these documents came into my possession. They came to me without solicitation through a doctor who received them from a member of the house of delegates of the AMA. He was sufficiently incensed by the story contained in them to ask that they be made public. At the same time he was sufficiently fearful of the powers of the officials of the AMA to refuse to allow his name to be attached.

Since receiving them I have satisfied myself that they have a definite bearing on the position of organized medicine on the two health programs now before Congress. I am making these documents a part of this record out of the conviction that the story involved should be known to every doctor in the country and to every man in public office who has any dealings with the lobbies of organized medicine and to every citizen who is concerned with the health of the people of this great Nation.

At the conclusion of my testimony, I desire to have them recorded in full in the record of this hearing.

Raymond Rich Associates is an eminently respectable public relations firm which was retained a number of months before the 1946 convention of the AMA to, and I quote—

* * * study the public relations of the associations and to make recommendations for their improvement.

At the December 1946 meeting of the house of delegates, the major recommendations were adopted. Yet in June 1947 Raymond Rich Associates resigned.

Why did Raymond Rich Associates resign? I quote from the telegram which was sent to the speaker of the house of delegates of the AMA on June 12:

Stated simply, the association has yet to take unequivocal and effective action on the policies which it adopted on our recommendation last year: to seek the truth on the economic and social aspects of medicine, to put the public first, and to become adequate in its responsibilities.

In the same telegram of resignation, Raymond Rich Associates declared:

As our May 24, 1947, report to the board of trustees points out, basic steps in the approved programs have not been taken in spite of our repeated urging that the AMA has submitted itself publicly to the test of accomplishment.

The issue is, therefore, clear: the very integrity and sincerity of the association are at stake.

To question the "integrity and sincerity" of a client is a serious charge, yet that is the charge this respectable firm makes against the officers of the AMA, which, we have been assured during these hearings, represent 80 to 90 percent of the doctors of the United States.

There are three major conclusions at which I have arrived as a result of the study of these documents:

1. The various reports and comments of Rich Associates substantiates the charges made by many witnesses before this committee that the AMA has failed to furnish enlightened aggressive leadership in the field of medical economics and the social aspects of medicine.

In the original survey of Rich Associates on the basis of which they were retained as public relations counsel, they observed that—

In many fields the conduct of the American Medical Association has been both positive and exemplary. But with respect to the economic and social aspects of medicine the position of the association for many years has been essentially of a defensive and negativistic character.

At San Francisco, the house of delegates, on the recommendation of the board of trustees, adopted three basic goals to guide the association in the field of medical economics and social medicine. I quote from the Rich report to the board of trustees on May 24, 1947:

These goals are:

1. To find the truth: The association must convince the public that it is "seeking the truth as honestly in the economic and social aspects of medicine as it is in the scientific." And since there is as yet no proven truth in these fields, a fair hearing week in and week out, year in and year out, must be given to those who with sincerity and intelligence are inclined to other viewpoints or who believe there are neglected developments and issues which need attention.

2. To put the public first: Study alone will not suffice. The American Medical Association "must show the public that it is actually following up the truth which it finds by doing everything in its power to bring medical care to all the people. In other words, its actions must be the organized embodiment of the first statement in the Principles of Medical Ethics."

3. To become adequate: The performance of the association must be adequate, because by adopting the national health program "it has submitted itself to the test of accomplishment."

This report on a year's progress toward these three goals is enlightening. First goal [reading]:

The principle of finding the truth must control the conduct of the association in the economic and social field as it has in the scientific field. It was for this reason that we recommended that the bureau of medical economics be rebuilt. We saw the close relationship between the potential activities of this bureau and various points in the national health program. Furthermore, we felt that the bureau would be a major force in implementing this first major goal. Thus far, however, we have been disappointed by the bureau's work. Here are a few problems which deserve far more attention than they have received:

1. It would be highly desirable, for example, that the bureau examine and attest to the economic soundness of each prepayment plan which applies, or has applied, for approval by the Council of Medical Service.

2. We should like, further, to see the bureau encouraged to make a study of the economic aspects of such new experimental plans as the health-insurance plan in New York City.

Yet, as a matter of record, three county societies, affiliates of the AMA, have specifically voted against their members participating in the health-insurance plan.

3. Yet, again the bureau should study the possibilities from an economic and insurance standpoint of extending the coverage provided by existing prepayment plans, with respect to (a) income brackets of the subscribers; (b) possible bases for determining equitable surcharges for subscribers having income above the brackets covered by the plan; (c) adding medical service in plans providing at present only for surgical care.

Again I interrupt the Rich recommendations to call attention to the original testimony of the AMA representatives which said that people do not want comprehensive programs.

4. Furthermore, if sufficient experience as to the incidence of need for medical care is unavailable, the bureau should ascertain how this data might be soundly

developed with the cooperation of the physicians of the country who, surely, have much to contribute with reference to these facts.

5. In relationship to the latter portion of section 2 of the national health program, we believe that it might prove fruitful to study possible methods, economically sound, for integrating under the prepayment plans medical care for all those unable to pay.

6. In connection with sections 3 and 4 of the national health program, a similar study might be made of economically sound methods for coordinating maternal and infant care with voluntary plans.

In short, it seems to us urgent that the work of the bureau be focused more sharply on projects which will bear clear witness to the AMA's determination to find the truth in matters of medical economics, in forms which can be applied for the benefit of the people.

Moreover, we must observe that there is as yet no department of medical economics in the journal. There have been only occasional articles, few if any of which, we regret to say, seem to us new contributions to thought regarding the economic and social aspects of medicine. Furthermore, there has been, in our view, no substantial improvement over previous years in providing for fair hearing of intelligent diverse viewpoints.

Again, I would like to interrupt the quotation from the Rich statement to comment that this lack of democracy has been one of the most telling comments of witnesses who have opposed the AMA point of view.

In summary, we believe that the association's advance toward the first goal through the work of the bureau has not yet been sufficient to contribute appreciably toward improved public relations.

We recommend [emphasis added] therefore that provision be made for closer supervision and guidance of the bureau of medical economic research—possibly by a special committee of physicians with an ancillary group of eminent economists—with a view to stepping up its contribution toward finding the truth [emphasis added] in these vital fields.

Second and third goals [reading]:

Let us turn now to consider the progress that has been made toward the second and third goals—to put the people first by following up the truth that is found, and to become adequate in that performance.

We assume that the truth which the association has found in economic and social fields prior to the reorganization of the bureau of medical economics is incorporated in the national health program—the 10-point program. Until further truth is discovered, this program must not only be promoted but promoted and implemented adequately. Otherwise the AMA lays itself open to the charge that it acts upon only a portion of the truth it finds.

We regret to say, however, that in no other field—with the possible exception of the recommended coordination of the association's public relations, detailed below—has the progress of the association been less satisfactory.

We are aware that certain points of the program have been implemented to a degree—and particularly those covering health education and cooperation with other organizations. Moreover, State and county societies have, in many instances, taken formal action to endorse the program. But formal action, however necessary and commendable, must not be confused with effective implementation. Therefore, with regard to points 1, 2, 3, 4, 5, and 6, we cannot escape the conclusion that implementation of the program has been gravely insufficient.

Among these important points in the AMA's national-health program is the promotion of voluntary prepayment plans. As stated in our survey nearly a year ago: "It is obvious that voluntary plans for medical care must be developed with sufficient rapidity and success to meet the needs of the Nation, if compulsory health insurance is to become unnecessary. The fact that relatively so little is yet being done to promote these modern measures reveals amazing shortsightedness. There must be positive, aggressive drive in their behalf. They must be developed to the point where they assure virtually all of the people adequate medical care."

The responsibility for advancing the national health program rests primarily, we understand, with the Council on Medical Service. As stated in our survey,

"we have from the first been impressed by the vitality of this council and the vigor with which its work has been advanced."

Again and again throughout the past 8 months we have urged informally and formally that truly adequate resources be made available for the advancement of these plans and the advancement of the entire 10-point program.

We regret that all these requests were denied.

The second conclusion I have drawn from this incident is that a careful study of these documents verifies the contention of many people that the AMA is now run by an entrenched bureaucracy which ignores not only the point of view of local medical leaders but, on occasion, that of the house of delegates itself.

Rich Associates reports that during the early part of 1947 the house of delegates—

acting as committee of the whole on our survey recommendations, voted, first, with respect to staff for executive assistant as follows:

(a) To engage a competent person to conduct a centralized service of pamphlet production.

(b) That all possible uses of visual techniques be utilized, backed by the advice of professional counsel.

(c) That the speakers' bureau should be not only initiated but activated and utilized to its fullest capacity.

It seemed obvious to us that each of these actions of the house implied that adequate personnel should be engaged to implement its decisions.

In addition, the house of delegates approved, subject to cost and demonstrated need, our recommendations:

(d) That provision be made for junior radio specialist on the staff, backed by highly experienced professional counsel.

(e) That the executive assistant be enabled to engage a competent promotional specialist.

In light of the unconditional house approval of three additional staff members, the executive assistant, in response to the request for a final budget in February, included provision for (a), (b), and (c) above.

Furthermore, the executive assistant included provision for (e) above. He believed, and we concurred, that the need for a promotional specialist has not only been proved but also was recognized by the board. This for the reason that the chairman of the board in San Francisco had reported with apparent approval our survey recommendations stressing the basic importance of the national health program and the need for developing it in the centennial year.

Yet, Rich Associates reported that at its February meeting—

The board rejected all three items and made other heavy reductions in the proposed budget for the office of the executive assistant.

If you turn to the section of the May 24 document, headed "Attendance at meetings," you obtain another glimpse of the complete disregard by the top officialdom of the attitude of the house of delegates.

Thirdly, the Rich episode indicates to me the wide gap in the point of view that exists between State and county medical societies and officials and official spokesmen of the AMA.

As part of their duties as public relations counsel, Rich Associates surveyed all State medical society secretaries, and the secretaries of a few large county societies on what they wanted to see in the AMA's public relations program. More than 40 sent confidential replies. All but four offered detailed suggestions.

Rich Associates reported to the board of trustees five findings which emerged from the systematic polling of the societies. I would like to quote two of these five findings:

The next most important field, from the viewpoint of these constituent societies, is a "constructive legislative program to promote interest and activity in health legislative matters." Here the foremost point of emphasis is to "let the

AMA speak openly for its own membership." This is followed closely by a request that widest possible publicity be given to positive legislative proposals made by AMA or supported by AMA. Again in this field, there is a wide desire that the Washington office be made an "effective arm of the association, expanding it if necessary." There is also the recommendation that unfavorable legislation be criticized only in the spirit of constructive evaluation. Furthermore, that emphasis should be placed upon positive action in the field of legislation rather than on lobbying against proposals made by others.

Foremost is the request that haziness on matters of policy be combated by stated thoroughly and clearly new policies or changes in policy as they take place, and especially after meetings of the house of delegates. This is followed closely by the recommendation that means be found to evaluate the wishes of State societies more speedily and put those wishes into effect.

Yet, even these reasonable suggestions were not acted upon by the board of trustees, even though they had originated with the local organization of the AMA.

Now I should like to make a few brief comments on the problem of assuring our people of access to needed medical care; comments from the point of view of a former Governor who has had to wrestle long and hard with matters of health in their relation to State finances and State administration.

I am quite familiar with the problems this subcommittee is faced with because in several Rhode Island programs we have gone further in trying to meet urgent and important health problems than any other State in the Union.

I am proud of the fact that during my administration, Rhode Island enacted the first State cash disability compensation law in the United States. The Rhode Island law provides that each employee contribute 1 percent of his wages into the State cash disability compensation fund. Out of this fund cash payments are made to an employee when he is out of work due to sickness or disability. The minimum payment is \$6.75 a week; the maximum payment, \$18 a week. The maximum duration of benefits is 20¼ weeks. The maximum total payment is \$364 in one benefit year.

The law thus provides a partial reimbursement for wages lost through illness; it helps pay the family's rent and its food bill. It helps mightily during illness. It is so successful that it has recently been expanded. But it does not and cannot assure access to medical care nor payment for that care. It proves the need for such insurance, proves that people are glad to pay such insurance, and proves that it can be properly administered.

We are also proud in Rhode Island that we have the highest proportion of population of any State enrolled in Blue Cross hospitalization plans. But these voluntary hospital plans do not cover the doctor's bills or most other types of medical costs. As a matter of fact, hospitalization costs represent only about 20 or 25 percent of the total costs of medical care. In other words, we still have a long way to go to provide comprehensive health protection to the people in our State.

I should also like to point out that Rhode Island has attempted through its comprehensive public welfare plan to provide medical care to needy persons through public assistance funds. This arrangement, while a necessity for those who become needy, by no means answers our problem. Our people in Rhode Island—like Americans

in every State in the Union—do not like and often refuse to get their medical care this way. And this arrangement, if continued indefinitely in all States, would result in a heavy burden on State and local revenues. Our experience convinces me that any large-scale expansion of the method of providing medical care only to needy persons, as proposed by S. 545, would be unsound.

These governmental and voluntary efforts of ours in Rhode Island have placed us at the top of the list of States in trying to solve our health needs. But we still do not think we have solved the health problem in Rhode Island.

And I want to say to you that it is my conclusion—reached only after working long hours on this matter while I was Governor—that neither Rhode Island nor any other State in the Union can have an adequate health program without health insurance, and effective Federal aid in making comprehensive health-insurance protection a reality.

I think we all now agree that health insurance is desirable and that some Federal aid to encourage the spread of health insurance is desirable. S. 545 confirms the fact that these broad principles are now accepted. But where there is disagreement is on whether health insurance shall be voluntary or compulsory and the extent and character of the Federal aid which can make health insurance a reality.

On these two points I wish to draw further upon our experience in Rhode Island.

We are not afraid of the bugaboo of “compulsion” in Rhode Island. We have a compulsory workmen’s compensation law; a compulsory unemployment insurance law; and a compulsory cash sickness insurance law. We are glad that our employers and employees are required to contribute for the protection provided under the compulsory Federal old-age and survivors insurance law passed by Congress. We have found out that these compulsory laws in actual operation are not an infringement on the freedom of the people. Instead, they are a guaranty to the people, and to the State, that the public welfare will be protected.

Furthermore, as a small and highly industrialized State, we know that no comprehensive health insurance plan can be truly effective unless—as has been demonstrated by world-wide experience—the employer pays part of the cost. That employers know the value of such programs to themselves and are willing to make their contributions is evidenced in many industry-wide bargaining agreements and in the pages of business periodicals. But the employers of any one State are understandably reluctant to undertake such a program so long as it would put them in an unfair competitive position as regards employers in other States. Only a Federal law, applicable equally throughout the Nation, can solve this problem.

The essential principle behind S. 1320, of which I am one of the sponsors, is that the Federal Government will overcome the handicap which every State now faces. Through appropriate legislation, which must originate in the House of Representatives, every employee and every employer would pay a small regular health insurance premium. This would assure that there would be no unfair competition as among employers or as among States or particular industries.

Then, under S. 1320, each State would have the opportunity to establish and organize health service for its people.

Part D of S. 1320, beginning at page 32 of the bill, entitled "State Administration", carefully spells out how the States may develop and administer their own decentralized medical-care programs.

A national plan, in my opinion, is the only way in which this program can be solved. I have thought about alternative solutions from many angles, but I always come face to face with this fact: In the United States people are constantly moving across State lines. Only a national insurance plan can cover everyone in the United States and yet at the same time assure adequate protection to our mobile population.

In my opinion, those who believe in States' rights must give the States the aid they need to meet the problems they must solve.

Those who advocate States' rights and then deny to the States the Federal help they must have are, in my opinion, the strongest supporters of eventual nationalization.

S. 1320 provides the necessary Federal action, assures the States of local control of administration, and guarantees the rights of both patients and doctors alike.

These are some of the reasons why I believe that S. 1320 merits support. I don't say that it is a perfect bill, but I do say its fundamental idea is sound. It will work.

I request that the documents previously referred to in my testimony be made a part of this record.

(The documents referred to follow:)

RAYMOND RICH ASSOCIATES,
New York 10, N. Y., June 12, 1947.

For your information, the following telegram was sent to the speaker of the house of delegates of the American Medical Association today:

As the house of delegates is aware, we have submitted our resignation as public relations counsel to the AMA. In view of the fact that vital issues affecting the general welfare of the medical profession are involved, however, we feel obligated to inform the house of the major reasons which impelled us to take this serious step.

The facts, briefly, are these: We were engaged in February 1946 to study the public relations of the association and to make recommendations for their improvement. We submitted our report in June 1946. In September the board of trustees entered into a new contract retaining us as public relations counsel. At its December 1946 meeting, the house of delegates adopted our major recommendations with only minor amendments. Since that time, as counsel, we have done everything in our power to advance the establishment and implementation of the program you have approved.

We took this course because our survey had demonstrated the urgent need that the association take effective action on an adequate program to meet the medical needs of the American people and to promote the future welfare of the profession. Also because we believed that such action was required to fulfill the spirit as well as the letter of your clear decisions.

As our May 24, 1947, report to the board of trustees points out, basic steps in the approved program have not been taken in spite of our repeated urging that the A. M. A. had submitted itself publicly to the test of accomplishment.

The issue is therefore clear: The very integrity and sincerity of the association are at stake. In view of this situation, we recommended to the board of trustees that the association must make this vital choice: Either to verify its desire to carry out the program approved last December or to indicate its wishes regarding a more limited program. From our meeting with the trustees, June 6, 1947, we became convinced that they were not prepared to resolve this issue or to submit our report to the house of delegates as a basis for clear decision. We therefore had no recourse but to submit our resignation from a position that had become professionally untenable.

Stated simply, the association has yet to take unequivocal and effective action on the policies which it adopted on our recommendation last year: To seek the

truth on the economic and social aspects of medicine, to put the public first, and to become adequate to its responsibilities.

In view of the seriousness of this issue, we believe that all members of the house of delegates are entitled to know the facts behind our resignation. We shall therefore be glad to send a copy of our report to any interested member who requests it.

RAYMOND RICH ASSOCIATES,
New York 10, April 8, 1947.

Dr. R. L. SENSENICH,
South Bend 5, Ind.

DEAR DR. SENSENICH: Since the latest meeting of the board of trustees, we have been devoting continuous study to the consequences of the decisions made at that time regarding the budget submitted by the executive assistant to the general manager for the operations of the new public relations division. As public relations counsel to the AMA, we feel it our duty to call attention to the very serious implications of those decisions and to urge reconsideration at the next meeting of the executive committee.

In making this recommendation, we are fully aware of the difficulties which the trustees faced by reason of the discrepancy between the grand total of all the budgets submitted and the estimated income. We recognize that when budgets generally had to be reduced, the amount for public relations had to be reduced also. We realize that economies were necessary; indeed, for that reason we advised a public relations budget appreciably below what would be desirable from the viewpoint of that division alone.

We note, however, that even this reduced budget for the work of the executive assistant was cut by nearly \$57,000. Only \$65,379 was allowed. We are convinced that this will *make it impossible to carry out the expanded public relations program approved by the association.*

In the light of the facts that first led the AMA to request a study of its public relations, and then to approve our major recommendations, we cannot believe that the board either foresaw or intended such a result. Certainly, it would be in direct contradiction to our best advice, the previous actions of the board, and the expressed desires of the house of delegates.

A brief review of the record may be of assistance:

1. As chairman of the board you stated to the house of delegates in San Francisco that "the board has authorized the general manager to endeavor to find a suitable public relations expert to fill this position of executive assistant together with the creation in the headquarters office of a division of public relations with enlarged responsibility and *sufficient personnel to carry out this program adequately* under the immediate supervision of the general manager and the general supervision of the board of trustees." [The italics are ours.]

In view of this statement we were quite willing to undertake, upon request of the general manager and without charge, an extensive search for the best available candidates for the position of executive assistant. Subsequently, we submitted two candidates. The first declined the offer made to him, and, as we reported informally to the general manager, the chief reason was apparently that he did not feel convinced that there was a sincere desire for an effective public relations program. The second candidate accepted the offer after he had read your San Francisco statement and the other San Francisco proceedings, and after we had assured him that we believed that he would have "sufficient personnel to carry out this program adequately." *The budget as it now stands does not fulfill this promise.*

2. At its meeting last December, the house of delegates, acting as committee of the whole on our survey recommendation, voted in part as follows:

(a) To engage a competent person to conduct a centralized service of pamphlet production.

(b) That all possible uses of visual techniques be utilized backed by the advice of professional counsel.

(c) That the speakers' bureau should be not only initiated but activated and utilized to its fullest capacity.

Obviously, each of these actions of the house implied that adequate personnel should be engaged to implement its decisions. Accordingly the budget submitted to the board included three staff members responsible respectively for each of these three functions. *All three items were stricken from the budget.*

3. In addition, the house of delegates approved our recommendation that a competent promotion expert be engaged when necessary "subject to cost and demonstrated need." The executive assistant believed, and we concurred, that the need had been proven. The 10-point program must be promoted, must be implemented, if the AMA is not to be laid open to the charge that it acts upon only a portion of its beliefs. (My further comments upon this point were presented to the board on February 21 and are incorporated in a memorandum which already has been transmitted to you.) *The item for this promotional expert was also stricken from the budget.*

Under these budget decisions the executive assistant is left with a staff consisting of one senior and one junior assistant and one stenographer to carry on the new program. (The previously existing unit of three—one senior, one apprentice, and one stenographer—which was transferred to his jurisdiction, is only incidentally available for any of the expanded program since its earlier duties continue.) In our best judgment, that is hardly enough personnel to deal with routine operations. Even with superhuman resolve and protracted overwork, it would be physically impossible for a staff of this size to do the job we believe the AMA desires done during the next few critical years.

That is why we say that the board's excision of all these items makes it impossible to carry out the expanded program. If not corrected soon, it will almost inevitably lend force to the contention of critics in and outside the AMA that the association does not genuinely intend to carry out its new policies.

A more serious consequence is that the reduced budget will prevent the AMA from aiding and guiding the public-relations programs of its component societies. Those bodies are now spending, in the aggregate, many times more than the full budget requested by the executive assistant. They are expending at least 10 times the amounts granted for public relations by the board of trustees. They desire public-relations aid, cooperation, and counsel from their national headquarters. Is the AMA going to deny a large proportion of their requests and thereby forfeit its opportunities for leadership in this field?

Finally, we would emphasize once again the statement made on several occasions in conference with the board of trustees and which was implicit in the report of our survey: *The public relations of the association are, in a critical state.* To be successful the movement to improve them must have sufficient force to be effective. To cite just one major problem: national health legislation, to which the AMA objects, may be stalled temporarily; but it will come up again and again until the problems from which it arises are met in some adequate fashion. The AMA must take the lead with a vital and adequate national health program if it is to have strength in the midst of changing conditions and, particularly, *if it is to make Government control of medical economics unnecessary.* Good public relations require enlightened conduct.

Because the present situation seems to us most serious, we respectfully request that this matter be placed on the agenda of the next meeting of the executive committee. We are sending copies of this letter to the other members of the board, to the ex officio members, and to the general manager and his executive assistant. We trust that they, as well as yourself, will appreciate that we have written this letter out of a sincere desire to promote the best interests of the association which we are honored to serve as counsel.

Sincerely yours,

RAYMOND RICH ASSOCIATES.

REPORT ON PUBLIC RELATIONS TO THE TRUSTEES OF THE AMERICAN MEDICAL ASSOCIATION, MAY 24, 1947, BY RAYMOND RICH ASSOCIATES

As the trustees know, our agreement to provide counsel on the public relations of the American Medical Association expires on June 30, 1947. It is fitting, therefore, that we report our observations on the work of the past 8 months as well as our recommendations regarding next step in these matters.

We are submitting this report at the present time in order that it may be considered in advance of the Atlantic City meetings. And we believe the trustees will agree that it will best serve the interests of the American Medical Association if we speak with as much candor now as we did in June 1946, when we concluded our survey assignment.

It will be recalled that as a result of that survey, we recommended the following basic measures:

1. To assign to the editor of the Journal responsibility for two functions: (a) Intensifying activity describing and dramatizing the progress of scientific medicine with particular attention to all the association has done and is doing to advance this program, and (b) vitalizing the magazine Hygeia.

2. To rebuild the bureau of medical economics under the direction of "a truly superior person of the highest caliber" with responsibility not only for the direction of the bureau, but also for: (a) Procuring and developing material for a department of medical economics in the Journal and (b) giving opportunity in this department for the expression of diverse opinions in order to "create a dynamic atmosphere which will go far to arouse the active interest of the many doctors whose lethargy has rightly been a matter of grave concern."

3. To accept an executive assistant to the general manager, with adequate staff, for the purpose of: (a) "coordinating and servicing the public relations activities of AM officers, councils, bureaus, divisions, and departments of the association," and (b) developing "with the full support of the board, ways and means of greatly broadening the system of interpretation of the association to the public on matters other than scientific medicine."

All of these recommendations were accepted.

We then stated (with subsequent approval by the house of delegates) that, viewing the field of medical economics and social medicine from a public-relations standpoint, there are three basic tasks, three essential goals, that must be held constantly in mind by the association. These goals are:

1. To find the truth. The association must convince the public that it is "seeking the truth as honestly in the economic and social aspects of medicine as it is in the scientific." And since there is as yet no proven truth in these fields, a fair hearing week in and week out, year in and year out, must be given to those who with sincerity and intelligence are inclined to other viewpoints or who believe there are neglected developments and issues which need attention.

2. To put the public first. Study alone will not suffice. The American Medical Association "must show the public that it is actually following up the truth which it finds by doing everything in its power to bring medical care to all the people. * * * In other words, its actions must be the organized embodiment of the first statement in the 'principles of medical ethics.'"

3. To become adequate. The performance of the association must be adequate because by adopting the national-health program "It has submitted itself to the test of accomplishment."

Let us examine first the progress that the association has made toward these three major goals during the past year.

ADVANCE TOWARD MAJOR GOALS

Progress in the public relations of the American Medical Association is inevitably conditioned by its deeds as well as its words. This principle applies especially in the case of the most critical issue facing the medical progression at the present time—medical economics and social medicine.

It will be recalled that in our survey we made the following observation:

"In many fields the conduct of the American Medical Association has been both positive and exemplary. But with respect to economic and social aspects of medicine the position of the association for many years has been essentially of a defensive and negativistic character. Now, however, the association has adopted a positive program. This is its greatest potential asset."

First goal

The principle of finding the truth must control the conduct of the association in the economic and social field as it has in the scientific field. It was for this reason that we recommended that the bureau of medical economics be rebuilt. We saw the close relationship between the potential activities of this bureau and various points in the national health program. Furthermore we felt that the bureau would be a major force in implementing this first major goal.

Thus far, however, we have been disappointed by the bureau's work. Here are a few problems which deserve far more attention than they have received:

(1) It would be highly desirable, for example, that the bureau examine and attest to the economic soundness of each prepayment plan which applies (or has applied) for approval by the council of medical service.

(2) We should like further to see the bureau encouraged to make a study of the economic aspects of such new experimental plans as the health insurance plan in New York City.

(3) Yet again the bureau should study the possibilities from an economic and insurance standpoint of extending the coverage provided by existing prepayment plans, with respect to: (a) Income brackets of the subscribers; (b) possible bases for determining equitable surcharges for subscribers having income above the brackets covered by the plan; (c) adding medical service in plans providing at present only for surgical care.

(4) Furthermore, if sufficient experience as to the incidence of need for medical care is unavailable, the bureau should ascertain how these data might be soundly developed with the cooperation of the physicians of the country, who, surely, have much to contribute with reference to these facts.

(5) In relationship to the latter portion of section 2 of the national health program we believe that it might prove fruitful to study possible methods economically sound for integrating under the prepayment plans medical care for all those unable to pay.

(6) In connection with sections 3 and 4 of the national health program a similar study might be made of economically sound methods for coordination of maternal and infant care with voluntary plans.

In short, it seems to us urgent that the work of the bureau be focused more sharply on projects which will bear clear witness to the AMA's determination to find the truth in matters of medical economics, in forms which can be applied for the benefit of the people.

Moreover we must observe that there is as yet no department of medical economics in the journal. There have been only occasional articles, few if any of which, we regret to say, seem to us new contributions to thought regarding the economic and social aspects of medicine. Furthermore there has been, in our view, no substantial improvement over previous years in providing for fair hearing of intelligent diverse viewpoints.

In summary we believe that the association's advance toward the first major goal through the work of the bureau has not yet been sufficient to contribute appreciably toward improved public relations.

We recommend, therefore, that provision be made for closer supervision and guidance of the bureau of medical economic research—possibly by a special committee of physicians with an ancillary group of eminent economists—with a view to stepping up its contribution toward finding the truth in these vital fields.

Second and third goals

Let us turn now to consider the progress that has been made toward the second and third goals—to put the people first by following up the truth that is found, and to become adequate in that performance.

We assume that the truth which the association had found in economic and social fields prior to the reorganization of the bureau of medical economics is incorporated in the national health program—the “ten point program.” Until further truth is discovered this program must not only be promoted but promoted and implemented adequately. Otherwise the AMA lays itself open to the charge that it acts upon only a portion of the truth it finds.

We regret to say, however, that in no other field, with the possible exception of the recommended coordination of the association's public relations (detailed below), has the progress of the association been less satisfactory.

We are aware that certain points of the program have been implemented to a degree, and particularly those covering health education and cooperation with other organizations. Moreover, State and county societies have, in many instances, taken formal action to endorse the program. But formal action, however necessary and commendable, must not be confused with effective implementation. Therefore, with regard to points 1, 2, 3, 4, 5, and 6, we cannot escape the conclusion that implementation of the program has been gravely insufficient.

Among these important points in the AMA's national health program is the promotion of voluntary prepayment plans. As stated in our survey nearly a year ago:

“It is obvious that voluntary prepayment plans for medical care must be developed with sufficient rapidity and success to meet the needs of the Nation, if compulsory health insurance is to become unnecessary. The fact that relatively so little is yet being done to promote these modern measures reveals amazing shortsightedness. * * * There must be positive, aggressive drive in their behalf. They must be developed to the point where they assure virtually all of the people adequate medical care.”

The responsibility for advancing the national health program rests primarily, we understand, with the council on medical service. As stated in our survey, "we have from the first been impressed by the vitality of this council and the vigor with which its work has been advanced."

At the same time, however, we found certain deficiencies and reported that the council needed to have available the following services:

1. Publicity.
2. Pamphlet production.
3. Visual presentations of various types.
4. Radio materials and time.
5. Liaison with other organizations.
6. Speakers Bureau.
7. Professional promotional and public relations counsel.

In short, in order to advance rapidly toward the second and third goals by implementing the national health program, the council on medical service greatly needed and still needs the services which we recommended be supplied to it by the new office of the executive assistant. Again and again throughout the past 8 months we have urged informally and formally that truly adequate resources be made available for the advancement of these plans and the advancement of the entire 10-point program.

We regret that all these requests were denied.

Need of coordination

The preceding review of the weaknesses in the association's progress toward the three major goals could be buttressed by many additional facts. We believe, however, that extension of the record is unnecessary aside from one final comment.

Above all, the experience of the past 8 months has made clear the need of coordination between the bureau of medical economics and the council on medical service, and of both which the over-all public-relations program of the association. These activities represent the most important phases of the association's work in the area which will most greatly influence the conditions under which the medical profession will operate in the future. Neither department, however, can function to its greatest efficiency without the coordinated support of the other, nor can they achieve their full and desired effect without adequate public relations direction and assistance.

We recommend, therefore, that appropriate measures be taken to coordinate the work of the bureau of medical economic research and the council on medical service under unified administrative direction comparable to that which has been provided for the various scientific councils.

CENTRAL SERVICING AND COORDINATION OF PUBLIC RELATIONS

Now let us review the record to date with respect to the recommended program for centralized servicing and direction of public relations. What has been accomplished toward creating the facilities needed to inform the public about AMA's activities in the public interest?

In San Francisco, the chairman of the board reported to the house of delegates¹ as follows. [The italics are ours.]

"The consultant recommends that the general manager be authorized to secure an executive assistant in charge of coordinating and servicing the activities of all officers, councils, bureaus, divisions, and departments of the association in relation to the profession and general public.

"He further recommends that this executive assistant have the responsibility of developing, with the full support of the board, ways and means of greatly broadening the system of interpretation of the association to the public on matters other than scientific medicine.

"*These recommendations meet the approval of the board of trustees*, and the board has authorized the general manager to endeavor to find a suitable public-relations expert to fill this position of executive assistant together with the creation in the headquarter's office of a division of public relations with enlarged responsibility and *sufficient personnel to carry out this program adequately* under the immediate supervision of the general manager and the general supervision of the board of trustees.

¹ J. A. M. A., vol. 131, No. 12, p. 997.

Search for candidates

In view of this statement we were quite willing to undertake upon the request of the general manager, and without charge, an extensive search for the best available candidates for the position of executive assistant. We sought men who offered (1) wide experience in nonprofit fields and (2) proven capacity to plan and direct programs involving budgets of from \$100,000 to \$200,000 per year.

We submitted two candidates.

The first candidate declined the offer made to him, and, as we reported informally to the general manager, the chief reason was apparently that, after conferring at AMA headquarters, he did not feel convinced that there was a sincere desire for an effective public-relations program.

The second candidate, Mr. Charles M. Swart, was interviewed by officers of the association and was offered the position of executive assistant to the general manager. He accepted after he had read the chairman's San Francisco statement and the other San Francisco proceedings and after he had been assured that he would have "sufficient personnel to carry out this program adequately." Moreover, in view of the expected scope of his duties, the association set the salary at \$15,000 per year.

Tentative budget

After a period of orientation in our headquarters, Mr. Swart reported for duty at AMA headquarters on November 25, 1946. Contrary to an impression in some quarters, he was not and never has been in our employ.

He was faced immediately with the duty of preparing a tentative budget for a portion of the new year, pending detailed action by the house of delegates upon the recommendations in our survey.

Just prior to the convening of the house in December, the board approved a small, initial, and strictly tentative budget which, with respect to staff, provided only for Mr. Swart's salary, a liaison and editorial assistant, a junior writer, and a secretary.

House of delegates' action

During the ensuing days, the house of delegates, acting as committee of the whole on our survey recommendations, voted² with respect to staff for the executive assistant as follows:

(a) "To engage a competent person to conduct a centralized service of pamphlet production."

(b) "That all possible uses of visual techniques be utilized backed by the advice of professional counsel."

(c) "That the speakers' bureau should be not only initiated but activated and utilized to its fullest capacity."

It seemed obvious to us that each of these actions of the house implied that adequate personnel should be engaged to implement its decisions.

In addition, the house of delegates approved, subject to cost and demonstrated need, our recommendation:

(d) "That provision be made for a junior radio specialist on the staff, backed by highly experienced professional counsel."

(e) "That the executive assistant be enabled to engage a competent promotional specialist."

Final budget

In light of the unconditional house approval of three additional staff members, the executive assistant, in response to the request for a final budget in February, included provision for (a), (b), and (c) above.

Furthermore, the executive assistant, included provision for (e) above. He believed, and we concurred, that the need for a promotional specialist had not only been proved but also was recognized by the board. This for the reason that the chairman of the board in San Francisco had reported³ with apparent approval our survey recommendations stressing the basic importance of the national health program and the need for developing it in the centennial year.

At its February meeting the board rejected all three items and made other heavy reductions in the proposed budget for the office of the executive assistant.

² J. A. M. A., vol. 132, No. 17, pp. 1089, 1090.

³ J. A. M. A., vol. 131, No. 12, p. 997.

Top-heavy program

We were fully aware of the difficulties which the trustees faced by reason of the discrepancy between the grand total of all the budgets submitted and the estimated income. We recognized that when budgets generally had to be reduced, the amount for public relations had to be reduced also. We realized that economies were necessary; indeed, for that reason, we advised a public-relations budget appreciably below what would be desirable from the viewpoint of that division alone.

The board was apparently unaware, however, that its February action left the office of the executive assistant with a grossly top-heavy budget, a \$15,000 per year executive assistant in charge of a \$40,713.30 program. (Meanwhile, contrary to our considered recommendations, the board appropriated a large amount for a new radio program which was uncoordinated with any other public-relations plan or activity.)

Attendance at meetings

Of particular concern to us in February was the fact that we were not admitted to the board meeting which made these decisions until after the budget action had been completed, and then for only a short period. Moreover, the executive assistant was admitted at no time either to explain or defend his budgetary recommendations or to become familiar with the board action on other matters.

This exclusion seemed contrary to the recommendation made in our survey and approved by the house of delegates in December, that, subject to administrative approval by the general manager, the executive assistant must "have the right to attend all board, council, and committee meetings and, when he considers it necessary, to express opinions regarding public-relations aspects of their deliberations."

We are happy to report that the board invited the executive assistant and us to attend its April meeting. We trust that this practice with reference to the executive assistant will be followed regularly in the future, for, if correct, and understanding interpretation and support are given to the policies of the board of trustees, the person charged with this responsibility must have an opportunity to know thoroughly the viewpoints of the board on all matters with which it deals. This requires attendance throughout all board and executive committee meetings.

Executive assistant's achievements

Throughout this entire period, and indeed up to the present time, the executive assistant and his staff have achieved substantial results despite the budgetary and other restrictions. The weekly news bulletin has been continued and in our judgment somewhat improved. A most comprehensive and systematic plan has been developed and is being executed for publicity in connection with the centennial celebration. Moreover, the weekly secretary's letter had been initiated, and on the whole has met with warm approval. (Since, however, some comments have been critical, we are currently seeking detailed comments from a representative sample of all the recipients.)

In addition, numberless miscellaneous questions and requests previously addressed to various officers and bureaus are now being referred to the executive assistant for action. Simultaneously, aid and counsel have been sought from the executive assistant by the president of the association, the director of the bureau of economic research, and various other members of the staff.

Most important for the future, in our judgment, are the plans which have been formulated for various phases of the expanded public-relations program, and the real progress which has been made in winning for the division of public relations increased reliance upon it by a majority of all units within the headquarters building.

Request for budget reconsideration

But even these forward steps still leave the association far from the position necessary to the well-being of the medical profession. Hence, greatly concerned by the general chain of developments with regard to the office of the executive assistant, we addressed a communication to all the trustees on April 8, 1947, requesting reconsideration of the budget for his office.

In this letter, as you will recall, we recounted some of the facts reported above and also made the following among other observations:

"Under these budget decisions the executive assistant is left with hardly enough personnel to deal with routine operations. Even with superhuman re-

solve and protracted overwork, it would be physically impossible for a staff of this size to do the job we believe the AMA desires done during the next few critical years.

"That is why we say that the board's excision of all these items makes it impossible to carry out the expanded program. If not corrected soon, it will almost inevitably lend force to the contention of critics in and outside the AMA that the association does not genuinely intend to carry out its new policies."

Since our request for a reconsideration of the budget was granted, the executive assistant submitted to the general manager the memorandum appended hereto as appendix B, and your counsel appeared with him before the executive committee on April 25, 1947.

The executive committee stated, however, that it could take no action and requested our appearance before the full board at Atlantic City in June.

Alternative courses for the future

Hence, at present, the public-relations program of the association stands in an untenable position. If, last July, we had been advised that only about \$55,000 would be available for its support, our staff recommendations would have been different. And if we had been advised of the limitations last December, the planning by the executive assistant and ourselves would have been basically different.

The program that was approved by the house of delegates last December cannot be conducted under the restricted budget voted by the board of trustees. If the association still desires this program, it must undertake to provide at least the minimum funds necessary to make it possible.

On the other hand, if the association does not now wish to carry out the expanded program, or cannot find the necessary funds, then the program and staff will both have to be completely replanned to conform with the new situation.

We recommend, therefore, as a matter of utmost importance that the trustees and the American Medical Association make a clear choice at the June meeting between two courses of action:

1. Provide an adequate appropriation to enable a program substantially as recommended by the executive assistant and ourselves at the April meeting of the executive committee—approximately \$75,000 for 1947 and \$127,000 for 1948, or

2. Determine what maximum amounts, less than the above, can be allotted for 1947 and 1948 and take steps toward the basic replanning of the association's public-relations program to conform with these limitations.

Inability to follow the first course would be highly regrettable. But, if necessary, a new plan of limited operations, under a revised concept, could be developed.

WHAT THE CONSTITUENT SOCIETIES DESIRE

In any planning or replanning of public-relations activities, it is highly important to take into account the desires of the constituent societies. As we pointed out in our letter of April 8, these bodies are now spending in the aggregate many times more than the full budget requested by the executive assistant. They are spending, we have ascertained, well over \$600,000, perhaps nearer \$800,000.

Six months ago, therefore, we asked all State society secretaries and the secretaries of a few large county societies to tell us what they most wanted to see in the AMA's public-relations program. More than 40 sent confidential replies; all but 4 offered detailed suggestions.

Many of the desires expressed by the societies were reflected in the advice which we gave to the executive assistant and hence in the recommendations submitted to the board of trustees in February. Since the required funds were not available, however, and since it appeared that a reduced program might become necessary, it seemed essential to determine priorities of importance among the many suggested program elements.

In April, therefore, we embodied all the suggestions in a composite checklist (see appendix C). We then submitted this list to the society secretaries with an invitation to indicate their ideas of the relative importance of the component parts.

The response has been most favorable in all but two cases. Secretary after secretary has urged that most, if not all, of the suggestions be given effect. A few quotations will illustrate this point.

From State societies:

"It has been extremely difficult to rate these various major headings and sub-headings in the order of their importance because so many of them seem to me to be of equal importance."

"Our thinking was that the items listed would *supplement* the existing services and activities of the AMA—not supplant them, except in cases where there would be duplication and overlapping."

"The value of almost all of these suggestions is such that in my opinion 'ranking them' by numbers should be considered fractional. I do not see a single idea of the list that would harm medicine—I would like to see them *all* carried out, and inaugurated speedily."

"If and when the majority of these are put into effect, there will be a tremendous upsurge of public approval. I will spend my own time and money to bring these things about."

And from large county societies:

"It is my sincere hope that you will get this program under way immediately, because I personally feel such action is imperative."

"Very hard to grade these suggestions. I think they are *all* good and urgently desirable."

The following findings, among others, emerge from the systematic polling of the societies:

First in importance, the majority say, is a "revitalized information and publicity service" which would give widest possible publicity to efforts and accomplishments of organized medicine in the extension of prepayment medical-care plans and which would also prepare and distribute to State societies news releases on matters which could best emanate from local sources. This revitalized information and publicity service should also, in the opinion of the societies, make readily available to all sections of the lay press, and particularly to national magazines, authoritative material regarding new medical discoveries and the work of doctors in the reduction of death and disease, with particular reference to the achievements of the AMA.

The next most important field, from the viewpoint of these constituent societies, is a "constructive legislative program to promote interest and activity in health legislative matters." Here the foremost point of emphasis is to "let the AMA speak openly for its own membership." This is followed closely by a request that widest possible publicity be given to positive legislative proposals made by AMA or supported by AMA. Again in this field, there is a wide desire that the Washington office be made an "effective arm of the association, expanding it if necessary." There is also the recommendation that unfavorable legislation be criticized only in the spirit of constructive evaluation. Furthermore, that emphasis should be placed upon positive action in the field of legislation rather than on lobbying against proposals made by others.

Third in the list of preferences is the bracket which calls for improvement of AMA's individual member relationships in order to "bridge the gap between the individual members and the AMA by cultivating a feeling of loyalty and support." Two outstanding suggestions are stressed in this connection. First, a letter to the membership, monthly if possible, over the name of the current president or general manager of the AMA, its work, its policies, its program, and what those members think about the AMA. This, they recommend, should be followed by appropriate measures to meet whatever situation is found to exist.

Fourth, is the closely related field of strengthening relationships between the AMA and its constituent societies. Foremost in this category is the request that haziness on matters of policy be combatted by stating thoroughly and clearly new policies or changes in policy as they take place and especially after meetings of the house of delegates. This is followed closely by the recommendation that means be found to evaluate the wishes of State societies more speedily and put those wishes into effect.

The fifth preference is for activities to promote voluntary prepayment plans by measures other than the publicity which was recommended in first place above. The chief need here, according to the societies, is thoroughly to inform and indoctrinate the individual physician members on the need for support of voluntary plans.

As of this date, steps are being taken to round out more fully the information from the State societies and, if the results warrant, a supplemental report will be submitted.

CONTINUED NEED TO GIVE LEADERSHIP

The confidential communications which we have been privileged to receive from constituent and component societies of the American Medical Association during recent months clearly indicate that they desire help and leadership. They underscore the validity of the statement made in our original survey that "State and local leaders are eager for aid and leadership. They do not want to be directed or told they must follow a certain line, but they are always reaching out for patterns which they may assimilate and later consider their own."

Again, because it continues to have such pertinence to the present situation, we would reiterate additional comments which appeared in our survey of a year ago:

"An organization cannot hope to be recognized as a leader if it has not mobilized its own resources to this end. * * * State representatives have told us repeatedly that they miss the leadership which they believe headquarters should give. * * * Therefore, continued hesitancy in giving leadership to the constituent societies would be inherently weak. A positive policy could be exceedingly strong if it were developed democratically and implemented with intelligence, imagination, and skill."

Yet more, we would emphasize the assertion in our letter of April 8 to the board of trustees that if the public relations of the association, which are now in a critical state, are to be improved successfully, the measures taken must have sufficient force to be effective. The AMA must take the lead with a vital and adequate national health program if it is to have strength in the midst of changing conditions, and particularly if it is to make Government control of medical economics unnecessary.

In the history of the association which Dr. Fishbein has been writing, he emphasized that since its beginning the American Medical Association "has kept abreast of the profession in its development."

This does not seem to us enough. And we would quote as the most vivid expression of this judgment a report received from a strong Middle Western medical society:

"There is now a feeling that, since it (the association) is fully organized and functioning smoothly, it should set the pattern for the profession, with advanced planning. To lead in this manner, it is felt that our national organization must be willing to concern itself more than previously with problems of national importance, even if they be only little concerned directly with health. In other words, the American medical profession, having now come fully of age, the organization which represents it must in most mature fashion be a part of the total society of this Nation, not apart from it."

This challenge obviously applies to activities in the field of medical economics and social medicine. It also applies, and indeed it was particularly written with reference to the public relations of the association. In our best judgment, the AMA cannot long afford either to ignore this challenge or to seek to meet it with the inadequate measures thus far taken.

* * * * *

It is our deep regret, which we are certain is shared by most of the trustees, staff, and membership of the association, that the past year has not seen greater progress in these fields. We recognize, however, that change in the attitudes and affairs of a great association which is comprised of men holding many diverse views must inevitably come slowly. The past year's work has done much to clean the seed and prepare the ground. We trust that the coming year will witness a great planting and a rich harvest.

Respectfully submitted,

RAYMOND RICH ASSOCIATES.

APPENDIX A

NOTE WITH REGARD TO THE NATIONAL PHYSICIANS COMMITTEE

It will be recalled that the "Special Committee on Executive Session for Consideration of the Rich Report" submitted the following findings to the house of delegates last December.

"This committee recognized: (1) That each member of the American Medical Association is primarily a citizen with the inalienable right to join any organization. (2) That the house of delegates has on two previous occasions endorsed and commended the work of the National Physicians Committee for the Extension of Medical Service. (3) In line with the new program in the process of accomplishment, this committee feels that the American Medical Association should

and must do its own public relations and legislative work. This implies no lack of appreciation of similar work done and to be done by other organizations devoted to the best interests of the public and of organized medicine. (4) In view of the controversial character of the Rich report and in view of lack of documentary evidence relating to the National Physicians Committee for the Extension of Medical Service, this committee recommends further study of this portion of the report."

Previous to the submittal of this committee's report, we had been advised of the belief in some quarters that our statement and recommendations with reference to the National Physicians Committee were insufficiently substantiated. We therefore made two statements to the board of trustees:

1. In public relations the attitudes people-express are in themselves pertinent facts. Whether fair or unfair, they form a body of evidence requiring careful consideration. To eradicate unfavorable opinions, if they are unsound, is one of the functions of public relations.

2. That nevertheless in view of the questioning of our report, we were prepared to make, for a token fee of \$5 a complete study of the National Physicians Committee.

This offer on our part was, we were told, reported to the house of delegates, although it does not appear in the proceedings as published in the Journal.

Since that time we have received neither an invitation nor an authorization to make such a study. Hence no study has been made although we still stand ready to do so if desired.

We reported this situation to the executive committee on April 25, 1947, and we were confirmed in our understanding that no report is expected.

STATEMENT OF SENATOR GLEN H. TAYLOR, IDAHO

I should like to submit, for the committee's consideration, this statement as to why I am proud to cosponsor the National Health Insurance and Public Health Act of 1947, S. 1320, and why I must oppose the passage of S. 545. I should like to discuss, in this statement, the bearing which these two bills have on the needs of America's farm families.

We have, in the past few years, learned much about the heavy toll levied on rural America because of inadequate health services and poor medical care. S. 1320 will, I believe, correct these deficiencies in a relatively short time. S. 545, on the other hand, will aggravate the evils.

Organized preventive services are most important to the 57,000,000 Americans who live in rural areas, and 43 percent of our Nation's population live in communities of less than 2,500 persons.

Preventive services are important to farm people because by their widespread application we can most effectively combat the evils which are preventing rural America from achieving a health parity with our urban population.

For example, cities of 100,000 or more have an infant mortality rate about one-fourth lower than do rural communities. Similarly, the big city maternal mortality rate is one-third lower. Diseases which are entirely preventable, such as typhoid fever and diphtheria, cause several times as many deaths in rural as they do in urban areas. It is reported that tuberculosis, long thought of primarily as a disease of the city, is becoming more prevalent among rural residents since the newer techniques of mass surveys and modern treatment have been applied with vigor only in the cities.

Despite the need for these preventive services, 40 percent of the Nation's population in 1946, primarily all rural, was not serviced

by district or local public-health departments, and in a third of the counties that were serviced, there were no health officers. Twenty-three of the States do not have even a single local public-health unit that measures up to minimum medical experience and training standards. Instead of the one to two dollars per capita required to provide adequate preventive services, rural areas are spending 50 cents. Is it any wonder that, with this lack of provision for adequate preventive health services in rural areas, preventable diseases still take an inexcusable toll of life?

Title II of our bill, the title on "Development and Expansion of Health Services," would provide means for correcting these very deficiencies. The Federal grants-in-aid to the States for expanded preventive health services, for maternal and child health services would come as a blessing to those millions of rural residents who do not now have the protection of full-time, adequately staffed and well-financed public-health departments.

Not only can programs for the control of tuberculosis and the venereal diseases be strengthened and extended, but impetus would be given to the establishment and maintenance of programs for the early detection, prevention, and treatment of mental disorders, dental disease, cancer, heart disease, and other diseases of our aging population.

In addition to adequate preventive services, our rural people are vitally interested in having access to hospital beds and in having enough physicians, dentists, nurses, and other health workers available to serve them. Congress has taken cognizance of the inadequacy of the Nation's hospital facilities by its passage of the bipartisan Hospital Survey and Construction Act. I am not sure, however, that the great disparity between rural and urban areas in this regard is generally appreciated.

Generally speaking, rural States have about half the supply of hospital beds found in the highly industrialized and urban States. Moreover, rural hospitals are usually small, poorly equipped, and without free beds since they are often privately owned.

Large cities have a 60 percent higher rate of hospitalization than do farm areas, and this lower hospital-bed occupancy exists in those very areas that have the fewest hospital beds. This is not because farm people need or desire less hospital care, but because they are less able to afford to purchase it.

The construction of hospital facilities under the Hospital Survey and Construction Act by itself will not bring sick farmers into the hospital. As a matter of fact, even for construction to be undertaken under that act, proof must be shown that the hospital can be maintained—a difficult task in a low-income rural county. A prepayment system that removes the economic barrier to hospital care and guarantees a community purchasing power to furnish the necessary maintenance is provided for by our bill.

In title II there is the provision that hospitals would be paid their full cost of service. In addition, the amount of money authorized under the Hospital Survey and Construction Act is increased and the span of its authority is extended from 5 to 10 years.

The need for physicians, dentists, and other health personnel in rural areas is acute. They have 43 percent of the population but only 18 percent of the health workers of the country.

This maldistribution of physicians means that there is only one country doctor for every 2.6 urban physicians. And the situation is growing worse since large numbers of doctors who went into the armed services from rural areas are now settling in the cities. Many rural counties have up to 5,000 and even 10,000 persons per physician against a minimum desired proportion of 1 to 1,000. Eighty-one counties recently reported no physician at all.

The unfavorable economic status of so many rural areas means a low medical purchasing power. This has been the major reason why professional people no longer settle in these areas. By assuring adequate pay for physicians in rural communities, the national health insurance fund would attract doctors to country district.

Furthermore, section 256 of title II, rural areas, makes special provision to end the shortage of professional people in rural areas by guaranteeing a minimum annual income, by paying transportation expenses of physicians establishing their practices in such areas, and by authorizing loans for the purchase of necessary office equipment.

We all know that up to date and adequate medical care is expensive. The use of insurance so as to meet this cost on a group basis is now a generally approved device.

Most farm families do not have the incomes to meet the high cost of medical care on an individual basis. And voluntary health insurance plans are no help in rural areas. Insurance is no good when you have no doctor. Besides the \$100 a year which is the average cost of comprehensive medical care for a family, is a sum out of the reach of about 80 percent of all farm families. The largest rural program of voluntary prepaid medical care, originally sponsored by the Farm Security Administration, has been sharply curtailed.

The Blue Cross hospital plans, so popular in the cities, reach about 3 percent of farm families and even these plans take care of only about one-fifth of the average family's yearly medical bill. Voluntary health insurance sponsored by the State medical societies cover only about 1 percent of the rural population and usually insure only against surgical and maternity care in the hospitals.

S. 1320 mobilizes the total resources of our Nation through an insurance plan based on income. Only in this way can farm families participate in a system which provides comprehensive health services at a cost they can meet.

I should like to indicate in closing, several of the implications of the Taft-Ball-Smith-Donnell bill, S. 545, which I feel will be disturbing to rural people. Farm people do not like to take charity. They do not want charity medicine as a substitute for health insurance. They want to pay their way, but they want the medical care they need. They would not willingly submit to a means test such as that required by S. 545.

S. 545 is apparently designed to give over control of the program to organized medicine, a monopolistic trend in medicine which I oppose as much as I oppose monopolistic trends in investment banking and in railroads. Both the National Grange and the Farmers Union have been outspoken in their opposition to medical monopoly to the exclusion of the people who pay for medical care in the planning and management of medical society prepayment plans.

In about 20 States there is restrictive legislation which prevents the consumers of medical care from forming their own health insur-

ance plans. Cooperative plans for the distribution of medical care have been very successful in many rural areas and our farmers will fight any attempt to prohibit the continued development of these plans in a democratic fashion.

Finally, S. 545 would set up a double standard of medical care—one for the rich and one for the poor. Since so many of our farmers are unable to meet high costs of medical care, they will not support legislation which at best would provide medical care of an inferior quality.

Therefore, in the interests of our Nation as a whole and particularly because it is badly needed by our farmers and their families, I urge prompt and favorable action on S. 1320, the National Health Insurance and Public Health Act of 1947.

STATEMENT OF SENATOR DENNIS CHAVEZ, NEW MEXICO

I am glad to take this opportunity to present the reasons which led me, as a Senator from the State of New Mexico and as reflecting the views of the peoples of our great Southwest, to join with Senators from Montana and New York, from Florida, Rhode Island, and Idaho in sponsoring S. 1320, and the reasons why, under my obligations to the Nation and to the people of my State, I must oppose S. 545.

Fortunately, one no longer has to argue over whether or not there is need for Federal action to assure our people of access to modern medical care and of a chance to maintain the good health which that care makes possible. Experts and statisticians have produced volumes of figures proving that our people are not getting the care they should.

During the last two sessions of Congress, both the existence of this need and the absolute necessity for Federal action in meeting the need have been recognized by leaders of the Republican Party as it had been long before by men of my own persuasion. This session has seen the introduction of S. 545, sponsored by Senators Taft, Ball, Smith, and Donnell, and of S. 1320, sponsored by Senators Wagner, Murray, Pepper, Taylor, McGrath, and myself. The need and the need for action has been agreed upon.

But the proposals set forth in S. 545 are so unsatisfactory that I am sure its sponsors cannot really have been aware of either the very great extent of the need in the Southwest or of the methods of meeting that need which would be acceptable to the people of the Southwest. It is on these points that I should like to comment. My colleagues will, I am sure, address themselves to the conditions pertinent to those varied sections of our great Nation which they represent.

New Mexico is a most fortunate State in most respects. Our people are rich in their cultural heritage, richly endowed by the climate and character of the land in which we make our homes, rich beyond measure in their deeply satisfying ways of living.

But New Mexico is an agricultural State and our people are not rich in the common usage of the word—in dollars. Recent figures indicate that the average effective income for each family in New Mexico in 1941 was only \$1,435. That was but 67 percent of the national average of \$2,133. In 1944, although the corresponding cash figures had almost doubled, New Mexico still stood at only 70 percent of the national average.

If this was the average income for New Mexico, the Senators, knowing that New Mexico has some very wealthy families, will realize that our average family had in fact an appreciably lower income. If even the AMA concedes that a family with \$3,000 a year cannot alone and unaided purchase good medical care, it becomes obvious that a bill like S. 545, which at best can aid only 5 to 10 percent of the population, cannot solve our problem. Only a program reaching 80 to 90 percent of our families, as does S. 1320, can do the job.

In October of 1942 there were 45 States with a more satisfactory ratio of people to each practicing physician than in New Mexico. At the same time throughout the country as a whole the distribution of practicing physicians was 1 for every 1,400 persons. Corresponding figures for New Mexico showed 1 physician for every 2,449 persons. There were only 2 States with more people per physician, the last State on the list having only 1 for every 2,806 persons. At the other extreme, 1 State showed 885 individuals for each practicing physician.

It is unlikely that more recent figures would show much improvement for New Mexico. Nor do such figures begin to tell the whole story because there are areas in New Mexico where the patient-physician ratio is even worse. Physicians, here as elsewhere, have located for the most part in the more urban communities where they have access to the medical resources necessary for the practice of high quality medicine.

Such a condition means that any bill which pretends to solve the problems but which makes no specific provision for the training and relocating of physicians and which, in addition, requires the State to match Federal funds, is in truth a mockery no matter how well intentioned.

One other factor, peculiar to the Southwest, must be given consideration. Our people are the proud representatives of three great cultures: the Indian, the Spanish, and the Anglo-American. In terms of Americanism, the claims of these first two groups antedate that of the people of practically any other part of the country. This heritage, together with the fact of citizenship in our United States, means that we in New Mexico are a proud people—rightfully so. It means that we are an independent people—very much so. And it accounts, too, for the extreme patience which characterizes our people.

