sary to continue this work on a global scale. America will be asked to give the equivalent of about $7 for each family so that the Red Cross may render these vital services for a whole year at a cost of about $25 for each man in our armed forces.

It will require a real sacrifice of time and effort in these busy days on the part of many of us to collect these good-will offerings. Surely we will not hesitate to face this task nor to make any sacrifice of time or means required, so that the Red Cross may continue, as the representative of all our people, to render these services of mercy to those who, on our behalf, are bearing the brunt of battle.

The total sum required, considered as a whole, may seem large. But I know of no contribution so useful or satisfying as the one given to the Red Cross, whose work among the armed forces is the greatest of all humanitarian undertakings.

I am sincerely convinced that there is no service in the world today that is comparable to that of the Red Cross in volume, efficiency, and humanitarian importance.

Address by Senator Murray Before Medical Society of County of Monroe, Rochester, N. Y.

EXTENSION OF REMARKS

OF

HON. ROBERT F. WAGNER

OF NEW YORK

IN THE SENATE OF THE UNITED STATES

Tuesday, December 21 (legislative day of Wednesday, December 15), 1943

Mr. WAGNER. Mr. President, I ask unanimous consent to have printed in the Appendix of the CONGRESSIONAL RECORD a very timely address delivered by the distinguished Senator from Montana [Mr. MURRAY], on November 17, 1943, before the Medical Society of the County of Monroe, Rochester, N. Y. It deals with a subject which is vital to our country: the expansion of our present social security program in order to bring about a wider and more equitable distribution of medical care and hospitalization for the American people.

There being no objection, the address was ordered to be printed in the RECORD, as follows:

Gentlemen and members of the Medical Society of the County of Monroe, I appreciate the opportunity of discussing with you tonight the problem of finding some sound method of making medical science and hospitalization more available to the masses of the American people. I think I should first explain how I came to be interested in this question.

Several years ago, I was made chairman of a Senate subcommittee to study the subject of social security, including plans for a system of insurance for medical care and hospitalization. At that time, I conducted extensive hearings on the original Wagner bill, S. 1620, introduced in 1939 and designed to etablish a national health program. A vast amount of testimony was then taken showing a real lack of adequate medical care available to people in the lower income brackets. In some sections of the country, we discovered that there were not enough doctors or hospitals. We found also in the crowded industrial areas of the Nation a serious lack of medical care and hospitalization available, particularly to the people of the lower income brackets. Even among people steadily employed, we found that sudden illness presented serious financial problems, and these conditions had very damaging effects. People avoided consulting doctors with the result that delay resulted in serious complications and much greater expense in the end. We found from those hearings that generally poor people and those in the middle brackets have more sickness than the well to do or wealthy, yet it was clear that they received much less care.

From all those studies, I became quite familiar with health problems and conditions in the country and was impressed with the necessity for legislation of some kind to make medical care more accessible to the masses of our people. Since those hearings were held, demand for legislation to meet the problem of providing a more adequate system of medical care has steadily grown throughout the country. In many sections voluntary health insurance plans and prepayment methods have undertaken to provide ways of meeting this situation, but these group insurance plans and prepayment methods appear to be reaching only an insignificant proportion of the population.

With these undisputed facts before me, I joined with Senator WAGNER recently in presenting Senate bill 1161, providing for an expanded system of general welfare, including a Federal system of medical and hospital benefits.

My contacts and experience with the medical profession in connection with the hearings on the original Wagner bill and the national hospital bill convinced me that we would have the cooperation of the medical profession and the representatives of the several hospital associations of the country in working out sound legislation of the purpose and character designed by this bill. During the time of the hearings, which I have mentioned, I had many contacts with the medical profession, as well as with representatives of the several hospital associations of the country. I found them uniformly constructive and helpful in our studies. At that time, I accepted generally the advice of the medical profession regarding amendments to the bills we had under consideration. The original health bill was supplanted by the national hospital bill and when it was finally reported, it included all of the suggestions and recommendations of the medical profession and representatives of the hospital associations. So, I want it understood here that I have always cooperated with the medical profession in the study of these problems. We all have a high respect for its great contribution to medical science, and if I considered that this proposed legislation now before the Congress would do an injustice or injury to the medical profession or cause any deterioration in the quality of medical service, I certainly would not want to advocate it or suport it. I am convinced, however, from my studies that it will not do anything like that. On the contrary, it will improve the quality of medical service as a whole and is merely a method by which the masses of our people will be protected against the emergencies of sickness and accident and be able to secure the best medical service that can be provided. That is the sole purpose and object of this proposed legislation.

With all this previous experience in mind, I have been greatly surprised to find that a large section of the medical profession is opposed to and extremely critical of the present bill. Of course, I could have avoided this task, but it occurred to me that a real problem existed which called for remedial legislation and I expected the aid of the medical profession in developing a proper program. The bill as presented, S. 1161, was intended as the basis for an honest, fair, and intelligent study of the subject. It was not assumed that it was free from any imperfection. Like all other bills, it was subject to extensive hearings and careful analysis before an appropriate Senate committee. It was my hope that a final bill could be agreed upon that would meet with the approval of the country and be of incalculable benefit to the general public.