Even in the face of shameful treatment as members of little-known or recognized minority groups they have exhibited unusual fortitude and forbearance. They, along with millions of others in this Nation of ours, were denied economic and social justice before the last war. Nevertheless, the record of volunteer enlistments from these groups in New Mexico was outstanding during the recent international holocaust dedicated to uprooting fascism. Their performance on every battle front during the war was heroic and many of them gave their lives in the performance of feats of bravery and endurance. Those who returned were fortified in their belief in the ultimate victory of democracy for all the people.

To the people such as this, a measure offering assistance only on condition that they accept the label of indigent, as does S. 545, would be completely unacceptable. Our people would recognize it at once for what it is, namely, a system of emergency relief with a double stand-

ard of medical care—one for the low income and another for those of wealth.

The people of New Mexico know that there is only one acceptable standard of medical care. We do not want to see separate systems of medical service, one for those who can afford to pay well and another for those who cannot, established in their State or for that matter anywhere in our Nation.

Such a proposal is archaic, a return to the Elizabethan Poor Laws of 1604. Those people needing medical care the most would scorn such a policy before bowing to the humiliation of accepting charity. They would rightfully resent the prying of the investigators who would be required to execute S. 545.

To the people of New Mexico, S. 545 means degradation, dependence on charity, poor medical care, and a compulsory tax on all the people for the questionable benefit of a few. Such legislation is abhorrent and no solution to a problem affecting over 90 percent of all the families in New Mexico.

The Senate subcommittee reporting on the 1939 Wagner health bill said, among other things:

Poor health leads to unhappiness, poverty, dependency, and even to crime; good health contributes to well-being, production, income, and wealth. The ideals and principles of American democracy call for equality of opportunity. Such equality of opportunity certainly cannot exist unless all groups in the population have access to those health services needed to prevent and cure disease, and to promote vitality and well being.

The right of all the people to medical care, which S. 545 ignores, makes this bill even more intolerable.

In contrast, S. 1320 really recognizes the basic philosophy of making medical care available to all the people. It rests on the right of the individual to health and on the economic need of society for a healthy population—one which is fit and able to produce.

S. 1320, as opposed to S. 545, would entitle practically every American family to medical care as a right, when it is needed, in return for contributions made while well. This is an extension of the social security principle which has already been accepted by the American people to replace the antiquated poor law system which S. 545 so closely resembles.

S. 1320 permits our people, along with those of every other section of the country, to proudly pay the proper percentage of their incomes for their medical care; it assures the man earning \$1,000 a year or \$1,500 or \$2,000 that he is doing just as much to insure the health of his family and of the Nation as is the man earning five or ten thousand; it enables him to seek and to receive medical care on the same rightful basis as any other man.

S. 1320 assumes even greater significance when the administrative aspects of the bill are reviewed. I shall leave a complete review of this phase to my colleagues. However, I should like to indicate in passing that S. 1320 very adequately and properly recognizes the importance of local control. In fact it provides for the distribution of health services in accordance with local customs and traditions. This, permit me to assure you, is extremely important to New Mexico. It is an amazing incongruity that such provisions are not apparent in S. 545.

S. 1320 further provides that the Federal Government must approve State plans and that there will be standards set for the quality of service rendered. I am not at all afraid, as other Senators seem to be, that such provisions will make the Federal Government dictatorial. Perhaps because we in New Mexico trust our Federal Government and its officials.

It also seems odd to me that any legislation involving the expenditure of Federal funds would not contain safeguards guaranteeing their wise expenditure. From this point of view, S. 545 virtually gives the medical profession carte blanche. It is no wonder that organized medicine is supporting S. 545. It is nothing more nor less than a subsidy for the voluntary prepayment plans which the medical hierarchy is now advocating but which they so bitterly opposed just a few short years ago.

I particularly approve of the provision in S. 1320 which permits a State to have the Federal Government handle the administration of the program if it so chooses. The densely populated and wealthy States have of necessity developed large departments of welfare and public health which could take the administration of a health program as outlined in S. 1320 in their stride.

Other States, finding themselves not so well situated in this respect might well prefer Federal administration. Again, as is true throughout all of S. 1320, there is a democratic adherence to freedom of choice. In contrast, S. 545 not only requires that the State administer the program, but it insists that the State health department be the administrative agent.

As heartily as I endorse health-department administration of medical care, I still insist that in accordance with our democratic traditions the State should be permitted to choose which agency it feels is best equipped to handle the program. It would appear that those who talk overily much of the principle of States' rights are afraid of the decisions which the State might make.

The provisions for rural areas which appear in S. 1320 are of great importance to New Mexico. They mean that, as an inducement to settle and practice in sparsely populated and low-income rural communities, physicians may be guaranteed a minimum income; reasonable expenses incurred in traveling to the chosen area may be paid; loans may be made for the purchase of office equipment; unusually costly travel expenses incurred in the transportation of patients may be paid; funds may be expended to educate the people in the areas as to the medical services available and how they may best be utilized; and, finally, funds are available not only to initially train medical personnel who will settle in rural areas but to permit post-graduate training of any medical personnel located or willing to locate in rural areas. Only in such a manner does a democracy improve the health of the people and fully realize the value of its largest single resource.

In closing I should like to indicate that the problems of medical care which we face in New Mexico are not peculiar to New Mexico. The problems of medical care of the low income, rural, and Negro groups are closely interrelated and follow the same pattern. All of these groups receive less medical and hospital service than do the high income, the urban, and the white populations, and have higher morbidity and mortality rates. Disease and poverty go hand in hand.

The satisfactory solution of the health problems of our Nation cannot of course be achieved by the medical profession alone. Public health services must also be included in any planning for the protection of the health of the community.

It also becomes increasingly important to give a strong voice to the consumer who pays the bill for medical services. This is not only democratic but it is good common sense to have the benefit of the experience and judgment of these groups.

If passed, S. 545 would deter us an unnecessarily long time in reaching a satisfactory solution to these problems.

It is an objectionable and undemocratic piece of legislation, while in contrast, S. 1320 provides the answer to the health problems of New Mexico and the entire country. It deserves the hearty recommendation of this subcommittee.

Senator PEPPER. Mr. Chairman, I won't ask that it be incorporated here except by reference, but I would like to have incorporated into the record at this point by reference the material appearing beginning at page 2257 of the hearings on the national health program, in connection with S. 1606, part IV, in May and June of last year, entitled "Comparative Death Rates of the United States and Other Countries," running from the middle of page 2257 of the hearings I have identified, down to the end of page 2261.

That gives a lot of data, Senator Donnell, with reference to the comparative death rates of the United States and other countries, and I am just incorporating it by reference here, beginning at page 2257 of the hearings of last year.

Senator DONNELL. By incorporation by reference you mean—

Senator PEPPER. I hereby call attention in this record to the hearings of last year, and specifically that part entitled "Comparative Death Rates of the United States and Other Countries", submitted by Mr. I. S. Falk of the Social Security Agency, beginning at page 2257 of the hearings on S. 1606 in May and June of last year, and running over to the end of page 2261, so that anyone reading this record, and interested in the subject, can turn back to the hearings of last year and see that very interesting material showing the unfavorable comparison.

I will read, if I may, Mr. Chairman, just the first paragraph of that section.

Senator DONNELL. Yes, sir.

Senator PEPPER. This material was prepared by the Social Security Board.

Table I gives the age specific death rates for males in the specified countries where such death rates were lower than the corresponding death rate for males in the United States. The death rate of infants under 1 year of age is in terms of 10,000 live births. For instance, the table indicates that the United States death rate for infants under 1 year of age per 10,000 births in the 3-year period 1934-36 was 641. Six nations in that general period had infant death rates lower than that in the United States. These were New Zealand, Netherlands, Norway, Australia, Sweden, Denmark, and Switzerland. All the other nations for whom information was available had death rates exceeding those of the United States. The striking fact in this table is that (a) at no age are death rates in the United States the lowest, (b) the death rates in the United States are comparatively most favorable for infants under one year of age. The comparative position of the United States becomes worse as we pass from infancy to older ages. Thus, while for male infant death rates the United States is in

seventh position, in death rates of children in ages 1 to 4 it is in ninth position, and progressively the ranges become less and less favorable as we pass to the older age groups.

Now, I just read the first paragraph of the material there.

Senator DONNELL. The incorporation by reference is noted, and I understand that the Senator does not intend that the data be reprinted.

Senator PEPPER. No, there is no need to reprint it.

Senator DONNELL. Because of the fact that I am not making extended observations on it, I do not mean by not commenting upon this data to concede at all that the analogy between the United States and New Zealand, Netherlands, Norway, Australia, Sweden, Denmark, and Switzerland, many of which are small countries and entirely dissimilar in many respects, is a proper one. There are very distinct differences, but that is a matter for argument at some future time.

Senator PEPPER. Yes.

Senator DONNELL. Mr. Louchheim and Dr. Davis, are either of you gentlemen present?

Mr. LOUCHHEIM. I am here. Dr. Davis is around.

Senator DONNELL. The committee has been continuously in session since about 9:30 this morning, with the exception of a slight interruption when the Senate convened, and we would like your indulgence, if we might have a little recess during which not only you, but we as well, might get a little nourishment.

Mr. LOUCHHEIM. Very well, sir.

Senator DONNELL. The committee will stand in recess until 2 o'clock this afternoon. We appreciate your cooperation.

(Whereupon, at 12:50 p. m., a recess was taken until 2 p. m., of the same day.)

AFTER RECESS

(The subcommittee reconvened at 2 p. m., pursuant to recess.)

Senator SMITH. The committee will please come to order.

I believe our first witness this afternoon is Mr. Joseph H. Louchheim, executive director, Committee for the Nation's Health.

Mr. LOUCHHEIM. Good afternoon, Mr. Chairman. That is pronounced Lock-heim, sir.

Senator SMITH. Thank you. I don't have the same difficulty in getting Smith pronounced, although I have heard "Smythe" pronounced "Smith."

STATEMENT OF JOSEPH H. LOUCHHEIM, EXECUTIVE DIRECTOR, COMMITTEE FOR THE NATION'S HEALTH, INC.

Mr. LOUCHHEIM. My name is Joseph H. Louchheim. I am executive director of the Committee for the Nation's Health, Inc.

As to my personal background, I was born in New Jersey. I am a graduate of the University of Pennsylvania and the University of Chicago Law School. I am a member of the New York bar. During the last 13 years, except for the 3 years spent in the United States Navy, I have been working or teaching in the field of public-welfare administration.

The views of the Committee for the Nation's Health on health legislation and specifically on S. 1320 and S. 545 will be presented by my-

self and Michael M. Davis, Ph. D., who is chairman of our executive committee. I will state the general program of our committee and its position on these two bills, and Dr. Davis will present in more detail our analyses of these two measures.

We appear today to testify in favor of the National Health Insurance and Public Health Act, S. 1320, and in opposition to the Taft-Smith-Ball-Donnell health bill, S. 545. We have been authorized to do this by our executive committee, who were so instructed by resolutions adopted at the annual meeting of our board of directors held on May 9, 1947.

In supporting S. 1320 and opposing S. 545 we wish to emphasize the fact that we do not consider these two bills as alternatives. S. 1320 provides for a broad national health program. S. 545, although it is entitled "A National Health Act," is a medical charity bill masquerading as a national-health program. We are prepared to support specialized health measures which are consistent with a broad national-health program, fit into a coordinated scheme of needed medical services, and operate under a sound pattern of administration.

An examination of the list of witnesses who have appeared before you reveals a remarkable contrast between the groups of people that favor and the groups of people that oppose the Taft health bill.

All witnesses favoring the Taft bill in whole or in part were representing medical societies, dental societies, hospital associations, the Blue Cross, voluntary medical-care plans sponsored by medical societies, or insurance companies—groups who would furnish the service and be the recipients of the public funds expended.

Witnesses testifying against the bill, on the other hand, reflected the point of view of a broad cross section of our society. You have heard testimony in opposition to the Taft bill from a wide variety of organizations representing physicians, attorneys, social workers, farmers, industrial workers, veterans, women, consumers, white-collar workers, Negro, and church groups. It is therefore proper to ask, "Whom does the Committee for the Nation's Health represent?"

The purpose of the Committee for the Nation's Health, as indicated in its certificate of incorporation filed February 1946, is to promote and support legislation which will help make available good medical services to every person in the United States, regardless of race, creed, color, or economic status. The committee is registered as a lobbying organization as defined under the Federal Regulation of Lobbying Act, passed during the last session of Congress.

It supports a national health program consisting of national health insurance and Federal aid to States for public health, maternal, and child services, medical research and education, medical care for the indigent, and construction of hospitals and health centers. It opposes medical charity for the self-supporting, and restrictive laws preventing consumers, farmers, workers, and others from organizing health-insurance plans.

Senator SMITH. Did you say you were the Washington representative of the Committee for the Nation's Health?

Mr. LOUCHHEIM. Margaret I. Stein is the Washington representative. I am the executive director.

Senator SMITH. You may proceed.

Mr. LOUCHHEIM. The Committee for the Nation's Health is non-partisan. It recognizes that sickness is no respecter of political affili-

ations. We hope that a Congress which has established a record of bipartisan foreign policy will solve this urgent domestic problem by giving bipartisan support for the only real national health bill before it—by supporting not a party program or a special interest program, but the people's program—national-health insurance.

Who does our committee represent? It speaks authoritatively only for its 2,562 lay and professional members who elect its board of directors and officers. Membership is limited to individuals who endorse the program just stated, and who, through large or small contributions, make it possible for the committee to spearhead the Nation-wide effort to have health insurance enacted.

Many millions of Americans share our opinion that the social security program should be extended to include health insurance. You have heard testimony to that effect both last year and this year from representatives of national organizations with mass membership.

In addition various public opinion polls, some financed by medical organizations opposed to national-health insurance, have demonstrated beyond question that there are not just a handful of people but many millions of people who favor in their thinking, and who will support by their votes, such a health program as the President has recommended and as is incorporated in S. 1320.

The board of directors, the elected officers, the members of this committee, without thought or prospect of personal gain, devote their time and spend their money to further the objectives of the committee. They are concerned with the interests of no special group but rather with that of all our people—of the purveyors as well as the consumers of medical care, of the articulate and the inarticulate, of all the people of America. Their sole objective is to make modern medical care economically and physically accessible to the people of the United States. They are convinced that it can best be done by universal prepayment for medical care—through an extension of our Social Security System.

Unfortunately, hearings on pending bills sometimes tend to becloud instead of clarify issues. We wish to make it abundantly clear that we do not consider that American medicine or the individual practitioner is on trial at these hearings.

To the question, "Generally speaking, do you not think that the medical profession is composed of high-minded, generous, and honorable people?" our answer is unequivocally, "Yes." The major issue is not that of rendering medical care. It is, rather, the manner in which medical care shall be purchased and the question of who shall make the decision—the buyer or the seller, the consumer or the producer, the public or the politicians of organized medicine.

Since Dr. Davis will only give a condensation of his statement, I should now like to place in the record at this point his full statement, and ask that it be copied into the record.

Senator SMITH. Will Dr. Davis be here this afternoon?

Mr. LOUCHHEIM. Yes, sir; he will.

Senator SMITH. You say he is not going to give his complete statement?

Mr. LOUCHHEIM. In the interest of saving time he is not going to read it—it consists of approximately 18 pages—but he will discuss it. However, we would like to have his full statement appear in the record, immediately following mine.

Senator DONNELL. I assume it is all right for it to appear in the record immediately following your statement, as you request, but we certainly want to have the opportunity to cross-examine Mr. Davis on his statement.

Mr. LOUCHHEIM. He is here now.

Senator DONNELL. May I ask a question?

Senator SMITH. Yes, sir.

Senator DONNELL. I want to ask you if you know John B. Lawrence, who is an incorporator of Cooperative Health Federation.

Mr. LOUCHHEIM. I do not know if he is an incorporator of Cooperative Health Federation. I know a Dr. Lawrence who is assistant professor of medicine, Washington University, and medical director of the Health Institute of St. Louis.

Senator DONNELL. Now, this meeting of the board of directors that was held on May 9, 1947—where was that held?

Mr. LOUCHHEIM. In New York City.

Senator DONNELL. In New York City?

Mr. LOUCHHEIM. Yes, sir; at the Town Club.

Senator DONNELL. At the Town Club?

Mr. LOUCHHEIM. Yes, sir.

Senator DONNELL. Was Dr. Ernst P. Boas there?

Mr. LOUCHHEIM. Yes, sir; he was.

Senator DONNELL. Was Dr. Channing Frothingham there?

Mr. LOUCHHEIM. Yes, sir; he was.

Senator DONNELL. Is Dr. Frothingham still chairman of the committee for the Nation's health?

Mr. LOUCHHEIM. Yes, sir.

Senator DONNELL. And Joe Davidson?

Mr. LOUCHHEIM. Joe Davidson is not on our board of directors.

Senator DONNELL. Is he an honorary vice chairman now?

Mr. LOUCHHEIM. That's right.

Senator DONNELL. He was not present at that meeting in New York?

Mr. LOUCHHEIM. No, sir.

Senator DONNELL. In the paragraph of your statement beginning with the sentence—

The purpose of the committee for the Nation's health, as indicated in its certificate of incorporation filed February 1946, is to promote and support legislation which will help make available good medical services to every person in the United States regardless of race, creed, color, or economic status—

then follows other language after that, and later on you say—

Membership is limited to individuals who endorse the program just stated.

Do you mean by that that you will not accept as a member on your committee anyone who holds views different from the views that you have expressed here today? Is that your meaning?

Mr. LOUCHHEIM. I mean specifically, sir, what is expressed in the rest of the paragraph of which you just read the first sentence.

Senator MURRAY. What page is that on?

Mr. LOUCHHEIM. That is on page 2 of the statement, sir.

Senator DONNELL. Just what do you mean by this language on page 3:

Membership is limited to individuals who endorse the program just stated, and who, through large or small contributions, make it possible for the committee to spearhead the Nation-wide effort to have health insurance enacted.

Just what program are you referring to in that sentence?

Mr. LOUCHHEIM. The program that supports national health insurance. You will find that very clearly stated on page 2:

It supports a national health program consisting of national health insurance and Federal aid to States for public health, maternal and child services, medical research and education, medical care for the indigent, and construction of hospitals and health centers. It opposes medical charity for the self-supporting, and restrictive laws preventing consumers, farmers, workers, and others from organizing health insurance plans—

and so forth.

Senator DONNELL. That is the balance of that page?

Mr. LOUCHHEIM. That's right, sir. In other words, in order to become a member, a person must not only support the program but must also make a contribution, either large or small.

Senator DONNELL. That is, you do not accept anybody as a member of your committee unless he first indicates adherence to these principles which you have set forth; is that correct?

Mr. LOUCHHEIM. That is correct, sir.

Senator DONNELL. All right.

Senator SMITH. Is that all?

Mr. LOUCHHEIM. Yes, sir.

Senator SMITH. Dr. Michael M. Davis.

Senator DONNELL. Mr. Chairman, at this point I would like to present for the record, with the request that it be incorporated and set out in full, a resolution on S. 1320 presented to the house of delegates of the Association of American Physicians and Surgeons and unanimously adopted by the delegates at their meeting in Chicago, June 28, 1947.

Senator SMITH. If there is no objection, it will be copied into the record.

(The matter referred to is as follows:)

Whereas a new version of the Wagner-Murray-Dingell bill was introduced into Congress on May 20, 1947; and

Whereas this legislation proposes compulsory sickness insurance for all employed persons; and

Whereas enactment of the legislation would tend to regiment all patients and physicians and thus foster governmental paternalism with its degrading and weakening influences; and

Whereas the proposed law gives no assurance of greater quantity of medical care, since it is reasonable to presume that most doctors would not participate in such a scheme, because to do so would be contrary to the public interest; and

Whereas the bill would lower the quality of medical care; decrease the quality and caliber of persons attracted into medicine; and hamper medical advances; and

Whereas the measure proposes to create a vast administrative political bureaucracy and place control of the Nation's health activities in the Federal Security Administration, which is neither qualified with professional personnel nor experience to administer medical care but whose past record is characterized by blundering ineptitude, waste, and unauthorized propaganda; and

Whereas enactment of the Wagner-Murray-Dingell bill would increase very substantially the costs of medical care and thus add greatly to the enormous tax burden already carried by American taxpayers; and

Whereas the bill would remove the patient's right to choose his own doctor, since all doctors would not enter into the scheme and thus eliminate the important, intimate, and confidential personal relationships existing between patients and physicians; and

Whereas no real need has ever been shown for a system of compulsory sickness insurance which would force all persons into the scheme whether or not they desired to participate; and

Whereas voluntary sickness-insurance plans are rapidly gaining increasing acceptance by both physicians and potential patients and if extended and given either State or Federal financial aid and encouragement for persons of low income, where needed and properly and safely administered, will soon adequately meet the medical care needs of the Nation; and

Whereas the extension of any form of governmental compulsion into the personal affairs of the people is not in the American tradition and decidedly against the public interest; and

Whereas the AAPS is dedicated by the provisions of its organization to preserve and extend for all the people of America the superb record of medical care in the United States and to countenance only those changes which are in the public interest: Therefore be it

Resolved, That the house of delegates of the Association of American Physicians and Surgeons at its interim meeting held in Chicago, Ill., June 27 and 28, 1947, go on record as strongly disapproving the Wagner-Murray-Dingell bill and copies of this resolution be sent to members of the Senate Committee on Labor and Public Welfare, now holding hearings on the bill; and officers of the association be instructed to oppose vigorously the legislation by enlightening Members of Congress and the American public of the bill's many objectionable provisions.

HOUSE OF DELEGATES OF THE ASSOCIATION
OF AMERICAN PHYSICIANS AND SURGEONS,
H. W. DETRICK, M. D., *Speaker*.

Dr. DAVIS. Mr. Chairman and Senators, Mr. Louchheim has requested that the testimony which I have prepared and is now in your hands in the form of mimeographed copies, in accordance with the regulations, be copied into the record, instead of my reading it into the record, in the interest of saving time. I presume you have had an opportunity to study it, and I will summarize it and comment on it in order to expedite matters, if that is agreeable to you. Will it be satisfactory for me to proceed in that way?

Senator SMITH. I have no objection, Dr. Davis, but I have not had time to read it yet. I had another committee meeting, so I didn't have time to read your statement. Is there any objection to proceeding in that manner?

Senator DONNELL. No objection.

Senator MURRAY. In summarizing it, you will cover all the important parts of the statement, I presume. Is that correct?

Dr. DAVIS. I had in mind covering the most important parts in my summary.

Senator SMITH. Go ahead. Your brief will be incorporated in the record, to follow your testimony.

STATEMENT OF MICHAEL M. DAVIS, PH. D., CHAIRMAN, COMMITTEE FOR THE NATION'S HEALTH

Dr. DAVIS. May I identify myself for the record as Michael M. Davis, a native of New York. I received a bachelor's and a doctor of philosophy degree from Columbia University and have been concerned throughout my professional life with the administration of hospital, clinic, and other health services and as a consultant concerning their economic and public relations. I appear here today as chairman of the executive committee of the Committee for the Nation's Health.

Senator SMITH. That is the same committee that the previous witness referred to?

Dr. DAVIS. Yes. Mr. Louchheim is executive director of the committee.

Mr. Louchheim has already made clear the general position of the committee, namely, that we favor the National Health Insurance and

Public Health Act, S. 1320, and that we oppose the proposed S. 545.

Too often both friends and critics of the National Health Insurance and Public Health Act talk about the provisions of the bill from the top down. It's much easier to understand them from the ground up.

In order to consider how the bill would work for a patient and a doctor in any community of the United States, in giving an illustration as to how the bill would work, I picked the town of Roanoke Rapids, N. C., to show the typical actual relationship between a patient and a doctor, a general practitioner or specialist, and I have shown how the obtaining of hospital care would not involve any contact between the doctor, the patient, or the hospital outside of the relationship to the State health agency of North Carolina, and in most instances really nothing outside of Halifax County or the service area, which might not be contiguous with the county. That is the main point I have endeavored to bring out in showing how this plan would work.

I cannot lay too much stress upon the point that in the operation of a bill of this kind we are concerned with services which involve a very large proportion of all the people in the country in the course of a year or two when sickness occurs to them, and most of the doctors of the country and the hospitals—

Senator DONNELL. Pardon me. I have some difficulty in following your illustration. I can't read at the same time you speak. I wonder if you couldn't tell us what this illustration is.

Dr. DAVIS. Tom Jones, the textile worker; is that what you're talking about?

Senator DONNELL. That's the illustration you are referring to, is it not?

Dr. DAVIS. Yes.

Senator DONNELL. I can't follow it and get your analysis at the same time. Can you tell us what the illustration is?

Dr. DAVIS. Perhaps I had better summarize that in some detail to make it clearer.

I asked the question: How would the bill work for Mr. Thomas Jones, a textile-mill worker, who lives with his family in the town of Roanoke Rapids, N. C.? He becomes sick, and he and his wife think he ought to have a doctor. The health insurance law is in operation. Tom Jones earns \$36 a week. He pays 54 cents a week, which is 1½ percent of his earnings, into the national health insurance fund, and his employer pays an equal amount.

Now that Tom Jones is sick, how does he get a doctor? Does he have to write to Washington or ask a local official? No. Tom Jones calls the doctor he had had before the law went into effect. Dr. Brown comes to see him, just as he would have come before the law was passed, but with two important differences. In the first place, Tom Jones won't get any bill from Dr. Brown. In the second place, Dr. Brown can prescribe what Tom needs and not just what Tom can afford—laboratory tests, for instance, or a specialist if Tom's illness proves obscure or takes a bad turn. Dr. Brown will be paid by the health insurance official of the area that covers Roanoke Rapids and Halifax County in which this town is located.

Where does the Federal Government come into all this? Not at all. The National Health Insurance Board would have paid North

Carolina its quota from the national health insurance fund. North Carolina would have allotted the Halifax County health service area its quota.

Suppose Dr. Brown thought Tom Jones had pneumonia, that he had a poor heart and might be in danger. Tom Jones or his wife, if they were anxious, or Dr. Brown, if he thought it necessary, could call in a specialist, Dr. George Johnson, the one internist within reach. Either of these doctors might decide to ship Tom at once to the Roanoke Rapids Hospital, where he could get better care than Mrs. Jones could give him at home. The local health insurance fund would pay this hospital the costs of its services to Tom Jones.

In all this, neither Tom Jones, nor Dr. Brown, nor Dr. Johnson, nor the Roanoke Rapids Hospital would have anything to do with any official or board outside of Halifax County.

I think that summarizes the point pretty well. I then go on to explain how the relationship would be in case they called in a specialist, and how the qualifications of a specialist would be determined, and his right to receive payment at the higher rates which would be paid a specialist, as compared to a general practitioner.

Senator DONNELL. Who would determine whether he is entitled to be considered a specialist?

Dr. DAVIS. The State agency administering the health insurance law would determine the lists of specialists—those in different branches who would be made eligible to receive payment as specialists. The national body—that is, the Board, the Federal Security Administrator, and the Federal Government, with the Advisory Council—would lay down the very general policy, such as, for instance, they would, as the law indicates, be required to recognize the standards set by the appropriate professional bodies.

Senator DONNELL. Pardon me a minute, if you don't mind. Who would determine whether or not he is entitled to have a specialist?

Dr. DAVIS. Dr. Brown would determine whether or not he should call in a specialist.

Senator DONNELL. Suppose Dr. Brown and the patient differ in their feeling as to whether or not a specialist should be called in? The patient thought it necessary; Dr. Brown thought it was not. Who would determine that?

Dr. DAVIS. Under those circumstances, the patient has a right to go to the nearest medical administrative officer available in that local service area, or in a neighboring one, and request, over the head of Dr. Brown, that he be allowed to have a specialist.

Senator DONNELL. How large are these areas?

Dr. DAVIS. Under the law the States are required to make the necessary surveys and divide the State up into local health-service areas. The procedure there follows rather closely what is already in operation now under the Hospital Survey and Construction Act, which of course sets up, as you gentlemen know, a procedure for making such service areas and dividing the State up into those service areas.

Senator DONNELL. I don't want to interrupt you, but I want to get these facts perfectly clear in my own mind. As I understood it, you said that if he and his physician, Dr. Brown, disagree as to whether Jones needs a specialist, Jones has the right then to go to an administrative officer; is that right?

Dr. DAVIS. A medical administrative officer.

Senator DONNELL. A medical administrative officer, either in that area or in an adjoining area?

Dr. DAVIS. Yes.

Senator DONNELL. Might that adjoining area be over in some nearby county?

Dr. DAVIS. In sparsely settled areas the State health insurance agency might not find it necessary, on account of the limited number of people and doctors, to have a full-time medical administrative officer in every service area. They might solve that problem by having a medical administrative officer who would cover more than one area, or they might employ a doctor in each area on part time if the amount of work required did not require full time.

Senator DONNELL. Of course, if a patient who considers that he needs immediate attention by a specialist finds it inconvenient to go over to some other area some miles away and have the specialist make this investigation, he just goes without a specialist—is that right—if there is disagreement between him and the doctor?

Dr. DAVIS. One can conceive of such a situation, but may I say this: Dr. Brown—that is the general family practitioner who is treating him—if the patient wants a specialist, and he for some reason or other doesn't think it necessary or doesn't want him to go to one for some reason or other, then Dr. Brown faces the risk, since Jones has free choice—if Dr. Brown doesn't do what Jones wants him to do then Jones can change to another doctor, which he has the right to do.

Senator DONNELL. And then if there is a disagreement between Dr. Brown and the patient, and that disagreement should arise, we'll say, over alleged disagreeable conduct on the part of the doctor toward the patient, then the patient can go to a local officer or committee, have a hearing and take an appeal; is that correct? What happens if the patient dies while all this appeal business is going on? Does the appeal lapse, or is there some provision for the heirs, successors, and assigns to carry on the appeal?

Dr. DAVIS. In the case of a complaint, Senator—I take it you are not referring now to the question of the specialist?

Senator DONNELL. No.

Dr. DAVIS. You are referring in general to the matter of complaints?

Senator DONNELL. Yes.

Dr. DAVIS. If Mr. and Mrs. Jones feel that Dr. Brown was negligent—he didn't come for 24 hours, and they waited and waited, and then when he finally did come he was hasty and disagreeable—they may enter a complaint about him. He may continue to treat them or they may change their doctor. But they might go to the local health service organization, which is described in the bill, and complain that Dr. Brown was a very disagreeable person and they wanted the health service organization to know that and they wanted to enter a charge against him. The nature of the charge might be so serious that it might even involve legal matters if it was a question of malpractice. It would be a legal case then, under general laws. Or it might be just a complaint.

The provision in the law, as you remember, is that the local health center would have to take one of two alternative forms, according to how the State may decide. I won't go into detail on that unless you

want me to. The local health service organization of the area has a primary hearing on the complaint. If the complaint is one that involves a patient and a doctor, it is heard by a mixed group, such as a local committee—a mixed group of lay persons and doctors.

If, for instance, Dr. Jones was called in as a specialist, we'll say, over the head of Dr. Brown, and if he came to the conclusion that there had been gross negligence on the part of Dr. Brown, he might, on the basis of the desirability of not having Dr. Brown carry on because Dr. Jones regards him as incompetent, enter a complaint against him on the ground of pure negligence, and that complaint would be heard before a committee which would be composed wholly of physicians because it would involve questions of professional medical judgment, with a determination to be made as to whether there was evidence that such acts on the part of Dr. Brown revealed that he was professionally incompetent.

Senator DONNELL. Dr. Davis, I would like to read this short excerpt from your prepared statement here. I take it this is correct:

Suppose Mr. Jones was dissatisfied, and complained that Dr. Brown had delayed 24 hours making his first call and then was hasty and disagreeable. A local officer or committee would reach some decision about this complaint. Hearings and appeals could be had if demanded.

That is a correct statement, is it?

Dr. DAVIS. Yes.

Shall I proceed without further discussion of Tom Jones and the local area?

Senator SMITH. Do you have any further questions, Senator Donnell?

Senator DONNELL. I want to examine him further, but not at this point.

Senator SMITH. Under the present system, if Mr. Jones didn't like Dr. Brown he would just give up Dr. Brown and call in Dr. Robinson; wouldn't he?

Dr. DAVIS. He can do that under this law, too.

Senator SMITH. He can do that now?

Dr. DAVIS. He can do that now.

Senator SMITH. Without this appeal proceeding?

Dr. DAVIS. Well, the appeal is only after there has been a complaint about the doctor. This statement about hearings and appeals relates to a complaint of misconduct on the part of a doctor.

Senator SMITH. I am thinking of a man who has an appendix that is hurting him badly. He does not think that Dr. Brown is treating it quite right, and his wife goes to the phone and tells Dr. Brown, "You needn't bother to come over any more. We're going to Dr. Robinson and have him take care of it."

Dr. DAVIS. Yes.

Senator SMITH. But Dr. Robinson has to be on the list or calendar of eligible doctors?

Dr. DAVIS. Yes.

Senator DONNELL. But suppose his list is full and this patient's name is not on his list, the patient could not go to him; could he?

Dr. DAVIS. No. I take it you may wish to discuss that particular issue later.

Senator DONNELL. Yes; later on.

Dr. DAVIS. I have given a good deal of thought to that. There is a great deal of difficulty along that line which I will be glad to discuss. It might be better to do so later on when we are on that phase of it.

Senator SMITH. Yes; go ahead.

Dr. DAVIS. The main point I wish to make in giving this description of the local operation of the law is to make the point against those declarations made by some opponents of this bill that under it the Federal Government could and would run the whole show; that the duties written out for State and local administration are just a smoke screen to hide a grab for power by a Federal bureaucracy. I consider this nonsense.

In the first place, the six Senators and two Representatives who have introduced this bill into Congress, and every other sensible person, know that it would be wholly impossible to run medical services at long range, or to have any uniform administrative pattern defined by national authorities for all parts of this great and varied country.

In the second place, the bill, as I read it, nowhere gives the Federal authorities power over State and local administration. It does give Federal authorities the power to make and enforce certain standards. Some of the standards are stated in the law itself; some would be defined in regulations.

From their nature, national standards must be in general terms. They must be adapted to differing local and State conditions, by State and local authorities. Having the power to require that hospitals' and physicians' services in every State shall meet certain general standards before these agencies and individuals may receive Federal funds is an entirely different matter from having power to control State and local administration.

I then raise the question, Should the Federal Government have anything to say about standards? The sponsors of S. 545—that is the bill itself—say “no,” in the sense that that bill rules out such Federal standards. This view, however, is not shared by the two expert professional bodies which have testified before this committee, both the American Public Health Association and the American Public Welfare Association. So did that distinguished body, the New York Academy of Medicine, in its testimony before the committee.

Actual experience with legislation—and I am speaking of health legislation primarily—including national standards has demonstrated that such provisions do not bring Federal dictatorship, as some opponents of S. 1320 declare, but on the contrary are consistent with harmonious Federal-State relationships.

I now take up the point of the charge that S. 1320 would bring one-man control.

A board of five members is set up in S. 1320 to administer health insurance at the Federal level. This board is made part of the Federal Security Agency, and therefore comes under the general supervision of the head of that agency. The words in the bill are “supervision and direction.”

S. 1320, however, gives to the board a series of specified powers. My opinion is that these powers given to the Federal Security Administrator in S. 1320 are simply those power which have been or

which ought to be vested in officers of Cabinet rank, as representing the President and the interests of the American people as a whole.

Senator DONNELL. Right at that point, may I read this one sentence from your prepared statement, at page 6 :

The Federal Security Administrator has the same authority over the Board that any Cabinet officer has over any one of his under secretaries or bureaus.

That is a correct statement, is it?

Dr. DAVIS. Yes, sir.

Senator DONNELL. All right.

Dr. DAVIS. I go on to speak about such broad oversight.

Senator DONNELL. Pardon me. You are referring now, I take it, to the language at the bottom of page 39 and the top of page 40 of the bill?

Dr. DAVIS. Yes; that is the determining language. There are some other points where the powers of the Federal Security Administrator are mentioned, but that is the general statement I refer to.

Senator DONNELL. Namely, if I may get it into the record that—

All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator. The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

Is that correct?

Dr. DAVIS. Yes, sir. May I call your attention to something at that point, Senator?

Senator DONNELL. Yes.

Dr. DAVIS. In a determination of the regulations it is extremely important to bear in mind that the wording of this bill seems to give the Board the final word over regulations, and does not give the Federal Security Administrator any power to revise those regulations. I agree—and obviously I am not an expert on bill drafting—that there may be some difference of opinion about that, but I feel quite sure, as far as I can interpret this, that the Board has the final power over the content of the regulations.

The Federal Security Administrator's powers of supervision and direction are of a general character, but I do not think that he has the power to say, "This regulation you cannot make."

Senator DONNELL. You think even on that point there may be some room for argument as to the meaning of the bill in that respect, is that right?

Dr. DAVIS. Senator, there are many points in this bill—I want to say to you now that I have read this bill several times, but I am not in the position of saying or believing that this bill is perfect. In the first place it is complex. Obviously, it is long, and it is complex, and in the second place there are many questions in it on which there is reasonable ground for difference of opinion, not only between opponents and proponents of the bill, but among people who believe entirely and completely in the objective but who differ as to the best method of doing it.

In the third place it is not easy to draft wording which shall express just what you want to say, even if you agree on something—and I have argued many items in this bill with various other persons who

have been concerned about it in discussions that I have been engaging in—so I am well aware of the fact that even among those who ought to be concerned about the drafting of the bill, of which I was not one of course, there is bound to be a difference of opinion as to whether the wording finally agreed upon is agreed upon by all as meaning the same thing.

Senator DONNELL. Some of the friends of the bill admit that the bill is susceptible of vesting in the Federal Security Administrator power superior to that of the Board, even with respect to the making of regulations. Some people admit that to be true, even among the friends of the bill.

Dr. DAVIS. I have not met any person among the friends of the bill who has taken that position. It is my own view that the extent to which the powers of the Federal Security Administrator may go is open to question under this bill.

I also think this, and this is one of the main points I would like to make. I think you have to interpret the administrative powers of the Federal Government in terms of this major fact, namely, that the Federal Government has got to administer its part of the law—that is, the Federal part—in such terms that it actually will yield the delivery of service on the State and local level in a way that is going to satisfy the people and the doctors in the country.

I have had some chance to observe in past years the administration conducted by the Public Health Service of their grants-in-aid provisions, where they are in constant relation with the States in administering the funds granted, where they have certain powers over States with which the States must comply, and powers of review to see that the States do comply.

Senator MURRAY. Dr. Davis, do I understand you to mean, then, that if the language in this bill as it now stands means that the Board is subject to the domination and control of the Federal Security Administrator, that it then should be changed in that respect?

Dr. DAVIS. I entirely agree that if the wording is such, in the opinion of reasonable people—

Senator MURRAY. Why can't you say yes or no?

Dr. DAVIS. I say "Yes."

Senator MURRAY. That is all I wanted to know.

Dr. DAVIS. Yes.

Senator MURRAY. Is it the intention of this language primarily to have the Board located in the Federal Security Administrator's office, and that it is not intended that the Administrator should be able to exercise any control or power to reverse the action of the Board?

Dr. DAVIS. I think that to answer your question I would say "Yes," and I would like to add this—

Senator DONNELL. Wait a minute. I understood he presented an alternative. You are answering "yes" to what part of it?

Dr. DAVIS. That if the language—I think his question, as I took his question I took it to mean that if the wording of the bill as it now stands was such as to give the Federal Security Administrator power to dominate the Board, that the wording of the bill should be changed.

Senator MURRAY. That was not the intention or you think that should not be the intention of the bill, is that right?

Dr. DAVIS. I do not think that should be the intention of the bill, or is the intention of the bill. The point I would like to make on that is this: I think that any committee of Congress that is going into a bill of this kind, as far as the matter of wording is concerned, has to face a major decision in policy. Shall this be an independent agency in the Federal Government, under a Cabinet officer, responsible to the President, like the Federal Health Agency set up in S. 545, or shall it be within one of the existing departments such as is contemplated in this bill, or which roughly corresponds to it, or as contemplated in the report of Senator Aiken's committee in reporting a revised version of the reorganization bill, with which I am sure you are all familiar, which places a new Cabinet officer in charge of health, education, and social security?

It seems to me the basic policy decision is, Shall this be a separate agency? And if you accept that, then, gentlemen, Shall it be under a board? Then that board has final powers subject only to the general supervision that the President and Congress exercise.

Senator SMITH. I think that is a fundamental question, either way you approach it, either by the S. 545 or the S. 1320 approach, whether you want an umbrella over education, health, and welfare, or whether you want health as a separate unit. We have discussed that with a number of witnesses. I am glad to get your view on it. You think it ought to be under the umbrella over the three activities?

Dr. DAVIS. I do. I followed the hearings and attended some of them, and attended some in connection with Senator Aiken's bill.

Senator SMITH. About setting up a Cabinet officer with regard to the three?

Dr. DAVIS. Yes; and it is my own view that the advantages of interrelating health, education, and welfare, or social security, whatever you want to call it, under one officer, are very great indeed, because of the close relationship, especially between health and various forms of social security involving both self-supporting people and dependent people.

This bill, S. 1320, goes along with that general theory, as you see, in this present set-up.

Senator DONNELL. Reverting a moment to your prepared statement, I quote from page 6:

S. 1320, however, gives to this Board a series of specified powers. The Federal Security Administrator has the same authority over the Board that any Cabinet officer has over any one of his Under Secretaries or bureaus.

Now, that is your construction of the meaning of S. 1320, is it not?

Dr. DAVIS. Yes, sir.

Senator DONNELL. Sir?

Dr. DAVIS. Yes; it is.

Senator DONNELL. Then, as you proceed you are not criticizing S. 1320 because the Federal Security Administrator does have the same authority over the Board as, you say, any Cabinet officer has over any one of his Under Secretaries or bureaus? You are not criticizing the bill on that ground, are you?

Dr. DAVIS. No. However, I wish to call attention to this point. I think those two sentences which you read have to be taken together. The second sentence compares the relation of the Federal Security Administrator to the Board with the relation of a Cabinet officer to

one of his Under Secretaries or bureaus. On the other hand, the first sentence qualifies that because the law does give to the Board certain specific powers. Consequently, the power of the Secretary, as a Cabinet officer, is limited by the statutory provisions.

May I say in addition, if I may enlarge upon this point, that in some discussions on this bill the comparison was made with the bill of last year, S. 1606, where the Public Health Service—that is, the Surgeon General—was the administrative officer. To my mind the device of putting in a board instead of the Surgeon General as the direct administrative head, and giving the Board certain specified powers, was with the intent of diminishing the power of the Federal Security Administrator from the point at which he would exercise detailed supervision, and at the point at which his supervision would be in very general terms.

Senator DONNELL. Wait a minute. The authority that a Cabinet officer has over any of his Under Secretaries or bureaus is an authority to direct that Under Secretary or bureau as to what to do, and make the ultimate decision; is that right?

Dr. DAVIS. Except insofar as he is limited by statute, as they are in this case.

Senator MURRAY. To give you an illustration, the Secretary of the Interior has control of the man who is head of the Bureau of Reclamation. Now, the Secretary of the Interior could not compel the head of the Bureau of Reclamation to ignore the law or disregard the rules and regulations laid down by Congress with reference to the conduct of the activities of the Bureau of Reclamation, yet the Bureau of Reclamation would be under the general supervision of the Secretary of the Interior. He would merely be seeing to it that the law was carried out, and that they did not evade the law. Wouldn't that be it?

Dr. DAVIS. That would be my understanding of the intent; yes.

Senator DONNELL. Well, Dr. Davis, in connection with your language here, contained in your statement, that the Federal Security Administrator has the same authority over the Board that any Cabinet officer has over any one of his Under Secretaries or bureaus, I take it that we would agree that an Under Secretary or a bureau under a Cabinet officer is subordinate to the Cabinet officer. That is true, is it not?

Dr. DAVIS. That's right.

Senator DONNELL. And then you follow that sentence in your statement with this sentence:

Unless the Health Insurance Board was set up as an independent agency responsible directly to the President, thereby divorcing health services from the closely related welfare and educational functions—an officer of Cabinet rank must intervene between the Board and the President.

You say that, don't you?

Dr. DAVIS. Yes.

Senator DONNELL. In other words, you obviously consider that the Federal Security Administrator has authority over this Board under the terms of S. 1320, do you not?

Dr. DAVIS. Yes, sir.

Senator DONNELL. And you say he has the same authority over the Board that any Cabinet officer has over any one of his Under Secretaries or bureaus. That is your construction of S. 1320, is it not?

Dr. DAVIS. Yes, sir.

Senator MURRAY. Define what that means then, will you please?

Dr. DAVIS. I have said before that that sentence which you read about the degree of authority corresponding to that of the authority of a Cabinet officer over one of his Under Secretaries or bureaus is limited by the preceding statement—that the preceding statement in the preceding sentence states that this law gives to the Board a series of specified powers. In other words, the powers of this Board, which corresponds to a bureau, are specified in the law in such a way that the administrator could not dictate the contents of the regulations.

Senator DONNELL. And yet again I quote the language from page 39 of the bill:

All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

There is no exception. The word "all" is used. Would you comment on that?

Dr. DAVIS. No; there is no exception; that is true; but I do not see how one can take a single sentence like that outside of the context, and I take it that the interpretation of the law, both by administrators and by any reviewing committee of Congress in determining subsequent appropriations, is made in the light of common-sense regulations and governmental procedures well established elsewhere.

Senator DONNELL. I have no objection to taking it with the context. I have emphasized in this testimony the context as well as that sentence, and that is the statement which I read, and it seems to me that it states very clearly "All functions," and I ask that emphasis be placed on the word "all." "All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator." The word "under" means subordinate, too, does it not?

Dr. DAVIS. Yes.

Senator DONNELL. It is not my intention or desire to argue the point further, but that is the language, is it not?

Dr. DAVIS. Yes, sir; I would say that. I would also like to add there that if I felt that construction were the only possible construction, I should certainly feel it would be advisable to reconsider this wording in order to make the thing clear. That is, that general supervision rather than detailed direction is what is intended here, and if revision is necessary, I hope it will be made.

Senator MURRAY. In view of all your discussion and all the attention you have given to this thing, don't you believe that it should be made a little clearer?

Dr. DAVIS. I do, on this and several other points. As I said before, I think the bill could well be revised in order to clarify the intent, irrespective of the policies.

Now, if I may proceed, the next point that I make in my testimony moves from the question of one-man control to the issue of lay control, and I point out that almost all of our major institutions of medical services and medical education are under lay control. Practically all of our medical schools today are under boards of trustees composed entirely, or almost entirely, of nonmedical men. The control of voluntary hospitals is not in the hands of physicians but of laymen, usually lay boards of trustees. City, county, and State hospitals are likewise controlled by lay boards or officials. Not more than 5 percent of the

hospital beds in this country are in institutions owned and controlled by physicians, and the number of hospitals of this type is diminishing year by year.

In the full testimony I somewhat enlarge on this point, and on page 8 I have included an extract from a set of general principles of hospital organizations, adopted some 20 years ago by the American Hospital Association, which is not merely a statement of principles but actually the type of organization to which the great majority of our hospitals all over the country do conform. The status of our hospitals—

Senator DONNELL. Just a moment, please. In order that we might have a little more of the language you use in connection with the subject we have just been discussing, namely, public control, in connection with this question of the Administrator, you have a statement there at the top of page 7, in which you say:

My opinion is that the powers given to the Federal Security Administrator in S. 1320 are simply those powers which have been, and which ought to be, vested in officers of Cabinet rank, as representing the President and the interests of the American people as a whole. Such broad oversight by an officer representing the general public interest is needed in order to insure that general policies laid down by Congress and approved by the President are carried out by the specialists who must administer them. The entire development of a great variety of Federal services and of grants-in-aid has actually proceeded under these principles.

Now, that represents your view, does it not?

Dr. DAVIS. Yes.

Senator DONNELL. Pardon the interruption, but I just wanted to read that.

Dr. DAVIS. I am very glad to have that put into the record, Senator. It emphasizes the point that I tried to make.

Proceeding with my statement, after the general principles that I just referred to: Does lay control of a medical organization mean interference by laymen in medical matters? Not at all. If it did mean that, American hospitals would be battlegrounds instead of partnerships. The doctor's job is the diagnosis, treatment, and prevention of disease. That is what he is trained for. Lay boards do not tell doctors how or when to operate or prescribe.

In a hospital, a medical school, or a voluntary health insurance plan run by its members, the lay board owns the property, manages the finances, appoints the medical staff, and authorizes the policies and the standards of the organization.

The appointment of the staff may require selection among medical men. The authorization of policies and standards, including professional standards, always requires the advice and guidance of medical men. This advice and guidance concerning personnel and standards the lay board gets from its medical staff. But the lay board has responsibility for final decision. In many instances the lay board is the disinterested and welcomed arbiter among a group of staff physicians who are in private practice and in financial competition with one another.

The standards of our hospitals would not be enforced half so well if the physicians instead of a lay board had the final control. Those who want evidence of this can find plenty of it. Above all is the major fact that it is upon this system of lay control that our American medical institutions have grown great.

This principle justifies the establishment of an administrative board which may include a majority of laymen, as in S. 1320. It justifies the placing of the whole system under a Cabinet officer, who will represent the whole public rather than the interests of a profession. It also justifies two other important requirements of S. 1320: on the one side, that issues, complaints, and other matters wholly concerned with the technical questions of medicine shall be settled wholly by physicians; and on the other side, that advisory and administrative bodies, except those wholly confined to technical questions, shall contain a majority of public representatives.

Senator DONNELL. Do you advocate that the Federal Security Administrator be made a Cabinet officer?

Dr. DAVIS. I am in favor of the principle of the reorganization bill, as reported recently, which would make the Federal Security Administrator a Cabinet officer. I realize there are other ways of dealing with that problem, but that way seems to me to be the best way to do it.

Now I move on to another section of my testimony, which begins on page 9, relating to monopoly and the American Medical Association. The subject has been discussed in a number of other sessions by other witnesses, and I am not sure that you want me to read this section. If you wish to have me do so, I will summarize it.

Senator DONNELL. I would like to have you give it to us pretty thoroughly.

Senator MURRAY. It is an important point.

Senator DONNELL. I did not have an opportunity to read your statement, although you sent it in; and, speaking for myself, I would like to get your theory on this phase of it rather fully. I don't want you to abbreviate it to the point where it is difficult for us to get your views completely.

Dr. DAVIS. All right, sir.

At the present time, the American Medical Association and its State and county medical societies are insisting upon control of the health-insurance system by physicians. This demand is incorporated in the administrative section of S. 545, written, we are told, as a result of conference with representatives of organized medicine.

Senator DONNELL. Which section of S. 545 do you refer to?

Dr. DAVIS. That is the opening title I.

Senator DONNELL. You mean the National Health Agency?

Dr. DAVIS. Yes. Title I—National Health Agency.

Senator DONNELL. That is the administrative section to which you refer?

Dr. DAVIS. Yes.

Senator DONNELL. Thank you.

Dr. DAVIS. The same demand appears in the organization of the medical-care insurance plans sponsored by medical societies, and in some 20 States the medical societies have endeavored to enforce this demand by getting a State law which will guarantee them control, if not monopoly.

Senator DONNELL. Do you include Wisconsin as one of those?

Dr. DAVIS. What?

Senator DONNELL. Do you include Wisconsin as one of those 20 States? You recall that medical bill which has been referred to as a bill creating a monopoly.

Dr. DAVIS. The bill in terms of its wording, Senator, does not create a monopoly; but, taken in conjunction with the fact that other laws, such as laws against the corporate practice of medicine in Wisconsin and many other States, have been passed or proposed, we require that in order that any medical-care insurance plan be established there must be an enabling plan or act. The only enabling act passed in Wisconsin up to very recently has been the enabling act passed at the instance of the State medical society.

Senator DONNELL. But that did not contain any provision which in any sense precluded the legislature from passing such a law with respect to other organizations.

Dr. DAVIS. I am not sure about the law, but it was my understanding that the enabling act with respect to lay groups has been passed by both houses and may have been signed by the Governor.

Senator DONNELL. I mean the so-called Medical Fence Act does not contain anything which purports to prohibit the legislature in any sense from subsequently giving like privileges to anybody it wants to give them to; is that right?

Dr. DAVIS. Certainly the State legislature, if I understand our Federal and State constitutions at all, has the right to do so, either by amending that particular enabling act or by passing another act and correlating and coordinating the two. Of course, the legislature could change that policy, if it was a policy.

Senator DONNELL. I just want to make that clear, Doctor. We had this in the testimony yesterday by Mr. Hansen. Did you hear Mr. Hansen's testimony yesterday?

Dr. DAVIS. No; I was not present.

Senator DONNELL. He is counsel for a national cooperative federation—I don't recall the exact title of it—but, at any rate, Mr. Hansen, who is a lawyer and comes from Minnesota, conceded that in his opinion the so-called Medical Fence Act does not constitute the creation of a monopoly. He takes the view that it is merely a permissive act which permits the medical societies to carry on the activities mentioned; but he did say, as a practical proposition, that under the common law a corporation cannot engage in activities other than those conferred upon it by the legislature, and that inasmuch as that was the act which conferred the powers, and those powers had not been conferred on somebody else, obviously, until they were conferred on somebody else, the medical society was the only one that could carry them out. Is that not a correct statement of the situation in Wisconsin?

Dr. DAVIS. Senator, it seems to me to be a correct statement of the situation in Wisconsin from a legal standpoint; yes; but the actual situation in Wisconsin, as I interpret it—and the statement I have made here does not approach it from the legal standpoint but from the standpoint of intent on the part of the medical association—in the State of Wisconsin, to my knowledge, in the last few years, two efforts by organizations of lay groups, most farm cooperatives or other organizations of farmers and their friends, have been blocked by the efforts of the medical society by the same methods which have been used in many other places, of bringing pressure upon the doctors, plus the evident pressure upon them directly under the law. In the second case, which was after this Medical Fence Act had been passed, they

were told that they would be blocked by the insurance commissioner if they tried to set up their scheme in this way.

But the actual working of laws of the Wisconsin type, which exist in several other States, has been in effect to give the medical society power to create and enforce a monopoly. There are laws in some of the States, such as Illinois. I don't know whether this was discussed yesterday.

Senator DONNELL. Yes.

Dr. DAVIS. Actually it does give the medical society, or requires that any medical-care insurance plan in Illinois must be in the control of physicians or that a majority of physicians be on the controlling body, nominated by the State medical society; so you do have control. And I imagine Mr. Hansen gave a report of the difficulties in Minnesota which the cooperative groups had found up there and the opposition of the State medical society there.

The point I am making is that the actual policy of State medical societies in many States, and this involves local medical societies also in the operation of those policies, has been such that they have endeavored to keep the principle that the control of health-insurance plans involving physicians' services shall be in the hands of physicians and shall be in the hands of physicians through a medical society.

Senator SMITH. Is the motive for so doing mostly one of gain to control the business, or is the motive mostly with respect to the quality of service?

Dr. DAVIS. Well, Senator—

Senator SMITH. Do you concede that the motive might be the rendering of top-quality service?

Dr. DAVIS. I would be glad to answer your question in this way: I think the mere motive of direct gain to the individual physician is a secondary motive. As Mr. Lasker said this morning, there is a business as well as a profession involved in the practice of medicine. Doctors have to make a living as well as serving mankind, and the business aspect has to influence policies, especially those of medical societies and groups of any kind, but I do not think that it is the primary motive.

There is a rather naive idea on the part of most physicians with respect to the conduct of an insurance program involving physicians' services, and the actual practice in medicine and the set-up and the history of the development of medical plans under medical societies, which have developed only in recent years, the earliest one going back to about 1939, have been such as to make it clear that that is the concept with which the medical society groups have approached it.

I had the occasion, Senator Smith, if I may say so—it happened by invitation—to sit with the committee of the New York State Medical Society at the time that they were getting their original plan, late in 1938 or early in 1939, underway. They asked me to come over there and sit with them. The president of the society was Dr. Carroll. I forget the names of most of the others I met with. And the one thing I said to them was:

Gentlemen, I think that you are making a very great mistake to want to set it up in this way. If you seek control by physicians you are seeking control of the payments and disposition of the payments. You gentlemen, necessarily, being the physicians operating this plan and rendering service, are the chief recipients of the payments which come from the pockets of the subscribers.

Such a position is not a wholesome position for any group of people to be in, and it tends to destroy or greatly diminish the incentive to economy, and tends to remove the possibility of control of abuses which exist the moment the subscribers have a major voice and a direct voice in the management.

I hope I have made it clear that I do not regard for a moment that the control of lay subscribers of an insurance plan shall involve control by them over the practice of medicine any more than the board of trustees of the Presbyterian Hospital or Emergency Hospital here in Washington. While legally they can discharge a doctor any time they like, practically they do not dictate to a doctor how he shall operate, or when, or what tests he shall make, though legally I guess they have the right to say, "You do this or you will be fired."

Senator SMITH. Without defending or criticizing the practice in any way, I think that the doctors setting up some of these group plans felt that the matter of standards to be maintained was something largely for medical men to decide, just like a group of lawyers setting up standards for the bar in the State. They don't want the fakers that always appear in any profession. You do admit that, do you not, Dr. Davis?

Dr. DAVIS. Yes.

Senator SMITH. You always have your fakers in every profession who want to get in because of some kind of money-making scheme that may be involved.

I am not too critical about their setting up these standards. Maybe the practice ought to be changed. I am not arguing with you on that.

But I am not critical of a group setting up these standards, and feeling that these certain standards of the medical profession would have to be maintained if the plan were to be successful in the long run. I don't like the use of the word "monopoly." I hesitate to use that charge against doctors at this stage of the game.

Dr. DAVIS. I have met so many physicians in discussing these matters that I entirely agree with you that the effort of the medical societies to get control of these plans in the hands of physicians is, I would say, certainly rationalized in terms of the control of standards and the maintenance of quality. I do not think that they have adopted the best method of attaining that goal, and I also would like to add that they have been driven in many instances, put on the defensive, to such a degree—I mean some of these groups of physicians—that it has become difficult for them to see the matter in a balanced way, because of the feeling that they are threatened. They may be mistaken, but the feeling is very real, and I appreciate that.

Senator SMITH. There has been a sort of feeling broadcast that because doctors may have wanted to have standards maintained and therefore have control of these organizations, that therefore there is something bad about the medical profession. Perhaps I am terribly prejudiced about the matter, but having been raised in a family of doctors, and knowing the efforts that my father continually made to raise the standards of the profession and the hand that he had in setting some of those standards up, I know that the motives of the people in that profession are beyond question. Maybe some of the methods are not as wise as they might be politically—perhaps not—but I want to state for the record that I think the motives of those men, of the leaders of the profession, have been very high indeed.

Dr. DAVIS. I would agree with you as regards the motives of the majority of the physicians. As far as their motives in these matters are involved, I would agree with you on that. On the other hand, I think I could cite, if there were time, which there isn't, a long series of examples where plans initiated or endeavored to be initiated by lay groups of people—industrial workers, farm groups, and so on, and sometimes by groups of physicians themselves in a group-practice unit—prepayment plans, have been bitterly fought both by local medical societies in the county in which the plan was situated, and by the State medical societies, in a way which indicates clearly that in the main the motivation on the part of a great many doctors was essentially a business motive, designed to prevent the competition of a type of enterprise or a practice clinic which they felt was something they did not want.

Senator SMITH. We have some things, of course, which must be eliminated, as I stated to the witness who testified regarding certain things in Minnesota, but I want to get away from any general condemnation of the medical profession because some of these things may have been done. I want to correct any evils of that type as much as anyone in the world does.

Don't let me hold you up, Dr. Davis. I just wanted to put that thought in the record when you spoke of monopoly, and I want to make it perfectly clear that I do not feel that the evil significance of the word "monopoly" ought to be applied generally to the medical profession. I have never seen it personally, and I have had a good deal of experience with doctors.

Dr. DAVIS. I have included in my testimony, on page 10, a paragraph in which I have incorporated some sentences in which I endeavor to state my view. I have had long contact with many doctors in different parts of the country. I am well aware that the great majority of doctors are sincerely devoted to the service of their patients, but there is a business side to medicine, and as soon as you deal with the problem of any organized scheme, the business side tends to come into the foreground to a degree in which it does not come between the doctor and his individual patient.

Senator SMITH. You make that charge against the Doctors' Hospital in New York, which was organized by doctors in the hope that it might be a reasonably profit-making enterprise, which it never was? The doctors were finding themselves obliged from time to time to put up their own money to meet the deficit, but nevertheless they carried on just the same, and that organization has done a wonderful job.

Dr. DAVIS. The majority of hospitals owned and run by doctors, and incorporated by doctors, have had a much harder time to keep going financially than have the other hospitals—

Senator SMITH. Definitely.

Dr. DAVIS. Run as community enterprises.

Senator SMITH. I agree with you. I have a brother-in-law connected with St. Luke's Hospital in New York. He is retired, and that is his life's work today. He is a pure layman, and knows no more about medicine than an ordinary man on the street. I agree with you that we need business management. I am getting at the motive behind the thing, so as not to leave the impression that at this

hearing we are saying that the medical profession is a monopoly or that its motives are anything but high-minded. I don't want any unfair implication to be made.

Senator MURRAY. Of course, Dr. Davis, a lay board would be inspired by motives of seeking the highest quality of medical research, would it not?

Dr. DAVIS: Yes.

Senator SMITH. A lay board, trying to make a profit out of something, might do a little charlatan stuff too. I don't think it depends on whether it is a doctor or a layman. Either can be honest or dishonest.

Dr. DAVIS. Along that line, gentlemen, I think experience has shown that the lay board does have a very strong incentive to maintain standards. The methods and the details and the contents of those standards, obviously, they must learn from physicians. It is also true of insurance plans, where the subscribers who are putting up their money are also the recipients of service. Obviously, they have a double motive, to get the most for their money and also actual service for themselves and their families. They want to keep the standards high as much as the doctors themselves do.

Senator SMITH. There is no question about that. I agree with you on that.

Dr. DAVIS. Now I will go on, if I may, to a point that is on page 10 of my testimony, under the heading "Restricted medical society plans."

Senator SMITH. I might also say that in previous testimony there was introduced the letter to Dr. Frothingham in connection with the American Medical Association, which was along the same line as what we have just been discussing, so that point has been covered in the testimony.

Dr. DAVIS. One of the reasons why I omitted it was because I knew it had been brought up, so I thought there was no need to discuss it further unless you wanted to ask some questions about it.

The chairman of the board of trustees of the American Medical Association declared in his testimony a few weeks ago, "The people do not demand a comprehensive medical service." He said that the experience of the voluntary health-insurance plans demonstrates that the people prefer limited service, chiefly for costly illness.

Is this statement true? Let us look at the facts.

At this hearing the AMA distributed a 24-page pamphlet entitled "Voluntary Prepayment Medical Care Plans." From the title, the charts, and the text one would assume that this pamphlet presented a picture of all the voluntary medical-care plans in the United States. This, however, it does not do. Quite the contrary. The pamphlet presents only those plans which have been sponsored by medical societies. It completely ignores the existence of a much larger number of plans organized under the auspices of other organizations and successfully maintained, many for a long period of years.

Whereas there are 90 medical-society health-insurance plans described in this pamphlet, there are 175, or nearly twice as many voluntary health-insurance plans under industries, unions, cooperatives, and other auspices. The membership of the medical society plans is estimated as approximately 5,000,000. The membership of the 175 other plans is about 2,300,000.

Senator DONNELL. You did not understand that the chairman of the board of trustees came in to testify other than with respect to the plans that had been put into effect by the medical profession, did you?

Dr. DAVIS. Well—

Senator DONNELL. You did not think there was any concealment on his part that there were other plans?

Dr. DAVIS. I do not say there was any concealment on his part, but the plans were ignored in a pamphlet gotten out and distributed by the American Medical Association, and, as I will go on to say in a moment, have been ignored by the AMA in its recognition and discussions of medical-service plans in all the published reports I have seen on the council of medical service.

Senator DONNELL. Do you have a copy of that 24-page pamphlet with you?

Dr. DAVIS. Not with me. I saw it the day of the hearing. It consists mostly of charts, with a rather brief text.

Senator DONNELL. That was introduced in the hearing.

Dr. DAVIS. Yes.

Now, most of these 175 plans provide comprehensive medical service, that is, the services of general physicians and specialists in the patient's home and the doctor's office, as well as in the hospital.

Here we have it. The plans organized by medical societies offer only limited services, but the plans which have been organized by the people who pay the bills supply comprehensive care.

Why have not the plans organized by the people, the 175 plans, grown more rapidly in number and membership? The chief reason is that the State and county medical societies, with the support of the AMA, have put every possible obstacle in the way of prepayment medical plans except those run by medical societies. The medical societies have made it uncomfortable for doctors who joined such plans. Sometimes they have expelled doctors who joined them.

Furthermore, in about 20 States, the medical societies have recently caused laws to be passed which give special advantages to plans organized by medical societies and which, in some States, actually prevent any other plan from being organized. We have been over that part before.

Senator SMITH. Of course I do not question the facts that you are stating here, but again I just want to note for the record that as I understand it, these medical groups have been trying to maintain standards and not let a fly-by-night organization grow up that does not meet those standards, and try to sell something to people that is not up to those standards. We want to consider that in this whole picture.

I do not agree with your statement that the plans organized by medical societies offer only limited services as compared with the other plans you speak of. We have had testimony here that they are trying to see, by experiment, trial and error, and by checking into various things, how much further they can go—the Blue Cross, the Blue Shield, and others—and now they are going into the whole field of how they can go into the house service as well. I don't think they are trying to limit their service, and I don't think the other plans have demonstrated that they have set up services that would give over-all coverage. I think it is a question of people who are experienced in the field of medicine trying to give the service in the group plan as rapidly

as they can, and I am very happy to say from testimony that has been given here that they have been very successful. I have been impressed by the progress that has been made.

I am not critical of your approach, but I am not critical of the doctors' approach either, and I want the record to show that.

Dr. DAVIS. The part on which I feel critical of the doctors' approach, Senator, has been on two counts. One, the direct attack which has been made, which I just stated, in a number of places, by county and State medical societies on efforts made by local lay groups to start plans, when they were not controlled by the medical societies, and when they employed physicians on a group basis, not full time, rather than individual payment by each patient to the doctor on a fee basis. That seems to me to be one of the elements which I think I would call an effort toward keeping control—monopolistic control.

That is part of an antiquated pattern, a familiar pattern, and I further think it is a mistaken policy from the point of view that it is checking the kind of experimentation we want to have in this country on a voluntary basis as much as possible. The only basic excuse for a long continuance of voluntary plans is that it gives an opportunity to find out how things work and what they cost, and I think the attempt to check experimentation has been one of the very serious obstacles which the A. M. A. has placed in the way.

Senator DONNELL. The medical societies have not been very successful in their efforts to place obstacles in the way, have they, when we find that 175 of these plans have been put into effect by groups of persons other than medical societies, as against 90 that have been put into effect by medical societies? So it seems to me that in spite of all these obstacles that you refer to, there have been twice as many health-insurance plans organized by people outside of the medical societies as by the medical societies themselves, which again indicates—and I would offer this for your consideration—that the medical societies obviously have not been able to form any monopoly here of these health-insurance plans, in connection with all these obstacles which you mention.

Dr. DAVIS. Let me say that a large proportion of the 175 plans are plans which have been in operation for quite a long time and got started, especially in industries, before the medical societies had become sensitized on these points.

Another very important fact is this: there is a very considerable proportion—I can't give you the figures from memory, but a considerable portion of the plans are industrial plans. Industrial plans constitute approximately between 110 and 120 of the 175 plans that I mentioned. These industrial plans are plans run for the benefit of employees of large industrial establishments. A considerable proportion of those plans are in industries sufficiently large to have a basis for such insurance; and in relatively isolated sections or in communities where the workers and their families constitute a large proportion of the total population, a majority of the medical service in the area is necessarily directed toward the employees covered by the plan. Therefore, a plan of the kind I speak of, when set up, is of direct and rather considerable industrial value to the employer as well as to the workers themselves.

Senator SMITH. You would approve such a plan; would you not?

Dr. DAVIS. Yes; I would approve such a plan if it were well run.

Senator SMITH. Doesn't the medical profession approve such plans?

Dr. DAVIS. In general. These plans—a large proportion of them—were started—well, some of them were, anyway—twenty or more years ago.

Senator SMITH. I have heard about a lot of them. I have watched them with great interest.

Dr. DAVIS. But it has become increasingly difficult to start any such plans. Also, you recognize that the number of industries under such circumstances are either isolated, like an isolated mining company—take the Homestead Mining Co. in Utah, for example, where most of the people in the town where the company is located are employees of the company or the families of the employees; or a large corporation which has maybe two-thirds of the total population of the town and its environs either employed by them, or the families of those employed by them. Most of the companies which are in that situation, or a large proportion of them, got their plan started some time ago, before this issue became such that the medical societies became sensitized to the matter. A notable example along this line that I might point out is the Kaiser case, where Kaiser's industries mushroomed during the war. It was opposed very strongly, and had it not been for the fact that there was a war going on and the Kaiser industries had grown so rapidly and it was absolutely necessary that some sort of medical service were provided, I imagine the opposition to the plan would have been successful; but because of the fact that it happened during the war, the opposition was not effective.

Senator SMITH. Why would there have been opposition to that? I am interested in your statement. I had not heard of any.

Dr. DAVIS. There are two reasons, Senator. In the first place, from the point of view of doctors—if I may interpret it from the point of view of doctors—there is a feeling of general antagonism to any change in the individual relationship between patient and doctor, and the feeling that if you change the method of payment you are going to change the personal relationship between doctor and patient.

The other factor is that the antagonism is purely on the business side, and they feel that these plans will be a form of competition. They will select a particular group of doctors who will be employed on a full-time or part-time salary, and the doctors not selected by the organization will be at a disadvantage, and there is some truth in this latter point.

It is a new form of organization. It is like the introduction of machine industry in competition with a hand industry—something of that order. And there is a competitive factor there which may be to the disadvantage of some physicians at a given time for a certain period, and one can sympathize with that in some instances and under some circumstances.

In many communities it would be reasonable, if one were doing this, to have a period of adjustment so as not to put doctors who have been practicing for years suddenly at a disadvantage with their patients by taking their patients away from them if they happen to be employees of the company, and they were not considered good enough to be taken on the staff of the plan.

I can see that side of it, too, but in the main I think the answer to the point that was raised is that it has become increasingly difficult to

start such plans; the attitude of the medical societies has become particularly sensitized about the thing almost all over the country, and I believe that the attempt to put control in the hands of physicians has been pretty deeply rooted in the policy of medical societies on all levels.

If I may, I will go on with my testimony.

Senator SMITH. Yes; go right on.

Dr. DAVIS. I am on page 11 of my statement.

Senator SMITH. I am very much interested in the subject. That is why I asked you these questions.

Dr. DAVIS. Study the contrast between the medical society plans and many of the voluntary health-insurance plans which are sponsored and controlled by the people who pay the bills. Some of these plans have been established for many years in large, well-known industrial establishments. One, for instance, has been operated for a long time in Baton Rouge, La. It covers about 15,000 persons, employees of the local plant of the Standard Oil Co., and the members of their families. The plan was started over 20 years ago with the cooperation of the company, which helped in financing the clinic building. But the plan is maintained entirely by voluntary pay-roll deductions from the workers and is managed by a committee in which both management and employees are represented, with a majority of employees. This situation is typical of a considerable number of well-established industrial health-insurance plans offering comprehensive medical and hospital services, and providing this service through group-medical practice.

Senator SMITH. You would approve of that set-up; would you not?

Dr. DAVIS. Certainly.

Senator SMITH. I do, too. I think that's right along the line.

Dr. DAVIS. Yes.

This method of organization has evolved as a result of experience, because when the people who pay the bills and receive the services for themselves and their families are in control they have a direct motive toward financial economy. It's their own money that is at stake. They also have a motive to maintain and expand good service. It's the health of themselves, their wives, and children that is at stake.

Much is said about the abuse of insurance plans by subscribers, especially if comprehensive services are offered. When the members themselves control the plan, they have a motive to check abuse, because abuses waste their own money. No pressure against malingering and other abuses by subscribers is more effective than pressure upon the abusers from their fellow members.

In a set-up of this type they are not able to take the immense advantage that comes from the other type of organization. That is one of the reasons why the medical societies, after experimenting with what they called a comprehensive plan—and some of them did experiment with such a plan—felt that they had to give it up, on account of the amount of abuse. A lay group would generally control that type of abuse better than a group of physicians would.

I wish now to take up some ideas which seem to be excessively popular among the opponents of S. 1320. One of these is the bogey of "socialization." At the beginning of these hearings, the senior sponsor of S. 545 said that people ought to pay for their medical care just as they do for their food, shelter, and clothing, and that if we

start socializing medical care we will find that only a step toward socializing the other parts of our economy.

Of course, people should pay for their medical care. Paying for what we need is always better than having things given us. What I point out, however, is that paying for medical care stands on a different basis from paying for food, shelter, clothing, or any of the other necessities and comforts in the budget of American families. Sickness costs are unpredictable as to when they will happen and how much they will be. You can plan your expenses on your food, rent, clothing, and every other commodity or service you buy, except one. That one is sickness costs. You cannot budget sickness costs in advance.

Therefore, there is good reason for putting the payment of sickness costs on a budgetable basis. That means an insurance basis. There is no such reason—in fact, it would be absurd—to advocate using the insurance principle for Mr. and Mrs. America's food or rent bills. There is, therefore, no justification whatever for suggesting that a widespread insurance system for medical care, either on a voluntary or a compulsory basis, furnishes a precedent for the rest of our economy.

But now comes another statement by Senator Taft. He says that national health insurance isn't insurance at all. He declares that a pay-roll deduction required by law is not an insurance premium but a tax. Of course it is a tax, from the legal standpoint. Any payment required of people by law is a tax. Nevertheless these pay-roll deductions, although they are a tax, are also insurance. They are insurance because they enable the people who pay them to protect themselves against an unpredictable risk. An individual alone cannot protect himself against such a risk, but large groups of people can do so. Spreading a risk among a large group of people and over a period of time is the essential characteristic of insurance, irrespective of the method or auspices through which this principle is applied.

Now I move on to another subject: Health insurance abroad.

Compulsory health insurance is attacked on the ground that it has been "a failure in foreign countries." The usual technique of this attack has been to repeat a series of misstatements over and over again, despite the fact that their inaccuracy has been demonstrated over and over again. Time permits only a few examples.

One common misstatement concerns administrative costs. To quote: "In the experience of Europe there would be an employee of the system outside the field of medical service for at least every 100 persons insured." From this statement, simple arithmetic leads to the conclusion that a great deal of the money paid by the people for health insurance would go to fatten government bureaucrats. A sixth grader can calculate that there would have to be a million pay-rollers if 100,000,000 Americans were insured.

The figure of 1 administrative employee per 100 insured persons is a gross untruth. Last year, Dr. Frank Goldman, associate professor of public health in that hive of intellectual rectitude, Yale University, and an internationally recognized authority on this subject, testified that in the well-established European systems the number of administrative employees is about 1 to every 2,000 persons.

Senator SMITH. Might I interrupt there to say that as a Princeton man I am highly interested in your statement that Yale University is a hive of intellectual rectitude. I am very glad to see you en-

dorse them in such a manner, as a graduate of a rival college. Thank you very much for the suggestion.

Dr. DAVIS. I'm afraid that I had in mind, Senator, some of the alumni of Yale, and I wasn't thinking enough of the location of Princeton.

Senator SMITH. We all feel we are in the same classification. We hope we are.

Dr. DAVIS. Where did the erroneous figure of 1 to every 100 persons come from? It goes back to a report on Sickness Insurance in Europe, published in 1938 by the late Mr. J. G. Crownhart. He was then secretary of the Wisconsin State Medical Society. The society sent him on a visit abroad.

Mr. Crownhart does not explain how he got his figure. His report is of the kind that would be written by a clever public relations man, such as he was. It is not documented, so that the source of the figures and statements can be checked. From personal conversation with him shortly after his return from that trip, I obtained some idea how he derived this figure; but that is another story.

Senator DONNELL. Is there any objection to telling us what that other story is?

Dr. DAVIS. No.

Senator DONNELL. It might be an important story.

Dr. DAVIS. I knew Mr. Crownhart at that time, and being, of course, particularly interested in this field, I made a special effort to see him as soon as I could after he returned so that I could talk to him about his trip. As near as I could get from him the basis for the figure—and, as I say, Mr. Crownhart was not a scholar and not a person who was accustomed to working out the details of sources and reporting each one and giving you a reference so that you could check his figures, and so on—his report, if any of you gentlemen have read it, is really a series of reports and impressions, without documentation. As near as I could get an impression from him as to how he arrived at that figure, he had visited the officers of the large Krankenkassen. The Krankenkassen is the insurance fund which is run under the German-Austrian system, and several of the other countries on the Continent have copied it more or less, whereby employees and employers make certain contributions. In Germany the worker pays two-thirds, the employer pays one-third, and the state pays nothing, except for national administrative expenses, and the group governing the Krankenkassen is made up of two-thirds of representatives elected by the employees and the other third elected by appropriate employer groups.

Mr. Crownhart visited the offices of the Krankenkassen in the city of Berlin, which at that time had a population of around 4,000,000 people. They had a peak membership of about 500,000 in that particular Krankenkassen, which represented about one-eighth of the entire population of Berlin. It is a large organization. I have personally been to the building where they have their offices, and it really is a huge building. Mr. Crownhart was unfamiliar with things.

To make a long story short, I came to the conclusion that he apparently had made two mistakes. In getting the facts about the number of employees involved he had identified the administrative scope of the people in this building with health insurance, whereas

they were concerned with the administration of, all of the various forms of social insurance which were accepted by law in Germany, and that included old-age insurance, invalid insurance, unemployment insurance, and so on, as well as health insurance.

Senator DONNELL. According to the name of it, it would indicate that it had to do with health insurance, would it not?

Dr. DAVIS. The building that he visited was not a building devoted only to health insurance; it was the central office, the administrative office, of the Krankenkassen. Not only was the Krankenkassen there, but included therein was the entire administration of social insurance.

I might say that the administration of the Krankenkassen is not run by the Government. They merely have to comply with requirements set down by the law, but they are not run by the Government.

To illustrate that, a prominent official of the Metropolitan Life Insurance Co., now dead, who went abroad on a trip to study the German system, came back and said:

I should say that the amount of supervision exercised over the German Krankenkassen by the German Government is somewhat less than that exercised by the State department of insurance in New York over the Metropolitan Life Insurance Co.

I just wanted to point that out to you gentlemen.

Now, Mr. Crownhart made another mistake. He had forgotten or he had not looked into the details enough to know that when he got his figures covering the insured persons in Germany they gave him the number of insured persons, but insured persons meant the workers who were insured, the amount of their payments, and the scope of the law provided service for their dependents, their wives and immediate dependents, as well as for themselves. Consequently, in getting the ratio between the number of employees and the number of persons insured, he had made the mistake of counting in employees who were dealing with other things besides health insurance; and he also made the mistake of assuming that only insured persons, instead of also the members of their families, which averaged about two and one-half persons per employee, were included in those figures.

As far as I could judge in talking to him, those were the mistakes he made.

Senator DONNELL. Did you mention those mistakes to Mr. Crownhart and get his answer to your conclusions?

Dr. DAVIS. Well, in my conversation with him a good many other things were discussed. He had visited a number of countries, some of which I had visited too, and he had been to some of the places that I also had been to, so that there were a good many other things on which I felt it necessary to be critical. His report had then been prepared and finished. I criticized his report on this and on a number of other grounds in my conversation with him. However, it was then too late to change it.

Senator DONNELL. Did you call to his attention these two mistakes which you thought existed?

Dr. DAVIS. Yes; I did.

Senator DONNELL. What did he say in response to your suggestion that those two mistakes had caused him to err?

Dr. DAVIS. It is a little difficult for me to remember exactly our conversation. It took place back toward the end of 1938 or the beginning of 1939, nearly 10 years ago, and I can't remember now just what

was said, but the gist of the conversation was that he believed the impressions which he had derived were sound. He took the position that he thought in general the impressions he had derived were sound.

He admitted that there might have been a slight error in the ratio of one to a hundred, but on the whole he thought the impression he derived was sound and that I was mistaken in judging that he had made such errors as I speak of.

I do not know whether in that particular place the ratio of 1 to every 2,000 persons existed, but it certainly would be above 1 to 1,000 persons, because the ratio of administrative expenses under which these organizations in almost every European country operate simply would not permit such a large number of administrative salaries to be paid in relation to the number of persons insured; 1 to 2,000 would be a better ratio, but at any rate it certainly would be over 1 to 1,000 persons, beyond a doubt.

The absurdity of the figure is apparent after very little consideration; 1 administrative employee for every 100 persons would mean an administrative cost of about 50 percent for salaries alone. Elsewhere in his report, Mr. Crownhart stated that the highest administrative cost which he found anywhere was 17 percent and that the figure in most of the countries was 10 to 12 percent, including not only salaries but other administrative expenses.

Mr. Crownhart's stuffed club has been used countless times to belabor national health insurance. I am sorry to call it that, but it has been used by others as a stuffed club.

Senator DONNELL. Pardon me, Dr. Davis, instead of 1 person to 100, which would mean an administrative cost of about 50 percent, his experience, as indicated elsewhere in his book, would show that the ratio of administrative cost was about 17 percent, or maybe only 10 or 12 percent?

Dr. DAVIS. Yes.

Senator DONNELL. Suppose we concede for the sake of argument that he was wrong by the difference between 10 and 50 percent. In other words, that instead of the administrative cost being 50 percent it was only 10 percent. That would mean then that instead of 1 administrative employee for every 100 persons there would be 1 for every 500 persons. That is about the net conclusion that you draw from this subsequent statement in Mr. Crownhart's book, is that right?

Dr. DAVIS. No.

Senator DONNELL. No?

Dr. DAVIS. That is not quite so, because the factors of administrative cost include other items besides salaries alone, and you have to take into account many other items besides the salary expense. You notice I speak of an administrative cost of 50 percent for salaries alone. There are other factors involved.

Senator DONNELL. How many people under S. 1320 do you figure would be insured persons?

Dr. DAVIS. How many would be insured persons, counting the number of persons in their families who would also be entitled to receive service?

Senator DONNELL. Yes. Would you figure it would be about 85 percent of our population?

Dr. DAVIS. I should expect so. It would vary with the number of employed persons earning above the amount specified in the bill.

Senator DONNELL. If we have 140,000,000 people in the country, that would be—let's see—that would be about 119,000,000 people who were insured—say 120,000,000 of our 140,000,000 population.

Suppose you take Dr. Goldman's figure of the number of administrative employees, of about 1 to every 2,000 persons. That would mean, according to my hasty figures here, about 60,000 employees, based on Dr. Goldman's figure, is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. Do you think the plan that you are supporting, S. 1320, would necessitate the employment of 60,000 administrative employees? Is that right?

Dr. DAVIS. Well, yes. I would think so. However, I would say this: In considering the number of new administrative employees, you would have to consider to what extent people already engaged in hospitals and other forms of public welfare administration involving medical services—to what extent the existing organizations and their administrators would be used. There would be some cut down. It is actually very difficult to estimate until you have made State by State surveys, such as are contemplated under this bill.

It is difficult for one to make a statement along that line, except that I think the figure would be in the order of the one you mentioned, rather than in the order of 5 or 10 times that many.

Senator DONNELL. Mr. Crownhart's figure would make it 20 times that, would it not?

Dr. DAVIS. Yes, sir.

Senator DONNELL. Which would be 1,200,000 employees, is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. That is right, is it not?

Dr. DAVIS. Yes.

Senator DONNELL. In other words your judgment as to the number of administrative employees that would be required in a plan of this sort, as I take it, in round numbers is based on Dr. Goldman's figures, which means that it would require 60,000 administrative employees to administer S. 1320. Mr. Crownhart's figures would increase that number to 1,200,000 such employees. And you state that you think Mr. Crownhart erred because of the two mistakes that you think he had made, and that you called those two mistakes to Mr. Crownhart's attention, and he still persisted in the view that his figures were approximately correct. Is that a true statement of your testimony, Dr. Davis?

Dr. DAVIS. Yes.

Senator DONNELL. Thank you.

Dr. DAVIS. I would also say this. I do not think that we could administer health insurance on a Nation-wide scale under this bill as cheaply as most of the European countries have, for two reasons. One, most of them have developed local organizations already established on a cooperative or industrial basis of some kind involving the workers themselves, which can be utilized and which already have been utilized.

The second factor is that we have a much larger proportion of sparsely settled areas than the European countries have, and you can-

not administer any such scheme as this as cheaply in a sparsely populated area as you can where you have a more congested population.

In other words, I should expect that our ratio of administrative cost, and therefore of employees, would be higher than would be found certainly in the older established European systems. I make that as a footnote to the estimate of 1 to 2,000, as being applicable to this country strictly, but it would be more along that order than along the order that Mr. Crownhart suggests.

Senator DONNELL. Thank you.

Dr. DAVIS. Recently I found his figure, slightly under-stuffed, appearing in an editorial from which I quote two sentences:

In Germany in 1935, for example, there were 36,000 political employees overseeing the work of 30,000 doctors. It is certainly reasonable to assume that we would have a comparable experience here.

The whole editorial is about 300 words long. It appeared in the Chronicle of Omak, Wash., at about the time President Truman's special health message was sent to Congress last May.

I also beg to report that I found the same editorial, identical word for word, appearing during the same week in 21 other newspapers scattered all over the country, and in several additional papers in condensed or slightly altered form. These editorials came through a clipping bureau and of course represent only a part of the total publication.

Senator SMITH. He referred in that editorial to doctors. That's a different figure from the ones we have had, which have dealt with administrative employees. If each doctor could handle 1,000 people, and that's a pretty high figure, then you would have about 1 administrative employee for each 800 people, in round numbers. I mean, under your own figures that's about where it would land, so that editorial isn't wrong. I assume that's about right.

Dr. DAVIS. Excuse me, Senator. I had that figured out. I'm sorry I didn't keep my figures with me.

Senator SMITH. I forget now the testimony we had with respect to the number of people per doctor.

Dr. DAVIS. If I remember correctly, I think it would be about 1 employee to about every 1,200 people, which is along the order I am speaking of, but the point I am making here is this. I was going on to another point. The figures used in this editorial may or may not be derived from Mr. Crownhart's figures, but the point is that Mr. Crownhart's figures have been widely used, and his figure of 1 employee for every 100 persons has been widely published in medical circles and in medical journals, so that the feeling has arisen that a very large administrative staff would be needed, and that the administrative costs would be very large. This editorial merely reflects that general mistaken conception.

The point I am trying to make is that I found this editorial in these 22 different newspapers, and from that I drew the conclusion, as I point out in the next paragraph of my statement, that there is some organized propaganda machine that gets material like this editorial out to all newspapers so that the same editorial appears in newspapers scattered throughout the country within the same week. I don't know who it might be who distributes these editorials, but I do know that the National Physicians Committee has a public relations staff which they

claim sends out material to a list of several thousand newspapers and periodicals.

Senator SMITH. I think that the so-called propaganda, frankly, has gone both ways. It has gone to prove the position you are taking. I have seen masses of it. I saw it in the PAC publications 3 or 4 years ago, when they started it up. I am not criticizing it. I think both sides try to show what they think it is going to cost us and what the expenses would be. It is reasonable to expect proponents on both sides will try to get their information out. That is the way we do things in America. It may not be the best way, but that is the way we do it, and I am not prepared to criticize one side more than the other in this controversy, for doing what both have a right to do. You have done a noble job in the advocacy of your cause, Dr. Davis. I have heard from you many times, and I have complimented you many times on the ability with which you have gotten your ideas across to the public. You ought not criticize your opponents for using exactly the same methods.

Dr. DAVIS. I appreciate what you have said, Senator, and I only wish to say this. I do feel—although I don't think this is particularly germane to the testimony—but I do feel that many of the items released by the National Physicians Committee—many of the so-called facts—are less than factual.

Senator SMITH. Just the facts?

Dr. DAVIS. Yes; but I also feel that I must make one other statement, and that is that I cannot help but feel a little envious of an organization that is able to spend per month—or was doing so, according to its reports as a lobbying organization over the last 6 or 7 months of the year—slightly more than the Committee for the Nation's Health was able to raise in the whole year. So a certain amount of envy crops up inside of me when I think of how much more we could have done if we had had 12 times as much money.

Senator SMITH. You have had splendid support from labor organizations, and so forth. The work has been very well organized. You have had good publicity. And in presenting your point of view, whether we agree with it or not, we compliment the ability of those who are able to get it out and circulate it. Let's not call those on the other side of the fence names, when we live in a glass house ourselves.

Dr. DAVIS. I hope at least my expression of envy will be regarded as pardonable.

Senator SMITH. It is.

Dr. DAVIS. Those who charge that there is organized propaganda in favor of national health insurance must admit that these identical attacking editorials suggest that somebody has organized propaganda on the other side. Who supports the writer whose brain child is multiplied thus in the free press of America? I do not know. I do know that the National Physicians Committee states that they have a public-relations staff which sends out material to a list of several thousand newspapers and periodicals. So maybe these editorials merely prove that the National Physicians Committee finds a market for some of its canned goods.

Health insurance in foreign countries is charged with a long list of other evils—poor quality of medical care, for instance, and promoting an increase of sickness. Some of these charges are based on

phoney statistics, or misuse of statistics. Some of them are stories of particular cases which are presented as if they were universal cases. These misstatements and exaggerations are repeated over and over again in the medical journals and in the pamphlets written by their public-relations men. These pamphlets are circulated to our newspapers with the authority of organized medicine behind them and, of course, no refutations made by people who know the subject will ever catch up with them.

If there were time, I would give examples, such as two well-intentioned articles by an American newspaper correspondent in New Zealand, published late in 1945 and since then enormously misused.

Senator DONNELL. Were those articles in the New York Times or the Christian Science Monitor?

Dr. DAVIS. I refer to two articles in the New York Times, sir.

Senator DONNELL. All right.

Dr. DAVIS. Last month the Woman's Home Companion published an article—

Senator DONNELL. Pardon me, Doctor, did you say two well-intentioned articles by an American newspaper correspondent in New Zealand were published in the New York Times?

Dr. DAVIS. Yes.

Senator DONNELL. The New York Times, I presume, is generally considered one of the leading newspapers in the country, and you give credit to the correspondent as having been well-intentioned, is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. Very well. Go on.

Dr. DAVIS. If you wish me to comment on the implications of that sentence, I will make some additional comments, if you wish.

Senator DONNELL. As you wish.

Dr. DAVIS. I would say briefly that at the time I read the articles I had already had some contact with correspondents and also with the development of the social security and health service in New Zealand during recent years, so I immediately wrote to a physician whose name is Dr. Douglas Robb, whom I had known for some years by correspondence, although I had never met him, and also the Minister of Health, who is minister of the department of government that administers the social security and health system in New Zealand, and I found out in the first place that the correspondent responsible for the articles was an Associated Press correspondent in Wellington, New Zealand.

Senator DONNELL. Do you remember his name?

Dr. DAVIS. I'm not sure, no. I would hesitate to say what his name was. I do not want to be critical of a man unless I am sure who he is. But I received word from Dr. Douglas Robb, a physician in New Zealand of very high standing, who has had at least two books published in addition to a good many articles and various things on this subject. I had his statement in a letter to me that this correspondent was a man who had long been there and was well thought of. Dr. Robb then proceeded to criticize this correspondent's article as presenting a distinctly one-sided view, and he also expressed the opinion that he believed this correspondent had gotten most of his information from representatives of the New Zealand Medical Association rather than by checking the statements of the government.

I will give one illustration of the main point. The main point of the article was that the abuses which had developed by 1945, since the New Zealand system had been established, particularly the increase in costs and the number of doctors—apparently a small proportion but a distinctive number—who were earning very large incomes and taking more patients than they could properly treat—that these abuses had reached such a point that the system would have to be scrapped, according to the article written by this correspondent.

As I said, I also wrote to the Minister of Health at the same time that I wrote to Dr. Robb in New Zealand, and he wrote back to say, commenting briefly on the article, that the article had some correct facts in it about the abuses, but the main effect of the article was to give a completely incorrect impression, because while it was the intention of the government which he represented to take steps to correct any existing abuses, the government had no intention of scrapping the system at all. They were going to take steps to control the system, and they hoped to have the cooperation of the New Zealand Health Association in connection with that control. However, as I stated, those two articles were widely publicized.

Senator DONNELL. To your knowledge, Dr. Davis, is it contemplated in New Zealand that they shall take the administration of this law off of a fee for service basis and put it on a per capita basis?

Dr. DAVIS. I cannot answer that question, Senator. I do not think that that question has been answered in the sense that they have reached a conclusion as to how to do it.

I would say this: The information that I have—the most recent information that I have on that—is from Dr. Douglas Robb again, and it is to the effect that he thinks the discussions which are in progress between the Government and the representatives of the organized physicians of the New Zealand Medical Association are in the direction of endeavoring to control the abuses under the fee for service system for general practitioners. The system of paying for specialists involves somewhat other factors, and the likelihood is that the payment for specialists may be put very largely on a salary basis.

Senator DONNELL. Mr. Chairman, might I interrupt at this point for a moment to offer at this time for the record, with the request that it appear immediately following Mr. Davis' testimony along this line, an article appearing in the Christian Science Monitor of April 12, 1947, entitled "Compulsory Health Insurance Costs Soar in New Zealand" with the caption under the headline "Special to the Christian Science Monitor," and with the location given as Wellington, New Zealand. I understand the article came from there.

Senator SMITH. Do you have the date on that?

Senator DONNELL. Yes, sir—April 12, 1947—I request that this be incorporated in the record.

(The article referred to follows:)

[From the Christian Science Monitor, Boston, Mass., April 12, 1947]

COMPULSORY HEALTH INSURANCE COSTS SOAR IN NEW ZEALAND

(Special to the Christian Science Monitor)

WELLINGTON, NEW ZEALAND.—Continually rising costs have marked 8 years of compulsory health insurance in New Zealand. Deep concern is felt by many New Zealanders over the high cost trend of the system.

Meanwhile overworked physicians find their offices crowded with persons whose complaints are often trivial, and sometimes quite imaginary. In these circumstances the worst cases do not always receive the attention to which they are entitled.

"Some evenings I find 50 persons crowded into my waiting room," one general practitioner told the writer. "It does not matter that I have had a heavy day, and have perhaps been called out the previous night; I have no option but to see them all. Probably 49 are routine, ordinary cases, but the fiftieth may be someone who is really ill. One is hardly in condition to give that difficult case the time and attention that is needed."

Summoning a physician at night is not an easy matter, especially if one is in a strange locality and is not known. After a long day a medical man is not anxious to turn out on what may prove an unnecessary errand. Some persons show a lack of responsibility in this direction, they complain.

LONG WAIT FOR ADMISSION

Further, if a case is not really urgent, there probably will be a long wait before admission to a hospital, for all institutions are overcrowded and understaffed. It is cheaper and easier to be treated at a hospital than at home, as the public has not been slow to realize, hence the demand for hospital accommodation.

Many doctors have retired under the strain of work, which was accentuated by wartime conditions. All, regardless of grade, are earning high incomes; but they are not happy about conditions, for much of their income goes in taxation, and they have little leisure time to enjoy what is left.

But if the medical profession complains about the attitude of the public, the latter have some things to say about the doctors. Every second person can quote instances of incivility, carelessness, and callous indifference on the part of some physicians.

The cost of the scheme is heavy and increasing, and in 1946 totaled £5,500,000, representing about 2 percent of all income. This sum covers medical, hospital, maternity, and other benefits, but not sickness pension (granted for temporary loss of wages) or invalidity pension (for those permanently unable to earn).

HEAVY LEVY ON INCOME

The entire social-security scheme, including the pension named plus a variety of others, is financed by a levy of 7½ percent on all wages and income, private and corporate, together with a subsidy from general taxation. While the national income remains at its present high level the tax will not cause great hardship, but a drop in production or in overseas prices would bring serious problems in its train.

An analysis of expenditures shows that in 1945-46 the hospital benefit cost £2,173,460; medical, £1,427,309; pharmaceutical, £1,133,366; maternity, £600,209; and other, £229,917. The expenditure on drugs, which approaches that for medical consultations and treatment, has been the subject of much comment. It is explained officially as due to a tendency for physicians to prescribe the more expensive drugs, but the figure is a fantastic one for a well-fed, prosperous community living in one of the healthiest climates in the world. Sheer waste no doubt plays a large part in building up this total.

The Government originally proposed that the medical practitioner should provide a service at a moderate fee, each member of the community to be enrolled with a particular physician. This was rejected by the medical profession on the ground that it robbed the patient of the liberty of changing his practitioner if he felt inclined, and was too much like the English panel system. The scheme now most generally operated is one by which the patient visits any physician he pleases, pays him 10s 6d which always has been the standard fee for a consultation, and receives a receipt which entitled him to collect 7s. 6d. from the state.

CHANGES PROPOSED

One unforeseen result of this system is that trivial cases who really want an audience more than medical advice, may consult a different physician every day of the week and hold a conversation at the taxpayer's expense. Probably in each case some medicine will be prescribed as an easy way of cutting short the visit, but whether the case ever takes any of the mixtures (paid for by the state) is a matter of indifference to all.

That the scheme has gone wrong somewhere is becoming more and more evident. As an alternative, the medical profession proposes a revision of the scheme to lighten the cost, but with a continuance of maternity benefits and other expensive items. They also propose that each citizen should pay directly for treatment of minor ailments, unless he is genuinely unable to do so. In the opinion of the medical profession this would help clear away the deadwood of triviality that makes up so much of a physician's working day at present.

Senator DONNELL. I also ask that there be incorporated in the record a letter dated June 30, 1947, addressed to "Miss Marjorie Shearon, Ph. D., Committee on Labor and Public Welfare, United States Senate", from Dr. J. P. S. Jamieson, of Nelson, New Zealand, the concluding two sentences of which read as follows:

The free general medical service or general practitioner's service, designed to replace the private family doctor by State doctors, is in a chaotic condition and had better be shunned. Free specialist service has not been undertaken yet. I will amplify later.

Yours faithfully,

J. P. S. JAMIESON.

I ask that this letter also be incorporated in the record.
(The letter referred to follows:)

NELSON, NEW ZEALAND, June 30, 1947.

MISS MARJORIE SHEARON, Ph. D.

*Committee on Labor and Public Welfare,
United States Senate.*

DEAR MISS SHEARON: I have your letter of June 19, 1947, regarding the social security medical services of New Zealand. It will take a little time to assemble what information I can offer, and your letter was received today. In about a week I will forward what I can. In the meantime, I can say that certain parts of the general scheme are proving beneficial, while other parts are having a seriously detrimental effect upon the practice of medicine. It would therefore be unwise to accept the New Zealand system in toto as a pattern to be followed.

The free maternity service, diagnostic X-ray service, and laboratory service are, in my opinion, all to the good—beneficial to the people, and help to the practitioners. Free hospital service has more good in it than bad; but it is as yet working imperfectly. The free general medical service or general-practitioner service, designed to replace the private family doctor by state doctors, is in a chaotic condition and had better be shunned. Free specialist service has not been undertaken yet. I will amplify later.

Yours faithfully,

J. P. S. JAMIESON, M. D.

Dr. DAVIS. May I add this word at this point. I had some contact with Dr. Jamieson almost 2 years ago. Dr. Jamieson has been one of the active representatives of the New Zealand Medical Association, and his general point of view was very strongly opposed to the scheme which the Government, a labor government, has been developing ever since.

Senator DONNELL. He is a man of high standing, is he not?

Dr. DAVIS. Oh, yes. Well, I assume a physician occupying a position of importance in a medical association usually is a man of high professional standing. I know nothing more about him except that he occupies such a position.

Shall I proceed?

Senator SMITH. Yes.

Dr. DAVIS. Last month the Woman's Home Companion published an article scareheading unnecessary operations by American surgeons. This article and the full-page newspaper advertisements about it have been read by millions, but does anyone take it as representing

the bulk of American surgery? No; we understand that the article describes certain abuses in our system of surgery which need remedy. Now suppose the *British Medical Journal* published an editorial damning American surgery as a whole on the basis of this article. That would be what many of our medical journals have done, with less evidence, to the British health-insurance system.

The big outstanding fact about health insurance abroad is that health insurance has grown for two generations in countries of all sizes, kinds, and political complexions; that it has extended in the proportion of the population covered and in the scope of services rendered; and that neither the people nor the doctors of these countries would think of abandoning it.

The British Medical Association opposed the enactment of national health insurance in 1911; but after experiencing its operation for 16 years, representatives of the association testified before a committee of Parliament that national health insurance had improved the medical care of the British people and the condition of the British medical profession. Not 10 American doctors out of a hundred know this, because the medical journals they read have never told them.

In 1943 the Canadian Medical Association officially approved the principle of compulsory health insurance, expecting that it would soon be incorporated into national legislation in their country. I did not see one word about this action in any official medical journal in the United States. Just think what would have been published if the Canadian doctors had taken action the opposite way. Frankly, a one-sided handling of it has been apparent in our medical journals.

Think also what has happened since the war in the western European countries, the democratic countries. All these countries were impoverished by the war and all of them except Britain and Sweden were occupied and more or less looted by the Germans. Yet despite their impoverishment all these countries are extending their health-insurance systems and the medical professions of these countries are cooperating with the governments in the process.

Certainly these facts are evidence that health insurance has not been a failure, but on the contrary that it has been serviceable to the people's health and to the national economy. In Britain, the extended national health program was put before the country in 1944 by Mr. Winston Churchill's government. Certainly that is evidence that the program was not the outcome of radicalism.

Here is a report—I'm sorry that I do not have the report here—published last March by the United States Public Health Service, describing these recent developments in six of these countries. If the picture had been unfavorable, it would have been gleefully publicized in the medical journals. But it gives an encouraging picture, and so far as I have seen, the medical journals have printed nothing about it at all.

The fact that health insurance has succeeded and is extending in foreign countries is no reason in itself why we should follow their example. But the fact that the American people are now considering various ways of extending health insurance is reason why we should learn what we can from foreign experience and therefore that we should study foreign experience dispassionately and not depend on self-interested organizations and their hired salesmen.

I want now to come back to our own land and to conclude with some remarks about costs. The medical propaganda machine—

Senator DONNELL. Pardon the interruption, Dr. Davis. By the way, I refer to you as Doctor, but I understand you are not a physician.

Dr. DAVIS. I am not a physician.

Senator DONNELL. You are a doctor of philosophy, is that correct?

Dr. DAVIS. That is correct.

Senator DONNELL. Do you know just who it was who prepared the report that was published last March by the United States Public Health Service?

Dr. DAVIS. I'm sorry. I do not.

Senator DONNELL. At this point I offer for the record an article appearing in the Christian Science Monitor of January 4, 1947, by A. M. Simons, formerly assistant director of the bureau of medical economics of the American Medical Association, and coauthor of *The Way of Health Insurance*, an article entitled "Hiatus in Sickness Insurance," further headed "Favorable evidence or praise found lacking in areas where system is adopted."

I ask that that be placed in the record.

Senator SMITH. So ordered.

(The article referred to follows:)

[Reprint from the Christian Science Monitor, January 4, 1947]

HIATUS IN SICKNESS INSURANCE—FAVORABLE EVIDENCE OR PRAISE FOUND LACKING
IN AREAS WHERE SYSTEM IS ADOPTED

(By A. M. Simons)

A. M. Simons was formerly assistant director of the bureau of medical economics of the American Medical Association and is co-author of *The Way of Health Insurance*, written after personal investigation in Europe.

There is one big hiatus in the testimony presented to the recent congressional committee investigating compulsory sickness insurance and in all the mass of arguments offered by its proponents in the press and over the radio.

Although we are told over and over that more than 30 nations now have such systems, no favorable evidence drawn from the working of such systems is ever presented. No unprejudiced visitor returns from any of these systems with praise for its operation or vital statistics of its accomplishments in improving the health of the people insured.

Reports of the British health organizations are never quoted to show the medical service has been improved.

Germany has been prolific in statistics of the operation of compulsory insurance, but none of the data ever claim to show that sickness has grown less, or that absence from work due to sickness has declined during more than half a century of insurance.

If these reports were ever presented, they would show a continuous increase in sickness during the life of these systems.

Many statements are available from the vital statistics of these and other countries under insurance showing that the combination of cash payment for a sickness which must be treated without cost to the patient if he is to be paid the cash removes the will to get well.

Statistics of the Leipzig Krankencassen, the largest sickness-insurance society in the world, evidence that the average day's sickness per member annually increased from 10.01 in 1887 to 19.05 in 1928 to 1930. Similar increases under compulsory systems in Britain, Austria, and other nations testify that this increase is due to the existence of compulsory insurance and not to any national peculiarities.

This conclusion is further confirmed when such nations as the United States, Australia, and Canada, without insurance, have shown an opposite trend.

There was so little illness among domestic servants in Britain when insurance was first made compulsory that they organized their own insurance society to make sure that they would receive the extra benefits which their previous lack of need for medical care would secure them from the surplus which they thought they had a right to expect.

* * * * *

A few years later the members of this society were showing one of the highest rates of sickness of any class of workers in the country and the expected surplus of income was becoming a deficit.

This increase of sickness has been shown to be a direct result of compulsory insurance. While the worker is well he must pay for medical care, but he is paid for the time he is reported ill. So sickness rises and falls in amount with economic rather than with pathological changes. It rises with depression and falls off as employment increases.

Students of these phenomena are almost unanimous that this is not due in the majority of cases to malingering or intentional feigning of sickness, although acceptance of this theory by administrators has led to the expenditure of millions of dollars to discover and expose such supposed action.

It is agreed by many physicians who are familiar with conditions that it is more nearly true to say that such sickness is genuine but bought, paid for, and delivered by the working of the insurance system.

The continuous bitter disputes over the validity of such sickness reveals some strange results. In Cologne, Germany, the Vertrauensaeerzten—a confidential physician or detective physician of insurance societies of whom he is an employee—which gives the second opinion if objection is made to the cash payment, declared that over 40 percent of the applicants applying for cash were not ill. The number was so large that a third physician was asked for an opinion and this resulted in about one-third of those who were declared sick by the first and well by the second were pronounced sick by the third physician.

* * * * *

Dr. F. Blum, a psychiatrist of Berne, Switzerland, comments thus on this whole situation: "So we arrive at the tragic fact that an institution created in response to the highest social impulses and to serve such social purposes encourages the antisocial attitude of the sick, undermines the desire for recovery, and endangers health."

Dr. A. B. Walker, regional medical officer of the Department of Health for Scotland, discussing the National Insurance Act, said: "It was reasonable to hope that the act, together with the improved environmental services, by providing early and effective treatment would have some effect not only in diminishing the amount and duration of disabling illness but also an important preventive element."

On the contrary, he found that not only the number of cases of illness but their average duration had increased.

The annual report of the medical officer of Swindon, England, states that he was puzzled by the fact that "from the study of mortality we know for certain that the amount of serious disease has dropped enormously during the present century, roughly about 50 percent, while from the reports of the insurance commissioners we find that sickness has steadily increased."

* * * * *

Another comment in a report of this same official throws light upon a phase of this subject. He is discussing the continuous and almost inconceivable increase in the amount of medicine which this peculiar increase in illness has called for when he says:

"Last year the insurance practitioners prescribed 60,000,000 bottles of medicine, the largest number on record. It is immaterial to my present argument whether this ocean of medicine did more good than harm, or whether it was prescribed necessarily or unnecessarily, but it is obvious that those persons who received these bottles of medicine either were sick or thought they were. Based upon the amount of medicine sold, 1936 was the most unhealthy year which has occurred in the history of mankind. Based upon the more exact methods which we use in vital statistics it was the healthiest."

Although most of those who favor compulsory sickness insurance in the United States never seem to have heard of the existence of such a problem in

systems like that proposed here, any examination of the existing systems would show a mass of heated discussion of this problem.

But no solution can receive much consideration while political and economic causes of sickness dominate the situation. Politicians know, though they are reluctant to admit it, that the real attraction of sickness insurance is the cash payments and not the medical care, and they adjust their attitudes to fit that fact.

Senator MURRAY. Dr. Davis, you say you do not have a copy of that report of last March with you?

Dr. DAVIS. I'm sorry, I do not. I meant to bring it with me. It was published in one of the Public Health Reports, which is the weekly publication of the United States Public Health Service, and I should say approximately that it appeared during one of the weeks during the month of February.

Senator MURRAY. Could you furnish the committee with a copy of that report, so that it may be incorporated in the record?

Senator SMITH. That report will be included in the record, Dr. Davis, if you will give us a copy.

Dr. DAVIS. Yes; I will have my secretary get it for you.

Senator SMITH. You will send it to the secretary of the committee, so it will go right in the record?

Dr. DAVIS. All right, sir.

Shall I proceed?

Senator SMITH. Yes.

(Subsequently Dr. Davis submitted the report referred to as follows:)

[From Public Health Reports, Vol. 62, No. 11, March 14, 1947]

Printed With the Approval of the Bureau of the Budget as Required by Rule 42
of the Joint Committee on Printing

HEALTH INSURANCE PROGRAMS AND PLANS OF WESTERN EUROPE

A SUMMARY OF OBSERVATIONS¹

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Among the most conspicuous aspects of postwar reconstruction in Western Europe are the attempts to establish broad social security programs with particular emphasis on health security. Data recently gathered from personal interviews and documents collected in England, France, Belgium, Sweden, Denmark, and the Netherlands reveal the scope and direction of the changes effected or proposed in these countries during or shortly after the war. In all these countries, legislation has been enacted to increase the protection afforded against risks of income loss from sickness, maternity, and permanent disability and to remove or reduce the financial obstacles to preventive, diagnostic, and therapeutic medical care.

All six countries visited—even Sweden which was not an active participant in World War II—have emerged from experiences that severely tested the strength of their social, political, and economic institutions. Yet far from losing faith in their social insurance programs, the people of these countries have united in efforts to expand these programs or other provisions for health security or both.

The two countries (England and Sweden) that escaped invasion and occupation by the German army have formulated comprehensive programs for health and medical care and have discarded all the income and occupational restric-

¹From the Divisions of States Relations and Public Health Methods.

The authors gratefully acknowledge the services of E. B. Kovar, Martha D. Ring, and Arthur Weissman in selecting, summarizing, and collating data.

tions that formerly limited the coverage of their health insurance programs. The British Government took prompt steps to effect the far-reaching Beveridge proposals—published in 1942 while the war outlook was darkest—and, before the close of 1946, Parliament had enacted laws for administering and financing social security programs for the entire population, removing the anomalous restrictions of earlier piecemeal legislation. Within the same period, Sweden took almost parallel steps toward health security and amended its universal old-age and invalidity program to authorize benefit levels that would make supplementary assistance unnecessary for the great majority of pensioners.

The occupied countries (France, Belgium, Denmark, and the Netherlands) face immediate problems of stabilizing currency, restoring productive capacity, and eradicating the effects of low nutritional standards on the health and morale of the population. Their current social security plans appear somewhat less extensive than those of England and Sweden, but they, too, are pursuing the broad objectives of their governments-in-exile or underground resistance forces, which placed social security among the foremost of their postwar aims.

In three countries (England, Sweden, and Denmark), the health security programs will be or already constitute broad, integrated services for public health, hospitalization, and other medical care. In three (France, Belgium, and the Netherlands), the expansion of health insurance coverage and the scope of medical and other social insurance benefits is receiving the greater initial emphasis.

Some of the more significant details of prewar, existing, and proposed social insurance programs for medical care and compensation of income loss during temporary and permanent disability are summarized below for each of the six countries visited.² No two countries follow identical paths; no two are wholly alike in social, political, or economic traditions or objectives. From their wartime or postwar health insurance programs, however, emerge general directions or patterns that characterize two or more countries.

1. All six countries initially based their nation-wide health insurance systems on voluntary mutual benefit societies or sickness funds, which, when they met certain requirements for Government approval, were responsible (except in the Netherlands) for administering cash benefits under the insurance system and (except in England) for administering medical benefits. In their new health insurance programs, two countries have abandoned use of these approved societies: In England, their functions in paying cash sickness benefits will be transferred to central, regional, and local government agencies; responsibility for administering medical benefits will be carried by executive councils, regional boards, and hospital management committees. In France, primary and regional funds have been set up with the responsibilities and much of the character of the funds which mutual benefit societies established for the administration of the earlier system. The four countries (Belgium, Sweden, Denmark, and the Netherlands) that retain sickness funds or mutual benefit societies in their national health insurance systems have developed detailed requirements for their operations.

2. All six countries—whether they discard or retain the approved societies or sickness funds in their national health insurance programs—urge the use of these organizations or similar associations to provide types of protection that will supplement, on a voluntary basis, that afforded by the national system.

3. All six countries seek to avoid "bureaucratic" control of health insurance administration by decentralizing operations, as well as by providing for administrative bodies and advisory groups which, by and large, include representatives of the general public, insured persons, management and labor, and the medical professions.

4. When their proposed programs are in effect, two countries (England and Sweden) will provide medical benefits for the entire population, while three countries (France, Belgium, and the Netherlands) still restrict the coverage of their compulsory health insurance programs to designated occupational or income groups. Denmark will retain income restrictions and the quasi-voluntary aspects of health insurance coverage in its national program. All six countries have developed compulsory invalidity insurance programs of wide coverage.

5. Four of the six countries (all but France and the Netherlands) have removed or propose to remove part of the costs of medical benefits from the health insurance program by substantial subsidies from general tax revenues.

6. All countries permit free choice of practitioners among those who agree to serve in the health insurance system, and all emphasize the "family doctor"

² No details are included on the workmen's compensation programs of those countries.

principle. Three countries (England, Denmark, and the Netherlands) use a capitation basis for paying general practitioners under the health insurance system, though new provisions in England leave the way open for a supplementary salary, and in Denmark fees for service are a common alternative to capitation payments. Three countries (France, Belgium, and Sweden) use the fee-for-service method of remunerating general practitioners, though Belgium has an additional provision for capitation, and in Sweden some salaried public doctors get fees for serving insured as well as other patients. No specific pattern for paying specialists appears predominant, except that the fee-for-service system is common when specialist care is not included as part of the hospital benefit.

7. The new laws or existing programs of four countries (all but France and the Netherlands) provide that public funds shall meet all or most costs of expensive illness requiring hospitalization and the services of surgeons and other specialists, removing nearly all financial barriers for these forms of medical benefits. Three of the countries (France, Belgium, and Sweden) require that insured persons bear some part of the costs of general practitioner's services and medicines, by providing reimbursement for only part (two-thirds or three-fourths in Belgium, three-fourths in Sweden's new program, and four-fifths in France) of the fees for service set forth in an approved fee schedule.

8. When an insured person receiving cash sickness benefits has a dependent wife and children, allowances for these dependents are, or will be, payable in three countries (England, France, and Sweden). The benefits payable for illness are, or will be, virtually unlimited in duration in all countries, either by assimilation with disability benefits (England), or by transfer to invalidity pensions (all but England) and subsequent transfer to old-age pensions. Public funds contribute toward cash sickness benefits in all but two countries (France and the Netherlands).

9. In all six countries, medical benefits for insured persons and their dependents, provided or proposed, include most essential services and supplies, though in all countries the existing or recently authorized programs face questions of numbers and distribution of personnel and facilities necessary to meet their health objectives.

10. All six countries are approaching their health-insurance programs with due allowance for the need to work out step by step administrative and other details of health-security programs in cooperation with the professional and technical personnel concerned and the persons covered by these programs. All recognize that success will depend on that cooperation and on the extent to which national income and productive capacity can be maintained at or raised to adequate levels.

11. In all six countries, medical practitioners and others concerned with health security problems agree, in general, on the value of insurance devices and the use of public revenues to finance medical-care programs. The differences of opinion voiced on the need for expanding these programs relate to the details of operation, the income level of the population to be covered, and the rates and methods of remunerating practitioners.

12. Either in conjunction with health insurance or as separate health security programs, all six countries propose to expand tax-supported services for maternity care; child health and welfare; dental care; early case finding and treatment of chronic conditions and tuberculosis, venereal, and other communicable diseases; immunization and vaccination; medical care of assistance recipients and old-age and invalidity pensioners; care of convalescents; and hospitalization. All are working out hospital plans to group small local units around central well-equipped establishments, so that persons in all parts of the country may have relatively prompt access to the most advanced techniques in the diagnosis and treatment of illness. These programs are cited in the following summaries only insofar as they throw light on the types of medical and maternity services proposed or provided in the health-insurance system.