It is, of course, essential that the medical profession and organized medical societies should contribute constructive assistance in formulating legislation of this kind. We who have been struggling to find an answer to the problem of making medical care more accessible to the general public reccgnize that it is an exceedingly technical and complicated problem. Health is more vitally important to our economic and social security than any other single element in life. And health of the American people is therefore a fundamental interest of every citizen in the country.

The great majority of the medical profession are men of high character and purpose, men who are anxious to improve on the present status of medical care so vital to the welfare of the country. They appreciate that the practice of medicine in the United States today is totally different from what it was many years ago when we were operating under an agricultural economy. Medical practice in the last half century has been wholly revolutionized. The great, modern advances in medical science have made medical care much more involved and more expensive. Today we are a highly industrialized Nation. This has created conditions of recurring unemployment, poverty, and distress amongst vast numbers of the population. It is obviously difficult for large sections of our people with uncertain earnings to be able to meet the emergencies of sickness and ill health and secure the kind of medical care they should have.

To you physicians in Rochester, an important and prosperous city in one of the wealthiest States of the Union, my statements may seem somewhat exaggerated. Unfortunately most of the communities of the country, especially rural regions and poorer States, do not possess the resources and prosperity which prevail here in Rochester. But even Rochester itself is not without its problems in this matter, as Dr. Smillie's 1940 survey has made clear. His Survey of Public Opinion shows that your voluntary plans in operation here do not reach those most in need of a prepayment service.

This is the very point on which the belief is based that only compulsory medical care insurance will provide adequate care to all the people. The blue cross plan, it is true, has been very successful in Rochester. A large proportion of the people belong to it. Forty-four percent of the people interviewed in the public opinion survey said that they had it. However, while two-thirds of those with incomes from $2,200 to $4,999 had joined, and six-sevenths of those with incomes above $5,000 a year had also joined, membership was reported to be slightly less than half of the families in what Dr. Smillie called the average income group ($1,300 to $2,199). Among families and individuals with incomes from $800 to $1,299, only 20 percent belonged, and among those with incomes below $800, none at all. This was the situation here in Rochester. It is worse, much worse, elsewhere.

What the selective service examinations (see Selective Service System, Causes of Rejection and Incidence of Defects, Medical Statistics Bulletin No. 2, p. 1) exposed about the health of our boys was shocking indeed. Surely we cannot be complacent when over half—52.8 percent—of the first 3,000,000

young men examined by selective service were not considered truly fit, and many had serious defects which, with proper care, could have been prevented or relieved. Of course, some of it was carelessness. They just didn't bother to secure treatment, but much of it was certainly due to the fact that they and their families just did not have the money.

The national health bill of 1939, which started my active interest in national health planning, was laid aside after the outbreak of the World War. Since 1939, the Congress has done nothing toward the solution of this problem. Certain groups in the population are prospering today, it is true, and doctors are sharing in their prosperity. But, when the war ends, there will be suddenly reduced incomes for many and downright unemployment for millions. Now, this period of prosperity is a strategic period to plan for the dangerous period we all know will soon come.

Some medical societies, as I have already said, have shown their realization of the need by setting up voluntary plans. Unfortunately, these plans are not comprehensive enough nor do they reach enough people. They cost too much to be within the means of the people who most need insurance against the costs of medical care. Even the hospital insurance plans reach only about one-tenth of our population.

Gentlemen, voluntary plans simply won't meet the need. They do not have, and cannot hope to have, a large enough coverage—a wide enough spread of risks and costs.

The European countries went through a voluntary stage and found that they had to come to compulsory insurance. In fact, the history of health insurance in Europe indicates that a compulsory system was adopted because the voluntary system had failed. Your own medical representatives on the Committee on the Costs of Medical Care pointed out over 10 years ago that if insurance is used, it had better be compulsory.

OBJECTIVES OF A COMPULSORY MEDICAL INSURANCE PLAN

Let me briefly reiterate the objectives of a compulsory medical care insurance plan. There should be:

1. As nearly universal coverage as possible to insure the widest possible spread of risks and costs.

2. Unrestricted access by the people, regardless of how low their income is to all necessary care.

3. Preservation of the personal relationship between physician and patient.

4. Preservation of standards of medical care.

5. Preservation of professional independence to the members of the medical profession.

6. Assurance of adequate payment to physicians, with financial recognition in cases of special training, as with specialists.

These objectives, I believe, are pretty well met in title IX, the medical care and hospitalization benefits section of S. 1161. I am confining myself in my address tonight primarily to this title of the bill since your interest and mine at the moment is centered in its provisions.

WHAT DOES THE BILL PROPOSE FOR THE PUBLIC?