England and Wales

Compulsory health insurance was inaugurated on July 15, 1912, under the provisions of the National Insurance Act of 1911. From 1919 to 1941, amending legislation increased benefits, coverage, and contributions. During 1944, 1945, and 1946, basic recommendations in the PEP (Political and Economic Planning) report of 1937, the Beveridge report of 1942, the reports issued by the Nuffield Provincial Hospitals Trust in 1945 and 1946, and in other studies were enacted into law.

The National Insurance Act of 1944 provides, among other things, for the transfer of all national health insurance functions, except the administration of medical benefits, from the Ministry of Health to the Ministry of National Insur-

ance, a new agency created by the act and established in 1945. The new Ministry will be the central body responsible for cash benefits for wage losses during illness; widows', orphans', and old-age pensions and supplementary pensions; unemployment insurance and assistance; and certain phases of workmen's compensation. In 1945, the Family Allowance Act gave the Minister of National Insurance additional functions, and, in 1946, the National Insurance (Industrial Injuries) Act placed an enlarged workmen's compensation program under the new Ministry. An integrated and extended system of cash benefits is incorporated in the National Insurance Act of 1946, providing substantially increased payments for wage losses during illness and increasing the coverage and benefit levels for these as well as other types of social security.

In 1946 the National Health Service Act was passed, authorizing a comprehensive medical care program under the Ministry of Health. The program, which the Government hopes to place in operation in 1948, is to provide all types of medical services for all persons in the population. On November 6, the day the National Health Service Act for England and Wales received royal assent, a similar bill for Scotland was introduced in the House of Commons.

The broad and integrated social security program adopted for England and Wales embodies all major objectives of the Beveridge plan. It assures some continuing income when family resources are reduced by unemployment, pregnancy, illness, disability, or death of all who work for a living, with supplementary benefits for the dependent members of the family. It provides income for all persons who are permanently disabled and for all aged persons, and distributes over the population as a whole some of the financial burden of rearing children by paying family allowances to all persons who have more than one young child to support. It plans, furthermore, to provide free medical, dental, nursing, and hospital treatment and pharmaceutical supplies for everyone, regardless of income level or insurance status. The effective dates of the National Insurance Act of 1946 and National Health Service Act will be set by the ministries responsible for administration.

Administration.—Medical benefits are to be administered nationally by the Ministry of Health assisted by a Central Health Service Council. Regional hospital boards and local hospital management committees will administer hospital and specialist services; local executive councils will administer the provisions of general practitioner, pharmaceutical, dental, and ophthalmic services; local health authorities will be responsible for providing preventive and domiciliary services, and for constructing and maintaining health centers and clinics. Basic regulations governing the National Health Service will be promulgated by the Minister of Health and reviewed by Parliament. Certain regulations governing superannuation, transfer, and compensation of personnel must be approved by Parliament before promulgation.

The administration of cash sickness benefits will be under the jurisdiction of the new Ministry of National Insurance. Approved societies will no longer participate in the compulsory system. Benefit disbursements will be made by the regional and local officers of the Ministry, who pay cash benefits under the other social security programs.

Coverage.—Comprehensive medical services will be available to all persons in the population, irrespective of insurance status, age, employment status, or income level. Provision is made for persons, who so desire, to purchase additional services, e. g., special appliances, or private-room care in nursing homes; moreover, all those who wish to receive their medical care and treatment outside the National Health Service may purchase such services through their own arrangements. Under the new National Insurance Act, coverage for cash sickness benefits will include employed (and self-employed) persons over school-leaving age and under pensionable age, without income limit. Persons of working ages who are not in the labor market will be subject to contributions and eligible for other insurance benefits, but will not receive cash sickness benefits.

Until the National Health Service Act becomes effective, coverage for medical benefits remains limited to persons between the ages of 16 and 70 who are employed under a contract of service in manual labor or—if engaged in nonmanual employment—who have a yearly income of not more than £420, without provisions for the care of dependents of insured persons. The Annual Report of the Ministry of Health for 1945 indicates that the total number of compulsorily insured persons in England and Wales was 22,006,000 as of December 31, 1943, or about 53 percent of the total population.

Financing.—Under the new National Insurance Act, cash sickness benefits will be paid out of the National Insurance Fund from which other social insurance

payments are made. The fund will be made up of contributions of insured persons and employers and of supplemental Exchequer contributions and grants. From these contributions, amounts ranging from 6d. (10c) to 10d. (17c) per insured person will be allotted to the National Health Service, even though medical services are to be provided irrespective of insured status—on the theory that the medical service will result in savings to the fund in expenditures for cash sickness benefits. The source of all funds for the National Health Service and the annual amounts estimated to be needed during the early years of operation are (4, p. iv) :

Source	Amount, in pounds sterling	Percent of total
Total.....	152,000,000	100
National Insurance Fund.....	32,000,000	21
Local authorities.....	10,000,000	7
Exchequer (net amount).....	110,000,000	72

Annual expenditures for health services during the early years of operation are estimated as (4, p. iii) :

Type of expenditure	Amount, in pounds sterling	Percent of total
Total.....	152,000,000	100
Hospital and specialist services.....	87,000,000	57
General practitioner, pharmaceutical, dental, and other services ¹	53,000,000	35
Local health authorities' services.....	12,000,000	8

¹ Includes superannuation and special compensation for medical and dental practitioners.

Single weekly contributions, varying with age, sex, source of income—and for employed persons, with rate of remuneration—will be paid for all cash sickness and invalidity, unemployment, maternity, survivors', and old-age benefits. For employees, the initial weekly rates will range from 2s. 2d. for girls under age 18 to 4s. 7d. for men aged 18–70 who earn more than 30s. a week; the weekly contributions of employers for their employees will range from 1s. 9d. to 5s. 9d. The range for self-employed persons will be from 3s. 1d. for girls under age 18 to 6s. 2d. for men aged 18–70, and for persons who are not gainful workers, from 2s. 3d. to 4s. 8d. These weekly contributions will be paid, as at present, by affixing insurance stamps to contribution cards. The Exchequer supplement will range from 4d. per week for girls to 1s. 1d. for adult males.

Until the new laws are in operation, health insurance contributions remain separate from those for the other social insurance programs and for insured persons, with certain exceptions, range from 2d. a week for juveniles to 5½d. for employed men aged 16–65; in general, the employers' contributions equal those of their insured employees, and the Government supplements the health insurance funds by periodic grants. In 1944, approximate receipts for national health insurance totaled £51,093,000. Of this amount, £34,821,000 represented contributions by employers and employees; £9,867,000 consisted of Parliamentary grants, and interest and miscellaneous receipts accounted for £6,405,000.

Regulations on remuneration of practitioners under the National Health Service Act of 1946 have not yet been promulgated, and agreements have not as yet been made between practitioners and the committee provided for in the act. It is believed, however, that capitation will be the basic method of payment. As under the existing program, patients will have the right to choose their doctor, and doctors will be free to accept or reject any persons who ask to be placed on their panels. Regulations may limit the number of patients on a doctor's list, and provision is made for limiting the number of practitioners in an area. Any physician whose name is entered on any list for the provision of medical care on the day the act becomes effective will be entitled to compensation (payable at retirement, death, or other specified time) for any loss suffered through inability to sell his practice, since the act prohibits such sale.

Until the new system is in operation, insurance practitioners are paid quarterly on a capitation basis, at an annual rate of 15s. 6d. per patient. Under certain conditions, mileage rates are paid for travel. Insured persons choose their own doctors from lists of insurance doctors, and the number of patients on a doctor's list is limited by regulation.

Cash benefits.—Sickness: Under the new National Insurance Act, the cash benefit for sickness will be the same as for unemployment and will be payable, after a 3-day waiting period, to insured persons above school-leaving age and below pensionable age, who meet contribution requirements. The weekly rate will be (2, p. 80):

<i>Sickness benefit</i>	<i>Weekly rate</i>
Married man with wife not gainfully employed.....	42s.
Single man or woman.....	26s.
Married man with wife gainfully employed.....	16s.
Married woman gainfully employed.....	16s.
Allowance for adult dependent, where payable.....	16s.
Allowance for first child.....	¹ 7s 6d.

The duration of the sickness benefit will be 52 weeks for persons with less than 156 contributions to their credit. For other insured persons, the duration can be unlimited, since no distinction is to be made between short-term and permanent incapacity for work.

Until the new provisions are effective, the rates of benefits are substantially lower (12, par. 33):

<i>Insured person</i>	<i>Weekly benefit rate</i>	
	<i>Sickness</i>	<i>Disablement</i>
Man.....	18s.	10s. 6d.
Unmarried woman.....	15s.	9s.
Married woman.....	13s.	8s.

Reduced rates are paid if 26 but less than 104 weekly contributions have been made, and the duration of cash sickness benefits is limited to 26 weeks. Disablement benefits, at a lower rate, are continued as long as the insured worker remains incapable of working and until he or she reaches pensionable age.

Maternity: The new law in England and Wales will provide a maternity grant of £4 and either a maternity or a housekeeping attendant's allowance to any woman, if a general practitioner certifies that she has been confined and if she or her husband meets the contribution requirements. The allowance for a housekeeping attendant is to be 20s. a week, payable for a maximum of 4 weeks beginning with the date of confinement. The maternity allowance will be 36s. a week for 13 weeks beginning with the sixth week before the expected week of confinement. Regulations may disqualify a woman from receiving the maternity allowance for periods in which she engages in gainful work or if she fails without good cause to submit to medical examination. Until the new law is in operation, the maternity benefit is a lump sum of 80s. payable to an employed woman insured in her own right, or 40s. if only the husband is insured.

*Medical benefits.—*The new law authorizes fee provision for all types of medical services for all persons: services of general practitioners and specialists; hospitalization (including in-patient and out-patient services, care in mental hospitals, and sanitariums); home nursing; maternal and child health; pharmaceutical, dental, and ophthalmic care; convalescent treatment; medical rehabilitation; vaccination and immunization; and spectacles, dentures, and appliances. Medical and preventive services are to be expanded by the establishment of adequately equipped health centers for use by general practitioners and local health authorities. Free hospitalization will be provided in all institutions except private nursing homes. Under the new act, the Minister of Health will take over all public and all voluntary (private, nonprofit) hospitals; all services of hospital personnel, including surgeons and other specialists, will be provided free of charge. Patients who so desire may make their own financial arrangements for private rooms in these hospitals, if facilities are available, and for services in private nursing homes.

In scope, the medical benefits authorized under the new law are in sharp contrast with the limited benefits (general practitioner services and routine medicines) under the national health insurance system. Under that system,

¹ This benefit is provided for the child ineligible for children's allowances under the Family Allowance Act of 1945.

additional benefits (including dental, ophthalmic, convalescent home care, surgical appliances, etc.) have been permitted, however, for approved societies with appreciable surpluses at quinquennial valuations of their funds. Thus, the amount and type of additional benefits have varied according to the financial status of the society in which the insured person was a member. Likewise, no provision has hitherto been made for hospitalization or for specialists' services for insured persons, except as additional benefits from approved societies with adequate financial reserves.

France

When the war broke out in 1939, France had social security laws providing workmen's compensation; old-age, invalidity, and survivors' pensions; cash and medical benefits for sickness; death benefits; and maternity insurance, including special allowances for nursing mothers and a system of milk vouchers for other mothers. Compulsory cash sickness benefit and medical care insurance was first established, in 1930, under a law enacted in 1928 providing, in addition, for maternity, invalidity, survivors', and death benefits. The law of 1928 was administered largely by approved mutual benefit societies, which established separate local and regional funds for each type of insurance benefit; these funds collected the contributions and distributed the benefits fixed by law.

Although some changes were made in this system of social insurance by the Pétain government during the German occupation, it continued to operate in substantially the same form until the liberation of France in 1944. Soon after liberation, laws were passed setting up a more comprehensive system of social security. The new legislation also provided extended coverage, increased benefits, and a new administrative structure for the social security system. The two major statutes which accomplished these changes were the Ordinance of October 4, 1945, establishing a new system to finance and to administer social insurance benefits, old-age grants, compensation for industrial accidents and occupational diseases, family allowances, and single-wage allowances (special payments to families in which there is only one wage earner), and the Ordinance of October 19, 1945, organizing a new social insurance system for persons employed in nonagricultural occupations covering sickness, maternity, invalidity, old-age, and death benefits. Most of the provisions of both laws went into effect on July 1, 1946.

Further extension of social insurance to cover virtually the entire French population was provided for in a law passed on May 22, 1946; it was stated in the text of the law, however, that most of its provisions were not to come into force until the French industrial production index had reached 125 percent of that of 1938. In September 1946, this index was about 70 percent of 1938.

Administration.—Health insurance, including benefits during sickness, maternity, and invalidity, is administered in France through a system of local and regional bodies called social security funds. The insurance system is based wholly on contributions from insured individuals and their employers. Government participation is limited to exercise of technical and financial supervision.

The function of local bodies, or primary funds, in the administration of health insurance is to award cash and medical benefits for sickness, maternity, and death benefits. In the local administration of health insurance, the primary funds supersede the formerly approved mutual benefit societies. Primary funds, set up on a provincial (départementale) basis, are governed by administrative councils on which two-thirds of the seats must be held by representatives of insured persons. The remaining third of each primary council's membership must represent employers, family associations,³ and professional social security experts. Depending on the number of members in a specific fund, its council has either 12, 24, or 36 members. Primary funds must create local sections for each group of at least 2,000 insured persons. In large cities, in addition to ordinary primary funds with 12- or 24-member councils, a central primary fund is established with 36 or 48 members on its administrative council. Two doctors are attached to primary fund councils in an advisory capacity.⁴

³ An Ordinance of March 3, 1945, promulgated by the Ministry of Population, gives family associations new legal status; they are defined as groups created for the moral and material protection of the general interests of families.

⁴ More recent information indicates some changes in composition and methods of selecting administrative councils of social security funds; higher maximums for cash sickness, maternity, and invalidity benefits; and an increase in the maximum wage on which insurance contributions for nonagricultural workers are based (Secrétariat d'Etat à la Présidence du Conseil et à l'Information, Direction de la Documentation: La Sécurité Sociale en France, Première Partie: Notes Documentaires et Études, No. 451; October 25, 1946.)

Regional funds, replacing the former regional unions of funds, administer health insurance for areas larger than a province. They are responsible for equalizing and reinsuring the risks covered by the primary funds in their area, organizing and directing medical control, and administering invalidity pensions. Regional funds are managed by 26-member councils, composed of representatives of the primary funds in the region.

A national social security fund, replacing the General Guaranty Fund of the prewar system, equalizes and reinsures the risks carried by the regional funds. Its administrative council is made up of representatives of the Council of State, the several ministries concerned with social security, the regional funds, the special funds for administering family allowances, and other national agencies. The representatives from the regional and family allowance funds must be elected.

A General Social Security Directorate in the Ministry of Labor and Social Security supervises the activities of primary, regional, and national funds. It carries out this task through regional social security directorates with supervisory authority over the regional and primary funds. These directorates are also responsible for enforcing the rules of affiliation and for payment of contributions to the funds. A Superior Social Security Council is established to aid the Minister of Labor by advising on all social insurance matters which he may refer to it.

Medical supervision of the work of primary funds is carried out by special medical advisers under a regional medical adviser appointed by each regional fund.

Private mutual benefit societies have lost their compulsory insurance functions under the new postwar legislation. An Ordinance of October 19, 1945, on the status of mutual societies, leaves them free, however, to provide voluntary insurance and benefits supplementing those of the compulsory system.

Coverage.—The Ordinance of October 19, 1945, makes compulsory health insurance applicable, with few exceptions, to all persons living in France who are employed in nonagricultural occupations (including self-employed), regardless of income. Formerly, manual workers were covered for compulsory insurance regardless of their yearly income, but other workers were subject to the compulsory system only if their annual income did not exceed Fr. 120,000 (about \$1,020). The spouse of an insured person and his nonworking children under age 16, in addition to certain classes of his dependent relatives, are covered for medical benefits by his contribution. If the insured person's children are invalids, apprentices, or are continuing their education, they are covered for medical benefits by his contribution even if they are older than 16.

Special categories of workers such as miners, railway men, Government employees (national and local), merchant seamen, and those in the gas and electricity industries retain their own occupational insurance schemes and do not come under the general system. Agricultural and forestry workers are insured through a special system of funds under the supervision of the Ministry of Agriculture.

The new law of May 22, 1946, extends benefits of the compulsory social insurance system to virtually the entire population of France. In addition to employed persons, businessmen and owners of industrial and agricultural undertakings are covered, as well as those engaged in occupations from which they receive no income and those with no occupation. The only persons not covered by this act are those covered by separate occupational systems.

Financing.—Payments for all social insurance benefits, including health insurance, are made by the funds out of contributions from employers and insured individuals. Under the Ordinance of October 4, 1945, the total contribution for all benefits for those engaged in nonagricultural work, is 12 percent of wages, based on a set maximum annual wage. Half the contribution is paid by the employer, the other half by the employee.⁵ The employer pays the total contribution to the

⁵ The new law of May 22, 1946, not yet in effect, increases the general contribution rate for groups covered for all social insurance benefits to 16 percent. Nonagricultural employees continue to pay a 6-percent contribution, but their employers must pay 10 percent. Exempt from contributions are dependent children, unemployed persons registered at an employment bureau, and various classes of pensioners, these groups, except the unemployed, receive only medical benefits for maternity and sickness. Only employed persons and those on the same footing and registered unemployed are entitled to daily cash benefits. The contribution basis for nonagricultural employees remains the same (Fr. 120,000 a year); for other gainful workers in the same occupations, it is taxable income from their occupations, with certain minimums, for nonworking spouses of these two groups, it is the maximum old-age pension payable to insured persons at age 65; for other contributors, it is either net taxable income (for those subject to income tax) or half the basic wage of the lowest-paid group of manual workers in the provincial capital. The law also sets contribution bases for gainful workers in agriculture and forestry, but retains their separate funds; and authorizes changes in the administrative councils of social security funds.

primary fund, deducting the employees' share from their wages. The primary fund then transmits to regional and national funds the part of the contributions due them, on an apportionment basis determined annually by the Minister of Labor and Social Security. Employers with less than 10 employees and the self-employed pay contributions on a quarterly basis; all other employers and the voluntarily insured pay on a monthly basis.

Doctors who work under social insurance are paid on a fee-for-service basis. Insurance patients have free choice of physician. Fee schedules set by agreements between insurance funds and local medical societies, become effective after approval by a special national commission composed of representatives of the funds, medical practitioners, and the ministries concerned. If agreement on fee schedules cannot be reached locally, this commission fixes the rates. Usually, the insurance doctor is paid directly by the patient, and the latter is then reimbursed by the funds in terms of the established fee schedules. The fee for a specific service performed by an insurance doctor is determined by the product of a key-letter (which denotes the type of treatment, e. g., "K," for specialist and surgical care, and the value of which is established for each province) and a coefficient (representing the relative value of the treatment itself) set nationally and published in an official list of professional services performed by all classes of medical practitioners. Special regulations in March and April 1946 increased from 80 percent to 100 percent the reimbursement to insured patients for any treatment, whether by a general practitioner or specialist, on the established list of professional services with a coefficient of 50 or more. Also, since May 1946, doctors are prohibited by law, except in specified circumstances, from charging insured patients more than the scheduled fee for a specific service. All expenses for medical treatment in connection with maternity or long-term illness are reimbursed 100 percent. The value of "K" in Paris and other large cities is now Fr. 75.

Hospital fees for bed, board, and other services for insured persons and their dependents are arranged, in general, by contract between funds and particular hospitals. The patient pays the hospital directly and is reimbursed up to 100 percent under the new regulations. The charges for general practitioner services in a hospital are added to the patient's bill, and he is similarly reimbursed by the funds.

The expenditure in 1945 for cash sickness and medical benefits is shown by the following table (18):

Type of expenditure	Amount, in francs	Percent of total	Type of expenditure	Amount, in francs	Percent of total
Total.....	6, 291, 000, 000	100. 0	Drugs.....	888, 000, 000	14. 1
General practitioner services.....	867, 000, 000	13. 8	Dental care.....	237, 000, 000	3. 8
Surgical care.....	348, 000, 000	5. 5	Hospital and free care.....	773, 000, 000	12. 3
			Daily cash benefits.....	3, 005, 000, 000	47. 8
			Medical control.....	173, 000, 000	2. 7

Cash benefits.—Sickness: The daily cash benefit for short-term illness, under compulsory insurance, is equal to one-half the basic daily earnings of the insured person, up to a maximum of Fr. 150 a day. If he has three or more dependent children, the rate is increased to two-thirds the daily earnings from the thirty-first day after the illness begins. If institutional treatment is required, the daily benefit is reduced by fifths, according to the number of dependents of the insured (by three-fifths if he has no dependents). For long-term illness, a monthly cash allowance 30 times the daily grant for short-term illness is paid by the funds, up to a maximum of Fr. 4,500 a month, or Fr. 6,000 if the insured has three children. If hospital treatment is required, the same reductions are made as in the case of short-term illness. The daily benefit for short-term sickness is limited to 6 months for the same illness; for long-term illness, the duration of the benefit may extend to 3 years. To receive cash benefits for long-term sickness, the insured person must undergo a special examination before the end of the third month of illness. This examination is made by the attending doctor and the medical adviser of the fund. To get cash sickness benefits, the insured person must notify the primary fund of his condition within 3 days after the onset of the illness.

Invalidity: Any insured individual whose earning capacity has been reduced by two-thirds may receive an invalidity pension, payable quarterly. If he is able to do part-time work, his annual pension amounts to 30 percent of his average

annual wage for the preceding 10 years; if he is totally incapacitated for work, he receives 40 percent of the same basic wage; if he requires the constant assistance of an attendant, he gets a special increment of 20 percent of the 40-percent pension for general incapacity. In no case may this increment, however, exceed Fr. 9,000, or may the total annual pension be less than Fr. 7,200. At the age of 60, the invalidity pension is superseded by an old-age pension which cannot be less than the invalidity pension it replaces.

Maternity: The daily cash allowance to insured women for maternity, calculated on the same basis as the cash sickness benefit, is payable for 6 weeks before and 8 weeks after confinement. If confinement results in medical complications, the woman receives sickness benefit instead. The funds fix the monthly allowance to an insured woman for nursing her own child; if the attending physician certifies that she is unable to nurse it, she receives milk vouchers, the value of which cannot exceed 60 percent of the nursing allowance. The amount and duration of the milk-voucher grant is fixed by the attending doctor. Allowances for prenatal and postnatal examinations are also provided in amounts established by each fund. For maternity benefits, the insured person must have been registered as insured for not less than 10 months before the probable confinement date, and provided she ceases all gainful work during the benefit period.

Medical benefits.—Compulsory insured persons are covered for general and specialist medical care; surgical operations; dental treatment (including necessary dentures); costs of drugs and appliances; laboratory analyses; medical examination at stated intervals; maintenance and treatment in hospitals, clinics, and dispensaries (and in private nursing homes if medically necessary); and ambulance service. The period for which the funds will pay in full for medical care in connection with tuberculosis treatment has been extended to 10 years (it was 3 years until 1945). Dependents of invalidity pensioners receive medical benefits for sickness and maternity.

Medical benefits for maternity include all expenses for treatment during pregnancy and confinement, provided the woman notifies the primary fund that she is pregnant 4 months before the probable date of confinement; if not, the fund will bear only 80 percent of the costs.

The funds reimburse insured patients for 80 percent of the cost of ordinary drugs, and some special drugs; for other special drugs, the funds repay only 40 percent.

Belgium

Before the outbreak of World War II, Belgium had social-security programs covering the risks of old age, invalidity, sickness, maternity, costs of rearing children, occupational accident and disease, costs of medical care, involuntary unemployment, and death, for persons dependent on wages or salary for a livelihood. All but a few of these programs, however, were on a voluntary basis, and functioned in accordance with the relative financial resources of various insurance societies, occupational groups, and geographic areas. Believing that social solidarity required a closer integration of provisions to protect workers against involuntary wage loss and costs of health care, representatives of workers and employers met secretly in Belgium as early as 1941 to plan a comprehensive, compulsory social-security program, broad in coverage of persons and risks and liberal in terms of benefits provided, to be financed by employer and employee contributions and general revenues. The new program was enacted into law on December 28, 1944, and its administrative agency, the National Social Security Office, was established on January 1, 1945, less than 4 months after liberation from German occupation. The compulsory health-insurance program became effective on April 1, 1945, supplanting the voluntary system which had been in operation since 1894.

Administration.—To administer national aspects of the health-insurance program, a Government agency, the National Sickness and Invalidity Insurance Fund, has been set up in the Ministry of Labor and Social Welfare. The Fund, headed by an Administrator General, is administered by a National Administrative Committee consisting of representatives of labor, management, unions of the local mutual-benefit societies, and Government Departments (Public Health, Finance, and Labor and Social Welfare). The National Administrative Committee makes no decisions on medical, dental, or pharmaceutical matters without the advice of its appropriate technical advisory councils; its functions are to distribute the Fund's resources, develop and effectuate regulations, and propose amendments to laws and legislative orders.

Provincial advisory commissions (composed of representatives of labor, management, and local mutual-benefit societies) supervise the operations of provincial

control centers, which, in turn, supervise the local health-insurance organizations. These insurance organizations are the approved societies which formerly administered the voluntary system. Persons covered by the system must enroll either in an approved benefit society of their choice or in the regional office of the National Sickness and Invalidity Insurance Fund of the area in which they live. The benefit societies and regional offices determine eligibility, pay cash benefits for sickness, maternity, and invalidity, and reimburse insured persons for medical expenses, including expenses for care of their eligible dependents.

Coverage.—Coverage is compulsory for nearly all persons bound by an employment contract. About half the 8,300,000 persons in the Belgian population receive their medical care through the health-insurance system. In 1946 the system had about 1,700,000 insured persons—20,000 enrolled as members of regional offices, and 1,650,000 as members of the 2,500 approved benefit societies, which are federated in five groups (Socialist, Catholic, Professional, Neutral, and Liberal). With eligible dependents of insured persons—young children and dependent parents, aged 55 or over—the number of persons eligible for medical benefits totaled about 4,000,000. Among the excluded groups are the self-employed; persons engaged in agriculture, domestic service, fishing, services in inland navigation, family employment, public employment; merchant seamen; and employees of the National Belgian Railway Company. All excluded groups may later be included by royal order, and coverage for self-employed persons is planned for 1947.

Financing.—For each quarter, employers send to the National Social Security Office the total amount of employer and employee contributions payable for the period toward the whole social-security program. That Office then sends to the National Sickness and Invalidity Insurance Fund the amounts allotted to health insurance, and the Fund, in turn, distributes to benefit societies and regional offices the sums which represent contributions by or on behalf of their members. These sums are determined on the basis of contribution certificates which employers give their employees to indicate the amount of wages from which the employees' health-insurance contributions have been deducted. The worker must give or send this certificate to the benefit society or regional office in which he is enrolled to show that his contribution record is in order. The certificates are sent each quarter to the National Sickness and Invalidity Insurance Fund.

Some 140,000 employers contribute for the health and invalidity insurance program 2.5 percent of the wages of manual workers and 2.25 percent of the salaries of office workers. Insured persons contribute 3.5 percent of their wages if they are manual workers and 2.75 percent of their salaries if they are office workers. For both employer and employee contributions, only the first Fr. 4,000 a month of remuneration is taxable.

The National Government adds a sum equal to 16 percent of total health insurance contributions as a subsidy to improve medical care. In 1945, the Government contribution was Fr. 350,000,000, or about Fr. 87.5 (\$1.75) per person eligible for medical benefits. The National Sickness and Invalidity Insurance Fund also contributes toward medical care for certain noncontributing persons and their families (old-age, survivor, and invalidity beneficiaries; families of persons called to the armed forces; and persons involuntarily unemployed).

Under the former voluntary system, members' contributions varied among funds; employers sometimes contributed for their employees who were members of mutual benefit societies organized for specific occupational groups; and the National Government paid approved societies a subsidy which approximately equalled the members' contributions.

Under the new program, doctors, dentists, midwives, and pharmacists signify each year, at the invitation of the National Fund, their willingness to participate in providing medical benefits under the fee schedules established by agreement between the professional organizations and the National Fund. Each union of mutual benefit societies and each regional office has medical advisers on its staff determined in proportion to its membership (1 medical adviser per 25,000 persons eligible for medical benefits). These medical advisers give no medical treatment; they are responsible for seeing that the medical treatment is effective and economical and for authorizing hospitalization and other special medical benefits.

Insured persons pay their own bills for general medical care, and the insurance organization reimburses them for three-fourths of their payments for office calls and two-thirds of their payments for home calls. The insured person pays no fees for hospitalization, care of specialists, or other special benefits, but, on recommendation of its medical adviser, the insurance organization may curtail these benefits in some cases. A lump sum is paid to an insured woman to cover medical

costs of a normal delivery unless, barring circumstances beyond her control, she has failed to call in a physician or registered midwife. The insured person is reimbursed for all but a flat amount (Fr. 4) for drugs and medicines included in the list of pharmaceutical products approved as medical benefits.

The insured person has free choice of practitioner among all persons legally authorized to practice the art of healing and may change at will. He likewise can choose among all hospitals or other institutions approved by the Minister of Public Health. As an alternative, he may engage a practitioner or group of practitioners, hospital, or clinic, to furnish his entire health care for 6 months or a year. In that event, the practitioner or organization accepting him for such care receives a periodic capitation payment, which may be supplemented by a small fee for service payable by the insured person. The fee, in general, would represent the amount for which the insured person is not reimbursed by the insurance organization (one-fourth the charge for an office visit and one-third that for a home call). The fee schedule adopted in September 1946 permits variations in fees for service with changes in the average hourly earnings of skilled and unskilled workers. A unit number is assigned to each medical service, representing the factor by which the average hourly wage (Fr. 7 at that time) is to be multiplied to derive the actual fee. Thus, a surgical delivery is assigned a factor of 300, which yields a fee of Fr. 2,100.

Cash benefits.—Sickness (primary incapacity): Insured persons are eligible for cash benefits, payable monthly, amounting to 60 percent of their average remuneration in the 4 weeks preceding the onset of illness. The maximum payable is Fr. 3,500 a month. The waiting period is 3 work days for manual workers and 30 days for office workers (by law, the employer is required to give the latter 30 calendar days of sick leave with pay).

Under the former voluntary system, the cash benefit varied among funds, but was at least Fr. 6 a day for men over age 18, Fr. 4 for women, and Fr. 2 for younger persons.

Maternity: An insured woman receives the equivalent of cash sickness benefits for 6 weeks before and 6 weeks after confinement, provided she leaves work for those periods. Since the maternity benefit is a form of wage-loss compensation, it is paid only to gainfully employed women. Formerly, the cash maternity benefit was a lump sum of Fr. 125, plus a daily benefit of at least Fr. 3 for 6 weeks.

Invalidity. If, after exhausting rights to cash sickness benefits, an insured person is found to have lost two-thirds of his earning capacity, he becomes eligible for an invalidity benefit equal to one-half his former average daily wage if he has dependents, and one-third if he has no dependents. Invalidity benefits cease when the insured person reaches the age of 65 and qualifies for an old-age retirement pension.

Medical benefits.—Regulations define the medical benefits as continuing medical surveillance aimed at maintaining and improving health; discovery and accurate diagnosis of all abnormal conditions to permit starting the treatment that will restore health and working capacity most rapidly, completely, and economically; and necessary treatment for all pathological conditions discovered. The participating practitioners, persons eligible for care, and insurance organizations must collaborate toward achieving these goals. No limit is set on duration of care, and no waiting period is required.

General care comprises consultations and visits at the office of a general practitioner or specialist; dental care given by a doctor of medicine or licensed or qualified dentist, excluding prosthesis and orthodontia; and pharmaceutical materials. Special care includes surgical operations, services for difficult confinements; examinations by specialists; radiology, laboratory analyses, physiotherapy; hospitalization; spectacles, hearing aids, bandages, and orthopedic appliances; prosthesis, including dental prosthesis and orthodontia; and vocational rehabilitation. Under the former voluntary system, the scope and duration of medical benefits varied among mutual benefit societies. Most of them provided medical and pharmaceutical benefits for at least 2 years and at least 3 months of free treatment for tuberculosis in a sanitarium.

Sweden

Sweden, one of the pioneer countries in Western Europe to establish broad programs of social insurance, public assistance, and provisions for health and general welfare, has recently enacted legislation to provide more comprehensive and liberal protection against threats to economic and social security. Under laws (Nos. 431-433) which received royal assent on June 29, 1946, and which will be effective January 1, 1948, the universal compulsory system of old-age and

invalidity pensions will require higher contributions and provide larger basic benefits, with supplements, related to need, to take account of geographic variations in the cost of housing and fuel. Contributions will be collected, as they now are, with income and property taxes, but pensions will no longer be related to contribution records.

Changes in the existing voluntary health insurance system are even more far reaching. On December 18, 1946, the Riksdag approved a bill to establish a compulsory system, to be effective in 1950, which will insure all persons for certain medical benefits, without age, health, income, or occupational restrictions.⁶ Under other proposed legislation, free hospital care will be available to the entire population.

Sweden's first national legislation to control and subsidize the operations of sickness funds was enacted in 1891. Subsequently, a basic Sickness Funds Order of 1931 (effective in part in 1935 and in part in 1938) required that, in addition to paying cash sickness benefits, approved funds should reimburse their members for medical expenses; called for registration of all funds with 50 or more members; and provided larger national subsidies. The voluntary system that has evolved through the years has been relatively limited in coverage and in scope of medical benefits. It should be considered, however, in relation to the extent to which rich and poor alike use tax-supported hospitals and other public-health facilities. Through district and municipal physicians, nurses, dentists, and hospitals, medical care of sick persons—at a small charge if they are able to pay—is closely associated with general public health services.

Administration.—The new compulsory health-insurance program will use the administrative machinery of the existing voluntary system. At present, the Royal Pension Board in the Ministry of Social Affairs carries national responsibility for approval of sickness funds, supervision of their activities, and authorization of national subsidies; it also administers the compulsory old-age and invalidity pension program. The Royal Medical Board in the same Ministry is the central authority responsible for determining national standards and issuing regulations for medical benefits. Local governments, district and municipal, administer public medical services through salaried physicians, dentists, nurses, midwives, and hospital staffs. Many of the salaried doctors receive fees under the health-insurance system for serving members of sickness funds.

Nearly all functions of health insurance administration are carried by local sickness funds (1,700 in 1946, 1,645 in 1943). Most of these funds are general or community funds, though some cover employees of individual factories or other occupational groups. As a rule, each rural area or small town has only one local fund, while large communities are divided into several districts, each with its own local fund. All local funds are attached to a central fund (29 in 1946, 28 in 1943), and all members of local funds must thus be indirect members of that central fund. Central funds pay cash sickness benefits to their indirect members after the exhaustion of rights to benefits in the local fund.

Coverage.—The new compulsory system will waive all coverage restrictions for medical care, but only gainfully employed persons will be insured for cash sickness benefits. Under the existing voluntary system, persons must be in good health and aged 15–40 (in some funds, aged 15–50) when admitted to membership in a sickness fund, and an income restriction applied to coverage for medical benefits excludes persons whose annual assessment for national income and property tax exceeds 8,000 kronor (about \$2,240).

On December 31, 1943, a total of 2,147,381 men and women, or approximately 42 percent of the adult population of Sweden, held membership in approved sickness funds. All women members were covered for maternity benefits, and 2,025,000 members had insured their children under age 15 for medical benefits. The total adult membership at the end of 1943 was distributed as follows (53, p. 8) :

Insurance carried	Total	Men	Women
Total.....	2,147,381	1,046,867	1,100,514
Medical benefits only	65,739	11,951	53,788
Cash sickness benefits only	115,439	83,420	32,019
Both types of benefit.....	1,966,203	951,496	1,014,707

⁶ No information is yet available on the date of royal assent or statute number of the new health insurance law; data on the program are taken mainly from the Government's bill, introduced September 27, 1946 (48).

All adults of working age are insured for old-age and invalidity pensions under the existing compulsory system.

Financing.—Under the new compulsory system, insured persons will contribute about Kr. 24 a year toward cash sickness benefits and the medical benefits provided by sickness funds, and the contribution will also insure their dependents for medical benefits. Under the voluntary system, contributions have varied among funds; they have differed also with the amount of cash sickness benefit for which insurance is carried and have been increased slightly if the children of the insured person are to be eligible for medical benefits. In general, a person now pays about Kr. 58 a year if his daily cash benefit is Kr. 4 and if he and his children are covered for medical care.

No employer contributions are required under either the new or existing health insurance programs, though some employers now contribute to occupational funds on behalf of their employees.

Under the new law, the National Government will pay a membership subsidy of Kr. 3-6 a year (now a flat Kr. 3 a year) for each contributor; the medical subsidy will continue to represent about half the sickness fund's expenditures for medical benefits; and the subsidy toward cash sickness benefits will also be one-half the fund's expenditures (now it is Kr. 0.50 for each day of cash sickness benefits or hospitalization). In addition, the National Government will bear the entire costs of supplementary cash allowances for the wife and children of insured persons who are in receipt of cash sickness benefits, allowances which are not payable under the voluntary system. The maternity subsidy is now Kr. 75 per confinement for any member of a sickness fund who is eligible for maternity benefits. Some towns also grant subsidies to local sickness funds under the existing voluntary system, and local revenues meet a large share of the costs of hospitalization for insured as well as other persons. Under new proposals, national revenues will bear a large part of these costs for the entire population.

In 1943 the total income of the voluntary health insurance system was Kr. 95,078,000 from the following sources (53, p. 22) :

Source	Amount, in kronor	Percent of total
Total.....	95,078,000	100.0
Contributions.....	58,684,000	61.7
National subsidy.....	26,628,000	28.0
Interest.....	1,822,000	1.9
Other.....	7,944,000	8.4

Total expenditures in the same year amounted to Kr. 81,038,000 (53, p. 22) :

Type of expenditure	Amount, in kronor	Percent of total
Total.....	81,038,000	100.0
Cash sickness benefits.....	40,044,000	49.4
Reimbursement for medical care.....	19,814,000	24.5
Maternity benefits.....	8,037,000	9.9
Administration.....	9,980,000	12.3
Other.....	3,163,000	3.9

The newly enacted provisions for invalidity pensions will require a maximum contribution of Kr. 100 a year (now Kr. 20) from all persons aged 18-65. This contribution, which varies with income, goes toward old-age as well as invalidity pensions, which are, and will continue to be, largely financed from national and local tax revenues.

The new health insurance law will continue the practice of providing reimbursement for a part of insured persons' expenditures for the services of general practitioners, and, as now, patients will have free choice of the practitioners who are willing to accept them. Insured patients will pay their own fees and will be reimbursed by the sickness fund for three-fourths (now two-thirds) of the amount set for the service in a fee schedule. These fees are now increased for a home call, night call, and the physician's mileage, and higher rates are set for home and office calls in Stockholm than in other parts of the country.

Cash benefits.—Sickness: Under the new law, nearly all gainful workers will be insured for a uniform amount of Kr. 3.50 a day, with supplements for the wives and children of insured men.⁷ The waiting period will be 3 days and the benefit will be payable for as much as 730 days. At present, persons who insure for cash benefits receive, after a 3-day waiting period (which is sometimes increased to 7 days), a daily amount ranging from Kr. 1 to Kr. 6. The benefit is now payable for 18 days by some local funds and for 90 days by those whose reserves are adequate; thereafter, the central fund with which the local fund is affiliated pays the benefit up to a combined total of 2 or 3 years for any one illness. To be eligible, a member must show that a physician has ordered him to abstain from work, or that illness has reduced his working capacity by at least one-fourth.

Maternity: No information is yet available on the legislative status of proposals to increase the cash maternity benefit and provide it, on a noncontributory basis, for all confinements. The lump sum proposed would be Kr. 200 (now Kr. 110); in addition, employed women would have a daily benefit of Kr. 2-7, depending on their income, payable for 180 days; other women would receive Kr. 1.50 a day for 90 days. Under existing provisions, sickness funds pay the lump-sum maternity benefit only to an employed woman who has been a member for at least 270 days before confinement.

Invalidity: Under the new law for old-age and invalidity pensions, the basic invalidity pension will be Kr. 1,000 a year for a single person, with supplemental amounts based on need. At present the basic amount is Kr. 70, increased in proportion to contributions paid and the pensioner's need. It is payable to any person aged 16-66 whose working capacity is reduced by two-thirds or more.

Medical benefits.—The proposed health security system includes hospital services for the entire population without charge, free drugs and medicines obtained on prescriptions, and other medicines at half cost. Medical benefits under the compulsory health insurance program will include reimbursement for three-fourths of amounts set in fee schedules for general practitioners' services and X-ray examinations and treatment by specialists. With other provisions for a comprehensive program of dental care, authorized in 1939, and recently expanded provisions for maternal and child health, both outside the health insurance system, the proposed health services financed from public funds will encompass broad fields of health security for the entire population.

Medical benefits under the present system now vary among funds. They are available without duration limit (except for hospitalization) to insured persons who meet the eligibility requirements and to the young children of members who have contributed on their behalf. General practitioner services comprise consultations and visits at the physician's office or in the patient's home. Specialist care is provided as part of the hospital benefit, which includes ward care for as long as 2 years (3 years in some funds) for any one illness. A few funds include X-ray and physiotherapy services, and a few pay part of the costs of drugs and medicines.

Denmark

The war and the nearly world-wide concern with measures to extend the scope of social insurance and health services have not greatly affected existing social security programs in Denmark or plans for the future. The reason lies, perhaps, in the breadth and integration of the programs established under the Social Reform Acts of 1933, as well as in the extent to which hospital and other medical services are available at minimal or no charge to nearly all the Danish population. Through liberal grants from national and local tax revenues and the mechanisms of social insurance and public assistance, virtually the entire population has long been protected against the fear of want in old age, invalidity, unemployment, and illness.

In its Sickness Fund Act of 1892, Denmark closely paralleled Sweden by establishing national standards and subsidies for voluntary sickness funds. Since 1921 the distinction between voluntary and compulsory membership in these funds has been virtually obliterated in Denmark. Nearly all persons of working age must pay contributions to the invalidity insurance system, and since these contributions are collected by the sickness funds of the health insurance system, membership in these funds is obligatory. Membership, however, may be passive (without rights to medical or cash benefits) or active (with such rights). Fines, larger in amount than the annual dues for passive membership, and loss of rights

⁷ Amounts will be lower for adolescents and aged persons. All amounts may be increased through voluntary insurance.

to a noncontributory old-age pension and contributory invalidity pension, as well as loss of franchise in the event of receipt of public assistance, serve as strong inducements to maintain membership in the voluntary health insurance system.

Administration.—The Sickness Fund Directorate, in the Ministry of Social Affairs, approves local sickness funds, supervises their operations, determines their financial adequacy, authorizes their contracts with physicians and other practitioners, and pays them the amounts due as public subsidies. The Directorate also supervises 18 nonsubsidized sickness benefit societies which offer membership to persons whose resources temporarily or permanently exceed the maximum for active membership in local sickness funds. In the administration of the health insurance program, the Directorate is assisted by a Sickness Fund Council composed of 12 representatives elected by committees of local sickness funds.

The National Invalidity Insurance Fund is also administered by the Sickness Fund Directorate, with the aid of an Invalidity Insurance Court that determines eligibility for invalidity pensions. All physicians must report to the Invalidity Court any condition among their patients under age 30 that might lead to considerable reduction of working capacity. That Court has authority to provide extensive measures for physical and vocational rehabilitation and financial aid to help start people in occupations suitable to their working capacity.

Local sickness funds, usually only one to a designated geographic area, are the local self-governing units for administering health insurance. Some funds are limited to certain occupational groups, but most are open to all residents of the area, and no one may belong to more than one fund. For Government approval, a fund must have at least 200 members; if the membership falls below that minimum, it must combine with another fund. On January 1, 1945, there were 1,591 approved and subsidized sickness funds. Active members of these funds elect their own officers and advisory committees and control the administration of medical and cash benefits, subject to the supervision of the National Directorate. In addition, the 18 nonsubsidized sickness benefit societies offer passive membership to all income groups and permit active membership (insurance for medical and cash benefits) for persons whose annual income bars them from active membership in the subsidized local sickness fund.

Coverage.—Active or passive membership in an approved, subsidized local sickness fund or in one of the 18 nonsubsidized benefit societies is compulsory for all adults under age 60 who are potentially able to make some contribution to self support. When admitted to active membership in a subsidized fund, a person must be aged 14–40, must be in relatively good health, and must not have an annual income exceeding 5,800 kroner (\$1,218) in Copenhagen, Kr. 5,400 in the provincial towns, and Kr. 4,400 in rural districts, with an additional Kr. 475 a year allowed for each dependent. The value of property owned is also taken into account. These restrictions bar only about 8 percent of the gainful workers of the country.

Active membership includes coverage for medical benefits for the members' children under age 15. Persons with active status in subsidized funds must transfer to passive membership when their property and income exceed the specified limits. Within certain age limits, persons with passive status may become active members when their financial resources decline.

On December 31, 1943, the health insurance system covered about 90 percent of the Danish population of 4,000,000. The membership was distributed as follows (62, pp. 9, 72; 66, p. 38) :

Type of membership	Total membership	Subsidized local funds	Nonsubsidized benefit societies
Total.....	3, 716, 862	3, 471, 262	245, 600
Active members.....	3, 473, 801	3, 230, 630	243, 171
Adults.....	2, 565, 320	2, 380, 630	184, 691
Children under age 15.....	908, 481	850, 000	58, 486
Passive members.....	243, 061	240, 632	2, 420

Financing.—Passive members pay Kr. 2.40 a year, plus an annual contribution of Kr. 7.20–9.60 toward invalidity pensions. Contributions of active members vary among funds. They also differ with the amount of cash sickness and death benefit for which the person is insured. In Aarhus, for example, insurance for medical benefits for the member and his young children costs about Kr. 2.60–2.80 a month without cash sickness benefits, depending on whether the

death benefit is the minimum of Kr. 100 or the maximum of Kr. 300. In addition, active members pay the same contributions toward invalidity pensions as do those with passive status.

Sickness funds collect the monthly contributions from their active members and affix stamps in the members' books to indicate that the contributions have been paid; the funds also collect the annual dues for passive membership and the annual premiums for invalidity insurance. The penalty for failure to pay contributions is Kr. 13 a year, and in certain circumstances may deprive persons of rights to regain active membership, or qualify for invalidity or old-age pensions. Employers do not contribute toward their employees' medical and cash sickness benefits but pay Kr. 6 a year toward invalidity pensions for those whom they employ for a full year.

The National Government pays each approved sickness fund a subsidy of Kr. 2 a year for each active member, plus one-fourth of the amount the fund expends for medical and cash benefits. In addition, the Government pays three-eighths of the fund's expenditures for medical and cash benefits to persons who have a chronic disability on admission. No subsidies or Government payments go to the 18 sickness benefit societies which insure persons in higher income groups.

The local government pays membership contributions for persons who are unable to pay their own dues and subsidies for those who are already disabled when they enter a sickness fund. They either defray the entire costs of hospital care or charge the sickness fund only half the rates nonmembers pay for ward care. In addition, national and local governments share in meeting the costs of invalidity pensions in excess of the amounts contributed.

In 1944, the income of subsidized sickness funds amounted to Kr. 127,321,268, derived as follows (62, p. 19) :

Source	Amount, in kroner	Percent of total	Source	Amount, in kroner	Percent of total
Total.....	127,321,268	100.0	National subsidies.....	28,765,655	22.6
Contributions:	82,824,320	65.1	Commune subsidies.....	3,680,128	2.9
			Interest.....	1,454,395	1.1
			"Control tickets" ¹	1,382,881	1.1
Passive members.....	674,677	.5	Other.....	8,539,212	6.7

¹ Special charges for calls at night or on Sundays or holidays.

Expenditures of subsidized sickness funds amounted to Kr. 123,932,602 in the same period, or Kr. 52.11 per active member (62, pp. 20-21) :

Type of expenditure	Amount, in kroner	Percent of total	Type of expenditure	Amount, in kroner	Percent of total
Total.....	123,932,602	100.0	Appliances, spectacles, etc..	1,643,710	1.3
General practitioners services.	28,326,608	22.8	Home nursing.....	1,737,665	1.4
			Cash sickness benefits.....	9,721,570	7.9
			Cash maternity benefits.....	6,693,245	5.4
			Funeral benefits.....	5,496,890	4.4
			Administration.....	13,280,013	10.7
			Other.....	10,612,044	8.6
			Specialist services.....	5,562,790	4.5
Hospitalization.....	20,308,612	16.4			
Dentistry.....	6,233,301	5.0			
Medicines.....	14,316,154	11.6			

During the same period, expenditures of the invalidity insurance system amounted to Kr. 52,148,961.

At the beginning of each fiscal year, active members of the sickness funds indicate the physician of their choice. About one-third of the subsidized funds, which together have about two-thirds of the total membership, use the capitation method of remunerating physicians. The other funds, mainly those in rural areas, use a fee-for-service method. Under both methods, the physician may charge a small added fee for certifying illness and for night, Sunday, and holiday calls. The capitation amounts and fees for service are agreed on by sickness funds and practitioners, but to be valid must be approved by the Minister of Social Affairs. The sickness fund pays the physician quarterly. The capitation fee varies among funds and differs with the scope of services provided. For a general practitioner in Odense, for example, it is Kr. 9 a year for each insured person (with or without children) on his list, but is 50 percent higher for insured persons who have a chronic disease when admitted to membership.

Cash benefits.—Sickness: After a qualifying period of 6 weeks, amounts varying from Kr. 0.40 to a maximum of Kr. 6 are payable daily to active fund members whose physicians certify their incapacity for work. Self-employed as well as employed persons may insure for cash benefits, but no one is permitted to insure for more than four-fifths of his customary earnings. Benefits are not payable for sickness of less than 4, or in some cases 7 days' duration. For protracted illness, the duration of benefits can be as long as 364 days. If the fund member is still incapacitated at the end of a year, he or she may qualify for an invalidity pension.

Maternity: Employed women who have been active members of a sickness fund for 10 months before confinement receive a cash maternity benefit equal in amount to the sickness benefit for which they are insured. The benefit is usually payable for only 14 days after confinement, but may be extended to as much as 4-6 weeks if the mother is nursing the child or needs longer maternity leave. It is also payable for 8 weeks before confinement, if a physician certifies that continuance at work would be detrimental to the mother's or child's health.

Invalidity: An insured person who retains less than one-third of his earning capacity is eligible for a monthly pension of Kr. 70.50-175.25, depending on sex, marital status, and the area in which he lives. The basic pension is increased by a supplement for young children dependent on the pensioner, by an additional supplement if the pensioner is helpless or if he is blind or nearly blind, and by a personal supplement related to need. When the invalidity pensioner reaches age 60, his invalidity pension is replaced by an old-age pension of approximately the same amount.

Medical benefits.—For Government approval and subsidy, a sickness fund must guarantee an active member and his or her young children all necessary services of a general practitioner, free hospital treatment, and three-fourths of the member's expenditures for certain prescribed medicines such as insulin and liver preparations. Many funds provide additional benefits, such as services of specialists, dental care, care in convalescent homes, home nursing, and part of the costs of medicines and appliances. For an adult, 6 weeks' active membership is required for eligibility for medical benefits, but there is no qualifying period set for care of his or her young children or for any condition resulting from an accident. If a member receives medical benefits for as many as 420 days in 3 consecutive years, he is transferred to passive membership for at least 12 months. He can be reinstated as an active member thereafter only on medical certification that he is in good health.

As in Sweden, hospitalization includes the free services of surgeons, other specialists, and all other hospital personnel. Central hospitals are already in operation or planned in all but two of the counties of Denmark proper, providing special equipment and personnel for the care of medical conditions which cannot be effectively or economically diagnosed or treated in the smaller hospitals of the country. Plans for more extensive public health and welfare programs are also under way.

The Netherlands

When the Netherlands was invaded in 1940, social security programs were in operation for workmen's compensation, old age, invalidity and survivors' pensions, cash benefits for maternity, and funeral benefits. A Children's Allowance Act had been passed in 1939, but not yet put into effect. These programs, varying in comprehensiveness and lacking in coordination, were financed, with few exceptions, by contributions of employers and employees. Mutual benefit societies, approved industrial associations composed of employees' and employers' representatives, and Government-controlled labor boards were authorized to carry out the provisions of the various insurance laws.

Before the war, plans had been made by the Dutch Government to revise the Netherlands' social insurance systems. These plans, directed toward improving administrative coordination, increasing benefits, and extending coverage, were temporarily interrupted by the German invasion. The occupation authorities, however, issued a decree in 1941, establishing a compulsory system of medical care insurance, based on plans that had been worked out by the prewar Dutch Government. Though sponsored by the Germans, this system eventually won favor among the Dutch and was retained after their liberation; it is still in effect and is being used as a basis for further extension of health insurance.

Since the end of World War II, the Dutch Government has again been considering plans for a more comprehensive and administratively simpler social

security system. Prepared in 1943 by the Government-in-Exile, these plans propose greater financial participation by the National Government in the provision of social security benefits.

Administration.—Compulsory health insurance in the Netherlands is administered under two statutes: the Sickness Law of 1929, providing cash benefits for wage losses during illness; and the Sickness Funds Decree of 1941, providing medical benefits. The cash-benefit system is administered by the Social Insurance Section of the Ministry of Social Affairs and the medical-benefits system by a director responsible to the Minister.

Locally, the Sickness Law of 1929 is administered largely by 24 regional labor boards and by approved industrial associations. The labor boards, public bodies made up of employer and employee representatives, are charged with administration of many of the social insurance programs, including invalidity and old-age pensions and children's allowances. The activities of the labor boards are supervised by the National Insurance Bank. This bank, governed by an 11-man council appointed by the Minister of Social Affairs, holds the funds contributed toward social insurance programs and is authorized to make regulations concerning them.

Approved industrial associations—nonprofit organizations established jointly by central bodies of employers and workers—also administer cash sickness benefits under the compulsory program. Employers may insure their employees for cash benefits either with the Government-controlled labor boards or with private industrial associations. If an employer does not insure for cash benefits with the associations, his employees are automatically covered in this respect by the labor boards. A large majority of employers in the Netherlands are insured with the industrial associations. By-laws of the associations must be approved by the Minister of Social Affairs.

The insurance work of the labor boards is coordinated by an Association of Labor Boards, and most of the industrial associations belong to a Federation of Industrial Associations, which is authorized to administer the cash-benefit system for its component associations. The Federation, in turn, is affiliated with a private agency called *Centraal Beheer* (Central Management); in addition, this agency serves mutual benefit societies and commercial insurance companies offering various kinds of voluntary insurance benefits. *Centraal Beheer* does not insure any risks itself, but merely administers the insurance systems of many of its member organizations. It collects contributions, pays cash benefits, and organizes medical control for some of the industrial associations belonging to it by virtue of their membership in the Federation.

The Sickness Decree of 1941, establishing compulsory medical care insurance, is administered by special funds, called general sickness funds. At the time the decree was promulgated, there were in the Netherlands more than 650 mutual benefit societies of various types, providing voluntary insurance for medical care. Some of them were approved by the Government, under the decree, as "General Sickness Funds" and authorized to administer the compulsory program for medical benefits; on April 1, 1946, there were 170 such funds. Lump-sum funeral grants, provided for by the 1941 Decree, are also administered by the general sickness funds. These funds must submit their by-laws to the Minister of Social Affairs for approval.

Coverage.—In general, all persons subject to the Sickness Law of 1929 are also compulsorily insured for medical care under the Sickness Funds Decree of 1941. Covered by both statutes are employees under age 65 who earn not more than 3,000 gulden (about \$1,140) a year.⁸ Contributions toward medical benefits cover, in addition to the insured person himself, his dependent spouse, his children under age 16, and, under certain conditions, his dependent parents and his spouse's parents.

Self-employed persons are not required to carry health insurance, but may insure themselves on a voluntary basis for medical care with one of the general sickness funds and for cash benefits with the labor boards, provided their annual income, if they live in cities, does not exceed G. 3,000. The income limit for this type of voluntary insurance varies from G. 2,000 to G. 2,500 for self-employed persons living in rural areas. Compulsory and voluntary insurance accounts maintained by the same sickness fund must be administered separately.

Approximately 3,500,000 persons were included under both types of compulsory health insurance on December 3, 1945, and another 2,550,000 were volun-

⁸ A bill has recently been introduced in Parliament to raise the income limit for the compulsory insurance system for cash sickness benefits to G. 3,750 a year.

tarily insured. The total number of insured persons represents about two-thirds of the Dutch population.

Among the groups excluded from coverage for both types of compulsory health insurance are casual workers; seamen on vessels which sail outside Dutch coastal waters; members of the armed forces; those suffering from occupational diseases (covered under the Accidents Law for compensation); all permanent Government employees; apprentices who do not receive cash wages; and those who earn less than G. 0.40 a day. Some of these groups, such as seamen and Government employees, are covered by separate programs.

Invalidity insurance applies, in general, to employees whose annual income does not exceed G. 3,000. In 1943, approximately 4,000,000 people were insured under the compulsory invalidity insurance program.

Financing.—Contributions for medical care and cash benefits under the compulsory system normally amount, together, to 7 percent of total wages; 3 percent (2 percent paid by the employer, 1 percent by the employee) goes to finance cash benefits, and 4 percent (2 percent each paid by the employer and employee) to finance medical benefits. Both sets of contributions are paid by the employer, who deducts the employee's share from his wages.

The contributions, collected periodically by the labor board sickness funds for cash sickness benefits, are deposited with the National Insurance Bank, and the boards draw on the central fund for payment of benefits. The industrial associations retain contributions collected for cash benefit payments.

A separate reinsurance or equalization fund is set up in the bank to meet the cost of medical benefits. The labor boards and industrial associations collect premiums from the employers every 6 months and deposit the receipts with the equalization fund, which then allots a prorated share of the total contribution to each general sickness fund to cover the cost of medical benefits to its members. A record is kept of the employees' share of the contribution for medical benefits by means of special coupons, purchased by the employers from the Government, and given to insured employees as receipts whenever a contribution is made on their behalf to the general sickness funds.

Premiums paid by voluntarily insured persons for either cash or medical benefits are fixed by the various insurance funds for each individual when he joins the system. Persons who are voluntarily insured for medical care pay their contributions directly to the general sickness fund with which they affiliate. For hazardous industries, such as mining, compulsory contributions for cash benefits are higher than in less dangerous types of work. The increased contribution in such cases must be paid entirely by the employer.

The maximum contribution for invalidity insurance is G. 0.60 per insured person per week, which is paid entirely by the employer. Recently, the National Treasury has also been contributing to the payment of invalidity benefits. Neither the cash sickness nor medical benefit systems, however, receive financial aid from the Government.

Costs of medical care for the 3,317,420 persons compulsorily insured for 1943 (latest available data), based on information received from 157 general sickness funds, have been officially estimated as follows (71, p. 9):

Type of expenditure	Amount, in gulden	Percent of total	Cost per insured, in gulden	Type of expenditure	Amount, in gulden	Percent of total	Cost per insured, in gulden
Total.....	50, 100, 000	100.0	15. 14	Dental care.....	3, 700, 000	7. 4	1. 11
General medical care..	10, 500, 000	20. 9	3. 18	Obstetrical care.....	1, 100, 000	2. 2	. 33
Medication.....	9, 300, 000	18. 6	2. 82	Hospital care.....	11, 800, 000	23. 5	3. 56
Specialist care.....	4, 800, 000	9. 6	1. 44	Administration.....	5, 800, 000	11. 6	1. 74
				Other benefits.....	3, 100, 000	6. 2	. 96

Total cash benefits for sickness paid in 1942 were G. 43,215,000, at an administrative cost of G. 6,397,000; total contributions for cash benefits for the same period were G. 49,100,000.

Persons insured for medical benefits have free choice of doctor, and may change every half year; they may also choose their own pharmacist. No more than 3,000 persons, including dependents of insured persons, are permitted on the insurance doctor's panel.

General practitioners are paid by the capitation system, receiving an average remuneration in cities of G. 3.50 per year per individual on their panel from the general sickness funds; a general practitioner with his own dispensary is paid G. 5.20 as a capitation fee. The funds pay specialists, in general, on a fee-for-service basis. These fees vary greatly throughout the country, in accordance with fee schedules which are drawn up by individual funds and doctors, and are comparatively uniform only in large cities.

The funds pay the municipal authorities, in large cities, a certain amount per insured person per year for hospital care; the individual hospitals are then paid by the municipality for care of insured patients. In rural areas, direct payment is usually made to hospitals by the funds.

Many of the general sickness funds operate dental clinics, paying dentists at the rate of G. 5.75 per hour.

Cash benefits.—Sickness: Cash benefits for illness are payable to an insured person for a maximum of 26 weeks, starting on the third day after the onset of the illness. The allowance, paid for each day during this period except Sunday, usually amounts to 80 percent of the average daily wage earned during the preceding 13 weeks, although, in certain cases, the Government may approve payment of a benefit equal to 90 percent of the average wage. The maximum daily wage on the basis of which the cash benefit may be calculated is G. 8. In certain circumstances, the 3-day waiting period may be reduced and the duration of benefits extended to 12 months. If an insured person receives cash payments for the same illness for a total of 156 days in a 12-month period, he may not receive cash benefits for more than 78 days for that ailment during the following year. Certification of incapacity for cash-benefit purposes is not done by attending doctors, but by special control doctors.

Maternity: A lump-sum grant of G. 55 is given for maternity whether the woman is insured in her own right or is the dependent of an insured man. This grant is made, however, only if a midwife attends the delivery. The midwife's fee and that of the obstetrical housekeeper-aide are usually met out of this sum. For 6 weeks before and after confinement, an employed woman receives, in addition, cash benefits equal to her full salary, up to a maximum of G. 8 per day. The postnatal payment may be extended to 6 months if childbirth causes incapacity for that length of time.

Invalidity: When the income of an employed person compulsorily insured for invalidity benefits drops to one-third of normal because of disability, he receives a weekly cash benefit, provided his employer has made 150 weekly contributions on his behalf. The amount of the pension is directly related to the number and amount of contributions made by the employer. Temporary invalidity benefits may be received after 6 months of illness, and permanent benefits whenever the fact of permanent invalidity is established thereafter. Those compulsorily insured for invalidity must register individually with the labor boards. Before the war, the maximum pension was G. 6 a week, but it has now been increased by a grant from the National Treasury to include allowances for dependent children of the insured person.

Medical benefits.—Medical benefits for compulsorily insured individuals and their dependents include general practitioner care; surgical, obstetrical, and other specialist treatment; hospitalization for 42 days; all necessary medical and surgical appliances; some dental treatment; ambulance service; and part of the cost of care in a tuberculosis sanitarium. Dental work for which the sickness funds pay in full includes extractions, surgery, and cleaning. Dentures are paid for in part by the funds; crowns and bridges must be paid for by the insured person himself.

In maternity cases, an insured woman or the dependent of an insured man is covered for all necessary obstetrical care. Usually, this is accomplished by the G. 55 cash grant provided for payment of the midwife and obstetrical housekeeper-aide. Specialist care during confinement is furnished by some sickness funds, but usually only if the midwife considers it necessary.

Although all drugs are free to those insured for medical benefits, doctors are often limited in the total cost of drugs they may prescribe. Some funds specify that a physician must pay for any drugs he prescribes above a limit set in terms of the average cost of drugs prescribed by the other doctors of the fund.

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Dr. DAVIS. I want now to come back to our own land and to conclude with some remarks about costs. The medical propaganda machine—I'm sorry to refer to it as such,

Senator SMITH. I'm sorry to have you refer to it in that manner, too.

Senator MURRAY. That's bad publicity to use in discussions of the problem.

Dr. DAVIS. The medical propaganda machine has tried to throw a lot of scare into people about costs, particularly by talking as if national health insurance payments would be a new tax out of people's pockets. Actually, the majority of Americans are now spending an average of 3 percent of their income annually for the physicians and hospital services which would be available under the bill S. 1320. The health-insurance payments of these people would be a substitute for, not an addition to, these present expenditures.

Let me call attention to two charts which have been clipped from the May 1947 issue of Fortune magazine. I have a few copies of them and if you care to have them I will give them to you. The charts I refer to are these two—the blue and the green. The accompanying text clearly explains their significance, and the charts follow a long article in Fortune representing a general economic study of conditions, of which the medical part is merely a small fraction. These are rather beautiful charts, and they present a graphic picture.

Senator MURRAY. Are you offering those charts for the record?

Dr. DAVIS. If it is feasible to reproduce those two charts and not the whole document, it would be advantageous to have them incorporated in the record so that they would be available to anyone reading it, although I have tried to word my testimony so that it is self-explanatory without the visual aid of the charts.

Senator SMITH. You mean the charts under the heading, "What they spend to stay alive"?

Dr. DAVIS. Yes, sir; those two charts.

The blue chart, which is the second one, shows the total percentage of family income. That is the chart with the blue bars on it. It shows the percentage of family income spent for medical care by American families of different levels. The lower the income, the higher the percentage. The higher the income, the less the percentage spent for medical care. This seems unfair, but unhappily it is true. In actual figures the families with incomes under \$1,000 a year—and they constituted about 20 percent of the people in 1945—spent from 5 percent to 8 percent of their income for medical care. The big middle-income group, which constituted about 70 percent of the population in the same year, spend about 4 percent of their income for medical care. Medical care here means all forms of medical care, including dentistry, as well as drugs, hospitals, and physician's care. The top 10 percent of the people spend only 2 to 3 percent for care.

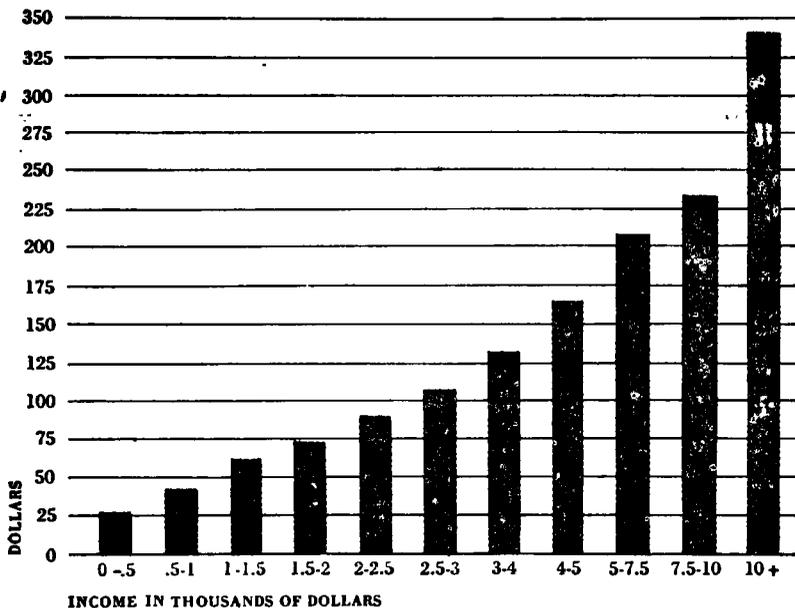
Now the charges levied under the national health insurance bill would be a percentage of earnings, 3 percent, in fact, calculated up to earnings of \$3,600 a year. This 3 percent would be paid in full by self-employed persons, or 1½ percent by employed persons for whom the employer pays the other half. Even the low-income people who paid 3 percent would be better off than they are now, and the middle group would be paying about the same, even if they paid the whole 3 percent.

Senator MURRAY. Do you want to offer these charts for the record at this time?

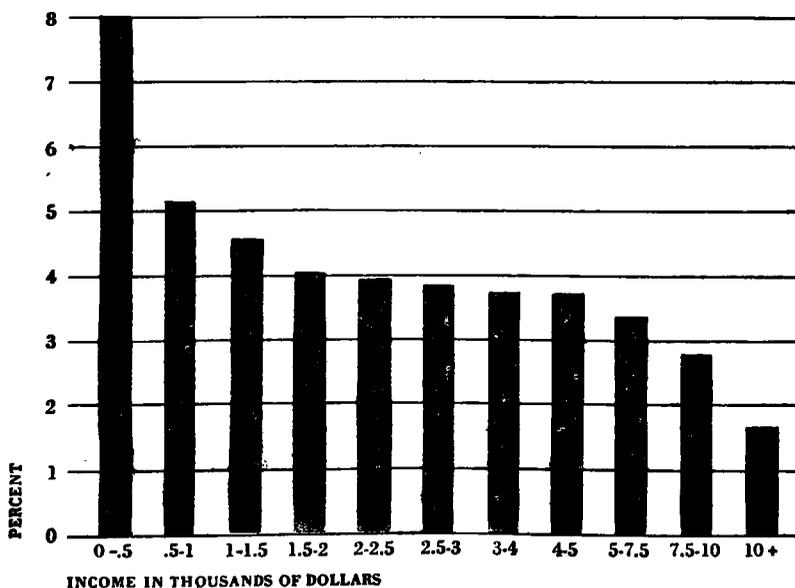
Dr. DAVIS. Yes; I think it would be a good idea to have them in the record.

(The charts referred to follow:)

Medical expenditures in relation to family income ...



... And as a percentage of total family income



Dr. DAVIS. Contrast this situation with the voluntary insurance plans which always charge a flat rate, not varied with income. The charges of the medical society plans and their affiliated hospitalization plans—that means many of them are affiliated with the Blue Cross plan—run from \$50 to \$60 per year per family, and these plans usually cover only care in hospitalized illness, which average only about half the total costs of medical care to a family.

A \$1,000-a-year family which joined one of these plans would have to double its average yearly expenses for medical care. A \$2,000-a-year family would have to add 50 percent to its medical expenditures if it joined. Half of the our population earns less than \$2,000 a year, even in this time of full employment.

Instead of these voluntary plans being cheap, they are expensive. I would like to add there that I mean expensive in relation to the paying power of a considerable part of our population. They are so expensive in proportion to the incomes and spending habits of many people that their sponsors now want Government subsidy for them. The Taft-Smith-Ball-Donnell bill makes a pass at offering a subsidy. By “making a pass” is explained in the language that follows. But look at these charts and think about these figures. You will then come to the conclusion that the subsidies would have to mount up to something like \$2,000,000,000 a year before most of the American people would be served; that is, this would be the case if Americans would accept the charity label which this bill would plaster on their faces, and if the difficult administrative problems of running such subsidies could be worked out.

In fact, S. 545 is essentially a bill starting a system of State medicine, the cost of which would fall mostly on the income-tax payers of this country, and therefore especially on the high-income-tax payers. The national health insurance bill, S. 1320, by contrast, would enable the mass of the people to pay according to their ability into the national health fund, and the supplementary amounts required from general taxation would be relatively small.

All voluntary plans are not expensive. There are plans controlled by the people who pay the bills, in cooperation with an organized staff of doctors, which offer comprehensive medical and hospital services at much lower cost. Some of these plans provide complete medical services at a cost of \$20 to \$25 per capita, or \$60 to \$80 per family per year. That is complete medical service. The reason is that they have an efficient form of professional organization—that is, group practice—and a form of administrative organization which gives incentive to disease prevention and to financial economy.

These plans are precisely the type which organized medicine has most strongly opposed. This type of plan might be wiped out by the medically controlled administrations which S. 545 would set up and by this bill's failure to include any antimonopoly provisions. Certainly further development of this type of plan would be stopped by S. 545. Under S. 1320, on the other hand, existing plans of this type would be protected and new ones could be started by either laymen or physicians, or by a body including both.

That concludes my testimony. The remainder of my statement is merely a summary of the points. I don't think you want me to read those into the record. They are already in the record as part of my complete statement, and there is no point in taking up your time.

Senator SMITH. Are there any questions?

Senator DONNELL. Yes; I would like to ask Dr. Davis some questions.

Dr. DAVIS, you were born in New York City; is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. And you took your doctor's degree at Columbia in 1906; is that right?

Dr. DAVIS. Yes.

Senator DONNELL. After that you were in Boston?

Dr. DAVIS. I was in Boston. I had my home in Boston or vicinity for 10 years.

Senator DONNELL. That would be from 1910 to 1920?

Dr. DAVIS. Yes.

Senator DONNELL. And you were the secretary of the Commission on Dispensary Development of New York City between 1920 and 1927?

Dr. DAVIS. That is right.

Senator DONNELL. And then in 1928 you became the director of medical services of the Rosenwald Fund in Chicago?

Dr. DAVIS. Yes, sir.

Senator DONNELL. In which capacity you served from 1928 to 1936, is that right?

Dr. DAVIS. Yes.

Senator DONNELL. Now, during your work in the Boston dispensary, what were your duties there?

Dr. DAVIS. I was the administrative officer; that is, I was the executive officer responsible to the board of trustees of an organization which had then been established for over a hundred years—one of the old Boston charities, which has maintained a large clinic that is a service for poor people who cannot afford private physicians. A small hospital, chiefly for children and diagnostic services, was also maintained by the institution; but the great bulk of its work, which included perhaps 100,000 visits from patients a year on the basis of 300 or so a day, was out-patient service. My job was to administer it, and the finances, and to oversee the running of it in conjunction with a medical board elected by the medical staff of the institution, which at times numbered about a hundred doctors.

Senator DONNELL. So you came closely in touch with physicians in your work there?

Dr. DAVIS. Intimately.

Senator DONNELL. Generally speaking, did you find those physicians to be men of high type in their desire to be honest and showing a high degree of integrity and skill?

Dr. DAVIS. I came into that institution with a favorable disposition toward physicians, largely because there was a medical man in my own family, and I certainly left my work at that institution, continuing in the medical field, with a very great respect both for the science and the art of medicine and for the great majority of physicians, who, as men and women, represent an exceptionally idealistic as well as skilled type of human being. They have to be. A student cannot make the grade in medical school unless he is well educated and intelligent. I have high regard for individuals in the profession,

although I have been perhaps brutally critical of some of the aspects of the behavior of organized groups of doctors.

Senator DONNELL. Quite a few of these doctors in Boston with whom you came in contact were members of the American Medical Association, were they not?

Dr. DAVIS. I think we did not accept any—I don't think any of our staff were not members of the County Medical Society of Boston or of the immediate vicinity, and that is the basis of their membership in the American Medical Association.

Senator DONNELL. Yes.

Now, with respect to your duties, just generally—I do not want you to go into detail—as secretary of the Commission on Dispensary Development in New York City between 1920 and 1927, did those duties call upon you to come in contact with the doctors there?

Dr. DAVIS. Yes, sir. That committee was a lay committee, with a medical advisory board which was made up entirely of physicians nominated by the New York Academy of Medicine, so I came in contact with the doctors who were active in the New York Academy of Medicine. Dr. Miller was the head of that.

Senator SMITH. I would like to add at that point that this Dr. Miller to whom you refer was associated with my father in medicine for a number of years, and I am sure that you have the same high regard for his devotion to public service, integrity, and skill as I have.

Dr. DAVIS. If I knew of anyone suffering from tuberculosis, an obscure case, there would be nobody in the country in whose hands I would rather see him than in the hands of Dr. Miller, either from the standpoint of his skill or from the standpoint of his complete integrity in devoting his interest to the service of humanity.

Senator SMITH. Did you know that in treating his patients, Dr. Miller never discussed what the fee was? He was willing to serve the poor as well as the wealthy at all times.

Dr. DAVIS. I would have to add to that that despite my great respect and affection for Dr. Miller personally, we have had very violent disagreement on some of the questions we are discussing today.

Senator SMITH. I think that is true, because he does not believe in a compulsory plan, and I can see why the two of you might disagree. But we are talking now with respect to character and from the point of view of conviction to public service. You probably would concede that he would have as high a desire to solve this problem as you have, would you not?

Dr. DAVIS. Without question, sir.

Senator DONNELL. You spoke of the New York Academy of Medicine generally. Did you observe that that same high quality of devotion to professional ideals and the desire to be of public service characterized the members of the New York Academy of Medicine with whom you came in contact?

Dr. DAVIS. Oh, yes. The work of that committee was supported by the Rockefeller Foundation, and it was designed to do certain things, to study clinical standards and to establish improved standards for the treatment of out-patients in charitable clinics and experiment in improving standards of clinics, subsidized by funds from the Rockefeller Foundation. I don't think it is necessary for me to go into further detail.

I think I might anticipate your next question by adding one more thing. By that time—by the time I went to New York—I had already begun to be asked to visit other places and study the medical facilities there, and I had become drawn into private consultations. Then in the latter twenties, when the work of the committee on dispensary development had been completed, I devoted my time for about 8 or 9 years to being a private consultant. I was engaged in an open competitive business of my own.

Senator DONNELL. What type?

Dr. DAVIS. Acting as a consultant at the request of hospitals and communities to make studies. I actually did three types of work. One was the actual study of communities. I took part in surveys of the hospital facilities, to determine if they were adequate and what was needed to make them adequate. In the city of New Haven I was in charge of a survey conducted to determine whether the hospital facilities in that city were adequate, what should be done to make them adequate, and what it would cost.

Then I acted as consultant with respect to individual institutions. If a hospital was in a bad way financially or the building was antiquated, they would come to me for advice as to how they should rebuild it. I acted as consultant to the architect, which is a common practice in the building or remodeling of hospitals.

I did very little work with respect to general hospitals. My work was specialized mostly in connection with out-patient service clinics, which sometimes involved hospitals also.

So for about 8 or 9 years I was a private practitioner in this particular field of consultation service, which took me into every part of the United States. And in the interim at various times I had the opportunity to make various trips abroad and study the situation abroad.

Senator DONNELL. Doctor, between 1910 and 1928, when you started in with the Rosenwald Fund, you had had a very wide contact with members of the medical profession in all parts of the United States; is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. I will ask you generally, without going into minute detail, whether your general impression of these gentlemen of the medical profession with whom you came in contact in various parts of the country was that they showed the same high type of devotion to public duty and sincere effort to consider the welfare of the American people as was characterized by the doctors you knew up in Boston when you were engaged there in your earlier career. Is that true?

Dr. DAVIS. I would say "Yes," so far as devotion to the interests of the individual patients was concerned. However, I would have to add this—that in the conception of his public responsibility a doctor is a very specialized individual, and his training and experience as an individual practitioner conditions him to understand individuals but to have very little understanding of organizations and of public policies. It is harder for a physician, for example, to understand public policies than it is for a lawyer or a businessman, because both lawyers and businessmen are constantly dealing with public relations and organizations. In the case of a doctor he is dealing with a series of individuals who are ill and dependent upon him because of their sick-

ness and their desire to submit themselves to his authority, and they employ him for that purpose.

Senator SMITH. You suggest that a doctor is better at the retail level than at the wholesale level?

Dr. DAVIS. Very much so. I don't mean that in the derogatory sense of those two words, but I think I understand what you mean. Yes, sir.

Senator DONNELL. Dr. Davis, you found then that individually these men, these doctors, all over the United States with whom you came in contact did show the characteristics of zeal and integrity and good intentions; is that right?

Dr. DAVIS. Yes, sir.

Senator DONNELL. I think I understand your view in respect to the American Medical Association. You comment in general detail on that, and I will not go into it at the moment.

Now, you started in with the Rosenwald Fund in 1928; is that correct?

Dr. DAVIS. Yes, sir.

Senator DONNELL. You were with it from then until 1936; is that right?

Dr. DAVIS. Yes.

Senator DONNELL. What was the Rosenwald Fund?

Dr. DAVIS. The fund was—and it is still in existence—a private foundation, a philanthropic foundation, established by Julius Rosenwald, of Chicago, who was living until 1932, at which time he died. He contributed \$1,000,000 to it as a capital fund, to be used up within 25 years after his death, principal and interest, and a part of its work was concerned with the study and promotion of improved medical services, and it was that department of his work that I had charge of.

Senator DONNELL. Did you prepare or collaborate in the preparation of a pamphlet entitled "Julius Rosenwald Fund, Eight Years Work in Medical Economics, 1929-36, Recent Trends and Next Moves in Medical Care," issued in Chicago in 1937?

Dr. DAVIS. That was prepared at the time I was preparing to leave the fund. It was drafted by me, and the responsibility for it was in the hands of the president of the fund, but I prepared it in the first instance.

Senator DONNELL. You prepared it, and the statements therein contained are true to your best knowledge and belief; is that right?

Dr. DAVIS. Yes.

Senator DONNELL. I would like to insert in the record at this time this paragraph from page 16 of this pamphlet:

The members of the staff—

that refers to the staff of the Julius Rosenwald Fund, I take it?

Dr. DAVIS. I presume so.

Senator DONNELL. All right.

The members of the staff were naturally called on for frequent public addresses. Articles in magazines of general circulation and in the special organs of various professional and lay agencies were prepared, or their preparation arranged for. Some of the more important facts were put into chart form and issued as A Picture Book About the Costs of Medical Care. The illustrations in this report are from the third edition of the Picture Book. Altogether, during the years 1933 to 1936, about 160,000 pamphlets and articles were distributed by the fund, mostly on request.

Is that a correct statement, Dr. Davis?

Dr. DAVIS. Of course, I do not remember the sources of the information at that time, but I'm sure it was carefully estimated.

Senator DONNELL. Yes. Now during the course of your connection there in those years, 1928 to 1936, how much money did you spend—how much money was expended by the Rosenwald Fund—in the activities mentioned in the paragraph that I have quoted?

Dr. DAVIS. I am afraid, Senator, that I cannot answer that from memory now. That's many years back. I can't remember it now. I think a financial report is stated there.

Senator DONNELL. There is, at page 43 of this document, the following language:

JULIUS ROSENWALD FUND, EXPENDITURES FOR MEDICAL SERVICE, 1929 TO 1936

Direction of program and consultation services, \$227,569.

Studies and publications, \$86,572.

Information service, \$13,077.

Committee on the Costs of Medical Care, \$90,000.

Then there are listed various other items which, so far as I know, have nothing to do with this matter.

The total of the expenditures for all the various activities listed in that financial statement, including the four that I have mentioned specifically—the aggregate total is \$868,071, of which the four to which I have referred, I take it, amount to approximately \$415,000, in round figures.

That statement is true to the best of your knowledge and belief, is it, Dr. Davis?

Dr. DAVIS. Yes.

Senator DONNELL. Did you have anything to do with the preparation or the formation of the Committee on the Costs of Medical Care, for which \$90,000 is recited as having been expended during this period 1929 to 1936?

Dr. DAVIS. Yes, sir.

Senator DONNELL. What part did you have in setting up the Committee on the Costs of Medical Care?

Dr. DAVIS. The committee was begun in 1927, just before I went with the Julius Rosenwald Fund. There was, therefore, no connection between the committee and the Julius Rosenwald Fund at that time as through any channels involving myself. I had become very actively interested in further studies of the needs of improved and more accessible medical care in this country; and, together with a few other people—about half a dozen other people—about 1925 to 1926 we began, about five or six of us, to have meetings to discuss how a really comprehensive study of the whole subject could be made and how it could be financed.

Along about the latter part of 1926 we thought we saw the way in which it could be done. We formed a small organizing group of not more than seven people, of whom I was one, and we went to Dr. Ray Wilbur, who had been Secretary of the Interior under President Hoover, and who later became president of Stanford University.

Senator DONNELL. Is he an M. D.?

Dr. DAVIS. Yes, a physician. He consented to become chairman of the committee. He had been chairman for many years of one of the

councils of the American Medical Association. Under his chairmanship, with that status given us, we were able to approach a number of foundations and secure donations from those foundations during the years 1927 to 1932. During those 5 years—a little over 5 years—the committee raised, almost entirely from foundations, something around three-quarters of a million dollars, from the Rockefeller Foundation, the Carnegie Corporation, the Twentieth Century Fund, the Russell Sage Foundation, and two or three other foundations. A total of about \$750,000 was raised and expended almost entirely from those foundations during that period from 1928, when the committee got into full and actual operation, to 1932, when it concluded its operations.

Senator DONNELL. And you were a member of that committee?

Dr. DAVIS. I was a member of the organizing committee, as I have described. I became a member of the governing board and of its executive committee. The governing board was a committee of 50 people; the executive committee was a committee of 11 people. I might add that on the membership of that executive committee were a number of physicians, among them Dr. Follansby, who at that time was chairman of the judicial council of the American Medical Association. Dr. West, secretary of the American Medical Association, was a member of the general committee but not the executive committee. The American Medical Association was consulted in the organization of the committee.

Senator DONNELL. On the executive committee was included Mr. Walton Hamilton, now connected with the law firm of which Judge Thurman Arnold is head; that is correct, is it not?

Dr. DAVIS. Yes.

Senator DONNELL. And of which Mr. Abe Fortas is also a member?

Dr. DAVIS. Yes.

Senator DONNELL. Now, Dr. Davis, when you mentioned that figure of three-quarters of a million dollars as having been raised and expended, you were referring to that sum of money having been raised and expended by the Committee on the Costs of Medical Care; is that right?

Dr. DAVIS. That is right.

Senator DONNELL. Over how long a period, did you say?

Dr. DAVIS. From 1927 to 1932—a period of a little over 5 years.

Senator DONNELL. Had you met Dr. Isidore S. Falk prior to the organization of the Committee on the Costs of Medical Care?

Dr. DAVIS. I had met him very casually in Chicago while I was in Chicago at various times. You see, before I went to Chicago with the Rosenwald Fund I had had occasion to visit Chicago many times in connection with consultation work, and when I met him he was then in the department of bacteriology in the University of Chicago.

Senator DONNELL. He left the department of bacteriology about December of 1929, did he not?

Dr. DAVIS. Yes.

Senator DONNELL. And was he made the associate director of study of the administrative staff of the Committee on the Costs of Medical Care?

Dr. DAVIS. He was appointed by the executive committee to the committee selected, and that was a position of great importance. He was the technical director of studies. The general director was Mr.

Harry H. Moore, who was charged with the general public relations and general financial matters of the committee. Dr. Falk was the technical director and associate director of study, and actually director of technical study of the committee.

Senator DONNELL. He was the man who actually headed the research staff, is that right?

Dr. DAVIS. Yes.

Senator DONNELL. Among other persons on his staff were Miss Margaret C. Klem, Dr. Louis S. Reed, and Dr. Nathan Sinai, is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. Morris Levin, a statistician, was also under the jurisdiction of Dr. Falk?

Dr. DAVIS. Yes, sir.

Senator DONNELL. During the course of the activities of the Rosenthal Fund to which you have referred, was any portion of the money expended by that fund expended in advocacy of compulsory health insurance?

Dr. DAVIS. No. The money was expended in studies or in the aid of experimentation. We helped various organizations set up schemes. There is no need to go into all the details. We helped community hospitals improve their service, and various other things.

Senator DONNELL. Of the moneys raised and expended by the Committee on the Costs of Medical Care, was any portion of that used for the dissemination of advocacy of compulsory health insurance?

Dr. DAVIS. The Committee on the Costs of Medical Care spent all its money in research and the publication of a series of 28 volumes—about 28, as I recall. It also published a series of abstracts of the larger volumes in pamphlet form, but the amount of money expended in distributing them was inconsiderable, because in general the policy was, when these pamphlets were sent out, to request a nominal fee, which covered postage and part of the cost of printing.

Senator DONNELL. Did the 28 volumes you refer to include any discussion of health insurance?

Dr. DAVIS. Oh, yes, but there were no studies made by the committee of European health insurance.

Senator DONNELL. But the 28 volumes did include, among other things, articles and books on the subject of health insurance?

Dr. DAVIS. That is right.

Senator DONNELL. Is that right?

Dr. DAVIS. Yes.

Senator DONNELL. Compulsory health insurance?

Dr. DAVIS. Well, there was one of the studies you refer to by Nathan Sinai and A. M. Simons on health insurance abroad. It was called *The Way of Health Insurance*. That was subsidized by the committee. They were commissioned and engaged to undertake that. Simons was not a member of the staff. He was commissioned to go abroad and make a report.

Senator DONNELL. Now, Mr. Davis, there are so many committees and commissions and different organizations here, I want the record to be perfectly clear that the committee you are talking about there is the Committee on the Costs of Medical Care, is that right?

Dr. DAVIS. Yes.

Senator DONNELL. Going back to the Julius Rosenwald Fund publications, was there not among other books published by that fund while you were with it, one entitled "The Concept of Social Medicine, as Presented by Physicians and Other Writers in Germany, 1779-1932," that was issued by the Julius Rosenwald Fund, which did pertain to the subject of social medicine, is that right?

Dr. DAVIS. Yes. It was a pamphlet rather than a book. It was purely historical, purely a review, not of the existing systems of health insurance but of the concepts underlying, as manifested in the published literature by physicians and others in Germany during the period covered by the dates you mentioned.

Senator DONNELL. And may I inquire also whether or not among the reprints issued by the Julius Rosenwald Fund while you were with it, was one entitled "Sickness Insurance in the United States" by C. Rufus Uram, published in 1932?

Dr. DAVIS. Yes.

Senator DONNELL. Was there another reprint, of which you yourself were the author, issued in 1934, entitled "How Europeans Pay Sickness Bills"?

Dr. DAVIS. That was an article, I believe.

Senator DONNELL. Was that written by you?

Dr. DAVIS. By me; yes.

Senator DONNELL. And that was issued by the Rosenwald Fund?

Dr. DAVIS. I am a little hazy about that. The article was first published in a magazine. It was later reprinted, and I would have to refresh my recollection as to whether or not the Rosenwald Fund paid for a certain quantity of reprints and their distribution. I am not quite sure about that.

Senator DONNELL. I hold in my hand this same publication to which I have previously referred, "Julius Rosenwald Fund, 8 Years' Work in Medical Economics, 1929-36," and I call your attention to the fact that at page 45 of that publication, under the headline "Reprints," is listed, with a little star in front of it—and the star down at the bottom of the page saying "Out of print"—the words "How Europeans Pay Sickness Bills" by Michael M. Davis, 1934.

That was then issued by the Rosenwald Fund?

Dr. DAVIS. Not the article.

Senator DONNELL. But the reprint?

Dr. DAVIS. As for the reprint, my recollection is that a quantity of the reprints were purchased by the fund for distribution. Perhaps I ought to explain to you how that article was written. I went abroad for some time in 1933 to study health insurance in Europe, and I wrote that article as a byproduct of my trip, and I got the president of the fund, who had the final say about the expenditure of money and just how much could be spent for various things, to make some of these reprints available for distribution.

Senator DONNELL. And the Rosenwald Fund bought some of them and did make them available?

Dr. DAVIS. That is correct.

Senator DONNELL. The office of the Rosenwald Fund was 4901 Ellis Avenue, Chicago; is that correct?

Dr. DAVIS. That is right.

Senator DONNELL. On page 45 of this same publication appears this notation after the list of reports, books, and reprints:

These reports and reprints as well as publications of the fund in other fields of its work, may be obtained from the offices of the fund, 4901 Ellis Avenue, Chicago.

Now, I would like to ask you also, Dr. Davis, whether or not you published a book of some 290 pages, printed by the University of Chicago Press in 1931, entitled "Paying Your Sickness Bills," and whether that was issued by the Julius Rosenwald Fund also.

Dr. DAVIS. No; it was not. The Julius Rosenwald Fund had an arrangement whereby it would make available to the University of Chicago Press, which is a nonprofit university press, such as is common to many universities, a pledge of a fund sufficient to make it possible for the University of Chicago Press to publish various books which it was felt might be a useful public service but which would command so small a public sale that they had to be subsidized. The fund had an interest in many other things—Negro race relations and Negro education especially—and the University of Chicago Press was therefore able to publish a number of books as a result of contributions made available to it in the form of subsidies by the fund for the publication of such books.

Senator DONNELL. Yes.

And you also issued a book, did you not, published in 1937 by the University of Chicago Press, which is listed here at page 45 of the Julius Rosenwald Fund publications above this notation to the effect that these reports, reprints, and publications may be obtained from the offices of the fund? The book to which I refer now is entitled "Public Medical Services, the Kinds and Extent of Tax Supported Medical Care in the United States"; is that right?

Dr. DAVIS. I prepared that book. It was purely factual—a purely factual study.

Senator DONNELL. Yes.

Now, in connection with this work of Mr. Falk, who was a member of the Committee on the Costs of Medical Care, did you engage Mr. Falk for that committee?

Dr. DAVIS. No. He was engaged, after careful consideration of Mr. Falk and other people, since it was one of our most important engagements—he was engaged by a unanimous vote of the executive committee after careful consideration, and the chairman of the executive committee, who was Professor Winslow of Yale University, Department of Public Health and Welfare, now retired, made the actual engagement. I was merely one of the members of the executive committee that voted in favor of his engagement.

Senator DONNELL. Now, Dr. Davis, this Mr. Hamilton to whom I referred a while ago, Walton H. Hamilton, now a member of Judge Arnold's law firm, and who was one of the members of the executive committee, along with yourself and others of the Committee on the Costs of Medical Care, prepared a minority report of the Committee on the Costs of Medical Care, in the course of which, at page 196 of the volume entitled "Medical Care for the American People" appears this sentence:

So it seems to me that the scheme called compulsory health insurance is the very minimum which this committee should have recommended.

That is right, is it not?

Dr. DAVIS. As I recall the statement, yes.

Senator DONNELL. Mr. Hamilton served on President Roosevelt's Committee on Economic Security in 1934, which drafted the Social Security Act, did he not?

Dr. DAVIS. I think so, as I recall it.

Senator DONNELL. And he also became the first Director of Research and Statistics of the Social Security Board, did he not?

Dr. DAVIS. I think he served in that capacity for a short time.

Senator DONNELL. In connection with your work with the Rosenwald Fund, did you live in Chicago?

Dr. DAVIS. Yes, when I wasn't traveling.

Senator DONNELL. When you were not traveling?

Dr. DAVIS. Yes.

Senator DONNELL. Subsequently you became the chairman of the Committee on Research in Medical Economics, Inc. You became that about 1937, did you not?

Dr. DAVIS. Yes.

Senator DONNELL. Is that particular organization a committee or a commission?

Dr. DAVIS. A committee.

Senator DONNELL. Did you say "committee"?

Dr. DAVIS. Yes; it is a committee.

Senator DONNELL. It is supported by grants from the Rosenwald Fund, the Rockefeller Foundation, and Mr. Albert Lasker, who testified here this morning; that is correct, is it not?

Dr. DAVIS. The committee has been supported chiefly by foundation grants. Its initial grant was from the Rosenwald Fund. Subsequently we asked for aid from additional other foundations, the Rockefeller Foundation, and later from the Albert and Mary Lasker Foundation, and grants were received from all those foundations.

Senator DONNELL. And you left the committee about January 1928; is that right?

Dr. DAVIS. No. I left the Rosenwald Fund at about that time. Excuse me. I left the committee in 1928. I left the Rosenwald Fund at the end of 1936 and moved to New York to take charge of this new committee, which was practically a committee to carry on specialized work in the field of studies in medical economics, because the Rosenwald Fund—and I concurred in the desire—felt that it would be freer if they had a special committee of people particularly interested in that rather than to be under a general board of a foundation that had a half dozen other major interests.

Senator DONNELL. The Rosenwald Fund in 1936 made the decision that it would be practical for it to turn over certain lines of work to other agencies, did it not, and made a grant of \$165,000 to be used over a 5-year period to the Committee on Research in Medical Economics?

Dr. DAVIS. That is right.

Senator DONNELL. When were those lines of work turned over to other agencies; do you recall?

Dr. DAVIS. No; I do not recall.

Senator DONNELL. I would just like to read the paragraph in this article about the Rosenwald Fund, preceding the paragraph in which appears reference to the grant of \$165,000:

The depression greatly accelerated the practical interest in medical economics among the public, among many thousands of physicians, and among public health

and social welfare authorities. Before the turn of the depression had arrived it had begun to be apparent that the need of promoting interest in the fund's work during 1932-33 was becoming less and less important. The very shortening of opposition from certain quarters proved again and again one of the most satisfactory evidences of a real forward movement arising. Emphasis in the past 2 years has gradually been focused upon the advancement of research in this field and upon the encouragement of group hospitalization as one specific line of action.

Does that refresh your memory as to what those two lines of work were that were committed to other agencies, Dr. Davis?

Dr. DAVIS. Well, I misunderstood you slightly. I thought you meant what lines of work other than those in the medical field. I would remember what lines of work in the medical field were committed, but in general the fund's interest in medical work was terminated almost entirely after the Committee on Research in Medical Economics had been formed.

Senator DONNELL. You were appointed on or about January 28, 1938, as the principal consultant in medical economics by the Health Studies Division of the Social Security Board under Mr. Falk, were you not?

Dr. DAVIS. Yes.

Senator DONNELL. Mr. Falk in the meantime had been appointed to the Social Security Board; is that right?

Dr. DAVIS. Yes.

Senator DONNELL. And you were subsequently appointed consultant in the Federal Hospital Council in 1946; is that right?

Dr. DAVIS. That is right. I was appointed a member, not a consultant.

Senator DONNELL. You were appointed a member of the Federal Hospital Council?

Dr. DAVIS. Yes.

Senator DONNELL. You were one of the organizers of the Committee for the Nation's Health, Inc.; is that right?

Dr. DAVIS. Yes.

Senator DONNELL. The Committee for the Nation's Health, Inc., is now located in Washington, is it not?

Dr. DAVIS. It has an office in New York and an office in Washington.

Senator DONNELL. It has an office in both places?

Dr. DAVIS. Yes.

Senator DONNELL. But your Washington office is located at 914 G Place, NW; is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. And that is the organization which gave out a release yesterday with respect to Thurman Arnold's charges? The heading of it is "Thurman Arnold charges AMA with monopolistic practices." Is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. Were you familiar with the fact that the release was given out?

Dr. DAVIS. Yes.

Senator DONNELL. And the letterhead directly sets forth the list of officers, chairman, honorary vice chairmen, treasurer, secretary, chairman of the executive committee, executive director, board of directors, and Washington representative; is that right?

Dr. DAVIS. Yes.

Senator DONNELL. May I ask you whether or not on April 2, 1946—last year—there was a committee appointed to lobby for the Wagner-Murray-Dingell bill, namely, the Committee for the Nation's Health; do you remember that?

Dr. DAVIS. The Committee for the Nation's Health, as Mr. Louchheim stated this morning, was organized or became incorporated toward the end of February 1946, and part of its obligation was to do whatever it could to assist in the promotion of legislation. It is definitely an organization which is designed to assist in the enactment of legislation along the lines stated this morning by Mr. Louchheim as being the policy which we are organized to promote and for which we were organized to promote.

Senator DONNELL. And the Committee for the Nation's Health was incorporated in February 1946 under the New York statute?

Dr. DAVIS. Yes.

Senator DONNELL. That is correct; is it not?

Dr. DAVIS. Yes.

Senator DONNELL. Did that committee, namely, the Committee for the Nation's Health, Inc., hold a meeting at the Carlton Hotel in Washington on or about April 1, 1946, with respect to the subject matter of the Wagner-Murray-Dingell bill? Do you remember that?

Dr. DAVIS. I do not recall any meeting of the committee—I do not recall any meeting of the committee at the Carlton Hotel. The meetings of the committees are numerous, and there have been special conferences called by subcommittees. I cannot recall whether there was any meeting of the committee on or about that date at the Carlton Hotel.

Senator DONNELL. May I refresh your memory by asking if you were present at a meeting in the Carlton Hotel at which Messrs. Altmeyer, Lasker, Representative Dingell, Mr. Abe Fortas, Dr. Frothingham, and others were present? Do you remember that?

Dr. DAVIS. There were several meetings. I cannot identify a meeting of that type at a particular date, sir. There were many meetings with some of those people and other people present. There were numerous meetings around about that time.

Senator DONNELL. Without reference to the identification of any particular meeting, do you remember that at one or more of those meetings the gentlemen to whom I refer were present, and Mrs. Keyserling, together with Mr. Raymond Swing and yourself, Dr. Allen Butler, Dr. Ernst P. Boas, and Dr. Goldman were present? Do you remember that quite a few of those meetings occurred at which some or all of those parties were present?

Dr. DAVIS. Yes, sir.

Senator DONNELL. And the purpose of those meetings to which I refer was to advocate the enactment of the Wagner-Murray-Dingell bill; is that correct?

Dr. DAVIS. It was largely in connection with the enactment of that bill or some measure to promote the cause for which the committee was organized, so we held meetings for that purpose.

Senator DONNELL. Going back for a moment to the Committee on Research in Medical Economics, you were chairman of that committee?

Dr. DAVIS. I am chairman.

Senator DONNELL. You are now?

Dr. DAVIS. Yes.

Senator DONNELL. Are Dr. Ernst P. Boas and Dr. John P. Peters on this committee?

Dr. DAVIS. No. The editorial board was maintained only while we issued our quarterly publication. It was abandoned in 1945 when we ceased to issue our quarterly publication because of war conditions. The editorial board has not been in existence since 1945.

Senator DONNELL. Were you an editor of a publication called Medical Care, which I believe was a quarterly journal dealing with the economic and social aspects of health service?

Dr. DAVIS. That is right.

Senator DONNELL. And did the editorial board consist of Dr. Boas, Dr. Bradbury, Dr. Munger, Dr. John P. Peters, Herbert Phillips, Kingsley Roberts, George Soule, and Mr. Winslow?

Dr. DAVIS. Yes, sir.

Senator DONNELL. That publication is no longer in existence?

Dr. DAVIS. No.

Senator DONNELL. Now, Dr. Davis, referring for a moment to the Committee for the Nation's Health, Inc., to which I have referred, that is one which was organized and incorporated in the early part of 1946; is that right?

Dr. DAVIS. Yes, sir.

Senator DONNELL. I want to mention particularly these persons as being active participants in the work of that committee, and I ask you if I am correct: Dr. Frothingham, yourself as chairman of the executive committee, Dr. Goldman, Dr. Boas, Dr. Butler, and Dr. John P. Peters; is that correct?

Dr. DAVIS. Yes. Dr. Peters has never been active in the work of the committee because of his other activities.

I am a little puzzled to know how to answer your questions on these points. I am not sure whether your questions in connection with these lists are an inquiry or implied indictment.

Senator DONNELL. I am not indicting anybody, but I am asking for information as to whether or not those gentlemen were active in the work of the Committee for the Nation's Health. I understood you to say that Dr. Peters was not.

Dr. DAVIS. He has been in touch with me, but I would not say he is an active member.

Senator DONNELL. But Dr. Butler, Dr. Boas, Dr. Goldman, yourself, and Dr. Frothingham have been active in connection with the work of the committee; is that a correct statement?

Dr. DAVIS. Dr. Boas was a member of the executive committee as well as on the board.

Senator DONNELL. Did you have anything to do with the organization of a group known as the Physicians' Forum, Inc.?

Dr. DAVIS. Nothing whatever.

Senator DONNELL. You know that Dr. Boas is connected with that organization, do you not?

Dr. DAVIS. Yes, sir.

Senator DONNELL. Were you present at a tribute dinner to Senators Robert F. Wagner and James E. Murray and Representative Dingell, sponsors of the national health bill, given under the auspices of the Physicians' Forum, Inc., at the Waldorf-Astoria Hotel in New York City on April 11, 1946?

Dr. DAVIS. I make that confession.

Senator DONNELL. You were there?

Dr. DAVIS. Yes.

Senator DONNELL. Do you recall that seated at the head table, among those seated there, were the following persons: Dr. Ernst P. Boas; Mr. Cruikshank, of the American Federation of Labor, who testified here yesterday; yourself; Representative Dingell; Dr. Channing Frothingham; Mr. Leon Henderson, who testified here the other day, too; Mrs. Frederic March; Senator Murray; and Dr. John P. Peters; do you recall that?

Dr. DAVIS. I remember the affair. I couldn't list those who were at the table, but I remember the affair very well.

Senator DONNELL. Were there funds solicited at that meeting for any purpose?

Dr. DAVIS. It is a little difficult for me to remember because I go to a good many dinners and there is a tendency now to solicit funds at dinners. At that particular dinner I think funds were solicited, and if they were I think it was probably—you see, the dinner was a very enthusiastic one; the hall, as I recall it, was filled, and the people were all very enthusiastic.

Senator DONNELL. Do you recall how much money was raised at that meeting?

Dr. DAVIS. I don't know.

Senator DONNELL. What was the purpose for which funds were solicited?

Dr. DAVIS. To support the Physicians' Forum.

Senator DONNELL. To support the Physicians' Forum?

Dr. DAVIS. Its membership dues have not been sufficient to maintain its budget.

Senator DONNELL. And the Physicians' Forum has as one of its primary objectives the advocacy of compulsory health insurance?

Dr. DAVIS. I cannot speak for the Physicians' Forum. I am not a member. Only physicians are entitled to be members of the Physicians' Forum, and I am not a physician, as you know. I think the purpose of the Physicians' Forum is more general, much more general, than that of the Committee for the Nation's Health. I would say the purpose of the Physicians' Forum is a broader program of education, particularly of physicians along the lines of advancement in the social and economic problems of medicine; and the advocacy of this particular legislation which they are advocating, as I understand it, is simply one of the things that they do, but it is not their primary function, by any means.

Senator DONNELL. Is the advocacy of compulsory health insurance the sole purpose of the Committee for the Nation's Health, Inc.?

Dr. DAVIS. The Committee for the Nation's Health, Inc., advocates compulsory health insurance, but I would not say that was its sole purpose. I should say its principal aim is the advocacy of a national health program, of which compulsory health insurance is an integral part. For example, this bill S. 1320 includes, of course, compulsory health insurance but also a very substantial program of grants-in-aid to States, which we regard as an extremely important part of, and a necessary supplement to, health insurance. The two things go together.

Senator DONNELL. One of the very important things, however, in fact, the primary objective which the Committee for the Nation's Health has been advocating, has been passage of the Wagner-Murray-Diingell proposed legislation; is that not correct?

Dr. DAVIS. Yes.

Senator DONNELL. Now, are you familiar with an organization known as the Committee on Research and Medical Economics?

Dr. DAVIS. Yes, sir.

Senator DONNELL. Your office is at 1790 Broadway, New York City?

Dr. DAVIS. I am chairman of that committee.

Senator DONNELL. Your office is at 1790 Broadway, New York?

Dr. DAVIS. Yes, sir.

Senator DONNELL. And that organization has its office at the same address, is that right?

Dr. DAVIS. Yes.

Senator DONNELL. Do any of these other organizations have their offices at 1790 Broadway, New York?

Dr. DAVIS. I don't think any of the other organizations you have mentioned have their offices there; no.

Senator DONNELL. Are you familiar with a publication known as Principles of a Nation-Wide Health Program, being a report of the health program conference?

Dr. DAVIS. Yes.

Senator DONNELL. That was issued in New York in November 1944?

Dr. DAVIS. Yes.

Senator DONNELL. Was there a health-program conference held pursuant to which this particular document, Principles of a Nation-Wide Health Program, was issued?

Dr. DAVIS. The 29 persons listed as members of that conference held several meetings—full meetings and subcommittee meetings—to prepare that statement.

Senator DONNELL. The Committee on Research in Medical Economics includes how many members?

Dr. DAVIS. Thirteen.

Senator DONNELL. Thirteen?

Dr. DAVIS. Yes.

Senator DONNELL. It has stationery, has it not, of which this is a copy?

Dr. DAVIS. Yes.

Senator DONNELL. A photostatic copy.

Dr. DAVIS. Yes. I don't know if that is the most recent list. Membership has changed.

Senator DONNELL. But there are only 13 members of that particular committee?

Dr. DAVIS. Yes.

Senator DONNELL. That committee is an incorporation, likewise incorporated under the laws of the State of New York?

Dr. DAVIS. Yes.

Senator DONNELL. May I say you also if, in addition to yourself as chairman of that committee, Walton H. Hamilton, a partner of Judge Thurman Arnold's law firm, is also a member of that committee; is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. And George Soule and Ruth Taylor are also members of that committee, are they not?

Dr. DAVIS. Yes.

Senator DONNELL. The editorial board of the *Quarterly Journal* issued by that committee is constituted by Dr. Ernst P. Boas, Dr. Bradbury, Dr. Munger, Dr. John P. Peters, Herbert E. Phillips, Kingsley Roberts, George Soule, and Mr. Winslow; is that correct?

Dr. DAVIS. That is the board as originally constituted, but it has not been in existence since 1945.

Senator DONNELL. I should have said that. That is the publication I referred to awhile ago.

Dr. DAVIS. Yes.

Senator DONNELL. And that was the editorial board of that publication?

Dr. DAVIS. Yes.

Senator DONNELL. Where does this Committee on Research in Medical Economics receive its funds?

Dr. DAVIS. By grants from foundations. The original grant was from the Rosenwald Fund; and the committee had since received grants from the Albert and Mary Lasker Foundation, as well as the Rockefeller Foundation, which has supported the committee.

Senator DONNELL. This committee of 13 is the one to which the \$165,000 grant was made by the Rosenwald Fund; is that right?

Dr. DAVIS. Yes.

Senator DONNELL. Now, the report that was issued by this health program conference—did that disclose anywhere, do you know, how many members there are of the Committee on Research in Medical Economics?

Dr. DAVIS. I do not think it contained a list of the members of the committee. The report had been prepared under the auspices of the committee.

Senator DONNELL. Did the report state how many persons were included in the health conference?

Dr. DAVIS. A list is printed on the front page of the report.

Senator DONNELL. That list of the 29 names appears under the words "Report of the Health Program Conference"; is that right?

Dr. DAVIS. That is right.

Senator DONNELL. Is there anything in this booklet entitled "Principles of a Nation-Wide Health Program" that indicates to the reader whether or not the health program conference was confined to those 29 persons or possibly included other persons?

Dr. DAVIS. I do not think any statement is made that other persons were included, but it gives a list of the 29 people. The names are all printed in several places in that report, and there is no statement that anybody else belongs to it.

Senator DONNELL. And on the flyleaf of this publication appears this language, does it not:

This report, by its 29 sponsors, is published with the cooperation of the Committee on Research in Medical Economics. Through the committee, arrangements were made for the meetings of the conference and of subcommittees, in the autumn of 1943 and in 1944.

The expenses of the conference and of this publication were met by gifts contributed for this purpose. The sponsors acknowledge with appreciation the generosity of these donors.

I assure you that is the correct language that appears upon the flyleaf.

Dr. DAVIS. Yes.

Senator DONNELL. Now, Mr. Davis, of the group of 29 persons that are listed on the front of this publication, of this report of the health program conference entitled "Principles of a Nation-Wide Health Program," I would like to direct attention to those that are connected with the United States Government here or anywhere. Dr. Dean A. Clark, of Washington—he is with the Public Health Service, is he not?

Dr. DAVIS. Not at present. He is on leave with the Health Insurance Plan of Greater New York.

Senator DONNELL. Sir?

Dr. DAVIS. He is with the Health Insurance Plan of Greater New York at present. I believe he is on leave from the United States Public Health Service.

Senator SMITH. That's right. I recall that he is on leave.

Senator DONNELL. So that he went to his present duties in New York from the U. S. Public Health Service and is simply on leave, is that right?

Mr. DAVIS. Yes.

Senator DONNELL. I quote further from the list of 29. Mr. I. S. Falk, of Washington. He is with the Social Security Board in the capacity of Director of Research and Statistics; is that right?

Mr. DAVIS. I think so.

Senator DONNELL. I ask also whether Mr. Frederick D. Mott, of Washington, was at the time this publication was issued, connected with one of the governmental departments, namely, the Department of Agriculture. Is that correct?

Dr. DAVIS. I think he was Medical Director of the Farm Security Administration.

Senator DONNELL. And Mr. George St. J. Perrott, of Washington, was with the Public Health Service and still is; is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. And Mr. Kenneth E. Pohlmann, of Washington, was with the Department of Agriculture; is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. Mr. Barkev S. Sanders—was he connected with the Government in the Social Security Department?

Dr. DAVIS. I think he was an assistant to Falk.

Senator DONNELL. Do you think he is still with Mr. Falk?

Dr. DAVIS. I think so.

Senator DONNELL. Do you know how widely disseminated this report of the health program conference was?

Dr. DAVIS. I can tell you, roughly. I had occasion to look it up recently in response to another inquiry. We printed about 3,000 copies and had to reprint it several times. About 12,000 copies in all were distributed on request for a nominal amount that was charged.

May I make just one word of general comment on this health program conference?

Senator DONNELL. Yes.

Mr. DAVIS. The Committee on Research in Medical Economics felt it was desirable to get a larger and especially expert group together to consider what should be the principles of a national health program.

The Wagner-Murray-Dingell bill had been introduced, and there seemed to be considerable confusion in the minds of many people. We brought together by invitation a group of people who we felt represented a group having expert technical knowledge. We brought them together and had a group meeting of the 29 people. I acted as chairman, and the meeting lasted 2 days.

No persons are more determined in their expressions of opinion than highly specialized people who have profound convictions regarding a certain subject. So the problem of getting an agreement was very difficult. However, we proceeded and did get a statement of principles. No legislation was advocated, but the group did reach an agreement on certain principles which were incorporated in the statement. We thought it was a good statement and one useful to stimulate thinking on the subject.

The Committee on Research in Medical Economics, which had to decide, after the technical group had prepared its report, whether it was in general a sound document for educational purposes, decided it was worth publishing, and it was published. We made it available for those who wanted it. We distributed it to a small list, and others bought it for a nominal fee.

Senator DONNELL. I should like to call attention at this point, Dr. Davis, to this excerpt from page 12 of this report of the health-program conference, entitled "Finances":

The chief support of a Nation-wide system of medical care should be contributory insurance required by law, with the amounts of payment from employees, employers, and self-employed persons related to the earnings of the contributors, combined with support from general taxation.

I take it from that that the health-program conference, of which you were a member, and to the principles of which you adhered, recognizes the fact that this compulsory plan under the Wagner-Murray-Dingell proposed legislation would be supported not solely from payments of employees, employers, and self-employed persons in relation to their earnings, but would necessitate additional support from general taxation, is that right?

Dr. DAVIS. Yes.

Senator DONNELL. Now, Dr. Davis, I would like to ask you whether you know who it was who prepared or had anything to do with the preparation of a certain booklet issued by the American Historical Association, prepared for the United States armed forces, and issued apparently by the War Department? At any rate the flyleaf contains this in a box:

WAR DEPARTMENT,
Washington 25, D. C., 16 January 1946.
AG 300.7 (16 January 1946)

EM 29, GI Roundtable: Is Your Health the Nation's Business?

Current War Department instructions authorize the requisition of additional copies of this pamphlet on the basis of one copy for each 25 military personnel, within limits of the available supply. Additional copies should be requisitioned from the United States Armed Forces Institute, Madison 3, Wisconsin, or the nearest Oversea Branch.

Do you know who had to do with the publication of that particular booklet entitled "Is Your Health the Nation's Business?"

Dr. DAVIS. I am not quite clear. I recall the booklet very vaguely. I think I remember seeing it, as you hold it up. I think I recall the pictures on the cover. I can't recall much about it beyond that. I can't answer your question "yes."

Senator DONNELL. You have no knowledge as to who prepared it?

Dr. DAVIS. No. If you put it in my hand I might be able to tell you whether or not I would recall.

Senator DONNELL. Here you are. I would like to call your attention, while you are looking at it, to the place where I had it open.

Dr. DAVIS. You mean on this first page here?

Senator DONNELL. No; in the middle there where I had it open, where reference is made to the Wagner-Murray-Dingell bill. You notice that?

Dr. DAVIS. Yes. My recollection is this, Senator. To the best of my ability I would say that I have occasion to be the recipient of a good many drafts of pamphlets and manuscripts and articles, and so forth, to review or go over on the request that I look them over and give my opinion as to their technical accuracy, and maybe their general value, and, as I look at it, I think I recall that this is a document which I saw either in proof or in manuscript—it might have been either. I seem to recall that I saw it, but I would not be willing to make a statement to that effect if I were under oath, so I beg you to pardon a faulty memory.

Senator DONNELL. I understand, and I am not undertaking to bind you. Your present impression is that you saw it in proof, is that correct?

Dr. DAVIS. In proof or in manuscript.

Senator DONNELL. Either in proof or in manuscript?

Dr. DAVIS. I think so, but I am not certain of it. I had no responsibility. If I did, it was only because I had been asked to look it over and give some comment on it.

Senator DONNELL. Yes.

Well, I offer into the record this particular book, and ask that it be printed in full in the record of these proceedings.

Senator SMITH. It is so ordered.

(The booklet referred to follows:)

IS YOUR HEALTH THE NATION'S BUSINESS?

(Prepared for the United States armed forces by the American Historical Association)

Why were draftees rejected? (selective-service examinations, 1941)

	Percent		Percent
Nervous and mental diseases.....	3.0	Venereal diseases.....	1.5
Eye diseases.....	5.0	Musculo-skeletal diseases.....	3.3
Defective teeth.....	8.3	Foot diseases.....	1.5
Ear, nose, and throat diseases.....	2.5	Overweight and underweight.....	1.3
Respiratory diseases.....	1.8	Obvious defects.....	5.0
Cardiovascular diseases.....	3.8	Other causes.....	4.0
Hernia.....	2.0		

IS HEALTH YOUR OWN BUSINESS OR THE NATION'S?

What are the achievements of American medicine? Do its services reach the people who need them? Is the battle against sickness a public question like the battle against illiteracy? What role should local, State, and National Government agencies play in supplementing private effort?

A widely accepted answer to the first two questions was given by the Senate Subcommittee on Wartime Health and Education (the Pepper committee) when it said in its report: The quality of American medicine at its best is very high. Unfortunately, American medicine at its best reaches only a relatively small part of the population."

The other questions—on the stake of the general public in preventing ill health and the role of government in the struggle against disease—are not new ones. Community responsibility for public health has long been recognized in laws and ordinances for sanitation, food inspection, and the prevention of communicable diseases. Does public interest also extend to bringing better medical care of all kinds to more people at less cost? This pamphlet presents some of the most widely discussed program for national health and the arguments pro and con touching them.

What are some of the facts and figures that have made the issues seem too important to be left to private effort or to public-health agencies as they now exist?

In 1935, more than 23,000,000 people in the country had a chronic disease or a physical impairment. In spite of tremendous advances in medical science, the death rate among low-income groups in our large cities is still as high as the national rate 50 years ago. Deaths among mothers and babies could be cut about one-third if all got good medical care.

The fact that struck hardest and startled the public most was the revelation from the selective-service figures that 30 percent of the men of military age were unfit for general military duty.

The gap between what modern medicine has to offer and the kind of medical care people actually receive is usually blamed on two things: People's inability to pay for good medical care under present arrangements, and the way health services are organized.

MODERN MEDICINE COMES HIGH

Modern first-class medical care is necessarily an expensive commodity. Many people cannot meet its full cost regardless of the method of payment. The cheapest medical and dental service compatible with good quality and high standards would probably cost about \$150 a year for the average-sized family. But studies of family spending show that most families under the \$2,000 level—or about half our population—simply cannot pay a full \$150 a year for this purpose. If their medical needs are to be fully met, such people need assistance. As it stands today, people in low-income groups, though they have twice as many days of sickness as the well to do, receive only about half as much physicians' care.

Not only does good medical care cost a lot, but the need for it cannot be predicted. If you can't foretell when illness will strike or how serious it will be, how can you prepare to meet its costs? Many a family able to budget \$150 a year for medical expenses is staggered or financially crushed for years to come by the cost of a single serious illness. Moreover, having to pay a fee for the doctor's services is a frightening prospect to people whose incomes barely cover living expenses—so they often put off going to the doctor. Thus they lose the benefits of preventive measures, early diagnosis and treatment, and perhaps have to pay more in the end.

Fortunately, though no one can predict when or how seriously an individual will be sick or injured, the frequency of such ills can be figured in advance with reasonable accuracy for groups of people. These facts led the Pepper committee to conclude:

"The pay-as-you-go or fee-for-service system, which is now the predominant method of payment for medical services, is not well suited to the needs of most people or to the widest possible distribution of high-quality medical care. It tends to keep people away from the doctor until illness has reached a stage where treatment is likely to be prolonged and medical bills large. It deters patients from seeking services which are sometimes essential, such as specialist care, laboratory and X-ray examinations, and hospitalization. Individuals with low incomes, whose need is greatest, are more likely to postpone or forego diagnosis and treatment."

HEALTH, WEALTH, AND GEOGRAPHY

Cost is widely recognized as a barrier between individual people and the medical services they need. Another difficulty is that people in some parts of the country don't have enough medical services at hand—regardless of price or

ability to pay. The extent of health services actually available in different parts of the country varies according to the wealth of whole communities. Counties, cities, and States which are well off have enough doctors, nurses, and hospitals, and adequate public health facilities; those which are poor have desperately few.

In New York State before the war, for example, there was 1 doctor in practice for every 500 people, while in Mississippi there was 1 for 1,500—exactly 3 times the number of people to be served by each physician. Moreover, the density of population in Mississippi is about one-tenth that of New York, so that not only does each physician have more persons to serve, but on the average, he has to travel farther to serve them.

In New York there was 1 general hospital bed for every 200 people, but in Mississippi 1 to every 650. Variations between counties are even more striking—17,000,000 people live in 1,300 counties that have no recognized general hospital at all. Thus, where communities are too poor to attract sufficient doctors or to build and maintain other health facilities, not only do the needy have to go without necessary medical services but so do those who can afford to pay but cannot seek care elsewhere.

HEALTH SERVICES ARE UNORGANIZED

Even the best general practitioner cannot adequately cope with emergencies or with baffling and complicated cases if he does not have the resources of a well-equipped hospital within reach and does not have colleagues in surgery and the other specialties available when needed. Even where there are first-rate hospitals, the general practitioner may not have the right to use them. In Baltimore, for example, almost half the general practitioners cannot care for their patients in hospitals.

Specialists usually set up offices in cities of some size. They are not easily accessible to country doctors or country patients. Moreover, specialists are not as a rule organized to work in combination with general physicians. Such teamwork can be found, however, in many of the leading hospitals and clinics where medicine is taught and in the outstanding group practice clinics such as, for example, the Mayo Clinic.

In today's medical schools students are trained under a system of group medical practice, centered about a hospital where the best available equipment and techniques can be employed and where the combined skills of a variety of specialists can be brought to bear on a puzzling case. Yet when they graduate, they go out into a kind of isolated practice similar to that of their grandfather's day. That is professionally unsatisfactory to physicians is shown by the fact that over half the doctors in the Army stated that they would like to go into group practice on returning to civilian life.

To sum up the problems of American medicine, then: Americans receive the benefits of medical science in a very uneven manner, partly because of the high cost of modern medicine, partly because medical services are not organized to serve everyone equally—regardless of where he happens to live or how much he can pay.

Clearly, then, the problem of paying for health services is very complex. Can some way be found for families to budget these costs and to assist those families which cannot reasonably afford the total costs? And can facilities for rendering health services be made more equally available in all parts of the country?

WHAT'S TO BE DONE?

President Roosevelt, in his "economic bill of rights" put before the Nation early in 1944, included "the right to adequate medical care and the opportunity to achieve and enjoy good health." Wendell Willkie declared in 1944, "Complete medical care should be available to all." Secretary Wallace recently said, "Your Federal and State Governments have just as much responsibility for the health of their people as they have for providing them with education and police and fire protection." Gov. Thomas E. Dewey appointed in 1944 a commission on medical care "in order to devise programs for medical care for persons of all groups and classes in New York State." In his special message of November 19, 1945, asking Congress to adopt a five-point national health program, President Truman said, "We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation."

Thus leaders of both political parties have followed the demand of farm, labor, and business organizations and of the public at large, as shown in various opinion polls, for an improvement in the way medical care is distributed.

Some professional medical organizations echo the cry. The American Public Health Association, an organization of physicians, nurses, sanitary engineers, and others engaged in public health work, adopted in the fall of 1944 an official policy which states that "a national program for medical care should make available to the entire population, regardless of the financial means of the individual, the family, or the community, all essential preventive, diagnostic, and curative services." The American Dental Association has declared that "dental care should be available to all, regardless of income or geographic location." The American Medical Association, representing the majority of private practitioners and on the record as a conservative professional organization, now recognizes the fact that there is a problem in the distribution of medical care. Up to a few years ago, it often asserted that, except in isolated instances, everyone needing medical care was able to get it, by paying for it or through charity.

WHAT DO PEOPLE PROPOSE TO DO ABOUT THE SITUATION?

Although a great many people know that ways must be found so that everyone can secure good medical care more rapidly and pay for it more easily, there is no such agreement on just how this should be done. In particular, opinions vary a good deal on the Government's role in the future of medical care. Some think no further Government activity is necessary. Others think that the Government must play a part, but differ as to how big that part should be. Proposals range from tax support for such limited purposes as school-health programs to a complete national health program paid for through national health insurance and general tax funds.

HANDS OFF, GOVERNMENT

Present governmental activities in providing health services are generally accepted. Each American citizen spends about a dollar a year for control of contagious diseases, installation of pure milk and water supplies, and other public-health services. That dollar is considered a good investment. Though State-supported hospitals for mental illness and tuberculosis are sometimes criticized as insufficient, no one wants them eliminated. Rather, public pressure is for their improvement and expansion. So on through the long list of local, State, and federally supported health services.

Yet, at first, almost all tax-supported service met violent opposition from small groups whose interests were temporarily affected. When, for example, the testing of dairy cattle for tuberculosis as a means of keeping contaminated milk from the markets was proposed, dairymen bitterly opposed it. They said that any such measure would mean political control and regimentation.

Similar protests have frequently come from representatives of the medical profession, who usually oppose the extension of tax-supported health services. In 1944, for example, the governing body of the American Medical Association, while recognizing the need for improved early diagnosis and treatment of tuberculosis, did not favor increased Federal responsibility in this field, and refused to support a bill in Congress extending Federal aid to the States for the control of tuberculosis. Aware that under present conditions over half the patients admitted to tuberculosis hospitals are already in an advanced stage of the disease, most public-health experts considered this bill a vital measure toward the ultimate wiping out of tuberculosis. In spite of the position taken by the American Medical Association, Congress passed the law without a dissenting vote 1 week later.

SICKNESS COSTS FALL UNEVENLY

Ten percent of families bear forty-one percent of costs.

Thirty-two percent bear forty-one percent.

Fifty-eight percent bear only eighteen percent.

The AMA today is strongly opposed to any form of Government-sponsored health insurance on the ground that it would bring political control of medicine and interfere with the personal relationship between patient and physician. For some years, the AMA has held that the intimate bond between patient and physician is threatened or destroyed when the patient himself does not pay his doctor on a fee-for-service basis. Yet the AMA, yielding to public pressure for an easier way of meeting sickness costs, now supports voluntary health insur-

ance run by commercial companies or by medical societies. This is a reversal of its position of 10 years ago when the AMA editorialized against proposals for voluntary health insurance as measures of "socialism and communism inciting to revolution." In July 1945 the AMA declared its position in a program, summarized in a later section of this pamphlet.

VOLUNTARY INSURANCE

Voluntary insurance against the costs of hospitalization and physicians' services has, however, had a considerable development in the United States. The oldest of these insurance plans are those organized in certain industries, especially in mines and railroads, which often operate in remote regions where medical services are scanty. Usually, a monthly deduction of a dollar or two is made from employees' wages and a like amount is often contributed by employers. These funds are then pooled and are used to pay for the medical care which may be needed by the employee. Employees' families are sometimes but not generally included. Few new plans of this type have been started in recent years, although one has received wide attention—that organized at the Kaiser shipyards on the west coast.

The largest recent development in voluntary insurance has been for hospitalization, especially the Blue Cross plans approved by the American Hospital Association. Blue Cross subscribers are enlisted voluntarily from among employee groups in the community. Subscribers usually pay about \$24 a year for insurance that covers hospitalization for employees and their families for a period of 3 to 4 weeks a year. The Blue Cross plans have expanded in the past 10 years from less than a million subscribers to more than 18,000,000.

Plans have also been organized to insure the costs of physicians' services. These have not been so successful as the hospitalization insurance plans but have nevertheless grown so that they now cover about 4 or 5 million people, chiefly for services limited to surgical operations and obstetrics.

Voluntary insurance plans have also been developed for low-income farmers, under the sponsorship of the Farm Security Administration, and about 300,000 rural inhabitants are now included in them. Farm families generally pay about \$25 to \$50 a year in these plans and receive limited medical, surgical, and hospital care.

Commercial insurance companies have made some progress in selling policies to cover the costs of hospitalization, surgical, and obstetrical care. Usually these policies are taken out by employers for their employees and their families, both employer and employee making monthly contributions to the fund. Approximately 8,000,000 persons are now insured under such policies.

The success of voluntary efforts in providing insurance against the costs of medical and hospital care has encouraged some groups to hope that all the major problems of health and medical care can be solved by voluntary measures, without the participation of Government. As mentioned above, the American Medical Association takes this point of view. The United States Chamber of Commerce also advocates further trial of voluntary methods.

Others feel that voluntary insurance, whether it is under the auspices of nonprofit organizations of physicians and hospitals or of commercial insurance companies is too limited to solve the problem. They point to the fact that, despite the rapid growth of some plans, not more than 20 or 30 million persons are subscribers to such plans in the United States up to the present time and that the insurance coverage of even these persons is largely confined to surgical, obstetrical, and hospital care.

Furthermore they offer the objection that most existing voluntary insurance schemes include no general medical expenses, no preventive care, and little family care. They feel that such insurance provides no incentives for improving the quality of medical practice and that its cost limits its sale to a rather narrow section of the population. In the case of commercial policies, they say that it is no great bargain—companies on the average pay out in benefits only about half of what they receive in premiums.

Those who believe that voluntary efforts cannot fully solve the problem emphasize two difficulties encountered by such insurance. In the first place, voluntary plans, by their very nature, face the problem of securing and retaining subscribers. There is an inevitable tendency for healthy families to stay out of the plans and for those inclined toward illness to enter and remain in them. This fact is apt to bring about financial difficulties. Because of the spotty, uneven coverage of the population, the healthier families do not bear a full

share of the costs. The second difficulty is that, if voluntary plans charge high enough premiums to cover the costs of complete medical and hospital care, they are so expensive that the lower-income groups, who need this care the most, cannot afford to subscribe.

GOVERNMENT AID FOR SPECIAL PROGRAMS

George Washington was still alive when the Marine Hospital Service for sick merchant seamen (now the United States Public Health Service) was established. Since that day a variety of tax-supported health services have one by one been added to the functions of government. Local and State governments and, to a minor degree, the Federal Government provide funds for a large number of hospitals, public health services, and medical care programs. These funds may be used either to combat particular diseases, such as malaria, tuberculosis, or syphilis, or to give all types of care to certain groups of the population, for instance, veterans, men and women in the Army and Navy, Indians, or the needy.

That such Government programs can be successful in delivering medical service of high quality is attested by the brilliant record of Army and Navy medicine in World War II. Official records of the War Department show, for example, that whereas 8.3 percent of the hospitalized wounded, excluding gas casualties, died in World War I, only about 4 percent died in this war. Although warfare in the fever-ridden tropics meant an increase in the number of men hospitalized overseas for disease, the annual deaths from overseas hospitalized illness amounted to only 6 per 10,000 men, as compared with 128 in World War I. Deaths from hospitalized illness in the continental United States accounted for another 6 per 10,000 men in contrast to 156 in World War I.

Such results are to be explained, in part, by recent scientific developments, like penicillin, the sulfa drugs, use of plasma, DDT, and air-borne evacuation of the wounded. But even these discoveries could not have been made effective without good organization, good direction, good equipment, good doctors, and nurses, and good use of doctors and nurses.

Not all Government-aided medical programs have the enviable record of the Army and Navy, but they have met important special needs. Nevertheless, for the total civilian population, these special programs do not meet other equally pressing needs. There are, and will continue to be, all sorts of proposals to fill in the gaps between existing tax-supported services.

The new tuberculosis control law is a good illustration of how an established State program can be expanded by the use of additional Federal funds. An all-inclusive service of early diagnosis, hospital care, and rehabilitation is being developed from a meager program of treatment.

Venereal-disease clinics in a way fit into State mental hospital programs. Early discovery and treatment of syphilis at a clinic can free from this disease vast numbers who might otherwise end up in mental institutions 20 years later.

Other diseases might be attacked in the same way through use of tax funds. Rheumatic fever, for one, which every year kills more children than all other childhood infectious diseases combined, might be much reduced in amount and severity by a concentrated program of attack.

Government aid will undoubtedly be requested for other special groups of the population. For example, tax funds might be sought to help needy parents provide their children with the medical and dental care recommended by school doctors or to help care for the needy in nongovernmental hospitals.

The necessity for many such special programs is generally recognized. Few attack them as undesirable, yet it is frequently felt that approaching the problem of medical care in this piecemeal fashion, disease by disease or by one special population group after another, is unsound. This approach, it is said, has led in the past to a piling up of agencies having to do with medical care—some local, some State, some Federal. Each has different standards and differing procedures for the patients to go through before securing care and which the doctors must follow before getting paid. Many, such as public city hospitals, are still run as charities which most people use only as a last resort.

Tax-supported services are so scattered and uneven that most people don't even know which ones they are entitled to use or how to go about getting them. Under most such programs, the patient must in effect prove that he is entitled to care not just because he is sick, but because he is eligible to become a beneficiary under some particular law.

As new health programs are added, critics of the piecemeal approach maintain, it is increasingly important that they fit into an organized system and

not bring along their own particular brands of red tape. "There is no functional or administrative justification," says the American Public Health Association, "for dividing human beings or illnesses into many categories to be dealt with by numerous independent administrations."

The AMA has long maintained that all Federal activities in the field of health should be brought together in a single Government agency, headed by a Cabinet member, instead of being scattered among different departments and agencies. Such a move might be beneficial in tying together some of the federally supported services, which, except for the Army and Navy, form a relatively small part of all tax-supported activities. But many feel that no fundamental change would be achieved by such a move alone. Confusion in the administration of existing health services is the inevitable result of a variety of laws and allocations for strictly limited purposes, they say. Until a person is entitled to medical care just because he is sick, and not because he is a sick soldier, or a sick Indian, or a sick orphan—until then there is bound to be a variety of standards and procedures to fit the needs of each separate program.

So, while some groups want no further Government action and others see the role of Government limited to special programs where there are certain dramatic health needs, still others feel that an over-all national health program is the only satisfactory way to assure good medical care to all who need it.

A NATION-WIDE HEALTH PROGRAM

What do those who want an over-all health service plan have in mind? Two reports have recently been published outlining the principles under which the respective backers believe progress in national health can best be achieved. One is a statement of the American Public Health Association (APHA), a second is a report of the Health Program Conference, a group of physicians, economists, and others interested in progressive health planning. These are not, of course, the only documents ever brought out in favor of a national health program. The demand goes back many years and has taken many forms. These two reports are used to represent the all-out program here because they are recent, comprehensive, and authoritative.

Neither report came out with a model law, in fact neither group supposed that a single law would cover all its recommendations. The reports were designed instead as guides to future action. Their goal is the same—a plan which would make good medical care, preventive, diagnostic, and curative, equally available to all the people, in all areas of the country.

WHY NATIONAL?

A comprehensive health plan must be national in scope, according to the views expressed in both these reports. Health programs organized on a State-by-State basis, with no Federal aid, they maintain, would fall into the same unequal pattern as at present. The same economic factors which make some wealthy States able to maintain good private and public health facilities would also lead to successful health plans in these areas. And the relative poverty of other States, which is now reflected in their scarcity of doctors and hospitals, would likewise mean very inadequate health plans among them.

The APHA and Health Program Conference reports also maintain that certain national standards are necessary to make sure that the quality of medical service everywhere meets at least minimum requirements. Because people in our country are always moving from place to place, national standards for the amounts and methods of payment to hospitals and doctors, conditions of service, and adjustment of complaints would also be desirable, they say. These, however, should be administered in a way that would take account of the differences in requirements between various parts of the Nation, they agree, because a health program in the hills of Kentucky, for instance, would present vastly different problems from a health program in Seattle.

Critics of a national program say that it would mean regimentation. In their view, it would be better to have State programs, even granting that the people in some States would be far better served than in others, rather than to run the risk of rigid Government control.

Both reports assume that Government regimentation is by no means inevitable if, in the framing of laws, flexible administration is recognized as all important. They agree that actual operation of a health program must be

directed largely in each individual community and State, and the program should be responsive to local needs. Strictly medical matters must be kept in the hands of the medical profession, which alone is competent to set medical standards, they say, and questions of public concern, such as financing and distribution of services, must be in the hands of the public.

Concluding that a wholly satisfactory health program must be Nation-wide in scope, the APHA and the Health Program Conference reports go on to outline what seem to them the essentials of any such plan.

WHAT ARE THE PILLARS OF A NATIONAL HEALTH PROGRAM?

Five key pillars are necessary to support national health, according to these reports. They are: (1) distribution of the costs of health services, (2) establishment of hospital and public health facilities, (3) organization of medical services to promote a high quality of care, (4) administration satisfactory to patients and the professions, and (5) promotion of continued scientific research and education.

DISTRIBUTION OF COSTS

Starting out with the twin assumptions that the present individual pay-as-you-go method of meeting medical costs has proved itself unsuited to the needs of the population and that voluntary insurance is too limited in scope, advocates of a national health program recognize two alternative ways of meeting medical costs. Both methods of payment are based on the fact that while individuals can never predict when they will be sick or how expensive their illnesses will be, the expected incidence of illness for large groups of people and its costs can be fairly well determined. By chipping in regularly to a common pool amounts which are fair in proportion to his income, each member of the large group can be sure that there will be funds to pay for his own health needs, whether large or small, whether they occur next year or tomorrow.

The first alternative is a system of national health insurance, combined with support from general tax funds. This method is advocated in both reports. National health insurance is no new thing, in fact it is in operation in 31 nations. In some it is over 50 years old. It works like this: Employed people turn in a certain part of their wages each month, through pay-roll taxes, to a government-administered health-insurance fund. Employers match the amounts each worker puts in, as under Social Security in the United States. When sickness strikes the wage earner or his family, doctor and hospital bills are paid out of the insurance fund.

Insurance of this type was designed originally for the wage earner, whose premiums can be easily collected through pay-roll deductions and for whom employers can also make their contributions easily. Such health insurance in other countries has seldom been available to farmers, people who run their own small businesses, domestic servants, and other similar occupation groups. Health insurance on this plan does not touch the sickness costs of nonworking people—the unemployed, the aged, the chronically ill. For this reason both the APHA and the Health Program Conference reports recommend that, if national health insurance is adopted, it be supplemented by general tax funds to include all groups of the population.

The second alternative method of financing, suggested by the APHA, is that the insurance features be forgotten and public health services be paid for simply and solely out of taxes—just like public schools. This, it is argued, would involve far less red tape. All groups of the population would pay for their health services by the same kind of taxes. The amount would vary according to the particular circumstances of the individual. Great Britain, which has had national health insurance since 1911, is planning a system in which two-thirds of the costs will be financed through general taxation along these lines.

Whichever may be the better way of enabling people to pay for medical care—whether by health insurance combined with taxation or by taxation alone—the reports of the APHA and the Health Program Conference agree that as long as payment is made in the manner of today, the "right to achieve and enjoy good health" will not be truly available to all, and that some such Nation-wide solution must be found for the problem.

But a method of paying for medical care is only part of the story. With a thousand dollars in his pocket, a man on a desert island with no doctor or hos-

pital could still not get his broken arm set. Both the APHA and Health Program Conference plans emphasize the need for construction of facilities in areas which lack them and improvement and enlargement of facilities where they are inadequate.

FACILITIES AND PERSONNEL

The keystone here, according to both reports, is the hospital. A hundred years ago the hospital was mainly a place for the sick poor to go, often only to die. Today, the hospital is a place to which any sick person goes to get modern treatment, and it is a place where he expects to get well.

The hospital is indispensable in practice to the provision of good medical care—yet 40 percent of the counties of the United States have no recognized hospital facilities. This situation would be bad enough in itself; yet it is also reflected in the number and kind of physicians such counties can attract. Younger physicians whose education and training is centered in well-equipped and well-organized hospitals cannot practice the kind of medicine they have so painstakingly learned in school unless there is a hospital to work in.

The result is that counties with no general hospitals have only half as many doctors per thousand inhabitants as counties of the same income level which are generously supplied with hospitals. Since counties lack hospitals directly in proportion to their inability to support them, those who favor a national health program think that Federal funds should be used to construct, enlarge, and modernize hospitals in the poorer counties.

The APHA report, in addition, to urging hospital construction, stresses the need for public health departments to serve all areas of the country. At present, 1,223 of the Nation's 3,000 counties lack any organized health department.

The need has long been generally recognized for health departments to insure safe water and milk supplies, sewage disposal, and control of communicable diseases, and for health centers where special clinics can be conducted, such as those for maternal and infant care or diagnosis and treatment of venereal disease. The APHA report again emphasizes this need and concludes that it should be woven into a national health program.

Both reports assume that modern hospital and public health facilities, combined with improved methods of paying for needed medical services, would, to a certain extent, automatically attract doctors, dentists, and nurses to areas which are now greatly undersupplied.

ORGANIZATION OF SERVICES

With a fairer way of paying the health bill and with hospitals and medical personnel distributed according to where they are needed, many of the objectives of a national health program would be realized. What about the quality of this care? Obviously, quality under any system of financing is, in the last analysis, what the individual doctor, nurse, dentist, or laboratory technician makes it. Nevertheless, certain methods of organizing professional services tend more than others to encourage advances in quality.

The report of the APHA and, more particularly, that of the Health Program Conference, stress encouragement of better professional organization as another essential of a national health program. The focus here, again, is the hospital, but a hospital that functions in a new and different way. It is to become not only a place where illness is treated, but also a center for preventing disease and for improving the whole practice of medicine in the surrounding area. It is suggested that such a truly modern hospital could, in addition to its usual facilities, house public-health clinics, the offices of physicians and dentists, and equipment for the common use of all. In such a group-practice unit, doctors would be encouraged to work more as a team, pooling their knowledge and skills.

GROUP PRACTICE

The general physician, it is assumed, would be the patient's main source of medical care. But at his elbow would be the hospital and the specialists whose services are necessary if he is to practice modern medicine. Freed through health insurance from the responsibilities of fee setting and bill collecting, the family doctor might, for example, find more time to act as guide and counselor in the emotional problems of his patients as well as providing them with other types of medical care. His role in the prevention of mental illnesses, one of our biggest unmet health needs, might be strengthened through the advice and teaching of his colleagues in psychiatry.

Working in groups, doctors are to some extent supervised by each other in the kind of services they render. For example, a young surgeon in a group is usually assisted by a more experienced colleague when undertaking an especially ticklish operation. The story leading up to the death of any patient is reviewed at staff meetings. These supervisory practices are not a new idea; they have been used for years in good hospitals to safeguard the quality of medical service, especially for ward cases.

Such supervision does not require an outside Government inspector. Under any health program it could be carried out, as at present, by groups of physicians themselves. Indeed, as mentioned before, group medical practice is no new idea, but a familiar phenomenon in the private group clinics scattered throughout the United States, particularly the Middle Western and Western States. What is new in the Health Program Conference report is the idea of encouraging this type of organization throughout the Nation, and combining it with a more favored place for the family doctor than exists now either in individual or in certain types of group practice.

A NETWORK OF HOSPITALS

Towns and cities of different types, sizes, and locations naturally require different sized hospitals and differently equipped hospitals. The country hospital, for example, could never make enough use of radium to justify the expense of owning it. A thinly populated area may need a highly trained brain surgeon only once or twice a year. Nevertheless, when these and other unusual services are needed, they must be accessible. What is the answer?

Both reports endorse a plan of organization somewhat similar to that of Army hospitals. They would encourage future construction of hospitals according to an integrated scheme of health centers (corresponding to the Army field station)—rural hospitals, district hospitals, and base hospitals.

To illustrate: A State might have one or more base hospitals, preferably connected with medical schools, where all types of medical service would be available and where the more unusual types of treatment would be carried out. Here, where they could answer any need in the State, would be the brain surgeons and the radium. Base hospitals would also be centers of teaching and medical research.

The many district hospitals, located in large towns or cities, would be large, and equipped to handle the more usual medical and surgical cases. Smaller rural hospitals would be far more numerous than at present and would be designed to take care of ordinary diagnosis and treatment, minor surgery, obstetrics, and so forth. They would refer complicated conditions to the district or base hospitals. Health centers, spotted about hospitals of all types, would house the offices of public-health nurses, laboratories, public-health clinics, doctors' offices, and some emergency beds.

Patients would, as a rule, go to the hospital nearest home, but for particularly difficult types of diagnosis or treatment might go to a base hospital, much in the same way that those who can manage it now go to a well-known clinic or medical center.

This scheme of integrated hospitals would make constant exchange of information, training, and personnel among them possible. On this foundation, a consultation service could be built so that at regular intervals specialists from the larger hospitals would visit rural hospitals and health centers. At the same time, rural physicians might go up to the base hospital for special postgraduate training, returning to their practice stimulated and better prepared.

Proponents of a Nation-wide health program see in hospital organization along these lines a tremendous inducement to physicians to organize themselves into strong professional groups. Whether or not doctors would wish to take advantage of these opportunities would, of course, remain to be seen. There are indications that younger members of the profession, in particular, would welcome the chance.

ADMINISTRATION

How could such a program be carried out so that both the patients who receive the services and the doctors, dentists, nurses, hospital people, and others who render the services would be satisfied? Here, the guiding principle, both reports agree, is that while the health program should be national in scope and while certain national standards are necessary to insure that public funds are used

to best advantage, nevertheless the responsibility for the detailed planning and working of the program must rest with local areas.

For example, the Federal Government might refuse to allot national health funds to hospitals without laboratories. Few would question that such minimum standards should be set. On the other hand, the Government would not be similarly justified in trying to tell doctors when to use a particular kind of laboratory test. Such judgments must of course be made by the doctor himself, subject to the staff regulations of his fellow physicians in the particular hospital.

Except for professional questions, the lay public, which receives it, should have a strong say on how the service is conducted, both in their own communities and at the State and National levels.

Certain freedoms are considered basic:

1. Patients should be free either to make use of services provided under the national program or to continue to secure medical services in the traditional manner, as they prefer.

2. Patients should be entitled to choose among individual physicians, organized groups of physicians, hospitals, and so forth. Likewise, they should be free to change their sources of service without difficulty.

3. Physicians should be free, as they now are, to accept or reject patients; to participate or not to participate in a national program; to furnish services as individuals or to associate with other physicians in groups.

4. Voluntary agencies (such as hospitals) should be encouraged to participate in the national program, maintaining their status as independent agencies and retaining full responsibility for their own administration, or not to participate in the national program if that is their preference.

INCOMES OF PHYSICIANS

Neither the APHA nor the Health Program Conference report offers a pat solution to the thorny question of how doctors should be paid. They agree that medical services should be provided as economically as is consistent with high quality. At the same time they feel that remuneration to doctors should be sufficient to attract and hold good men and should be scaled so that there are financial rewards for professional excellence.

There are three principal ways doctors could receive payment under a national health program. The health fund could pay doctors in individual practice: (1) a fee for each service rendered to patients, in the same way that most doctors now collect fees from their private patients, or (2) a set amount per year, called a "capitation fee" for each person choosing the doctor's services. Doctors working together in group practice could be paid by salaries from their groups. In such cases the health fund could pay (3) a lump sum to the organized group, determined by the extent of medical service the group provided or the number of patients using it.

Although fee for service is most used in private practice today, there are also many physicians in the United States who are paid by the other methods and apparently find them satisfactory. When faced with the prospect of payment by the Government, however, doctors are naturally concerned lest they be underpaid. Medical education is expensive, and it takes a number of years after graduation before doctors begin to earn a living by their practice. It is natural for doctors to wonder whether a Government system would offer a reasonable income. The example of poorly paid school teachers, government clerks, public health nurses, and "city physicians" does not reassure them. Many people feel that the question of payment to physicians lies at the heart of doctors' opposition to a national health program.

Both the APHA and the Health Program Conference reports agree that there is room for experimentation with methods of paying physicians, but argue that a physician's yearly income must be adequate, as measured by the incomes usual among other physicians of the same age and training and in the same type of community, and by the incomes of other professional groups.

RESEARCH AND EDUCATION

Under any type of health program, the quality and the continued improvement of medical services lean heavily on research and medical education. The half billion dollars invested in these fields by private philanthropy over the last 50 years are held to be largely responsible for the high place of American medical science today. Advocates of a national health program say that Government

funds must be forthcoming where private funds leave off if knowledge is to march steadily forward. In fact, during the war, the Federal Government sponsored and in many cases subsidized both medical and nursing education and a variety of scientific research. The results—for example, discoveries as to the processing and uses of stored blood—are familiar enough to those in the armed forces.

In addition to funds for research, the Health Program Conference report emphasizes the need for more opportunities for postgraduate training for physicians. Medical science advances so rapidly that the physician who graduates from medical school this year will find it necessary next year to bring himself up to date. Too often the busy practitioner has no time to keep up with advances through study and reading; rarely is he in a position where he can afford to take a month off for postgraduate study. This is particularly true of the country doctor. Opportunities for doctors to get postgraduate medical education could be greatly furthered by the use of public funds, advocates claim, although even more important day-by-day results would be obtained through improved organization of medical services.

THE OSRD REPORT

The use of Federal funds to support a program of scientific research was recommended to President Truman in July 1945 in a report of Dr. Vannevar Bush, director of the Office of Scientific Research and Development—the Government agency responsible for the use of Federal funds for such research during the war.

In this report the war against disease is given first consideration. Dr. Bush strongly advocates Government support of medical research as basic to any national program of expanded medical training and research and to the promotion of public health.

The report, which recommends the establishment of a national scientific research foundation responsible to the President and Congress, was received with widespread public interest.

HAS A NATIONAL HEALTH PROGRAM BEEN PUT BEFORE CONGRESS?

Do these principles of a national health program appear in practical form in the legislative proposals brought before Congress? What manner of national health program is it anyway that has been advanced for public discussion and eventual congressional decision?

Beginning in 1943 with the original Wagner-Murray-Dingell bill to add health insurance to the social-security system, several bills have been proposed embodying the principles. They include the Hill-Burton hospital-construction bill, a new version of the Wagner-Murray-Dingell bill introduced in May 1945, and a still later revision of November 1945.

THE FIRST WAGNER-MURRAY-DINGELL BILL

National health insurance was but one of several provisions of this bill. Other provisions, such as extension of social security, the nationalization of unemployment compensation, and Federal aid for general relief, are beyond the scope of this discussion.

The bill provided that health insurance would be established by the creation of a national medical-care and hospitalization fund, to which employers and employees would each contribute 1.5 percent of the first \$3,000 of annual wages, making 3 percent in all. Self-employed would contribute the entire 3 percent themselves. Contributions amounting to an additional 4.5 percent of wages would be made by employers and employees, 9 percent in all, to pay for the other benefits of the bill. Two of these latter provisions have an important bearing on health, namely, those providing for cash payments during temporary and permanent disability.

For every insured person and his family, the medical care and hospitalization fund would pay for unlimited doctors' care, including specialists, for hospitalization up to 30 days, X-rays, and laboratory tests. Dental care, nursing, medicines, and drugs would not be paid for.

Patients would be free to choose their physicians from among those participating in the program, whether engaged in individual or group practice. Standards of competence for specialists and hospitals would be established by the Surgeon General of the United States Public Health Service. Any licensed physician could participate in the program as a general practitioner.

The national fund would pay physicians for the services rendered to patients covered by the system through any of several methods—fee-for-service, capita-

tion, part-time or full-time salaries, or by a combination of these methods. The physicians of each area would choose by majority vote the method of payment to be adopted in that area. Hospitals would be paid up to \$6 per day for each day of care they furnished.

REACTION TO THE BILL

The 1943 Wagner-Murray-Dingell bill never came to a vote in Congress. Nevertheless it caused a storm of comment. Backed enthusiastically by organized labor and some farm organizations, it was considered by them "so enormous an improvement over our present social-security provisions that no responsible person, deeply concerned with the welfare of our country, can fail to support it."

At the same time it was vigorously opposed by representatives of organized physicians, in whose minds it was "socialized medicine." The opposition groups said that the bill implied that sick people would have to depend on a doctor paid by the Government to work only 8 hours daily—emergency cases would have to wait until the doctor checked in. Patients would have to go to the doctor assigned to them by political bureaucrats, and doctors would become incompetent because methods and remedies would be fixed by bureaucratic superiors. Largely to oppose this bill, physicians and drug houses raised and spent over a quarter of a million dollars in giving out "information" of this nature. Extremes were reached with statements like, "It is doubtful if even nazidom confers on its gauleiters the powers which this measure would confer on the Surgeon General of the United States Public Health Service."

One group of physicians attempted to promote a national movement to boycott any legislative program such as the Wagner-Murray-Dingell bill, giving physicians this advice: "If such legislation as the Wagner-Murray-Dingell bill passes and your patients come to you for services under the plan, tell them you don't serve the politicians, you serve them. If they want to know what they are going to get for the money deducted from their pay checks for health insurance, you don't know."

It is, of course, debatable whether an insurance scheme as that proposed in the bill would in fact have the disastrous effects predicted by its opponents. Certainly the bill itself had no provisions for assigning patients to doctors, for regulating physicians' hours of work, income, or methods of practice, except for the elementary requirement that specialists meet national standards of competence in their particular fields.

Many persons in favor of Federal legislation for health and medical care felt, however, that the first Wagner-Murray-Dingell bill fell far short of providing a truly adequate health program for the Nation. They pointed out that it included, for example, no provision for the construction of hospitals and health centers. It contained nothing to encourage the expansion of preventive health services. It offered nothing to induce physicians to modernize their methods of practice by joining together in groups instead of continuing in the traditional solo practice of the old-time family physician.

Some felt, too, that the whole population should be protected under the plan, rather than merely employed persons and their families. For this reason, and to promote preventive health services, support from general taxes as well as from the pay-roll contributions of employer and employee was urged.

Finally, disinterested critics generally felt that the bill permitted too centralized an administration of the program. They said that the program did not require sufficient participation by State and local governments nor by local representatives of the professions and the public. The American Bar Association made the additional point that it failed to provide for court review of administrative decisions.

THE NEW WAGNER-MURRAY-DINGELL BILLS

A revised Wagner-Murray-Dingell bill, introduced into Congress in May 1945, proposes a pattern essentially similar to the earlier one, but has added features which meet some of the criticisms made of the original. It had not been acted upon when President Truman sent to Congress his special message of November 19 asking national health legislation.

The President strongly advocated a program of five related proposals for action by the Federal Government:

1. Financial and other assistance for the construction of hospitals and other health facilities where they are most needed.

2. Increased grants to the States for public-health services and maternal and child-health-care programs.
3. Support of medical education and research.
4. Expansion of compulsory insurance under the social-security system to cover medical, hospital, nursing, laboratory, and dental care.
5. Cash benefits to cover some of the wage losses during periods of sickness and disability.

In order to meet, at least in part, the President's request, Senators Wagner and Murray and Representative Dingell promptly lifted, rewrote, and introduced as a separate bill the health provisions of their earlier measure.

These health provisions include, besides medical-care insurance, increased Federal grants to the States for public-health work and for the care of mothers and children, but no funds for construction of hospitals and health centers. Benefits of the medical-care insurance have been increased by adding limited home nursing and dental care. An attempt has been made, too, to increase the responsibility of States and communities through advisory committees, although the final administrative control remains in the Federal Government. Court review of administrative decisions is, however, specifically authorized.

Groups of physicians, as well as individual practitioners, may participate in the plan, but they are not expressly encouraged. The physicians of an area may still decide by vote how they wish to be paid, but such a vote is no longer binding upon all the doctors of the area. General taxes are to be used more generously to supplement the funds contributed by employers and employees, but the plan does not yet cover the entire population.

SUMMARY OF OPINION

Discussion of national legislation for health will doubtless be focused about the Truman proposals and the latest Wagner-Murray-Dingell bill for some time to come. It will be useful, therefore, to repeat the principal arguments for and against the original bill. The groups supporting the 1943 measure emphasized the necessity for Nation-wide action in order to equalize the opportunity for health services among all groups of the population in whatever part of the country they happen to live. They also stressed the need for a method of paying for medical service by which people can pay in known, regular amounts, month by month, in accordance with their earnings.

Those opposed to the first bill, on the other hand, made an issue of the danger of political control over medical matters, of a possible threat to the individual freedom of patients and doctors, and of the limitations that it might impose upon physicians in professional status and—by implication—income.

The Nation-wide discussion that took place as a result of the introduction of the bill had broad educational value. It stimulated people everywhere to greater awareness of the issues. It provoked painstaking inquiry by numerous non-professional organizations and groups as to the true facts of medical care in their own communities and in the Nation as a whole. All this served in some degree to clear the air, to dispel false notions and groundless fears, and to aid the country in facing realities. With this increased interest and knowledge as a background, the public is better prepared, with the introduction of the November 1945 bill, to resolve differences of opinion and to focus its attention upon specific points for action.

THE HILL-BURTON HOSPITAL CONSTRUCTION BILL

This measure, introduced in the spring of 1945, would provide Federal grants to States for the construction of hospitals and health centers. Designed to encourage over-all planning by the States of an ordered network of health facilities, the bill calls for each State to study its existing hospital resources and unmet needs, in order to develop a master plan of construction. The Federal Treasury, after State plans had been approved by the Surgeon General of the United States Public Health Service, would supplement funds for construction raised within the States, paying a larger share of Federal funds in poorer States, and a smaller share in richer ones.

Besides providing for the construction and improvement of State, city, and county hospitals for general care, mental illness, and tuberculosis, this bill would also aid in the construction of those nongovernmental community hospitals which are not operated for profit.

Supported by the American Hospital Association, organized labor, farm groups, and the American Medical Association, this bill has aroused little opposition. It fits into the principles of a national program in the following ways:

1. Differences between States in availability of hospital facilities might be greatly lessened because national tax funds would share the costs of construction.

2. Improved organization of services centered around hospitals is made possible if hospital administrators, physicians, and the public wish to avail themselves of the opportunity, because construction would be based on State-wide planning.

3. Decentralized administration within the States, subject only to general national standards, would reflect the particular needs and circumstances of the various States and communities.

4. The principle that private, nonprofit agencies can maintain individuality within a national, tax-aided program is recognized by the inclusion of improvements and new construction for this type of hospital.

The bill, however, is criticized to some extent by farm and labor groups because the general public, who would use the hospitals, would not have a great deal to say about where they are to be located. As provided in the bill at present, the committees who determine the location of the hospitals would be composed largely of hospital administrators and physicians.

The most serious criticism of the Hill-Burton bill is that it can meet only limited needs. It does not attack the problem of paying doctors' and hospital bills. A modern, well-equipped hospital is of little value to a community if the people in that community cannot afford to use it. At present, it is the sad truth that areas which have the least hospital facilities in proportion to population are also the areas where such hospitals as do exist are the least used. In other words, where communities are too poor to build adequate hospitals, the people living there are too poor to pay for hospital care under present arrangements. To guard against the possibility of putting up white elephants, in the shape of hospitals which would not be used, this bill provides that communities wanting new hospitals must show ability to support them after they are built. If this cannot be shown, no Federal money would be forthcoming.

Were the Hill-Burton bill passed in this form—and in the absence of any measure to meet the patient's problem of paying hospital charges—some critics think that most new hospitals would be built in wealthy areas which need them less than other localities but which can afford to support them after they are built.

The Hill-Burton hospital construction bill is of great significance because it is the first national measure related to medical care which has received support from all major professional groups as well as major farm and labor groups. Yet even its most ardent sponsors recognize that at best it can meet only limited needs as long as the problems of paying doctors' and hospital bills are still unsolved and that at worst it might result in an even less equitable distribution of general hospital beds than at present.

WHAT IS THE AMA PROGRAM?

In July 1945 the American Medical Association announced its program to meet the admittedly unsatisfactory health situation in America. This program emphasizes the need for intensification of voluntary efforts to solve the problem of paying the medical bill. Sustained industrial and agricultural production is urged to improve living conditions and therefore health conditions. State surveys are suggested to determine the need for additional medical care and to appraise the adequacy of voluntary insurance plans in meeting such needs and in improving the quality of medical service. Extension of preventive public-health services to all parts of the country is advocated. The expansion of voluntary insurance against the costs of hospitalization and physicians' services, so as to serve all communities, is proposed.

The AMA report further suggests that the medical care of the needy be met from local tax funds paid as premiums to voluntary sickness insurance plans directed by doctors. Supplementing State and local funds by national tax funds is proposed where definite need for such aid is demonstrated. Emphasis is placed upon the importance of informing the public about the nature of voluntary insurance plans, with recognition that they need not involve any increase in taxation.

Finally, the report urges postponement of the consideration of "revolutionary changes" while large numbers of men and women, including medical officers, remain in the armed services, and proposes measures for rectifying the present and future shortage of medical personnel, particularly in rural areas. The question of the organization of medical services around a network of hospitals, or in group practice, is not touched in this report.

WHAT ARE THE MAIN ISSUES?

Public discussion in recent years indicates widespread concern about the quality and distribution of health services in the United States. Five principal problems are generally recognized:

1. How to arrange payment so that all the people can regularly pay specified amounts in accordance with their earnings rather than be burdened irregularly and unexpectedly with the large costs of unpredictable illness.

2. How to pay for medical services and facilities so that they can be available more evenly throughout the country.

3. How to organize America's health services to use our medical resources most effectively and furnish service of high professional quality.

4. How to make necessary changes and yet preserve the best of our present medical practice, avoid undesirable and arbitrary governmental controls, and guarantee freedom within the program for both patients and physicians.

5. How at the same time to stimulate continued and improved medical education and research.

Although there is much disagreement as to how it should be done, most groups of the professions and the public appear to agree on the basic principles that people can more easily pay for medical service by some type of insurance than by the traditional fee-for-service method; that Federal funds from general taxation will be needed if hospitals and other facilities are to be built in needy areas; that medical services can be supplied more economically and with better guaranty of quality by the use of group medical practice than by individual practice; that local representatives of the professions and the public must control the distribution of services on the basis of broad national standards; and that national funds will be needed to support improved and extended medical education and research.

Controversy has been most pointed about the proper role of Government in any changed organization of health services. Opinions range from those who would limit Government aid to specific problems—such as sanitation, communicable disease control, the care of the needy, institutional care for mental illness and tuberculosis—to those who would have Government, particularly the Federal Government, take steps to assure adequate health and medical services to all.

TO THE DISCUSSION LEADER

Every human being is faced with the problem of his own personal health. The head of a family has the added responsibility of looking after the health of his wife and children. Civic-minded individuals recognize that health is also a community concern—that good health for the individual often depends on improving health conditions and health standards for the community.

This pamphlet presents major points of view on the important question of improving health. It does not try to give an answer. That is something for the individual to think through for himself.

It is doubtful whether any reader of this pamphlet or any member of a discussion group would argue against the improvement of health. Discussion leaders will encounter plenty of conflicting opinions, however, when they raise the question of how health can best be improved. This question of how it should be done is something to talk over at your discussion meeting on the basis of the soundest information available.

HOW CAN YOU PLAN A DISCUSSION MEETING?

Discussions are ideas in action. You cannot have a lively voluntary discussion unless you bring together individuals who are interested in a subject. Therefore, you need two things: A subject that will interest some people very much, and a means of letting people know that a discussion meeting is to be held on that subject.

"Is Your Health the Nation's Business?" is a subject that will probably interest many people.

Your first major task as a discussion leader, therefore, is to let people in your area know that you are planning a discussion meeting on health.

How can you do this? There are several possibilities. You can show a copy of this pamphlet to the editor of your local newspaper and explain to him the type of program you are planning. You can prepare notices to be placed on bulletin boards. You can prepare posters for reading rooms where you have placed copies of this pamphlet. You can suggest that local librarians arrange reading-table displays of this pamphlet and other suggested reading material on public health. Finally, you can talk it up to certain individuals who will pass the word along to their friends that a discussion meeting is going to be held on this subject. This procedure on your part will give people who are interested an opportunity to plan to attend your meeting.

WHAT KIND OF DISCUSSION WORKS BEST?

Each discussion leader is probably his own best judge as to what type of discussion will be most satisfactory for his group. If you are in doubt you might discuss this matter with qualified advisers. In making this decision you should consider several important factors. How large will the discussion group probably be? What kind of facilities are available at the meeting place? What type of discussion has proved most popular with local discussion groups in the past? What good speakers might be obtained for this particular subject?

You should be certain that you understand the general advantages and disadvantages of various types of discussion. Forums, panel discussions, symposiums, and general group discussion are the form most frequently used. EM 1, Guide for Discussion Leaders, tells just how they differ from one another. Below are some specific suggestions.

Forum.—A competent doctor who is a good speaker might make an excellent forum speaker on health. One who has had both civilian and military experience in dealing with health problems might be particularly well qualified. After his preliminary talk on health, members of your group could question the speaker on points of particular interest to them.

Panel discussion.—Health is a subject that would lend itself particularly well to a panel discussion if you can get four or five qualified speakers. A group of young doctors, or a combination of doctors, dentists, and psychologists, might make a panel that would keep the discussion ball rolling in a lively manner. Time should be allowed for members of your group to question the panel participants.

Symposium.—Two or more doctors, particularly those with diverse ideas about how to improve health, would make good symposium speakers. You should limit each to about 10 minutes so that members of your group will have an opportunity to question all the speakers.

Informal discussion.—Since health directly concerns every individual and each has his own ideas about maintaining health, your entire program could be conducted as an informal discussion. It will be necessary for you, as discussion leader, to be familiar with the contents of this pamphlet and to be prepared with well-organized questions to bring out major health issues for discussion.

CAN DISCUSSION HANDBOOKS BE HELPFUL?

Discussion leaders will find many helpful suggestions on planning and conducting discussions in EM 1, Guide for Discussion Leaders. This guide discusses in detail the various types of discussion possible. It gives helpful hints on handling difficult personalities at discussion meetings. It emphasizes the importance of careful planning and outlining a program of discussion. Study of this handbook will enable a discussion leader to improve his program; it challenges him to use his own ingenuity to make his program interesting and worth while.

Some discussion leaders face the problem of planning and conducting programs to be broadcast over the radio or on a loud-speaker system of Armed Forces Radio Service. They will find EM 90, GI Radio Roundtable, full of sound advice and usable suggestions.

QUESTIONS FOR DISCUSSION

You should jot down your own questions as you read this pamphlet and outline your discussion program. You should encourage members of your group to ask questions. Sometimes the most helpful questions grow out of the discussion

itself. It is well, however, to be prepared. Below are some questions which you may find helpful.

1. Has civilian medical care been accessible and satisfactory to members of the discussion group and their families? Has the problem of payment for physicians' care or hospitalization been difficult? Have doctors and hospitals been located reasonably near at hand? Has it been easy or difficult to obtain the services of necessary specialists? Why?

2. Would the problem of payment for medical service be eased by insurance against the costs? Do you think voluntary insurance against the costs of sickness can provide a satisfactory solution for the problem of payment throughout the country? In urban communities? In rural areas? In all geographical areas?

3. Would there be professional advantages in a scheme in which physicians practiced in groups? Economic advantages? From the patient's point of view? From the doctor's point of view?

4. How do the advantages and disadvantage of medical practice in the military services compare with those of present-day civilian medicine? From the patient's point of view? From the doctor's point of view?

5. Is the normal peacetime distribution of civilian physicians and hospitals satisfactory? What factors influence this distribution the most? Could they be modified by physicians? By the public? How?

6. What measures have recently been proposed by the American Medical Association to meet the Nation's health needs? What effect do you think these proposals, if carried out, would have upon (a) the ability of people generally to pay the costs of sickness? (b) The distribution of doctors' and hospital services? (c) The quality of medical and hospital services?

7. Do you think the United States Government should (a) do nothing further in the health field? (b) Support only special health programs such as those to benefit mothers and children or combat venereal disease, tuberculosis, and mental illness? or (c) sponsor national action for health care on a broader basis by insurance or tax support? Would action by the Federal Government tend to improve or lower the quality of medical care received by people generally? Why? Would most doctors benefit or suffer economically and professionally as a result of Federal action? Why?

8. Should the Federal Government aid in the construction of hospitals where they are needed? How should such hospitals be supported if built? Who should own them? Who should determine their location? What doctors should be eligible to use them? What patients should be eligible for admission to them? Would hospitals built without Federal Government aid serve the public better?

Senator DONNELL. Now I want to ask you this, Dr. Davis: During the last 10 years—that would be from 1938 on down to this time—you have been very closely associated with, among other persons, these three gentlemen: Dr. Thomas Parran, Surgeon General, United States Public Health Service; Dr. I. S. Falk; and Mr. Watson B. Miller; is that correct?

Dr. DAVIS. To varying degrees of closeness; yes.

Senator DONNELL. And you have consulted frequently with Dr. Falk on the question of compulsory health insurance, have you not?

Dr. DAVIS. Yes.

Senator DONNELL. And you and he, Mr. Miller, and Dr. Parran have together conferred on that subject from time to time?

Dr. DAVIS. I don't recall attending any conference at which all those people you have named were present at one time. I may have been.

Senator DONNELL. Doubtless that was an inaccurate question. You have conferred separately with each one, or possibly with one or more at different times; is that right?

Dr. DAVIS. Would you care to have me enlarge upon that at this point? I might make a very brief general statement which would cover perhaps the point that you seem to be interested in.

Senator DONNELL. That would be all right.

Dr. DAVIS. I would like to say this. I will go back for a moment.

When I went to the Boston Dispensary, which was back a long time ago in 1910, I had had some interest in medicine and medical things generally and I was interested in seeing an improvement in people's health. Every day there, I came in contact with a large number of sick people who came in to be helped and who could be helped only when they could demonstrate that they could not afford to pay a private doctor. I saw doctors who came in there and were anxious to help and who gave the best service they could to people whose home conditions were often such that the best medical service would do very little good under those conditions without additional help.

As a result of seeing that daily stream of suffering people and the efforts of doctors, skilled doctors, to render them help, I became convinced that the system in the first place—a charity system—did not take us very far. In the second place, a great many people did not come to the doctor soon enough because they realized the fact that they would be investigated in an effort to determine whether they were entitled to medical care—the income, the size of the family, and so on, had to be determined before they could be admitted under the charter of the institution, so I became convinced within a few years that something much more fundamental had to be done.

I then became interested and studied the subject to find out what had been done elsewhere. I became familiar with the few voluntary insurance plans then in existence in this country, and I became interested in the insurance plans that were in existence abroad. I went abroad shortly after that period, and I also had the opportunity to visit many parts of this country as I began my consultation work.

During the First World War I was not involved in service, but I had a war job which took me to many communities in connection with dealing with the problem of the health and living conditions of immigrant groups, whose loyalty might be questioned and whose living conditions, if depressed under severe economic strain, might yield unfavorable reaction. I came into contact with many doctors of all classes, and among other things I became convinced that a very large number of doctors are as much the sufferers under the present system as a very large number of the patients.

The young doctor has to struggle along for years before he can become well off. Unless he has some relative or a good close friend who puts him in as an assistant, he struggles for years to build up his own private practice, during which period he can barely manage to keep going, especially if he is injudicious enough to marry and start raising a family.

I became convinced, through analysis and observation, that the business of medicine is very often in very serious conflict with the wonderful service tradition of medicine and that something much more radical had to be done to deal with the economic problems of medicine; and about 1915 I became convinced that I wanted to start to make a study and research into medical economics. I began to work with it and got enough backing from foundations to enable me to make some studies, and by 1920 I was able to get sufficient funds from the Rockefeller Foundation to set up a committee in New York—some half million dollars was made available for expenditure over a period of 5 years

to make an audit of improving the quality of medical services rendered in a large city.

From then I got into consultation work, which took me over the country, and I also had occasion to go abroad several times, sometimes at my own expense, sometimes for an organization, to study the situation of health insurance abroad.

I became gradually convinced of what was needed in this country, but it was not until very recently that I was prepared to come out for national compulsory health insurance. I discarded the voluntary plans, I discarded the purely State system grant-in-aid plans, and finally I became convinced that we had to go as far as, I would say, this bill, with various modifications which I would be glad to discuss.

But this bill in principle seems to me to be about the thing that we need to do for the people of this country. I recognize that in the minds of many people, even outside the medical profession, it is considered to be too big a step to take at once. But I am not afraid of the United States taking big steps. We have taken a good many big steps at different times. One of the things Americans are justly proud of is the fact that they are not afraid of doing things.

So in substance I have tried to give a brief history as to how I gradually became convinced that in the interests of both the people of the country and the doctors themselves a comprehensive system of health insurance, supplemented by necessary taxation for certain purposes, is desirable and necessary in the United States, and we ought to have it just as soon as possible.

Senator SMITH. Do you think, Doctor, that the whole existing system ought to be changed then, that we should make an over-all change of existing methods in the handling of the health problem? I can see you have given your life to that; it is a crusade with you. And you believe that this extreme change should be made?

Dr. DAVIS. Senator, I do not consider that this bill would change our basic system in its most fundamental respects.

Senator SMITH. I thought you said the existing system was wrong?

Dr. DAVIS. With respect to the way the doctor is paid by the patient, yes; but not in the way that medicine is practiced.

Senator SMITH. It is just a question of the way he is paid?

Dr. DAVIS. Yes; that is the fundamental change that I see necessary. I regard the development of a better technique of organization in medicine through group practice as necessary, but I feel that you cannot legislate group practice. You have to educate and encourage people, and remove obstacles to set up the kind of an organization that would make group practice easy.

I think those obstacles are rather detailed, but the big obstacle to group practice is that the average doctor has been trained in his private practice to individual work, and he takes group practice as being something rather difficult.

This illustrates my point. I have a friend who lives in Philadelphia, a layman, who is chairman of the board of a large hospital. They have a medical staff of 150 doctors. He has a brother who is a member of the board of directors of the Philadelphia Symphony Orchestra, and my friend has told me that there is one subject on which he and his brother endlessly debate without ever coming to any definite conclusion, the subject of the debate being: Which is the most difficult

group to get to appreciate the advantages of organization, physicians or musicians?

And I think that is one of the things we face. That is one of the reasons for this extreme emotionalized antagonism to a measure of this kind, which unfortunately has created a contagion of fear and anxiety on the part of a great many physicians of the highest degree of integrity and skill, which hinders an intelligent consideration of a measure such as this.

Senator SMITH. You will admit that this would be a complete change from your existing system when you propose a tax on all the people—and you are saying that everybody has to pay this tax—to create an over-all medical system. That is a pretty drastic change.

I would like to ask you this question, in order to get your opinion on it. Can't you suggest some way in which we could try a less comprehensive plan to start with? Why couldn't you take a State like California, for instance. They are interested in this sort of thing out there. Why not advocate an experiment being made in one State to see just how the thing works out in practical experience before asking that everyone go along with it the whole way in an over-all national plan?

Dr. DAVIS. Naturally, I have given a good deal of consideration to that, because California and the Governor of California, Governor Warren, as you know—

Senator SMITH. There is testimony here that he recommends a health-insurance plan.

Dr. DAVIS. He has twice recommended compulsory health insurance—not completely comprehensive—in some of the legislation he has recommended.

On the whole, Senator, the way I feel about that is this: I recognize that the State-by-State road has certain advantages in this particular field. However, the groups of our people who are in greatest need, relatively speaking, are not the industrial workers and the city dwellers, but the rural people, not only those who live in the open country but people who live in small places where the proportion of doctors and hospital facilities is far less than we have in urban sections.

The wide disparity in facilities and paying power among our States, particularly between rural and most urban sections, is so great that I feel a State-by-State experimentation does not deal adequately with the situation or soon enough.

You know what the experience has been with such a program as workmen's compensation, which began in 1911, and I think Mississippi has not yet passed a workmen's compensation law—they may have done so this last year, but up to a year ago we still had one State, since 1911, which had not passed a workmen's compensation law for industrial accidents. That road is a very slow road, and I don't think we ought to go it slow.

Senator SMITH. That is because you have come to the conclusion that there is no other answer, but there are a great many people in this country who do not share your views.

Where you have an extreme measure like this, which would involve a complete change, a great many people are in favor of experimentation, like trying it out in some local area before saying to everybody, "You've got to do it." That is where your resistance and your problem

comes in, and I am sympathetic to the resistance because I think you are asking for the complete turn-over of a whole social system, by putting everybody completely under this umbrella of social security.

You might very well say, "We will have a fund set up and charge them on the pay roll, and then when they are sick we will give them money to take care of their health needs. The other thing that might be contemplated is having the Government guarantee the service. That means that you have to put your hand on the medical profession and the hospitals, and everything else, and say, "We have to be able to organize this in a way to give value received for the taxes imposed on the individual who pays for the service." And that is a very much more drastic thing than simply saying we will have a fund set up and when a person is sick we will give an allowance to take care of that.

Dr. DAVIS. May I comment on that?

Senator SMITH. Yes. I want to see what you think about it.

Dr. DAVIS. First may I comment on the cash benefit, the so-called indemnity benefit, by giving people cash? I have had an opportunity to observe that sort of scheme, and I do not think there is enough of value in a strictly indemnity or cash payment plan to provide for a neighborhood patient to pay his medical bills to justify much good to bring it about. I think there is no guaranty of medical service. There is very strong insistence on the part of most medical societies that there must be an income limit above which the physician shall be free to charge the patient any amount they may agree upon on the usual fee basis.

The other point you raise seems to be a very real point, which I regard as the toughest nut to crack, namely, the problem of passing a law like this and putting it into effect on a sufficiently comprehensive scale, and rapidly enough, to enable the Government, which is taking in money from people by law, to deliver the services which are involved in the law. I think that is the point you have in mind.

Senator SMITH. That is correct.

Dr. DAVIS. My answer to that and my justification for recognizing the nature of that problem while nevertheless favoring this law, is this: In the first place we have to consider the medical service which people receive in terms of a practical standard of comparison as between what people in a given community and in a given walk of life have been accustomed to get and accustomed to expect; and we must not expect that everybody is going to receive at once the same kind of service which a well-to-do person in a large city can now command when there is no economic barrier, and he has intelligent advice and guidance in selecting his doctors and hospitals.

We have to proceed on a practical basis. We also find in practice that the lack of sufficiently intelligent demands on the part of many people for medical service is a barrier to good medical care, and that is also one of the very important reasons why it is practicable to put this law into effect, because demands on the part of the people do not suddenly jump from nothing or from very little medical care because they have not been accustomed to having it except in emergencies, to a volume of medical care corresponding to that which good professional judgment would call adequate. It works up slowly.

Senator SMITH. You will have to admit that if you are going to deduct a certain amount of money per week from a person's pay roll

in order to give him medical care, and he knows it is being deducted, he is going to send for the doctor the minute he feels the least bit ill, or else he won't think he is getting value received. And the doctors say it would amount almost to a fraud if you deduct taxes and then don't give them service. I don't see how you are going to do it unless you go into an extensive campaign to organize the whole Nation so that the Government can deliver the goods that they undertake to deliver when they tax the people for that purpose.

Dr. DAVIS. I believe that within a period of time, administratively a period of a year or so between the time the law is enacted and the time service becomes effective, which is contemplated in this law, that service could be delivered to people corresponding to what has been available and what they have been getting and to that which they would demand. And I am sure that it is not true that people would suddenly demand a large amount of medical care because they are paying for it. I don't think there would be any great increase in the amount of medical care they would demand over what they have been getting.

Senator SMITH. You mean that today you think we have enough doctors, dentists, nurses, hospitals, and enough public health services to give the kind of service that would be undertaken by S. 1320, if everyone were to be taxed for this thing? Witnesses who have testified before this committee have stated that it might take 4 or 5 years to organize, and some say a generation, and we would not be acting in good faith if we taxed people without having it organized to deliver. Do you think we could do it right away?

Dr. DAVIS. The American Medical Association published in its Journal 2 weeks ago an editorial on the subject of the supply of doctors, in which they took the position that the supply of physicians in the United States was adequate if there were proper distribution.

Under this bill—under the provisions of this bill—there could be and would be very rapid redistribution of doctors. There are numerous places where the competition is very severe because there is approximately 1 doctor to every 500, 600, or 700 people, and some of these could be redistributed to places where there is only 1 doctor to every 1,500 or 2,000 or 2,500 or even more people. And under the provisions of this bill, during the preliminary period while you are getting ready to administer the law, there is a period of about a year or a year and a half in which you could actually put a good many doctors in places where they are needed most. I don't mean by that, hiring doctors and sending them out.

Senator SMITH. What do you mean?

Dr. DAVIS. Doctors will move if they can have some economic assurance.

Now, I have been a member of the Federal Hospital Council and have been closely concerned in the past year and 9 months, working with the Surgeon General, in studying how we could pick the places that need to have hospitals built under that law, and there is a problem even there.

Senator SMITH. It is getting late, and Senator Donnell has some more questions, so we will not linger on that point, but you will admit that is a tough nut to crack—organizing that thing and expecting people to gravitate into those vacuum areas. You would

have to have a good deal of Government supervision with respect to those vacuum areas, whether State or Federal. It would have to take a lot of thinking and blueprinting to set up a system that would meet the obligation undertaken by the Government if such a law were passed.

Dr. DAVIS. May I make one comment on that to illustrate the way I think it would work?

Senator SMITH. Yes.

Dr. DAVIS. This bill provides for a State survey preliminary to the formation.

Senator SMITH. So does S. 545.

Dr. DAVIS. Yes; both bills do.

Now, under S. 1320 those State surveys require that the State shall find out what the shortage spots are, and what the needs are, and to be able from the fund—when the fund becomes available after taxes begin to be collected, when the allocation of that becomes available—to take the steps permissible under this bill, through the State agency and not by the Federal Government, to try to set up inducement which will induce doctors to go into those areas.

Senator SMITH. And it is your testimony that there are plenty of doctors today—that there are enough doctors today—to carry out the program under S. 1320?

Dr. DAVIS. My opinion is this: I do not agree with the American Medical Association that we do not need more doctors, Senator, but I think the problem of redistribution is the most important factor in connection with the problem of increasing the supply, and my opinion in connection with the problem of increasing the supply of doctors is that the rate of increase in demands on the part of the population under the universal prepayment system would not be so rapid as to embarrass us. We should take steps to catch up, but I feel that that is of secondary importance.

Senator SMITH. Your testimony is in direct conflict with that of other sponsors of the bill who think that we are woefully short of doctors, and that the first thing to do is increase the number of our medical schools. It takes 10 to 12 years to educate a doctor properly, you know.

Dr. DAVIS. Even though I do not think that we are so short, I am very much interested in developing a plan to educate more doctors.

Senator SMITH. There has been so much evidence that there is a shortage of doctors, dentists, and nurses that I think we ought to do something to build that army up. And I feel sure that you will admit that it is one of the difficult problems we have confronting us. I won't dwell on it any longer.

Senator MURRAY. Before we leave that point, could I ask one question?

Senator SMITH. Yes.

Senator MURRAY. In the present situation of the distribution of medical practitioners, is it not a fact that many doctors are practicing in locations where they are not fully occupied and are not making an adequate income? Is that true?

Dr. DAVIS. Yes, sir. I would say that is true. There are two great sources of additional medical manpower. One is the young men. I would say that in the first 5 years of the average young medical man's

career, after he completes his internship and gets into practice—at least one-third of his time is not utilized—at least one-third.

Senator SMITH. You believe in the old adage that patients like their doctors, like their cheese, old, that patients have more confidence in doctors who have had more experience?

Dr. DAVIS. Yes. But nevertheless, either by direct contact with patients or by being able to work with an older doctor as an assistant, who can give him necessary prestige, the younger doctor becomes more experienced. At the present time there is some difficulty in older doctors taking on younger doctors as assistants, because of the fact that the older doctor may not have enough paying clients to be able to give any sort of a guaranty of salary to his assistant. The paying power of an insurance system will give that guaranty, and the older man's prestige will give the younger doctor the necessary experience.

Senator SMITH. That would be helpful. I will agree with you that the younger doctor's greatest experience is gained by working with an older man while he is learning the ropes. Dr. Miller, whom we spoke about before, worked for several years as a young doctor with an older man, and then when he became older, he took on a younger assistant.

Dr. DAVIS. Now, with respect to the other point in Senator Murray's question in relation to older doctors who are not earning enough money, the chief reason they do not earn enough is because the people in the area which they serve do not have sufficient paying power. Of course, you are always going to have a few doctors, a handful, who are incompetent or drunk, and nobody will go to them if they can avoid doing so. But the main reason why some of the older doctors do not earn enough money is because of the limited paying power of their clientele, and they do not go to the doctor unless they absolutely have to, being driven by pain.

We have the same situation applying to hospitals. We have the same tragic parallel in our hospitals. The hospitals that have the lowest occupancy rates—that is, I mean the largest proportion of unoccupied beds—are the hospitals that are in the poorest areas, where there is the greatest lack of hospital service. The reason there again is low paying power.

Again this bill would give paying power which would rapidly increase the utilization of doctors and the utilization of hospitals.

Another factor is the larger use of the hospitals by the doctors which this bill would promote because it would support the hospitals. It would also add to the efficiency of the doctor because it would enable the doctor, particularly the younger men, to utilize the services of nurses and technicians, which he cannot afford in his own private office, but with whom he can work in a hospital at no cost to himself.

I think it would add considerably to the medical manpower of the country without adding one mite of increase to the number of doctors, if you could give the people paying power, as this bill would give.

Senator DONNELL. I have some more questions to ask of Dr. Davis.

Senator MURRAY. I have only one or two more questions.

Senator DONNELL. I would like to continue with my examination.

Senator MURRAY. Well, go ahead.

Senator DONNELL. Dr. Davis, I want to ask you a few questions about some matters here, and then I want to ask you a few questions about some observations of yours on the bill.

Senator SMITH. Would you rather adjourn until tomorrow morning? It is getting rather late.

Senator DONNELL. I would rather finish now, if I could.

Senator MURRAY. I had one or two more questions to ask Dr. Davis, but I'm sorry to say that I won't be able to remain. I have an engagement.

Senator SMITH. Would you like for Dr. Davis to come down tomorrow?

Dr. DAVIS. I'm sorry, Senator.

Senator MURRAY. If I could ask him just one more question here, I'll be satisfied.

Senator SMITH. Can you wait with your questions for a moment?

Senator DONNELL. All right.

Senator SMITH. Go ahead, Senator Murray.

Senator MURRAY. You have gone into rather considerable detail in listing a number of organizations that you have been connected with. Were these organizations all devoted to an honest and careful study of the problem of finding a manner in which we can bring about the better distribution of medical care in this country?

Dr. DAVIS. Yes, sir. My interest is not in any other kind of organization. I do not want to be associated with any other kind of organization.

Senator MURRAY. Another witness testifying here before this committee said that he would like to see a situation in this country where the relative merits of these bills would be honestly and openly discussed in the country. Are you familiar with the National Physicians' Committee, Dr. Davis?

Dr. DAVIS. Yes, sir.

Senator MURRAY. Is it devoted to an honest, open study of the problem that we have been discussing here this afternoon?

Dr. DAVIS. I would not consider that it has been, and I would like to say this further about it. It has been a source of very great regret to me that physicians, who are individuals of a very high standing in their profession and have a great deal of devotion to their patients, have been willing to lend their moral and financial support to the National Physicians' Committee, because I feel in the main that the National Physicians' Committee can be characterized thus: A group of physicians constituting its governing board of trustees have been prepared to turn over the conduct of their public relations to a group of men and women whom they have employed as their staff and who have been skilled advertisers and public-relations salesmen in the technical sense of those words, and who have absolutely no regard for intellectual honesty or for fairness in dealing with opposing views. And it seems to me very tragic indeed that the compulsions of fear and anxiety have led a number of physicians to support an organization whose staff has been characterized in the way I feel it is necessary to characterize it.

Senator MURRAY. Have you seen any literature that has been sent out across the country by the National Physicians' Committee?

Dr. DAVIS. I am not on their mailing list, Senator, for reasons which apparently are fairly obvious, but in view of the fact that

most physicians in the country are on their mailing list, I think I have seen most of their literature, which has been sent to me, I might say, by some of my friends.

Senator MURRAY. Does that literature fairly and honestly present criticisms of this proposed measure that we have been discussing here?

Dr. DAVIS. I think the literature describing the bills and the Wagner-Murray-Dingell bill in various forms in the last few years, gotten out by the National Physicians' Committee, has been characterized by a large number of misstatements and enormous amounts of appeal to fear and prejudice, based on those misstatements, which has prevented intelligent thinking on the subject by physicians, who are the chief beneficiaries of this propaganda that is gotten out by the National Physicians' Committee.

Senator MURRAY. That is all.

Senator DONNELL. You were at one time a member of the National Citizens' Political Action Committee, were you not?

Dr. DAVIS. Yes.

Senator DONNELL. And among other members were Dr. Will W. Alexander, vice president of the Julius Rosenwald Fund?

Dr. DAVIS. Yes.

Senator DONNELL. And Mr. Clark Foreman, president of the Southern Conference for Human Welfare, is likewise a member? I am speaking about the National Citizens Political Action Committee.

Dr. DAVIS. I don't know. That's a large body. I think Mr. Alexander was. I don't know who other members of the Political Action Committee were.

Senator DONNELL. Mr. Sidney Hillman was chairman of that committee. You knew him, did you not?

Dr. DAVIS. Yes.

Senator DONNELL. And didn't you know that Mr. Clark Foreman was the secretary of the National Citizens Political Action Committee?

Dr. DAVIS. When you speak of it, yes. I associated him chiefly with his Southern Conference for Human Welfare.

Senator DONNELL. And Dr. Ernst P. Boas, to whom we referred earlier, was also a member of that committee; you knew that, did you not?

Dr. DAVIS. Yes, sir.

Senator DONNELL. And Mr. James B. Carey, who testified here yesterday for the CIO, was also a member; you knew that, did you not?

Dr. DAVIS. I don't know, but I would assume that he would be because of his connections.

Senator DONNELL. And Mr. Bruce Bliven of the New Republic, and Mr. George Soule, to whom we referred earlier today, associate editor of the New Republic—you knew that those gentlemen were likewise members of the same committee, did you not?

Dr. DAVIS. I do not know whether they were or not.

Senator DONNELL. Now, Mr. Davis, I want to ask you whether or not you have ever heard of a film which has been issued with respect to medical insurance, entitled "Medical Insurance, A Pathway to Health"? Did you ever hear of that film?

Dr. DAVIS. I do not recall.

Senator DONNELL. You do not recall?

Dr. DAVIS. No, sir.

Senator DONNELL. Have you ever seen such data as I show you here: "Medical Insurance, A Pathway to Health. Narration for Film-strip. Copyright 1947 by Current History Films, 77 Fifth Avenue, New York 3, N. Y."?

Dr. DAVIS. I'm not sure. If I can glance at it I may be able to tell. I have seen one film strip.

Senator DONNELL. I will show you one thing that may refresh your memory.

Dr. DAVIS. You see, I get a good many things of this kind to look at.

Senator DONNELL. I would like for you to notice this acknowledgment at the top of this page:

We wish to acknowledge with thanks the generous assistance and cooperation of the staff members of the Committee for the Nation's Health in supplying data and valuable advice.

Does that refresh your memory?

Dr. DAVIS. Let me see. Yes; I think I recall. This is a film strip, not a movie. It is a film strip. The people came to us and asked us to review the script which was to accompany a film strip. They had prepared the films, and they had prepared a script. They asked us to review the script as to its accuracy, as I recall.

Senator DONNELL. Did you review it as to its accuracy?

Dr. DAVIS. Yes, sir.

Senator DONNELL. Did you approve it as to its accuracy?

Dr. DAVIS. I have not personally read the script since it was in final form. That is why I did not recall it. When I first read it there were several suggestions I had to make to correct defects in it. I have never read it, that I recall, since it was in its final form.

Senator DONNELL. Did you make any suggestions that you thought would make it more accurate and correct?

Dr. DAVIS. Yes.

Senator DONNELL. Do you remember what suggestions you made?

Dr. DAVIS. I couldn't say that.

Senator DONNELL. How long ago was it that this film-strip narration was presented to you for your consideration?

Dr. DAVIS. I should say something like—well, it was within the last 10 months, I should guess.

Senator DONNELL. Who are the staff members of the Committee for the Nation's Health referred to in this acknowledgment?

Dr. DAVIS. The committee has only a small staff. Mr. Joseph H. Louchheim.

Senator DONNELL. He is the gentleman who testified before you today?

Dr. DAVIS. Yes. He is executive director. And myself in New York. Miss Margaret I. Stein is our Washington representative, with headquarters here.

Senator DONNELL. She is the lady who is here in this room this afternoon; is she not?

Dr. DAVIS. Yes; I see her here. And we have had a public-relations man. At the moment I think we have none, because we are just changing, but I think we have had a public-relations man.

I might add that my own time I give without compensation. I give about half of my time to the Committee for the Nation's Health,

and part of that time is spent in acting as a technical person in going over material; the other part of my time in organization contacts, and that sort of thing.

Senator DONNELL. Now, Dr. Davis, Miss Stein, Mr. Louchheim, and yourself—is that right?—furnished data and advice with reference to this film strip?

Dr. DAVIS. Not Miss Stein, I don't think. I don't think it came to the Washington office at all.

Senator DONNELL. You think it was all handled in New York?

Dr. DAVIS. I think so.

Senator DONNELL. So that would be just you and Mr. Louchheim?

Dr. DAVIS. Yes.

Senator DONNELL. It would be just you two who assisted in the matter?

Dr. DAVIS. Yes.

Senator DONNELL. Who was it who brought the film strip narration to you, if you remember?

Dr. DAVIS. I don't recall. I don't recall the individual. I think it was someone connected with this firm getting it up who knew about us. We are sufficiently notorious, so they might know we were in the picture.

Senator DONNELL. What is a film strip, by the way, as distinguished from a movie?

Dr. DAVIS. A film strip is a series of still pictures put on so you can run it through a projecting machine—a series of still pictures run through as distinguished from pictures that give the impression of motion.

Senator DONNELL. In other words, they are films projected in a moving-picture theater, but as still pictures rather than motion pictures?

Dr. DAVIS. Yes. A series of still pictures. But this particular thing, as I recall it, was designed for use in lecture rooms and in groups of smaller audiences, not necessarily in a theater—a small film which they use for educational groups and in classes.

Senator DONNELL. I observe that on the flyleaf, which is in advance of this film-strip narration, appears this statement:

Film strips are primarily an educational medium—a visual aid to teaching and learning. They are not intended for relaxation or entertainment. They are not designed to replace motion pictures and are not a substitute for discussion but rather an instrument to stimulate questions and discussion.

There are various other statements contained thereunder. And you understood that to be true when this was distributed to you?

Dr. DAVIS. Yes. As I recall the script and the pictures, they dealt mainly with the question of the needs of health insurance—the health needs in rural and urban communities—broken down into various income groups of the population. It dealt very little with the solution—only a little with the solution—very little. You can't do much about solutions in a film strip, because you can't so organize and legislate in a film strip.

Senator DONNELL. I call to your attention the fact that among other things there appears in this film-strip narration, over on the left-hand side, a series of numbers under the caption "Frame No.," and these numbers from 1 to 85 run for page after page, finally concluding with

the number "85." And included in this film-strip narration, after various preliminary things—I will offer this entire document in the record in a little while—is this language, at No. 30 to No. 32 and following:

30. How can this barrier be broken down? How can the economic separation between patient and doctor be closed so that all people, in all income groups, may receive the medical care they need and must have for good health and a happy life?

31. The most important proposal yet made for bridging this economic gap is a system of prepared national medical insurance.

32. Such plan is contained in the much discussed and controversial National Health Insurance Act. What is in this act? How would it work? That is what we will see next.

Now, Dr. Davis, what insurance act is referred to in that text?

Dr. DAVIS. It referred to this act.

Senator DONNELL. To S. 1320? Or its predecessor, S. 1606, the Wagner-Murray-Dingell bill of last year?

Dr. DAVIS. Yes.

Senator DONNELL. Quoting further from this film-strip narration:

33. National health insurance would work very much like life insurance. Individually, most of us could not provide life insurance for our dependents. Collectively, we can. Each of us pays a small premium into a common fund held by an insurance company. When the need arises the insurance is drawn from this collective barrel. We call that the principle of sharing the risk and spreading the cost.

Then, after an observation in frame No. 34 on fire insurance [reading]:

35. That is the idea of national health insurance. Everyone covered by the plan would pay a small premium into a national fund to be used solely for medical care. Like any other insurance, it would operate on the principle of sharing the risks of illness and spreading its cost over millions of people. Since this is a national problem, instead of having this protection operated by a private company, it would be handled by an agency of the Federal Government.

Do you remember, on reflection, the fact that those observations were contained in this film strip as submitted to you?

Dr. DAVIS. You have read them.

Senator DONNELL. Do you remember them?

Dr. DAVIS. I recall.

Senator DONNELL. And you understood that the primary purpose of this film strip was for educational purposes, to be sent out to schools all over the country to serve in an educational capacity; is that right?

Dr. DAVIS. Yes.

Senator DONNELL. And you thought it would have very considerable value in that connection, I assume; is that right?

Dr. DAVIS. I was not greatly impressed by its value, inasmuch as small film strips are usually pretty unimpressive. Young people accustomed to the beautiful technique of the modern motion picture are usually not much impressed. I was not much impressed by it except for use in classes, as distinguished from general audiences. General audiences are not impressed by the poor technique that is apparent in most small film strips.

Senator DONNELL. Were you told whether it was going to be used at all for public audiences?

Dr. DAVIS. I think this firm, as I recall, wanted to sell it. I was not greatly impressed with its possibilities. I do regard the use of any

visual techniques as a good thing for educational purposes, and I so regard any correct presentation of a bill of this kind—I mean as an educational measure.

Senator DONNELL. And you understood this film strip was going to present this bill?

Dr. DAVIS. Part of it, although I still go back to the point that a large part of it dealt with the problem of need.

Senator DONNELL. I observe that down at the bottom of this film-strip narration is a series of references, among which are the following:

Health for the Nation, Michael M. Davis, Survey Graphic, December 1944.

Principles of Nation-wide Health Program, Report of the Health Program Conference, Committee on Research in Medical Economics, 1790 Broadway, New York 19, 1944.

That is this document which we were discussing a little while ago. [Continuing:]

Medical Care in a National Health Program, An Official Statement of the American Public Health Association. American Journal of Public Health, December 1944.

Is Your Health the Nation's Business? EM 29, GI Roundtable, War Department, Washington, D. C., January 1946.

That is the pamphlet for which I secured leave a little while ago to have incorporated in full in the record, with the mention in the fly-leaf that—

Current War Department instructions authorize the requisition of additional copies of this pamphlet on the basis of 1 copy for each 25 military personnel, within limits of the available supply. Additional copies should be requisitioned from the United States Armed Forces Institute, Madison 3, Wis., or the nearest oversea branch.

I notice also that a further reference is stated to be:

Medical Care Insurance—A Social Insurance Program for Personal Health Services. Report from the Bureau of Research and Statistics, Social Security Board, 1946.

That is the Bureau of which Mr. Falk is the head, is it not?

Dr. DAVIS. I think so.

Senator DONNELL. Another reference is:

National Health Act of 1945—Need for Medical Insurance. A memorandum prepared by Bureau of Research and Statistics, Social Security Board, Washington, D. C., 1946.

That is followed by this further statement:

Further information regarding national health insurance may be obtained from the Committee on the Nation's Health, 1790 Broadway, New York 19, N. Y., and the Physicians Forum, Inc., 510 Madison Avenue, New York 22, N. Y.

Those various committees, without going over them in detail, are the ones that we have been referring to here in the testimony this afternoon, are they not?

Dr. DAVIS. Yes.

Senator DONNELL. And the Physicians' Forum—that is the one of which Dr. Boas is head?

Dr. DAVIS. Yes.

Senator DONNELL. And this Bureau of Research and Statistics mentioned in connection with the National Health Act of 1945 is the same Bureau of Research and Statistics of the Social Security Board referred to when I interrogated you a few minutes ago as to whether

that is the bureau with which Mr. Falk is connected; that is correct, is it not?

Dr. DAVIS. Yes.

Senator DONNELL. I call attention also to the fact that it is stated in this document here that I offer in evidence with respect to this narration for film strip, as follows:

Photos used in this film strip are from the Library of Congress, Federal Security Agency, United States Public Health Service, Farm Security Administration, OWI—

that is the Office of War Information—

and Underwood & Underwood, New York City Public Library.

Now, Mr. Davis, you readily gave the desired cooperation by looking this over, did you not?

Dr. DAVIS. Yes.

Senator DONNELL. The address of Current History Films, by the way, which is mentioned here on this publication, is 77 Fifth Avenue, New York City, is it not?

Dr. DAVIS. I don't recall it.

Senator DONNELL. That is the address on here. Now, do you know that lodge 500 of the International Workers Order at 80 Fifth Avenue is directly across from 77 Fifth Avenue? Do you know that to be true?

Dr. DAVIS. I don't know.

Senator DONNELL. But you do know that 80 Fifth Avenue has been used for a whole series of Communist-front organizations, including the Artists League? Were you informed of that?

Dr. DAVIS. No, sir.

Senator DONNELL. I observe that in this film strip it says under frame No. 3, after giving the title in No. 2, "Medical Insurance, a Pathway to Health"—an "ERG Production." Do you know who the persons are for whom ERG stands?

Dr. DAVIS. No.

Senator DONNELL. Did you not know that ERG stands for Mr. Eisman, Mr. Roberts, and Mr. Goldman, who have been investigated by the Committee of the House of Representatives on Un-American Activities? Did you not know that?

Dr. DAVIS. I did not know anything about it beyond this one fact, Senator. We are a service organization—and I am speaking now for the Committee for the Nation's Health—and we are perfectly prepared to do what we did in this case—render technical information in connection with material that comes to us in good faith when anyone asks for it.

Senator DONNELL. Now, Mr. Davis, you observed that it said in here "Title: An ERG Production"—you saw that, did you not?

Dr. DAVIS. The "ERG" didn't mean anything to me. These people had done a script already. They wanted to know whether, technically, it was reliable. We gave them a review of it.

Senator DONNELL. I offer into the record at this time a paper which represents, so I am reliably informed, and believe to be true, data derived from the report of the Special Committee on Un-American Activities of the House of Representatives, Seventy-eighth Congress, second session, in respect to Messrs. Eisman, Roberts, and Goldman,

and also with respect to Mr. Charles Keller, who, it appears, is the author of the narration, and it also appears from the paper I am now submitting, was reported in the Daily Worker, February 13, 1947, as being art editor of the New Masses. Do you know what the New Masses is?

Dr. DAVIS. Yes.

Senator DONNELL. The paper which I am presenting, which contains this information about Mr. Eiseman, Mr. Roberts, Mr. Goldman, and Mr. Keller, is not presented as an excerpt from the report of the Committee on Un-American Activities, but is a compilation of data which, I am informed, is derived from that report, and which I believe to be a correct compilation.

I offer this paper into the record, if you please.

Senator SMITH. No objection. Go ahead.

(The material referred to follows:)

FILM STRIP NARRATION ON MEDICAL INSURANCE—AN ERG PRODUCTION

ERG represents the initial letters of the names: Eiseman, Roberts, and Goldman.

Script of the film is by Samuel Roberts, production by Leslie A. Goldman, photography by Hall Eiseman, and narrations by Charles Keller.

The above-cited men have long records of communist-front association and were cited in the reports published as a result of the investigation of un-American propaganda activities in the United States. The Special Committee on Un-American Activities, House of Representatives, Seventy-eighth Congress, second session, on House Resolution 282, published in 1944, contains this information on the men who produced this film on medical insurance.

Samuel Roberts. On March 31, 1941, Rockwell Kent, Communist vice president of the International Workers Order (since made president thereof), sent out a letter regarding the birthday jubilee celebration for Norman Tallentire. (Committee Rept., sec. IV, p. 1154.) Kent was chairman of that Tallentire Jubilee Committee which was endorsed by lodge 500, IWO. Among the sponsors were Sam Roberts; Peter Shipka of IWO; Max Bedacht, Communist general secretary of the IWO; William Z. Foster, Communist candidate for President in 1932; and James W. Ford, Communist candidate for vice president for 1932. Bedacht, Foster, and Ford are members of the IWO. The activities of Norman H. Tallentire are discussed on pages 830, 852, 904, 1154, 1364, and 1640 of the House reports above cited.

Leslie A. Goldman. He is cited in the House report, page 544, as treasurer of the American Youth Congress. Of this organization the report states:

"For a period of 7 years—from 1934 to 1941—the American Youth Congress was one of the most influential front organizations ever set up by the Communists in this country. The Communist control of the organization was so adroitly handled (at various periods during its life) that a large number of unusually prominent persons were drawn into the circle of its supporters. In the end, however, it was all but universally recognized that the Communists were in complete control. Joseph P. Lash, one-time executive secretary of the American Student Union, who was for years an influential figure in the American Youth Congress, admitted in sworn testimony before an executive session of the Special Committee on Un-American Activities that the Youth Congress was a Communist-front organization (executive hearings of the Special Committee on Un-American Activities, p. 2812)." (House report above cited, p. 525.)

Charles Keller. Reported in Daily Worker, February 13, 1947, as art editor of the New Masses. He is cited on pages 485 and 1101 of the above report.

Senator DONNELL. I also offer at this time this document to which I have been referring and from which I have been quoting, the narration of the film strip entitled "Medical Insurance, a Pathway to Health."

Senator SMITH. No objection. It will be received.

(The document referred to follows:)

MEDICAL INSURANCE—A PATHWAY TO HEALTH

NARRATION FOR FILMSTRIP

(Copyright 1947 by Current History Films, 77 Fifth Avenue, New York 3, N. Y.)

HOW TO USE THE FILM STRIP

Film strips are primarily an educational medium—a visual aid to teaching and learning. They are not intended for relaxation or entertainment. They are not designed to replace motion pictures and are not a substitute for discussion but rather an instrument to stimulate questions and discussion.

METHOD

Know the subject of the film. Read and prepare *beforehand*.

Precede the showing with a very brief introduction which will help *lead* the audience *into* the subject.

During the showing feel free to depart from prepared narration with your own words. Ask the audience questions. Go back to earlier frames to make a point. With some subjects it should be possible to cite *local examples* of what the film shows.

After showing, try to have a discussion period with *questions* and *answers* designed to sum up and emphasize what was seen and heard.

PREPARATION

Rehearse with the film *at least once* before the regular showing so as to become familiar with narration and pictures. This is essential—often makes the difference between good and poor presentations.

Read the material supplied with the film strip kit—it will help you *prepare* and answer questions.

Be certain you have enough light to read the script. A pocket flashlight will often suffice.

Anticipate difficulties. Some well *before* the time set for showing and set up equipment.

Check details. Make sure you have the *proper* projector. A film strip is shown with a 35-mm. *single frame* film strip projector. There are many different types available.

Make sure electric outlet is convenient and that *power* is available at the outlet. If needed, get extension cord.

See that stand or table is secure, in position. See if screen is *in position* and a clear path from machine to screen. (Note: If regular screen is not available use a white sheet or large white cardboard. In a pinch a white or flat light-colored wall will be adequate.)

OPERATION

The film may be *shown* by the same individual who speaks the narration. But—it has been found that if one person operates the projector and another concentrates on the narration—better results are obtained. With such an arrangement, the narrator and projectionist work as a team. Each time the speaker is ready to have the next frame (picture) on the screen, he signals to the operator by tapping lightly with a pencil or other object or by using a flashlight.

Remember! Preparation is 90% of success. (1) Read up beforehand on your subject. (2) Rehearse. (3) Be ready before your audience arrives.

FILM STRIP NARRATION

Frame No.—

1. (Title: Current History Films presents.)
2. (Title: Medical Insurance—A Pathway to Health.)
3. (Title: An ERG production.)
(Start narration.)
4. The most important resource of a country is its people.

5. And the most precious possession of the people is their health—it follows that a healthy population makes a healthy nation.
6. But millions today in America do not receive the medical care needed to maintain and protect their health.
7. To what degree our Nation's health has been neglected and undermined was emphasized during the war. Thirty percent of the men examined were rejected as physically unfit for military service. In other words, almost one out of every three men had to be rejected.
8. Illness affects millions of Americans every day of the year. A national survey revealed that on an average day 7,000,000 persons are unable to carry on normal activities because of illness, accidents, or physical defects. This figure does not include those who keep going in spite of their ailments.
9. A shocking number of persons—about 23,000,000, according to authoritative figures—are suffering from chronic diseases. An example is the increase in the number of cancer cases. It has climbed to second place among the Nation's chronic killers. Yet many forms of cancer can be arrested or cured if detected in time.
10. These conditions exist in a country which is capable of providing the best medical facilities and personnel in the world.
11. We have the doctors—not as many as we could use but we have the colleges and universities to train more.
12. We have the surgeons skilled in the art of saving life.
13. We have the scientists and technicians to search for the causes, the preventions, the cures of diseases.
14. (Title: Then What Is Wrong?)
15. This is one of the principal reasons for much of our illness—not the only reason but one of the main causes for the state of the Nation's health—there is an economic barrier between those who need medical protection and the doctors who are able to provide it.
16. Paid for as at present, medical care is a commodity which is economically out of reach for an overwhelming majority of the American people. The amount of medical attention you get depends on your income.
17. This family, representing the higher-income groups of the country, can purchase all the medical care it needs at all times. It has the least amount of sickness and receives more than twice as much physician's service as the lowest-income families.
18. This middle-class family has no financial worries in paying for normal medical needs, but is unable to budget for the heavier costs.
19. And this family, representing the lower-income groups, more than half the population of the country, could purchase practically none of its medical care out of current earnings. Most, in this class, are forced to neglect medical attention until a condition is serious. This family, in order to pay for treatment, must either sacrifice other necessities or go into debt.
20. And this family, representing the poorest in the Nation, both Negro and white, has the highest rate of illness and the least means to purchase medical services. Negro families, in addition, suffer discrimination, which creates further barriers to obtaining health protection.
21. Families on such streets, all over America, suffer most illnesses and need the most medical protection. But, unfortunately, they are the ones least able to obtain it.
22. Again let us recall the main reason—the economic barrier, which stands like a high wall between the people and the doctors.
23. The facts are that after paying for food, shelter, and clothing, and other expenses, the average wage worker, as an individual, has very little left over to pay for medical needs.
24. Let us see more specifically the connection between health and income. In 1945 as in prewar years, about half the population of the United States earned less than \$2,000 a year. How much medical care did this half of our population receive under present methods of paying for doctor's services?
25. How much doctor's care were they getting—some 36 percent were getting this care when needed, but two out of every three were not.
26. Only 16 percent were getting proper dental care. The rest, five out of six, were compelled to neglect their teeth and look with envy on those who could boast of "the smile of beauty."
27. One-third of this low-income group was getting hospitalization when urgently needed, but the biggest number, two out of every three, were not.

28. Only 9 percent were receiving regular health examinations. The rest, 9 out of every 10, we repeat, 9 out of every 10 persons in this group, were going along without any medical check-up whatsoever.
29. We know that periodic examinations are necessary to detect an illness before it goes too far. How many young men rejected for military service came from homes which were unable to afford doctor's care? How many of those dead of chronic diseases could have been saved by the routine of early diagnosis and early treatment?
30. How can this barrier be broken down? How can the economic separation between patient and doctor be closed so that all people, in all income groups, may receive the medical care they need and must have for good health and a happy life?
31. The most important proposal yet made for bridging this economic gap is a system of prepaid national medical insurance.
32. Such plan is contained in the much discussed and controversial National Health Insurance Act. What is in this act? How would it work? That is what we will see next.
33. National health insurance would work very much like life insurance. Individually, most of us could not provide life insurance for our dependents. Collectively, we can. Each of us pays a small premium into a common fund held by an insurance company. When the need arises the insurance is drawn from this collective barrel. We call that the principle of sharing the risk and spreading the cost.
34. Fire insurance works on a similar principle. We pay during the time we are secure for future protection. It is possible to do this because thousands of people pay into a common fund and share the common risk.
35. That is the idea of national health insurance. Everyone covered by the plan would pay a small premium into a national fund to be used solely for medical care. Like any other insurance, it would operate on the principle of sharing the risks of illness, and spreading its cost over millions of people. Since this is a national problem, instead of having this protection operated by a private company, it would be handled by an agency of the Federal Government.
36. Instead of meeting the problem as individuals, all medical costs would come out of this national fund. The exact manner of payment would be determined by the medical profession itself.
37. First of all it would provide complete family-doctor service. Instead of paying the doctor on the spot, as now, he would be paid out of the insurance fund. You and your family could afford a physician at all times. Illness, instead of being neglected, could be attended to properly and in time.
38. The medical insurance fund would also pay for surgery and for specialists.
39. It would pay for hospitalization—up to 60 days a year.
40. Nursing care would also be paid for—as directed by the doctor.
41. X-ray and laboratory costs—this is also provided for as part of the plan.
42. Dental care for the whole family. This too, would be covered by the health insurance system. The amount of service would depend on the number of dentists available.
43. Payment for eye care and eyeglasses is also included. In short, complete medical coverage necessary to protect and maintain health.
44. The answer is: Approximately 85 percent of the population—or nearly everyone in the country.
45. The workers.
46. Farmers and farm workers.
47. Professionals, such as teachers, lawyers, clergymen, and the like.
48. The self-employed—like this shoemaker, and other small business people.
49. How much would it cost? That is an important question about which there has been a great deal of confusion.
50. National health insurance would be financed by a 3 percent pay-roll tax. One-half to be paid by the wage earner; the other half by the employer. It would be paid for in the same way as the present social-insurance deductions.
51. For example, if this man earned \$44 a week, he would pay approximately 66 cents a week into the insurance fund for complete medical coverage for himself and his family.
52. This shoemaker, as a self-employed person, would pay the entire 3 percent on an income up to \$3,600 a year, himself.

53. The National Health Act would help complete the present social insurance structure of the land, adding health insurance to unemployment and old-age insurance, now an accepted idea of social responsibility.
54. By national planning, national organization, cooperation, and responsibility almost every family in the country would be assured of receiving the medical care it needs for year around health protection.
55. (Title: What Opponents Say.)
56. Opponents of the plan charge that prepaid health insurance would lead to "political medicine." This cartoon, from a booklet issued by the National Physician's Committee, connected with the American Medical Association, says that the National Health Act would cause the regimentation of patient and doctor, and destroy free enterprise.
57. Could you choose any doctor? The answer is "yes."
58. The bill is very explicit on this point. You would be permitted to choose any doctor you wished from those subscribing to the plan.
59. At the same time the doctor would still have the privilege of refusing or accepting a particular patient.
60. Who would administer this national health insurance system? How would its provisions be applied fairly and efficiently to every city, town, and village? Main responsibility for administering the services and funds would be given to the States and localities.
61. Each area would have a committee composed of representatives of the public and medical profession. These committees, together with local officials, would direct the health plan in the individual communities of the Nation. For national coordination there would be a Federal board operating as part of the Federal Security Agency.
62. Since no plan, involving people, can work perfectly, the act realistically also provides for local boards to hear complaints from physicians and patients.
63. (Title: What Would it Mean to Physicians?) Contrary to popular opinion, only few physicians earn very high incomes.
64. Consider the earnings of nonsalaried doctors in the highly prosperous year of 1929. The well-to-do doctors, represented by the figure up front, comprising 14 percent of the total, had an average weekly income of \$300. The next group earned around \$150 a week, and included 23 percent of the doctors. Next, we come to a \$75-a-week group which included about 22 percent of all physicians. Finally, there is the doctor at the bottom. These men earned less than \$50 a week. And this group included 40 percent of the doctors, or 4 out of every 10. To sum up—the average income for all doctors, high and low, in one of the most prosperous years on record, was a little more than \$5,000 a year.
65. With everyone covered by national health insurance, all physicians, not just a favored few, would be assured of a steady flow of paying patients throughout the year, and a better, guaranteed income and security.
66. Young doctors, just starting out, would especially appreciate the plan. Many struggle for years trying to establish a practice among income groups which can afford to pay while many areas with people of lower incomes are tragically in need of physicians.
67. Relieved of the problem of insecurity, assured of a guaranteed income, doctors would have freer minds to study and keep abreast of new developments—thus they would be better able to render higher quality services.
68. (Title: Better Distribution of Doctors.)
69. At present, most doctors prefer locating in the larger cities, close to those who can afford services and nearer to better equipped facilities and hospitals.
70. With everyone covered by health insurance, and with the building of more hospitals, doctors would be more inclined to locate in places like this—in rural areas, where there is a serious shortage of physicians today.
71. More doctors would be willing to open offices in workers' neighborhoods where, with the insurance plan, there would be no question of ability to pay.
72. (Title: Opponents Say: Public Medical Insurance is Socialism.)
73. In reply, supporters of the National Health Insurance Act ask, "Is this socialism? Public education. Individually, the great majority of the people could not provide decent education for their children. Only a public system with costs spread over all income groups makes the public-school system possible. Just so with the national health plan."
74. (Title: Opponents Say: Voluntary Insurance Can Meet the Need.)

75. The fact is that after many years, only 3 to 4 percent of the people are now covered by private voluntary medical plans. It's an old jalopy that can only accommodate a few. In most cases, these plans are too expensive for lower income groups and do not provide both hospitalization and all around medical care.
76. National prepaid health insurance is a method of removing the economic barrier which prevents the majority of the population from obtaining adequate medical care and health protection. While adoption of this plan would be a big step forward, we must be very clear that it is not a panacea—not a cure-all by itself. There are other barriers that also need to be removed.
77. We need more hospitals. Many more. At present some 15,000,000 people live in communities which have either no local hospitals, or else hospitals far below decent standards. In other places, hospitals are greatly overcrowded. This situation is particularly serious in rural areas.
78. We need more public-health centers like this one. Did you know that 40,000,000 citizens of the United States live in communities lacking full-time public health services. Absence of these facilities is a hazard to health.
79. We need more research. More funds to investigate the causes, prevention and cure of illness now afflicting us. We need to end discrimination in medical education to allow persons of all races and faiths to enter this vital field of human service.
80. Above all we need a decent standard of living, so that everyone is well-fed, well-housed, and well clothed—for, after all, is not that the foundation for good health?
81. Meanwhile, removal of this barrier, would, as the late President Roosevelt advocated, give the American people "the right to adequate medical care."
82. Adoption of prepaid health insurance along the lines of proposed in the National Health Insurance Act is a democratic and cooperative way of solving one of the major and immediate health needs of the Nation.
83. We started off by saying the the most precious possession of a country is its people. The National Health Act is a means of bringing good health to the present generation and guaranteeing it for future generations. And let us remember, a healthy people makes a healthy nation.
84. The end.
85. Credits.

ACKNOWLEDGEMENTS

We wish to acknowledge with thanks the generous assistance and cooperation of the staff members of the Committee for the Nation's Health in supplying data and valuable advice.

Some of the material used in the film is adapted from the pamphlet *Health Care for Americans*, by C. E. A. Winslow, published by the Public Affairs Committee, Inc.

Photos used in this film strip are from the Library of Congress, Federal Security Agency, United States Public Health Service, Farm Security Administration, OWI, and Underwood & Underwood, and New York City Public Library.

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 Further information regarding national health insurance may be obtained from the Committee on the Nation's Health, 1790 Broadway, New York 19, N. Y., and the Physicians Forum, Inc., 510 Madison Avenue, New York 22, N. Y.

Senator DONNELL. I also would like to read into the record at this time the following from the Daily Worker, New York, Monday, June 2, 1947:

NEW FILM STRIP DRAMATIZES NEED FOR HEALTH INSURANCE

America's health problem and the question of national health insurance, now the topic of Nation-wide discussion, is the subject of a new film strip just issued by Current History Films, 77 Fifth Avenue, New York City.

The film, entitled "Medical Insurance—Pathway to Health," puts on the screen, in a new visual style, the facts and figures on America's health conditions and dramatizes the proposals contained in the controversial National Insurance and Public Health Act, introduced into Congress May 20.

In a simple, straightforward manner, it boils down reams of research in medical economics and thousands of pages of professional writing into an interesting series of highly graphic illustrations and pictures which give the layman a quick grasp of an involved technical subject.

The film is excellent for discussion and current events groups and social studios classes.

Medical Insurance—A Pathway to Health tells its story in 83 frames. Running time with narration is 17 minutes. The most complete with narration and documented background material is \$2.60 postpaid. It may be obtained from the IWO Film Division, 80 Fifth Avenue, New York City, or directly from Current History Films.

Do you know what "IWO" means, Mr. Davis?

Dr. DAVIS. Oh, yes.

Senator DONNELL. That is the International Workers Order?

Dr. DAVIS. Yes.

Senator DONNELL. I refer to the New Masses, in connection with Mr. Keller. Do you know who issues the New Masses?

Dr. DAVIS. No.

Senator DONNELL. Is that a Communist publication, to your knowledge?

Dr. DAVIS. I have probably seen two or three copies of the New Masses in my whole life. I don't know anything about it. I know about it by reputation.

Senator DONNELL. You do not know who issues it?

Dr. DAVIS. No.

Senator DONNELL. Have you ever heard who issued it?

Dr. DAVIS. If I have, I have forgotten.

Senator DONNELL. I ask if you know who issues the Daily Worker?

Dr. DAVIS. I believe it is a Communist Party organ. That's all I know. I don't read it, so I don't know anything about it.

Senator DONNELL. I call to your attention that in this issue of June 2, 1947, from which I have just read—I am speaking about the Daily Worker—there appears this statement:

Daily worker—published daily except Sunday by the Freedom of the Press Co., Inc., 50 East 13th St., N. Y. C. 3, N. Y. Telephone ALgonquin 4-7954. Cable Address: "Daiwork," New York, N. Y.

President—Benjamin J. Davis, Jr.; Secretary-Treasurer—Howard Boldt.

Then follows the names of various persons as editor, associate editor, and so on, and Mr. Rob F. Hall is listed as the Washington editor.

Do you know Mr. Rob F. Hall?

Dr. DAVIS. No.

Senator DONNELL. Do you know Bill Lawrence, the general manager?

Dr. DAVIS. I do not.

Senator DONNELL. You understand, however, as a matter of your own knowledge, that the Daily Worker is a Communist publication? Is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. I now offer this in evidence for the record.

Senator SMITH. You don't want to offer the whole paper, do you?

Senator DONNELL. Just this excerpt.

Senator SMITH. Just the excerpt?

Senator DONNELL. That is correct. I offer that into the record.

(The clipping referred to follows:)

NEW FILM STRIP DRAMATIZES NEED FOR HEALTH INSURANCE

America's health problem and the question of national health insurance, now the topic of Nation-wide discussion, is the subject of a new film strip just issued by Current History Films, 77 Fifth Avenue, New York City.

The film, entitled "Medical Insurance—Pathway to Health," puts on the screen, in a new visual style, the facts and figures on America's health conditions and dramatizes the proposals contained in the controversial National Insurance and Public Health Act, introduced into Congress May 20.

In a simple, straightforward manner, it boils down reams of research in medical economics and thousands of pages of professional writing into an interesting series of highly graphic illustrations and pictures which give the layman a quick grasp of an involved technical subject.

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Dr. DAVIS. Might I ask, Mr. Chairman, on that point, as to the relevancy of this discussion. I am very much puzzled as to its relevancy. The Committee for the Nation's Health—

Senator DONNELL. The relevancy—

Dr. DAVIS. Might I finish my statement, please?

The Committee for the Nation's Health offers its services generally in any capacity in which it can furnish expert technical assistance on the subject matter, and I had not thought that we would be obliged to investigate the political background of an organization that asked us to review, for technical reasons, a document or a visual thing which they submitted to us with the request that we give them the benefit of our technical knowledge.

As far as I can see, we would have had to go into considerable research in order to get the background which you or your staff say it has developed on this case. I don't quite see how it can be expected that the Committee for the Nation's Health set up criteria of that sort before we are willing to give service on requests from any organization that comes to us for advice.

Senator DONNELL. Did you know who it was who brought in this film-strip narration? Do you have any recollection as to who it was?

Dr. DAVIS. I don't know.

Senator DONNELL. You don't know?

Dr. DAVIS. No. He just came in.

Senator DONNELL. Do you know his connection?

Dr. DAVIS. No. It was no person I had ever been familiar with before. The name of the man who brought it in was no one I recognized at all.

Senator DONNELL. Did you make any investigation as to the character of the people who were going to issue this film-strip narration?

Dr. DAVIS. We had no responsibility whatever, but to go over their manuscript and look at this series of films.

Senator DONNELL. Did you make any investigation as to the reliability or nature of the group?

Dr. DAVIS. Only as to the reliability of the material they submitted to us.

Senator DONNELL. You did not make any investigation as to who the people were, and you have no recollection who any of them were?

Dr. DAVIS. No.

Senator DONNELL. You would not know the name of the man or woman who brought it to you?

Dr. DAVIS. Oh, no.

Senator DONNELL. You have no recollection of that?

Dr. DAVIS. Considering the number of people that I see under such circumstances, I certainly would not remember a person I had never seen before.

Senator DONNELL. Do you know Mr. Rockwell Kent?

Dr. DAVIS. No. Not other than that I have seen his name signed to some of his drawings in books.

Senator DONNELL. You know him to be the president of the International Workers Order, do you not?

Dr. DAVIS. I think I may have known that. I don't know anything about the International Workers Order.

Senator DONNELL. Did you have anything to do with furnishing to anybody on this committee the name of Mr. Kent as a prospective witness for use in the advocacy of the Wagner-Murray-Dingell bill?

Dr. DAVIS. No, sir.

Senator DONNELL. Did anyone on your staff suggest his name, to your knowledge?

Dr. DAVIS. Not as far as I know.

Senator DONNELL. Do you know Mr. Max Bedacht, general secretary of the International Workers Order?

Dr. DAVIS. The name sounds a little familiar to me, but I couldn't say that I do. Bedacht? No, I don't recall.

Senator DONNELL. Did anyone on your staff or in your organization have anything to do with the substitution of Mr. Rymer or Mr. Bedacht as a witness here before this committee?

Dr. DAVIS. I am certain that if that had happened I would have known about it, and therefore I am certain that it did not happen.

Senator DONNELL. I would like to emphasize at that point, frame Nos. 82 and 83 of this narration for filmstrip, which reads as follows:

82. Adoption of prepaid health insurance along the lines proposed in the National Health Insurance Act is a democratic and cooperative way of solving one of the major and immediate health needs of the Nation.

83. We started off by saying the most precious possession of a country is its people. The National Health Act is a means of bringing good health to the present generation and guaranteeing it for future generations. And let us remember, a healthy people makes a healthy nation.

Now, Dr. Davis, in this excerpt I read from the Daily Worker of June 2, 1947, you will recall that I read a reference to "the controversial National Insurance and Public Health Act, introduced into Congress

May 20." Would you refer to S. 1320 and see on what date S. 1320 was introduced in Congress?

Dr. DAVIS. May 20.

Senator DONNELL. May 20, 1947, is that right?

Dr. DAVIS. Yes.

Senator DONNELL. Does that not refresh your memory to the effect that the film strip was brought to you much later than 10 months ago?

Dr. DAVIS. It doesn't refresh my memory. As far as the Daily Worker is concerned, I never see the Daily Worker. I don't know that I have ever had a copy in my hand. It means nothing to me.

Senator DONNELL. Now I want to show you also another document, which is marked "Prepared by the Committee for the Nation's Health," entitled "Brief History of Health Insurance in United States." I hand you that document and ask that you look at it please, and tell me whether you ever saw one of those before, or if you don't recognize it, Mr. Louchheim, I see, is still here, and perhaps he would recognize it.

Dr. DAVIS. Do you recall this, Mr. Louchheim?

Mr. LOUCHHEIM. I recall, sir, that we were asked to prepare a brief history of health insurance in the United States. I have never seen this one, though.

Senator DONNELL. You have not seen that?

Mr. LOUCHHEIM. No.

At the same time these people came in and suggested that we look over that, they asked us for a brief history of health insurance in the United States. We had one, and gave it to them.

Senator DONNELL. It says the data were prepared by the Committee for the Nation's Health.

Mr. LOUCHHEIM. We have distributed a history of the health insurance movement very often. That was the same data, and they put it in that form.

Senator DONNELL. Who put it in that form?

Mr. LOUCHHEIM. The people who put it out.

Senator DONNELL. And who put it out?

Mr. LOUCHHEIM. I don't know.

Senator DONNELL. This "ERG" organization?

Mr. LOUCHHEIM. I don't know. I assume so, since you have the two together.

Senator DONNELL. Did you assist Mr. Davis in going over this film strip narration to which I have referred?

Mr. LOUCHHEIM. Yes, sir.

Senator DONNELL. You remember criticizing it?

Mr. LOUCHHEIM. I remember doing it.

Senator DONNELL. How long ago was it done?

Mr. LOUCHHEIM. I would say within the last 5 months.

Senator DONNELL. Within the last 5 weeks?

Mr. LOUCHHEIM. Five months.

Senator DONNELL. Within the last 5 months.

Mr. LOUCHHEIM. Yes.

Senator DONNELL. Now, Mr. Davis thought it was within the last 10 months. Are you sure whether it was subsequent to May 20 that you went over it?

Mr. LOUCHHEIM. No, sir, it was prior to May 20.

Senator DONNELL. It was prior to May 20, 1947?

Mr. LOUCHHEIM. Yes.

Senator DONNELL. The name "National Health Insurance Act" appears on this film strip, does it not?

Mr. LOUCHHEIM. I see it does.

Senator DONNELL. Do either of you gentlemen have a copy of S. 1606 with you?

Dr. DAVIS. I have none.

Mr. LOUCHHEIM. Neither do I.

Senator DONNELL. Did that have the same title?

Mr. LOUCHHEIM. It was called the National Health Insurance and Public Health Act, as I recall.

Dr. DAVIS. Last year's was just the National Health Act of 1946.

Senator DONNELL. Do you know whether or not the names of the two bills were identical?

Mr. LOUCHHEIM. I believe the 1946 bill was the National Health Act, and the 1947 bill is the National Health Insurance and Public Health Act.

Senator DONNELL. I have here, Mr. Davis, the bill of last year, namely, S. 1606 as set out in the hearings, and the title—

Dr. DAVIS. Of course—

Senator DONNELL. Just a minute. The title as set forth in that bill and the enacting clause is "National Health Act of 1945." That appears at page 9 of the hearings on S. 1606.

Now, the name of the present bill is "National Health Insurance and Public Health Act of 1947." I call to your attention the fact that last year's bill did not contain the word "insurance" at all, whereas the film strip contains that word as part of the bill, namely "Health Insurance Act."

Is it not a fact that on reflection, gentlemen—one or both of you—you recall that this film strip narration was brought to you gentlemen after S. 1320 was introduced into the Senate this year?

Dr. DAVIS. I would say that my recollection is that it definitely must have been before May 20.

Mr. LOUCHHEIM. I know it was before May 20, because at the time they came in to discuss it, I pointed out to them that a new bill was going to be introduced.

Senator DONNELL. You knew a new bill was going to be introduced?

Mr. LOUCHHEIM. Yes.

Senator DONNELL. How did you know a new bill was going to be introduced?

Mr. LOUCHHEIM. Because of the fact that we knew a new bill was going to be introduced since the old S. 1606 was still a matter of interest on the part of people who wanted to have a new health insurance bill introduced in Congress.

Senator DONNELL. Had you learned authoritatively from anybody in the Senate that a new bill was going to be introduced?

Mr. LOUCHHEIM. I learned authoritatively even before May 20.

Senator DONNELL. From whom?

Mr. LOUCHHEIM. You will recall that in my testimony I stated that on May 9, I think, we had—

Senator DONNELL. There was a dinner?

Mr. LOUCHHEIM. A board of directors meeting.

Senator DONNELL. Yes.

Mr. LOUCHHEIM. At which time, in principle, we approved S. 1320. Senator DONNELL. How did it happen that you were able to discuss it 11 days before it was introduced?

Mr. LOUCHHEIM. Because we received a blueprint from Senator Wagner's office.

Senator DONNELL. I want to ask you just one or two further questions.

Who was it who brought this film strip narration to your office?

Mr. LOUCHHEIM. You mentioned, I believe, the name of Roberts.

Senator DONNELL. You think it was Mr. Roberts?

Mr. LOUCHHEIM. Yes.

Senator DONNELL. That would be the writer of the script, Mr. Samuel Roberts, is that right? Or do you know?

Mr. LOUCHHEIM. I believe it was Mr. Roberts who came in.

Senator DONNELL. Was anyone with him?

Mr. LOUCHHEIM. No, sir. Just Mr. Roberts alone.

Senator DONNELL. How long did you gentlemen have this film strip narration in your possession?

Mr. LOUCHHEIM. We never had it in our possession. We looked it over and made certain suggestions and they took it back with them.

Senator DONNELL. You had just one conference with Mr. Roberts, is that right?

Mr. LOUCHHEIM. Just one conference with him, and then I believe he came back and showed us the strip itself.

Senator DONNELL. Do you remember what changes and suggestions both you gentlemen, or either of you, made to Mr. Roberts for incorporation in the film strip narration? Do you recall?

Mr. LOUCHHEIM. I don't know if he followed them out. I know there was this one section in which he dealt with the earnings of the physicians. He gave the earnings on a weekly basis, which I thought was very unclear. I don't know whether he still kept it that way.

Senator DONNELL. Did you give him the name "National Health Insurance Act"?

Mr. LOUCHHEIM. No.

Senator DONNELL. Do you know whether that name appeared in the film strip narration when it reached your attention?

Mr. LOUCHHEIM. I am pretty certain that it did not, and it was for that reason that I said there would be a new bill.

Senator DONNELL. I call to your attention this yellow paper which I handed you a few minutes ago, the concluding paragraph of which I read:

The National Health Insurance and Public Health Act, 1947.

The Wagner-Murray-Dingell bill, with the above title and in slightly revised form, was reintroduced into the Eightieth Congress. It is a blueprint of a comprehensive national health program and when adopted will become an extension of our American social security system.

Did you furnish this—which I will mark at this time as exhibit X for identification—did you prepare that document and give it to the same person, Mr. Roberts, to whom you referred?

Mr. LOUCHHEIM. We prepared that document at a later date from the time he came in and showed us the script. And we sent it to him. I did not hand it to him.

Senator DONNELL. You sent him this document, which I have marked as exhibit X?

Mr. LOUCHHEIM. We sent him material in this.
Senator DONNELL. I offer exhibit X in the record.
(The document referred to follows:)

BRIEF HISTORY OF HEALTH INSURANCE IN UNITED STATES

BEGAN IN 1798

Health insurance has a long history in the United States. It began with compulsory health insurance in 1798, established by Congress for the medical care of merchant seamen. Later this developed into the Marine Hospital Service (now under the United States Public Health Service), whereby seamen get medical and hospital care at national expense.

INDUSTRY AND FRATERNAL SOCIETIES

Some industries and fraternal societies started health-insurance plans for their employees and members a half century or more ago. Some of these plans are in existence today.

FIRST WORLD WAR

Just about the time of the First World War, compulsory health insurance was proposed in the legislatures of several States, and a bill passed one branch of the New York State Legislature. The American Association for Labor Legislation drafted this and other bills for State action.

VOLUNTARY PLANS GROW

During the twenties there was slow but continual extension of voluntary health-insurance plans of different kinds, and during the depression of the thirties a much more rapid growth. Unmet medical needs were ascertained and publicized by studies of the Committee on the Costs of Medical Care, the United States Public Health Service, the Departments of Agriculture and Labor and other bodies.

HEALTH CONFERENCE CALLED BY PRESIDENT ROOSEVELT

In 1938, President Roosevelt appointed an interdepartmental committee to hold a national health conference. This conference led to the formulation of a national-health program, the main points of which were incorporated in subsequent legislative proposals and in Truman's special health message of November 10, 1945. The extension of public-health services, of hospital facilities, maternal and child care, more and better care for needy persons, and nationwide health insurance were all part of this program.

SENATOR WAGNER INTRODUCES BILL, 1939

Much of this program was incorporated in a bill introduced by Senator Robert F. Wagner (Democrat, New York), into Congress in 1939. There were extensive hearings on this bill before the Senate Education and Labor Committee, but no action resulted. The growth of voluntary health insurance plans, however, continued at an increasing rate and popular interest in health insurance was accelerated thereby.

ORGANIZED MEDICINE MOVES

The American Medical Association, which had opposed even voluntary health insurance, was brought to accept it (when under medical society control) and one after another of its State medical societies began to establish health-insurance plans, offering limited services but committing them to the health insurance principle nevertheless.

LABOR SUPPORT

In 1939 for the first time, all branches of organized labor united in supporting national health insurance, thus giving Senator Wagner's bill of that year important political status.

FIRST WAGNER-MURRAY-DINGELL BILL

In 1934, Senators Wagner, Murray, and Congressman Dingell introduced the first Wagner-Murray-Dingell bill, a comprehensive revision of the Social Security Act, including a broad national-health program, with national health insurance as its central feature. The other parts of the national-health program met no important opposition and Congress voted, and has continued to vote, additional grants for the extension of public health services and of maternal and child care. Congress also adopted in 1946 the Hospital Survey and Construction Act, carrying out that part of the program which related to the extension of hospitals and the establishment of new hospitals where needed, especially in rural areas.

SECOND WAGNER-MURRAY-DINGELL BILL

In 1945, the Wagner-Murray-Dingell bill was reintroduced into the Seventy-ninth Congress, with some changes. A little later the health provisions were separated from the general revision of the Social Security Act and introduced as a separate measure, the Wagner-Murray-Dingell National Health Act, S. 1606. Extensive hearings on this bill were held in 1946 before the Senate Education and Labor Committee.

TAFT HEALTH BILL

Shortly after the Eightieth Congress convened in 1947, Senator Robert A. Taft, Republican, Ohio, in association with Senators Smith, Ball, and Donnell, introduced a bill which he termed a substitute proposal for national health insurance as a solution to our Nation's health problem. This bill provides Federal grants-in-aid to States for charity medical care for the needy.

THE NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH ACT, 1947

The Wagner-Murray-Dingell bill, with the above title and in slightly revised form, was reintroduced into the Eightieth Congress. It is a blueprint of a comprehensive national health program and when adopted will become an extension of our American social-security system.

(Prepared by the Committee for the Nation's Health.)

Senator DONNELL. I don't mean this specific paper, but the material contained in this exhibit X you sent to Mr. Roberts later on, you remember that?

Mr. LOUCHHEIM. Yes.

Senator DONNELL. Did Mr. Roberts tell you what he was going to do with this exhibit X?

Mr. LOUCHHEIM. He said he was going to distribute it along with the film strip as background material for educational purposes.

Senator DONNELL. Did he tell you he was going to advertise the film strip narration extensively?

Mr. LOUCHHEIM. I knew he was going to sell it for two-dollars-and-sixty-odd cents, so I assumed that he would try to sell it and distribute it as much as possible.

Senator DONNELL. Did he tell you how extensively he was going to advertise it?

Mr. LOUCHHEIM. No; he did not. He did say that he wished it to be used in small groups and colleges, and so on. Our only interest in the matter was in giving him material, and we do give material to all organizations and all people coming in and asking for material.

Senator DONNELL. Did you see this article in the Daily Worker of June 2, telling about this film strip narration?

Mr. LOUCHHEIM. I have seen no article in the Daily Worker at any time.

Senator DONNELL. I want to show you also, Mr. Davis and Mr. Louchheim, another document entitled "Federal Security Agency,

Washington 25, D. C., June 1, 1946," which is a fact sheet summarizing data from the United States Public Health Service and the Social Security Board of the Federal Security Agency, which provides a background for consideration of the Nation's health needs and of the national health program proposed by the President. It states that the text may be reproduced or additional copies may be secured in limited quantities from the Director of Information, Federal Security Agency, entitled "The Health of the Nation."

I will ask you gentlemen to tell me whether or not either of you has seen that document, or one of like content.

Mr. LOUCHHEIM. Yes, sir. I have seen that document.

Senator DONNELL. Where did you see it, and who prepared it? Do you know?

Mr. LOUCHHEIM. I don't know who prepared it, but I have seen it.

Senator DONNELL. Where did you see it?

Mr. LOUCHHEIM. In my office.

Senator DONNELL. Who brought it to you? How did it get there?

Mr. LOUCHHEIM. It was part of our library. It is dated, I see, June 1, 1946, as you stated. It was some material that was in the office when I got there.

Senator DONNELL. Was that paper or were copies of that paper disseminated by your office in any way?

Mr. LOUCHHEIM. It may well have been, sir. We distribute documents because distributing documents saves us writing documents.

Senator DONNELL. Do you know whether or not Mr. Falk had anything to do with the preparation of this particular document, dated June 1, 1946?

Mr. LOUCHHEIM. I do not know, sir.

Dr. DAVIS. May I just add at that point, Senator, that as far as the distribution of documents is concerned, we make an effort to accumulate in our office pamphlets, reports, documents, and information of any kind, and if it seems to us that the information is useful we will keep it or endeavor to get a small stock to distribute to organizations on request or to be able to refer inquiries that come in from organizations for information to the sources of such information.

Senator DONNELL. May I put into the record in connection with this article in the Daily Worker, a Communist publication, the following taken from a booklet entitled "Program of the Communists' International," issued by Workers Library, Publishers, New York, 1936. The following excerpt appears at page 43 under the general subject, "The Dictatorship of the Proletariat":

Social insurance in all forms, sickness, old age, accident, at State expense and at the expense of the owners of private enterprises where they still exist, insurance of affairs to be managed by the assured themselves.

Do you advocate that the insurance of affairs be managed as far as possible by the insured themselves?

Mr. LOUCHHEIM. I respectfully request that this last document not be put in the record during our hearing, since we have nothing to do with it.

Senator DONNELL. I offer it at this time, Mr. Chairman, in the record of this hearing.

Senator SMITH. The Senator has a right to ask that it be incorporated in the record of this hearing.

Dr. DAVIS. I should like to state this very frankly. I do not wish to be discourteous, but I believe I am entitled to express an opinion on this. This seems to me like an effort to include the Committee for the Nation's Health activities in Communist activities. It seems to me that that is entirely irrelevant as well as being untrue. The program which the Committee for the Nation's Health is advocating is essentially the program which has been recommended twice to Congress by the President of the United States. It has also been advocated by a large number of other organizations.

The Committee for the Nation's Health happens to be an organization especially formed to promote or spearhead this. It seems to me not to be a satisfactory example of American procedure to infer that its advocacy of such a program is linked with a subversive un-American organization such as the Communist party. I should like to have that in the record as a statement of opinion.

Senator DONNELL. Did you make any inquiry of Mr. Roberts when he brought you this narration for film strip as to his identity?

Mr. LOUCHHEIM. I did not in his case, nor in the case of hundreds of others who come to us requesting information. Hundreds of individuals have come to our office asking for information.

Senator DONNELL. Did he tell you where his place of business was?

Mr. LOUCHHEIM. I don't believe he did, sir, although he must have given me an address to send the material to him at a later date.

Senator DONNELL. And you did send the material to that address?

Mr. LOUCHHEIM. I did, sir.

Senator DONNELL. Now, Mr. Davis, in the course of your discussion of the bill you referred quite extensively to the Tom Jones illustration. I will not go into great detail on that. It is getting very late, and it is largely argumentative matter. But may I ask you this: I think you made some reference—at least there was some reference in my mind, perhaps you did not mention it—to the freedom of choice of physicians. Did you refer to that?

Dr. DAVIS. I did mention it. I think we all take it for granted as being a necessary and desirable thing.

Senator DONNELL. You regard it as necessary and desirable?

Dr. DAVIS. Yes.

Senator DONNELL. You are familiar with the fact that S. 1320 permits physicians in various localities of the country to determine whether or not the method of payment shall be by fees for services or on a per capita basis, is that not correct?

Dr. DAVIS. Yes, sir.

Senator DONNELL. On page 20 of the bill reference is made to the practitioner's list. You are familiar with that provision, are you not?

Dr. DAVIS. Yes.

Senator DONNELL. Let me ask you this: Suppose that in the place where Tom Jones lives there are three doctors, and that those three doctors have elected to avail themselves of the panel plan provided under this bill. Suppose to Dr. Jones there were allotted 500 persons—he has 500 names on his panel. Dr. Smith likewise has 500 names on his panel, and Dr. Williams also has 500 names on his panel. Suppose that Dr. Jones was generally considered the best doctor in the community, and as a result his panel of 500, when the opportunity was offered, was promptly filled, and 500 people came and asked for permission to go on that panel, and were granted it.

Suppose soon thereafter Tom Jones comes to Dr. Jones and asks that he be included in his panel. Is there, in your opinion, anything in this bill that would permit Tom Jones to select Dr. Jones for the purpose indicated, the panel having been filled?

Dr. DAVIS. Senator, the point of this inquiry is whether or not under the provisions of this bill—under that provision of this bill which permits a limit to be set as to the size of the panel—we are not restricting the freedom of choice, is that the point of the inquiry?

Senator DONNELL. I wanted to get the specific illustration answered there.

If you have a panel of 500 names, and then another man comes after the five hundredth name on the panel has been filled, does the man who arrives No. 501 have a right to be on that panel?

Dr. DAVIS. On the assumption you have stated, no; but, Senator, it is necessary for me to point out two things. One, the statement as you have phrased it seems to imply that somebody has authority to say how many patients Dr. Brown may have on his panel, and some other doctor, Dr. Thompson, might have a different number. There is no such provision in the bill.

The bill provides for limitations to be set on the number of patients which a doctor may have on his panel, and it permits that maximum number to be varied according to local conditions and the various requirements which you gentlemen will recall. In other words, it sets up a maximum number, and the purpose of setting up that maximum number is to protect the quality of service. That number must be, from its nature, Senator, a maximum number, because if it is set too low then clearly a large number of people—for instance, the 500-limit is a purely academic limit, subject to conditions in the different communities.

Senator DONNELL. What would you suggest as a more appropriate figure?

Dr. DAVIS. It would vary with the locality, but it would be unlikely that any organization, even a local group of doctors, would set up a limit for a doctor lower than 500. That would be very unlikely. The limitation I am talking about applies almost exclusively to general practitioners. In connection with the limitation on the number of patients for general practitioners, we would have something like—I doubt if any area would set up a number as low as a thousand.

Senator DONNELL. Let's put it at 500, if you think that is more appropriate.

Dr. DAVIS. Yes.

Senator DONNELL. Now would you answer the question as applied to that? Unfortunately I started to refer to Dr. Jones in connection with your Tom Jones illustration. I will call him Dr. Smith. Dr. Smith's panel is 500, let's say. Sometime after that panel is filled, you, Tom Jones, and I come up some day and say, "Dr. Smith, we would like to go on your panel." He looks at his panel and says, "I'm sorry. It is filled. Under this provision of the statute at page 24 the maximum limit has been fixed, and that's all I can take."

You, and Tom Jones and I could not get the services of Dr. Smith, could we?

Dr. DAVIS. No. But if I were Tom Jones and I was a little resentful about it, and if he had the time to make an explanation to me, or if I went in and explained it to the administrative office of the local com-

mittee, they would explain to me that a limit had been set for my protection, so that the quality of medical service would not be impaired, and if that were properly explained to me I would be glad that I was not forced upon a doctor who already had as many patients as he could properly care for—I would be glad that there was such a limit set, and I would say, "Well, I guess I'm in hard luck then. I'll have to pick another doctor." That's all.

Senator DONNELL. The point I am getting at is that there is not an entire freedom of choice of physicians by the patients under this bill.

Dr. DAVIS. I regard the limitation of choice under this particular section to be, in the first place, a limitation in the interest of both doctor and patient, and if you had no such provision in the law you would find in many areas that the local practitioners would do everything possible to get some kind of ruling that would enable them to set restrictions.

I say that for this reason: As I told you, I have been through this experience in connection with international health insurance, and I have also observed the work of public-health centers providing medical service to large numbers of indigent persons.

At one time in Chicago during the thirties I was on the advisory group. We had 400,000 people receiving care. And, Senator, what I am getting at is that the doctors themselves wanted the welfare department, and finally got the public welfare department, to set limits in order to protect themselves from the pressure that was put upon them by doctors who happened to be so popular, or because they were guaranteed a fee from the welfare department, which is exceptional, but you have to protect yourself from a few.

They wanted a limit set and limits were set, because the doctors insisted on it. So the county medical society advisory group under the public welfare department put it into effect, and I am saying that if you did not have this in the law you would find the administrative authorities under tremendous pressure to set up a limit for the protective of everybody concerned, and the limitation of free choice there is less of a limitation than we have today imposed by the economic limitation of most patients at the present time.

Senator DONNELL. I will not take up much more of your time. I would like to question you, if we had time, in connection with these panels being made up at a given time, and you and I might get on Dr. Jones' list at that time and then 2 years after we might have a disease which we would like to have Dr. Williams treat instead of Dr. Jones, and Dr. Williams in the meantime might have his panel filled. We could discuss that at length, but I don't do that because of the lateness of the hour.

But I do want to ask you this: You do not anticipate that the fee-for-services plan would be used exclusively in this country if S. 1320 went into effect?

Dr. DAVIS. I would anticipate as far as general practitioners would be concerned, because there is a marked distinction there—I think that a great many doctors, especially in middle-sized and small communities, as soon as they appreciated the advantages of the per capita system, would elect that system by a large majority.

Senator DONNELL. You would like to see the capitation system go into effect?

Dr. DAVIS. By the election of the doctors. Under the law it would be their choice.

Senator DONNELL. And would it not in your judgment be the greater part of the country that would go under the capitation system?

Dr. DAVIS. Yes; gradually, as doctors come to appreciate the value of it.

Senator DONNELL. And you agree with this observation of Dr. Ernst P. Boas:

Insurance guaranteeing complete medical coverage cannot be set up except at a prohibitive cost if the fee-for-service principle is maintained.

Do you agree with that?

Dr. DAVIS. I would not agree with that. I have seen it operated. It can be operated provided physicians are willing to accept sufficient types of administrative controls, and there are examples where it can be done. The chief difficulty that the physicians find is that you have to really force all the physicians to do a certain amount of extra paper work in order to control the abuse which perhaps 5 percent, certainly not more than 10 percent, will be guilty of. And they don't want to accept it, and it isn't a good scheme to make them do it, so the general tendency will be away from the fee-for-service plan.

Senator DONNELL. And in favor of the other?

Dr. DAVIS. I would only say this, Senator. The problem of administering the preventing of abuses under the fee-for-service system will be much less under a system in which the insured persons have a substantial voice and are represented on the managing committee, and so on, than under a system run as most of our medical costs are now run. There would be substantially much less difficulty in administering the fee-for-service system in that way that when it is wholly in the hands of physicians.

Senator DONNELL. What I want to close with is that you agree, in your judgment, that a per capita plan which would involve practitioners' lists, such as I have described, would doubtless increasingly cover the country if S. 1320 were adopted, is that true?

Dr. DAVIS. Yes. I would answer "Yes," but I would also say, as far as emphasis on lists is concerned, that there is not much difference there. Whether the doctor is paid on a fee basis or on any other basis, he will have a regular clientele the same as now. You will always have a few drifters—some people are built that way. That is something that most doctors do not like. But there will be very little difference. It will be a formal list on a per capita basis, but I think most doctors, as soon as they realize the advantages of the per capita system, would be in favor of it.

Senator DONNELL. That is all.

Senator SMITH. Thank you, Mr. Davis.

(Dr. Davis submitted the following brief:)

TESTIMONY CONCERNING S. 1320 AND S. 545 BY MICHAEL M. DAVIS, PH. D., CHAIRMAN, EXECUTIVE COMMITTEE, COMMITTEE FOR THE NATION'S HEALTH, BEFORE THE SUBCOMMITTEE ON HEALTH OF THE SENATE LABOR AND PUBLIC WELFARE COMMITTEE

Mr. Chairman, may I identify myself, for the record, as Michael M. Davis. I am a native of New York; received a bachelor's and a doctor of philosophy degree from Columbia University; and have been concerned throughout my professional life with the administration of hospital, clinic, and other health services, and

as a consultant concerning their economic and public relations. I appear today as chairman of the executive committee of the Committee for the Nation's Health.

Mr. Louchheim has already made clear that this committee favors the National Health Insurance and Public Health Act, S. 1320. I will discuss some of the changes which appear in S. 1320 as compared with S. 1606, the bill on which extensive Senate hearings were held last year. I will deal with some objections which have been raised to S. 1320 and will contrast it with the Taft-Smith-Ball-Donnell bill, S. 545.

Too often both friends and critics of the National Health Insurance and Public Health Act talk about the provisions of the bill from the top down. It's much easier to understand them from the ground up.

HOW HEALTH INSURANCE WOULD WORK

How would the bill work for Mr. Thomas Jones, a textile mill worker who lives with his family in the town of Roanoke Rapids, N. C.? Tom Jones comes home from work one day feeling flushed and achy. He coughs a good deal of the night and the next morning his wife thinks he ought to have a doctor. The health insurance law is in operation. Tom Jones earns \$36 a week. He pays 54 cents a week, 1½ percent of his earnings, into the national health insurance fund. His employer pays an equal amount.

Now that Tom Jones is sick, how does he get a doctor? Does he have to write to Washington or ask a local official? No. Tom Jones calls the doctor he had had before the law went into effect. Dr. Brown comes to see him, just as he would have come before the law was passed, but with two important differences. In the first place, Tom Jones won't get any bill from Dr. Brown. In the second place, Dr. Brown can prescribe what Tom needs and not just what Tom can afford—laboratory tests, for instance, or a specialist in Tom's illness proves obscure or takes a bad turn. Dr. Brown will be paid by the health insurance official of the area that covers Roanoke Rapids and Halifax County in which this town is located.

Where does the Federal Government come into all this? Not at all. The National Health Insurance Board would have paid North Carolina its quota from the national health insurance fund. North Carolina would have allotted the Halifax County health-service area its quota.

Suppose Dr. Brown thought Tom Jones had pneumonia, that he had a poor heart and might be in danger. Tom Jones or his wife, if they were anxious, or Dr. Brown, if he thought it necessary, could call in a specialist, Dr. George Johnson, the one internist within reach. Either of these doctors might decide to ship Tom at once to the Roanoke Rapids Hospital where he could get better care than Mrs. Jones could give him at home. The local health insurance fund would pay this hospital the costs of its services to Tom Jones.

In all this, neither Tom Jones, nor Dr. Brown, nor Dr. Johnson, nor the Roanoke Rapids Hospital would have anything to do with any official or board outside of Halifax County.

Suppose Mr. Jones was dissatisfied, and complained that Dr. Brown had delayed 24 hours making his first call and then was hasty and disagreeable. A local officer or committee would reach some decision about this complaint. Hearings and appeals could be had if demanded. Suppose the trouble were between Dr. Brown and Dr. Johnson, the specialist believing that Dr. Brown had made an unpardonably bad diagnosis when he finally did get around to calling on the patient. This being strictly a medical dispute, it would be dealt with by a committee composed wholly of physicians.

Where would the Federal Government come into all this? Not at all.

How and how much would Dr. Brown and Dr. Johnson be paid? Dr. Brown, being a general practitioner, would be paid by the method which the majority of these practitioners in Halifax County voted for. If, however, Dr. Brown or one or two of his colleagues wanted to be paid differently, for example, a salary on whole or part time instead of by fees, these doctors would have the right to negotiate this method of payment with the Halifax County health insurance agency.

How would the fee or salary rates be determined? The State health-insurance agency would have worked out a fee schedule with the State medical society. This schedule, however, would be flexible enough to be adapted by local health-service areas to their particular conditions. There would be no uniform national schedule of fees, of capitation rates, or of salaries for doctors.

HOW WOULD SPECIALISTS BE FOUND?

How would Dr. Johnson be paid as a specialist? Who would decide whether or not Dr. Johnson was entitled to be paid the higher rates due to specialists?

Here there would be standards for the qualifications of specialists laid down by the National Health Insurance Board after consultation with its advisory council. These standards would recognize the already existing standards of our national boards of physicians in each specialty. The national standards would be flexible enough, however, so that if Dr. Johnson had been recognized as a specialist for years by the medical profession and the public of Roanoke Rapids and vicinity, he could be paid as a specialist. The North Carolina health-insurance agency would, with the advice of a professional committee, have the say about this. The North Carolina health-insurance agency would also have to make sure that the Roanoke Rapids Hospital complied with national hospital standards and with State licensing laws before the hospital could be paid out of the health insurance fund. The same State agency would have to see that Dr. Brown and Dr. Johnson were licensed under the State law to practice medicine.

In all this, neither the Federal Health Insurance Board or the Federal Security Administrator would have any more right to dictate the running of Tom Jones' case or the selection of payment of his doctors than the Secretary of the Treasury has to say about how New York City sells its bonds.

I talk about Tom Jones and Dr. Brown because it is from them and for them that health insurance will operate. S. 1320 is better than last year's bill because it spells out much more fully the responsibilities of the States and of local areas. Let me now review a series of provisions which S. 1320 makes to insure State and local responsibility.

STATE AND LOCAL ADMINISTRATION

First in logical order is the requirement that the money of the national health insurance fund, though collected nationally, is to be allocated among the States according to formulas written into the law. The State authorities, in planning how to provide the services called for under the act would know in advance the amount of money they would have available. Their budget would not be given at the arbitrary discretion of a Federal authority.

Next are the requirements that the States shall make surveys of their medical and hospital needs, shall prepare a State plan of action, and after dividing the State into local areas appropriate for the administration of the medical and hospital services, shall allocate their State fund among these areas according to a formula. Thus the local administrative authorities are in turn assured a definable budget with which they can operate.

The next point is the authority given to the State to establish a responsible State agency for the administration of the law. The State has full discretion in determining such agency. By contrast, S. 545 violates the principle of States' rights because it compels the States to designate a particular agency. The one selected is the one most likely to be under medical society control.

In S. 1320, the State is required, as in other Federal-State programs, to meet certain general national standards in making and administering its plans. Among these requirements is the designation of a State advisory committee, which must include both popular and professional representations, with the non-professional representatives in a majority.

Next and of major importance comes the local administrative area. The local area can have one or another form of administrative authority, as may be determined by the State. In any case the local body is given specific powers to arrange for the actual furnishing of the medical and hospital benefits to the people of the area. This means making the arrangements with the physicians and hospitals of the area, informing the people of the services available and of the physicians and hospitals available to render them, paying the physicians and hospitals (except insofar as the State may decide to pay directly), and adjust complaints. These responsibilities, specified in S. 1320, are those of an effective local administrative authority. The local officials and committees are to be selected so as to be familiar with conditions within the area. The local authority has no responsibility to any outside authority beyond its own State.

It has been declared by some opponents of this bill that under it the Federal Government could and would run the whole show, that the duties written

out for State and local administration are just a smoke screen to hide a grab for power by a Federal bureaucracy. This charge is nonsense. In the first place, the six Senators and two Representatives who have introduced this bill into Congress were not born yesterday. They are certainly familiar with the universal objection that would arise from the American people if so personal a matter as medical care were attempted to be run by directives at long range. As practical men, they and every other sensible person know that it would be wholly impossible to run medical services at long range, or to have any uniform administrative pattern defined by national authorities for all parts of this great and varied country.

MAINTAINING STANDARDS

In the second place, the bill nowhere gives the Federal authorities power over State and local administration. It does give Federal authorities the power to make and enforce certain standards. Some of the standards are stated in the law itself; some would be defined in regulations. From their nature, national standards must be in general terms. They must be adapted to differing local and State conditions, by State and local authorities. Having the power to require that hospitals' and physicians' services in every State shall meet certain general standards before these agencies and individuals may receive Federal funds is an entirely different matter from having power to control State and local administration.

As an illustration, take the emergency maternity and infant-care program administered during the war with Federal funds by the Children's Bureau for the wives and infants of servicemen. As you all know, many millions of dollars were spent in this program. The Children's Bureau was empowered to require and did require that Federal funds should be paid only to physicians possessing qualifications for the services which they would be called upon to perform. The Children's Bureau required that the hospitals in which the wives and children of servicemen were cared for must comply with certain standards. Of course, the Children's Bureau utilized, as S. 1320 calls upon the Federal authorities to utilize, the standards in such matters laid down by the appropriate and already existing professional bodies. Did the Children's Bureau take part in or interfere with the administration of the hospitals in which these women and babies were cared for? Did it attempt to direct the doctors diagnosing and treating them? Of course not. What would have happened to the Children's Bureau if it had tried to do this?

Again, the Veterans' Administration is now paying out Federal funds to hospitals and physicians on an immense scale in its home-town-care plan for veterans. The hospitals and the physicians must meet appropriate standards before they can be paid for the care of these veterans. But the Veterans' Administration does not direct the local doctors or interfere in the administration of the local hospitals which it utilizes in this program.

I use the illustrations to bring out the vital difference between defining general standards and administering services. Under S. 1320, the Federal Government would have something to say about standards, but it would not administer the services or pay the doctors and hospitals that provide them.

Should the Federal Government have anything to say about standards? The sponsors of S. 545 say "No." This view, however, is not shared by the two expert professional bodies which have testified before this committee, the American Public Health Association and the American Public Welfare Association. These bodies are composed largely of experienced administrators who moreover view these matters more from the State and local than from the national level. They regard the lack of Federal standards as a major deficiency in S. 545. One of them called it "unprecedented" in Federal-State programs.

The Senators will also recall that that distinguished body, the New York Academy of Medicine, declared forcibly in its testimony before this committee that absence of any Federal standards in S. 545 is a serious defect. Federal funds for which the Federal Government is responsible are to be paid to States and localities to support medical services to the people. Health programs using Federal funds should include certain standards with which States and localities must comply before they can get these funds. The New York Academy of Medicine states: "Without minimal Federal standards and the right of the Administrator and the Director to inspect and determine whether such standards have been met by the States receiving Federal grants-in-aid, the bill could result in lowering the level of medical practice."

Actual experience with legislation including national standards has demonstrated that such provisions do not mean Federal dictatorship as some opponents of S. 1320 declare, but on the contrary are consistent with harmonious Federal-State relationships.

PUBLIC CONTROL

The charge is also made that S. 1320 would bring one-man control. A board of five members is set up in S. 1320 to administer health insurance on the Federal level. This Board is made part of the Federal Security Agency and therefore comes under the general supervision of the head of that agency. S. 1320, however, gives to this Board a series of specified powers. The Federal Security Administrator has the same authority over the Board that any Cabinet officer has over any one of his under secretaries or bureaus. Unless the Health Insurance Board was set up as an independent agency responsible directly to the President, thereby divorcing health services from the closely related welfare and educational funds, an officer of Cabinet rank must intervene between the Board and the President.

As you all know, this issue was recently thrashed out by the Senate Committee on Expenditures in the Executive Departments. You are all familiar with the result. The report of the committee recommends in favor of a department to be under a Cabinet officer and to include the functions of health, education, and welfare. Senator Taft agreed to this principle. A Cabinet officer representing the general public would thus have final authority of the same order as is involved in the present wording of S. 1320.

For over a century the United States Public Health Service, or its predecessor under another title, has been responsible for a variety of duties, beginning with running hospitals in different parts of the country, to serve merchant seamen and others. Until recently the Public Health Service was part of the Treasury Department and the Surgeon General was under the direction of the Secretary of the Treasury. Did the Secretary of the Treasury, within the memory of living men, interfere with the professional work of the Public Health Service or with the management of its hospitals? A few years ago the Public Health Service was placed within the Federal Security Agency, and therefore under the Federal Security Administrator. Since then has the Public Health Service been distressed by interference and dictation by the Federal Security Administrator in the performance of its many different functions of research, hospital care, and grants-in-aid?

My opinion is that the powers given to the Federal Security Administrator in S. 1320 are simply those powers which have been and which ought to be vested in officers of Cabinet rank, as representing the President and the interests of the American people as a whole. Such broad oversight by an officer representing the general public interest is needed in order to insure that general policies laid down by Congress and approved by the President are carried out by the specialists who must administer them. The entire development of a great variety of Federal services and of grants-in-aid has actually proceeded under these principles.

Of course, those who attribute to Federal officials the power lusts of Mussolini and the scheming ability of Dr. Morris Fishbein will take no stock in any of this. I have not forgotten that a "blueprint for the nationalization of medicine" had been declared to exist, that a few minor Government officers and a handful of their nongovernmental cronies have been charged with planning to sovietize medicine as a prelude to collectivizing the United States. These people, we are told, are so clever as not only to draft a piece of diabolical legislation, to wit, the national health insurance bill, S. 1320, but also to mislead and ensnare a growing group of really important persons, samples of whom include the executive council of the American Federation of Labor, at least six Senators, several millionaires, and the President of the United States. If there are any sane people who really believe that witchcraft of this kind actually operates today, these people will, of course, talk as if every clause of S. 1320 was subversive in intent and as if every administrator of it would be malevolent. With people who approach this proposed law in that spirit there is no argument. But the common sense of most Americans will deflate these people and the more rapidly as the people give publicity to their own hysteria.

NEED OF "LAY" CONTROL

Opponents of S. 1320 attack it as not only one-man control but as lay control of medicine. The fact is that almost all of our major institutions of medical

services and medical education are under lay control. The American Medical Association was largely responsible for the great reform in medical education during the decade beginning in 1910. An essential part of this reform consisted in transferring the ownership and control of a great many of the medical schools from the hands of the doctors on their medical faculties into the hands of lay boards of trustees. Practically all of our medical schools today are under boards of trustees composed entirely or almost entirely of nonmedical men.

Again, consider our voluntary hospitals, which provide the large majority of the general hospital beds in the United States and are one of the American accomplishments to which physicians, hospital administrators, and civic leaders point with pride. The control of voluntary hospitals is not in the hands of physicians but of laymen, usually lay boards of trustees, city, county, and State hospitals are likewise controlled by lay boards or officials. Not more than 5 percent of the hospital beds in this country are in institutions owned and controlled by physicians, and the number of hospitals of this type is diminishing year by year.

I might quote here, for the record, a statement of general principles of hospital organizations, adopted by the trustees of the American Hospital Association over 20 years ago and still not only valid in principle, but actually observed in the great majority of our hospitals.

GENERAL PRINCIPLES OF HOSPITAL ORGANIZATIONS

As stated by the trustees of the American Hospital Association, 1924. Reference: Proceedings of the American Hospital Association (1924), page 467:

1. *Unified governing authority.*—The hospital should have a single governing authority, a board of trustees, with complete power over the management of all branches of the institution.

2. *Composition of board.*—(a) The board of trustees should be composed of public-spirited persons, representing varied community interests. (b) Members of the professional staff of the hospital should not be members of the board.

3. *Unified medical responsibility.*—There should be a medical staff which should have the entire responsibility for the professional care of patients.

4. *Unified administrative authority.*—All administrative authority over all departments of the hospital should be vested by the governing board in one executive officer.

5. *Medical staff.*—The appointment of the medical staff should be vested in the board of trustees.

6. *Relations of staff and board.*—Representatives of the staff should meet with the board or representatives from the board at regular intervals.

Does lay control of a medical organization mean interference by laymen in medical matters? Not at all. If it did mean that, American hospitals would be battlegrounds instead of partnerships. The doctor's job is the diagnosis, treatment, and prevention of disease. That is what he is trained for. Lay boards do not tell doctors how or when to operate or prescribe.

In a hospital, a medical school or a voluntary health insurance plan run by its members, the lay board owns the property, manages the finances, appoints the medical staff, and authorizes the policies and the standards of the organization. The appointment of the staff may require selection among medical men. The authorization of policies and standards, including professional standards, always requires the advice and guidance of medical men. This advice and guidance concerning personnel and standards, the lay board gets from its medical staff. But the lay board has responsibility for final decision. In many instances the lay board is the disinterested and welcome arbiter among a group of staff physicians who are in private practice and in financial competition with one another. The standards of our hospitals would not be enforced half so well if the physicians instead of a lay board had the final control. Those who want evidence of this can find plenty of it. Above all is the major fact that it is upon this system of lay control that our American medical institutions have grown great.

This principle justifies the establishment of an administrative board which may include a majority of laymen, as in S. 1320. It justifies the placing of the whole system under a Cabinet officer, who will represent the whole public rather than the interests of a profession. It also justifies two other important requirements of S. 1320: On the one side, that issues, complaints, and other matters wholly concerned with the technical questions of medicine shall be settled wholly by physicians; and on the other side, that advisory and administrative bodies, except those wholly confined to technical questions, shall contain a majority of public representatives.

MONOPOLY AND THE AMA

At the present time, the American Medical Association and its State and county medical societies are insisting upon control of the health-insurance system by physicians. This demand is incorporated in the administrative section of S. 545, written, we are told, as a result of conference with representatives of organized medicine. The same demand appears in the organization of the medical-care insurance plans sponsored by medical societies, and in some 20 States the medical societies have endeavored to enforce this demand by getting a State law which will guarantee them control, if not monopoly.

In view of these demands for control on the part of medical societies, it seemed to the officers of the Committee for the Nation's Health that it would be well to obtain from a member of the legal profession, who had had special experience in such matters, as to the probable effect of S. 545 on the existing monopolistic tendencies in medicine. The chairman of our committee, Dr. Channing Frothingham, therefore requested Judge Thurman Arnold, former Assistant Attorney-General of the United States and now engaged in the practice of law in Washington, for an opinion on this subject. Judge Arnold responded to Dr. Frothingham's inquiry with a letter which has already been placed in the hands of this committee, and which I assume will be inserted into the record as part of this testimony.

I summarize Judge Arnold's conclusion as follows:

"The organized medical profession has not only assumed power over the practice of a profession, licensed by the State, but over the civil rights of American citizens." Judge Arnold refers to the State legislation which organized medicine has secured and which gives the medical societies virtual control over prepayment medical insurance plans, excluding plans operated by nonmedical groups, as 'monopolistic laws' which he deems 'an unwarranted interference with private enterprise and experimentation in new ways of financing medical services.' He is of the opinion that the Taft bill S. 545, if enacted, 'would substantially increase the powers and the monopolistic control of organized medicine.' His reasons for this belief are that the administrative provisions give 'control over the policies for expending the Federal funds appropriated under this bill to officials who would be the creatures of organized medicine and to councils, a majority of whose members would owe their allegiance to organized medicine rather than to the public.' Domination by organized medicine would apply not only at the Federal level but within the States where the State agencies, operating almost wholly independent of any Federal standards, 'would be practically controlled by State and local medical societies.' Under the terms of this bill the State agency, could grant funds to medical society prepayment plans to the exclusion of all other plans operated by nonmedical groups."

I am well aware that the great majority of doctors are sincerely devoted to the service of their patients. They serve sick people with the best that the doctors' own skill and the patients' resources can command. But the physician must live, like any one of the rest of us and he has to be a businessman in his practice as well as a physician. The actual tendency of the medical society plans has been in the direction of reducing the scope of the services which they offer and of increasing—rather than reducing—the cost to subscribers. This outcome is the natural result of the demand of the doctors who control the plan to keep the fees rates up and moving up. Medical care insurance plans controlled by the doctors who work in them suffer from the fatal deficiency that they lack motivation for either the extension of service or financial economy.

RESTRICTED MEDICAL SOCIETY PLANS

The chairman of the board of trustees of the American Medical Association declared in his testimony a few weeks ago, "The people do not demand a comprehensive medical service." He said that the experience of the voluntary health insurance plans demonstrates that the people prefer limited service, chiefly for costly illness.

Is this statement true? Let us look at the facts.

At this hearing the AMA distributed a 24-page pamphlet entitled "Voluntary Prepayment Medical Care Plans." From the title, the charts, and the text one would assume that this pamphlet presented a picture of all the voluntary medical-care plans in the United States. This, however, it does not do. Quite the contrary. The pamphlet presents only those plans which have been sponsored by medical societies. It completely ignores the existence of a much larger number

of plans organized under the auspices of other organizations and successfully maintained, many for a long period of years.

Whereas there are 90 medical society health-insurance plans described in this pamphlet, there are 175, or nearly twice as many, voluntary health-insurance plans under industries, unions, cooperatives, and other auspices. The membership of the medical-society plans is estimated at approximately 5,000,000. The membership of the 175 other plans is about 2,300,000.

Now, most of these 175 plans provide comprehensive medical service, that is, the services of general physicians and specialists in the patient's home and the doctor's office, as well as in the hospital.

Here we have it. The plans organized by medical societies offer only limited services, but the plans which have been organized by the people who pay the bills supply comprehensive care.

Why have not the plans organized by the people grown more rapidly in number and membership?

The chief reason is that the State and county medical societies, with the support of the AMA, have put every possible obstacle in the way of prepayment medical plans except those run by medical societies. The medical societies have made it uncomfortable for doctors who joined such plans. Sometimes they have expelled doctors who joined them. Furthermore, in about 20 States, the medical societies have recently caused laws to be passed which give special advantages to plans organized by medical societies and which, in some States, actually prevent any other plan from being organized.

PLANS RUN BY THE PEOPLE

Study the contrast between the medical-society plans and many of the voluntary health-insurance plans which are sponsored and controlled by the people who pay the bills. Some of these plans have been established for many years in large, well-known industrial establishments. One, for instance, has been operating for a long time in Baton Rouge, La. It covers about 15,000 persons, employees of the local plant of the Standard Oil Co., and the members of their families. The plan was started over 20 years ago with the cooperation of the company, which helped in financing the clinic building. But the plan is maintained entirely by voluntary pay-roll deductions from the workers and is managed by a committee in which both management and employees are represented, with a majority of employees. This situation is typical of a considerable number of well-established industrial health-insurance plans offering comprehensive medical and hospital services, and providing this service through group medical practice.

This method of organization has evolved as a result of experience, because when the people who pay the bills and receive the services for themselves and their families are in control, they have a direct motive toward financial economy. It's their own money that is at stake. They also have a motive to maintain and expand good service. It's the health of themselves, their wives, and children that is at stake. Much is said about the abuse of insurance plans by subscribers, especially if comprehensive services are offered. When the members themselves control the plan, they have a motive to check abuse, because abuses waste their own money. No pressure against malingering and other abuses by subscribers is more effective than pressure upon the the abusers from their fellow members.

BUDGETING MEDICAL COSTS

I wish now to take up some ideas which seem to be excessively popular among the opponents of S. 1320. One of these is the bogey of "socialization." At the beginning of these hearings, the senior sponsor of S. 545 said that people ought to pay for their medical care just as they do for their food, shelter, and clothing and that if we start socializing medical care, we will find that only a step toward socializing the other parts of our economy.

Of course, people should pay for their medical care. Paying for what we need is always better than having things given us. What I point out, however, is that paying for medical care stands on a different basis from paying for food, shelter, clothing or any of the other necessities and comforts in the budget of American families. Sickness costs are unpredictable as to when they will happen and how much they will be. You can plan your expenses for your food, rent, clothing, and every other commodity or service you buy, except one. That one is sickness costs. You cannot budget sickness costs in advance.

* Therefore, there is good reason for putting the payment of sickness costs on a budgetable basis. That means an insurance basis. There is no such reason, in fact it would be absurd to advocate using the insurance principle for Mr. and Mrs. America's food or rent bills. There is, therefore, no justification whatever for suggesting that a widespread insurance system for medical care, either on a voluntary or a compulsory basis, furnishes a precedent for the rest of our economy.

But now comes another statement by Senator Taft. He says that national health insurance isn't insurance at all. He declares that a pay-roll deduction required by law is not an insurance premium but a tax. Of course it is a tax from the legal standpoint. Any payment required of people by law is a tax. Nevertheless these pay-roll deductions, although they are a tax, are also insurance. They are insurance because they enable the people who pay them to protect themselves against an unpredictable risk. An individual alone cannot protect himself against such a risk, but large groups of people can do so. Spreading a risk among a large group of people and over a period of time is the essential characteristic of insurance, irrespective of the method or auspices through which this principle is applied.

HEALTH INSURANCE ABROAD

Compulsory health insurance is attacked on the ground that it has been "a failure in foreign countries." The usual technique of this attack is to repeat a series of misstatements over and over again, despite the fact that their inaccuracy has been demonstrated over and over again. Time permits only a few examples.

One common misstatement concerns administrative costs. To quote: "In the experience of Europe there would be an employee of the system outside the field of medical service for at least every 100 persons insured." From this statement, simple arithmetic leads to the conclusion that a great deal of the money paid by the people for health insurance would go to fatten Government bureaucrats. A sixth-grader can calculate that there would have to be a million payrollers if 100,000,000 Americans were insured.

The figure of 1 administrative employee per 100 insured persons is a gross untruth. Last year, Dr. Frank Goldman, associate professor of public health in that hive of intellectual rectitude, Yale University, and an internationally recognized authority on this subject, testified that in the well-established European systems the number of administrative employees is about 1 to every 2,000 persons.

Where did the erroneous figure of 1 to every 100 persons come from? It goes back to a report on sickness insurance in Europe, published in 1938 by the late Mr. J. G. Crownhart. He was then secretary of the Wisconsin State Medical Society. The society sent him on a visit abroad. Mr. Crownhart does not explain how he got his figure. His report is of the kind that would be written by a clever public relations man, such as he was. It is not documented, so that the sources of the figures and statements can be checked. From personal conversation with him shortly after his return from that trip, I obtained some idea how he derived this figure; but that is another story.

The absurdity of the figure is apparent after very little consideration. One administrative employee for every 100 persons would mean an administrative cost of about 50 percent for salaries alone. Elsewhere in his report, Mr. Crownhart stated that the highest administrative cost which he found anywhere was 17 percent and that the figure in most of the countries was 10 percent to 12 percent, including not only salaries but other administrative expenses.

Mr. Crownhart's stuffed club has been used countless times to belabor national health insurance. Recently I found his figure, slightly understuffed, in an editorial from which I quote two sentences: "In Germany in 1935, for example, there were 36,000 political employees overseeing the work of 30,000 doctors. It is certainly reasonable to assume that we would have a comparable experience here."

The whole editorial is about 300 words long. It appeared in the Chronicle, of Omak, State of Washington, at about the time President Truman's special health message was sent to Congress last May. I also beg to report that I found the same editorial, identical word for word, appearing during the same week in 21 other newspapers scattered all over the country, and in several additional papers in condensed or slightly altered form. These editorials came through a clipping bureau and, of course, represent only a part of the total publication.

PROPAGANDA AGAINST HEALTH INSURANCE

Those who charge that there is organized propaganda in favor of national health insurance must admit that these identical attacking editorials suggest that somebody has organized propaganda on the other side. Who supports the writer whose brain-child is multiplied thus in the free press of America? I do not know. I do know that the National Physicians Committee states that they have a public relations staff which sends out material to a list of several thousand newspapers and periodicals. So maybe these editorials merely prove that the National Physicians Committee finds a market for some of its canned goods.

Health insurance in foreign countries is charged with a long list of other evils—poor quality of medical care, for instance, and promoting an increase of sickness. Some of these charges are based on phony statistics, or misuse of statistics. Some of them are stories of particular cases which are presented as if they were universal cases. These misstatements and exaggerations are repeated over and over again in the medical journals and in the pamphlets written by their public relations men. These pamphlets are circulated to our newspapers with the authority of organized medicine behind them and of course no refutations made by people who know the subject ever catch up with them.

If there were time, I would give examples, such as two well-intentioned articles by an American newspaper correspondent in New Zealand, published late in 1945 and since then enormously misused.

Last month the *Woman's Home Companion* published an article scare-heading unnecessary operations by American surgeons. This article and the full-page newspaper advertisements about it have been read by millions, but does anyone take it as representing the bulk of American surgery? No; we understand that the article describes certain abuses in our system of surgery which needs remedy. Now suppose the *British Medical Journal* published an editorial damning American surgery as a whole on the basis of this article. That would be what many of our medical journals have done, with less evidence to the British health-insurance system.

The big outstanding fact about health insurance abroad is that health insurance has grown for two generations in countries of all sizes, kinds, and political complexions; that it has extended in the proportion of the population covered and in the scope of services rendered; and that neither the people nor the doctors of these countries would think of abandoning it. The *British Medical Association* opposed the enactment of national health insurance in 1911; but after experiencing its operation for 16 years, representatives of the association testified before a committee of Parliament that national health insurance had improved the medical care of the British people and the condition of the British medical profession. Not 10 American doctors out of a hundred know this, because the medical journals they read have never told them.

In 1943 the *Canadian Medical Association* officially approved the principle of compulsory health insurance, expecting that it would soon be incorporated into national legislation in their country. I did not see one word about this action in any official medical journal in the United States. Just think what would have been published if the Canadian doctors had taken action the opposite way.

Think also what has happened since the war in the western European countries, the democratic countries. All these countries were impoverished by the war and all of them except Britain and Sweden were occupied and more or less looted by the Germans. Yet despite their impoverishment all these countries are extending their health-insurance systems, and the medical professions of these countries are cooperating with the governments in the process. Certainly, these facts are evidence that health insurance has not been a "failure" but, on the contrary, that it has been serviceable to the people's health and to the national economy. In Britain the extended national-health program was put before the country in 1944 by Mr. Winston Churchill's government. Certainly, that is evidence that the program was not the outcome of "radicalism."

Here is a report published last March by the *United States Public Health Service*, describing these recent developments in six of these countries. If the picture had been unfavorable, it would have been gleefully publicized in the medical journals. But it gives an encouraging picture; and so far as I have seen, the medical journals have printed nothing about it at all.

The fact that health insurance has succeeded and is extending in foreign countries is no reason in itself why we should follow their example. But the fact that the American people are now considering various ways of extending health insurance is reason why we should learn what we can from foreign experience and therefore that we should study foreign experience dispassionately and not depend on self-interested organizations and their hired salesmen.

COSTS OF HEALTH INSURANCE

I want now to come back to our own land and to conclude with some remarks about costs. The medical-propaganda machine has tried to throw a lot of scare into people about costs, particularly by talking as if national health insurance payments would be a new tax out of people's pockets. Actually, the majority of Americans are now spending an average of 3 percent of their income annually for the physicians and hospital services which would be available under the bill S. 1320. The health-insurance payments of these people would be a substitute for, not an addition to, these present expenditures.

Let me call attention to two charts which have been clipped from the May 1947 issue of Fortune Magazine. The first chart shows the percentage of family income spent for medical care by American families of different levels. The lower the income, the higher the percentage. The higher the income, the less the percentage spent for medical care. This seems unfair, but unhappily it is true. In actual figures, the families with incomes under \$1,000 a year (20 percent in 1945) spent from 5 to 8 percent of their income for medical care. The big middle-income group (about 70 percent of the population) spent about 4 percent of their income for medical care. The top 10 percent of the people spent only 2 to 3 percent for care.

Now the charges levied under the national health insurance bill would be a percentage of earnings, 3 percent in fact, calculated up to earnings of \$3,600 a year. This 3 percent would be paid in full by self-employed persons or 1½ percent by employed persons, for whom the employer pays the other half. Even the low-income people who paid 3 percent would be better off than they are now, and the middle group would be paying about the same even if they paid the whole 3 percent.

Contrast this situation with the voluntary insurance plans which always charge a flat rate, not varied with income. The charges of the medical-society plans and their affiliated hospitalization plans run from \$50 to \$60 per year per family, and these plans usually cover only care in hospitalized illness, which average only about half the total costs of medical care to a family. A \$1,000-a-year family which joined one of these plans would have to double its average yearly expenses for medical care. A 2,000-a-year family would have to add 50 percent to its medical expenditures if it joined. Half of our population earns less than \$2,000 a year even in this time of full employment.

Instead of these voluntary plans being cheap, they are expensive. They are so expensive in proportion to the incomes and spending habits of many people that their sponsors now want Government subsidy for them. The Taft-Smith-Ball-Donnell bill makes a pass at offering a subsidy. But look at these charts and think about these figures. You will then come to the conclusion that the subsidies would have to mount up to something like \$2,000,000,000 a year before most of the American people would be served; that is, this would be the case if Americans would accept the charity label which this bill would plaster on their faces and if the difficult administrative problems of running such subsidies could be worked out.

In fact, S. 545 is essentially a bill starting a system of State medicine, the cost of which would fall mostly on the income-taxpayers of this country, and therefore especially on the high-income-tax payers. The national health insurance bill, S. 1320, by contrast, would enable the mass of the people to pay according to their ability into the national health fund, and the supplementary amounts required from general taxation would be relatively small.

All voluntary plans are not expensive. There are plans controlled by the people who pay the bills, in cooperation with an organized staff of doctors, which offer comprehensive medical and hospital services at much lower cost. Some of these plans provide complete medical services at a cost of \$20 to \$25 per capita or \$60 to \$80 per family per year. The reason is that they have an efficient form of professional organization (i. e., group practice) and a form of administrative organization which gives incentive to disease prevention and to financial economy.

These plans are precisely the type which organized medicine has most strongly opposed. This type of plan might be wiped out by the medically controlled administrations which S. 545 would set up and by this bill's failure to include any antimonopoly provisions. Certainly further development of this type of plan would be stopped by S. 545. Under S. 1320, on the other hand, existing plans of this type would be protected and new ones could be started by either laymen or physicians, or by a body including both.

May I, in conclusion, summarize the reasons why the Committee for the Nation's Health supports S. 1320 and opposes S. 545.

REASONS FOR SUPPORTING S. 1320

We support the National Health Insurance and Public Health Act for these reasons:

1. It would assure the people of the United States that they can get doctor and hospital services without having to worry about sickness bills. Studies demonstrate that this is what millions need. Opinion polls show that this is what millions want.
2. It would enable people to pay regularly for these services in a self-respecting way, without charity and in proportion to their ability to pay; and, by utilizing the people's existing expenditures for medical care, would minimize new financial burdens upon taxpayers.
3. It would place the Nation's financial strength behind the States in caring for the indigent and in providing expensive special health services and facilities.
4. It would guarantee continued professional freedom and greater economic stability to physicians and hospitals.
5. It would recognize private effort but would prevent control by private interest.
6. It would place a national floor under standards of service and finance but would give responsibility for administration to the States and localities.

REASONS FOR OPPOSING S. 545

We oppose the Taft-Smith-Ball-Donnell bill (S. 545) for the following reasons:

1. It would place the administration of National and State funds in the control of private interests, inviting medical politicians instead of public administrators.
2. It would require large staffs and high administrative costs for the means tests, unless these were laxly applied or their income limits were high, in which case many times the money would be required than is envisaged by the authors of the bill.
3. The Federal administrative organization which it proposes violates sound principles and well-established precedents, at the evident behest of the American Medical Association and its allies.
4. It provides national funds for medical care without any assurance that these funds shall maintain high standards of care.
5. It violates States' rights although it makes a parade of emphasizing them.
6. It might practically destroy the United States Public Health Service and would certainly subordinate it under the control of organized medicine.
7. It would promote monopolistic control of voluntary-insurance plans by medical societies.
8. Its proposed aid to voluntary insurance plans is illusory because of insufficient appropriations.
9. It requires annual examinations of all school children, which competent authorities consider wasteful and unnecessary and which absorb funds that should be used for needed treatment of children.
10. It would start a program of dental care under the obnoxious charity principle, with present and prospective appropriations wholly inadequate to meet dental needs.
11. It would make public relief instead of medical service the basis of a national health program, forcing charity upon the self-supporting.

(Subsequently, Senator Murray addressed the clerk as follows:)

UNITED STATES SENATE,
 COMMITTEE ON LABOR AND PUBLIC WELFARE,
 July 25, 1947.

Mr. PHILIP R. RODGERS,
*Committee Clerk, Senate Committee on Labor and Public Welfare,
 United States Capitol, Washington, D. C.*

DEAR MR. RODGERS: Will you please insert the attached correspondence in the record of the hearings on S. 545 and S. 1320. If possible, it should appear at the end of the transcript for July 11.

Sincerely yours,

JAMES E. MURRAY.

COMMITTEE FOR THE NATION'S HEALTH, INC.,
 Washington 1, D. C., July 18, 1947.

Hon. JAMES E. MURRAY,
United States Senator, Washington 25, D. C.

DEAR SENATOR MURRAY: As you will undoubtedly have noted from the transcript of the hearings held before the Senate Health Subcommittee on July 11, Senator Donnell questioned Dr. Michael M. Davis and myself at length regarding a film strip produced by ERG Productions and distributed by Current History Films. In our testimony, we stated that we had given ERG Productions technical information in the preparation of the strip at their request. Enclosed you will find a copy of the letter received by the committee from ERG Producers, dated February 18, requesting our assistance and our letter of February 21 in reply.

Unfortunately we were not questioned about or given an opportunity to bring out the fact that we have received many hundreds of requests for information and technical assistance from other organizations and individuals.

We have received requests for information from both Congressmen and Senators. For example, on March 10, we received a letter from Carter Manasco, Member of Congress from the Seventh District of Alabama, asking us to send material to one of his constituents.

We have received more than 100 requests from city, county, and State libraries for our material. For example, on March 26, 1947, we received a request from Mr. Charles Compton, Librarian, St. Louis Public Library, St. Louis, Mo. He specifically requested the following material:

What is National Health Insurance?

What the National Health Act Would Mean to Businessmen.

What the National Health Act Would Mean to Farmers.

What the National Health Act Would Mean to Veterans.

We have received more than 40 requests for material from public and private schools throughout the country. For example, we have received requests from the Germantown Academy in Philadelphia and from the Palo Alto Senior High School in Palo Alto, Calif.

We have received more than 60 requests from university libraries for material. For example, on December 3, 1946, we received a letter from Mr. J. Gomley Miller, librarian of the New York State School of Industrial and Labor Relations, Cornell University, of which Senator M. Ives was dean.

We have, in addition, been consulted by feature writers for large magazines and scrip writers for national hook-ups. It is both our purpose and our privilege to disseminate information dealing with the President's five-point national health program.

The Committee for the Nation's Health, as you know, is a nonpartisan organization directed by people who are of the conviction that they can effectively help build a strong America by improving the health of the American people. It resents any attempt to identify this endeavor directly or inferentially with the program of un-American organizations.

We would appreciate having this letter and the enclosed correspondence inserted in the record of the hearings held on S. 545 and S. 1320.

Sincerely yours,

JOSEPH H. LOUCHHEIM, *Executive Director.*

FEBRUARY 21, 1947.

MR. SAMUEL ROBERT,
ERG Productions, New York 3, N. Y.

DEAR MR. ROBERT: Under separate cover I am sending you Senate Committee Print No. 5 entitled "Medical Care Insurance." On page 52 you will find a table giving the distribution of physicians according to net income. You will note from this table that 40.7 percent of the nonsalaried physicians had net incomes of less than \$3,000 during the year 1941.

Appendix B, starting on page 178, contains a detailed comparison of published studies dealing with the income of physicians.

The figures you quoted to me in your letter for the year 1929 are correct. In that year the average net income was \$5,467 for physicians in private practice, however, as you know averages are overweighted by a few very large incomes. I believe, therefore, that it is more accurate to use the median figure instead of the average. The median net income in 1939 was \$3,705. Thus in that year half the doctors had net incomes of less than \$3,705, and half had net incomes of more.

I look forward to the opportunity of reading your script, and wish to assure you that our committee is anxious to be of every possible service to you.

Sincerely yours,

JOSEPH H. LOUGHHEIM, *Executive Director.*

ERG PRODUCTIONS,
New York 3, N. Y., February 18, 1947.

COMMITTEE FOR THE NATION'S HEALTH,
New York 19, N. Y.

GENTLEMEN: We are producing a film strip illustrating the need for prepaid medical insurance. One of the points covered is the income of physicians during prewar years. We were given some data on this but we are not positive on how reliable it is.

This is our information: "Taking a highly prosperous year, 1929, we find the following: The net average income of the American doctor was \$102 a week. Half the doctors earned less than \$75 a week and many had an income of around \$50 weekly."

Could you help us by either confirming the correctness of these figures or giving us more authoritative ones. Please give us the source, also.

When our film is completed, and before we issue it to the public, we would like to have someone in your committee check it for accuracy. Could this be arranged?

Accept our sincerest appreciation for any cooperation you may be able to extend us.

Very truly yours,

SAMUEL ROBERT.

Senator SMITH. The meeting will stand recessed until the 23d of July at 9:30. It is impossible for the committee to meet this coming week.

(Whereupon, at 6:35 p. m., the subcommittee adjourned until 9:30 a. m., Wednesday, July 23, 1947.)

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