First of all, there will be almost complete coverage on a compulsory basis of all employed workers, including groups hitherto excluded—domestic servants, farm workers, persons employed in nonprofit agencies and organizations, the self-employed, small business people, professional persons, and independent farmers. Dependents of all these groups are covered. Certain groups of employees of State and local governments may also come in under compact. States are empowered to include medical care among the provisions for persons in receipt of public assistance.

Second, contributions for all forms of social insurance guaranteed under S. 1161 will be levied by means of a single contribution, thus greatly simplifying the employer's work in making reports and payments, and resulting in low administrative costs. No contributions will be levied on that portion of wages, salaries, or incomes which is in excess of $3,000 per year.

Third, aside from the other social-security benefits, the bill guarantees under medical benefits: General practitioners' services, specialists' services; X-ray and laboratory services for nonhospitalized patients, hospitalization up to 30 days in any 1 year.

Fourth, the freedom of choice of doctor, so much prized by physicians, is guaranteed under the bill. Even more important, freedom of change is also assured to the patient.

Fifth, there will be free access to specialists on recommendation of the general practitioner. When circumstances make it advisable, specialists' services may be obtained directly.

Sixth, patients will be as free to enter the hospital of their choice as they are today—freer, because fear of the costs will no longer be involved.

WHAT DOES THE BILL DO FOR THE DOCTORS?

First, it improves the opportunity of the doctor to serve all patients who select him without any financial problem being intruded. The patient pays for services in advance through an insurance fund built up under the act.

Second, the relation of physician and patient is not interfered with as the physician, under the act, is as free as he is today to accept or reject patients and is also free to enter the system as he chooses.

Third, the method of payment to the general practitioner is left to the choice of the majority of physicians in the local area (sec. 905, subsec. 7, p. 46).

Fourth, the bill explicitly states that remuneration must be adequate, such as to "provide professional and financial incentives for the professional advancement of practitioners and to encourage high standards in the quality of services furnished."

Fifth, through their representation on the National Advisory Medical and Hospital Council, physicians will have a voice in the determination of all important policies (sec. 904, p. 41).

Sixth, specialists will be entitled to higher fees than general practitioners if their training and experience measures up to the standards established by the Surgeon General after consultation with the advisory council, utilizing the standards already established by professional agencies and organizations. This proviso is for the protection of physicians and patients alike.

WHAT DOES THE BILL DO FOR THE HOSPITALS?

First, it permits free choice of hospitals to the patient, as free a choice as he has today. It wisely provides, just as the Blue Cross Plan does, that hospitalization will be on the recommendation of the attending physician.

Second, it guarantees a fair and reasonable payment to the hospitals, the method of payment to be either on a cash indemnity or a service basis, as may seem best after consultation with the advisory council, on which hospitals will have adequate representation.

Third, it interferes in no way in the management of hospitals. The type of reports and records that will be required are no more than well-administered hospitals are accustomed to keep for themselves. A good deal has been said about the control which the Surgeon General would exercise over the voluntary hospital system if the bill became law. This is nonsense. Nothing in the bill states or implies that. The standards used in setting up the hospital lists will undoubtedly be such as are already recognized by hospital authorities, such standards as the American Medical Association utilizes in determining whether or not a hospital shall be included in its register. Provision is made, however, for the common-sense relaxing of standards in communities where hospitals are scarce or limited in the scope of their activities. No hospital of standing in its community, no hospital meeting proper professional standards, need have any fear that its name will be left off the list. Patients will have quite as much freedom of choice as they have today—indeed more, and hospitals will have a financial security which they have not heretofore possessed.

Let us now turn to the subject of standards:

WHAT CAN WE EXPECT FOR MEDICAL CARE IF S. 1161 BECOMES LAW?

I am convinced that the provisions of title IX, far from resulting in deterioration of medical care, should do much to stimulate its progressive improvement. Paragraph (6) of section 905, "Guiding Principles and Provisions for Administration," sets down very definite principles for the Surgeon General's guidance to: "Encourage high standards in the quality of services furnished as benefits * * * through the adequacy of payments to practitioners, assistance in their use of opportunities for post-graduate study, coordination among the services * * * aid in the prevention of disease, disability, and premature death."

The Advisory Council is also authorized to advise the Surgeon General in these respects, and the Surgeon General is required to consult the Council on all these important professional matters.

The practicing physician certainly should be able to do a job more satisfactory to himself and more beneficial to his patient when the state of a patient's pocketbook no longer determines the kind or amount of care his physician is able to give him.

The funds available under section 1111, "Grants-in-Aid for Medical Education, Research, and Prevention of Disease and Disability," will provide a much-needed stimulus to research and to improvements in medical education. The meagerness of the sums available for research in many medical schools and teaching hospitals is well known.

Briefly, these are the aims the bill is designed to achieve for the public, for physicians, for hospitals, and for medical progress. In writing the bill, every effort was made to meet the objections raised against the 1939 bill, to incorporate suggestions made by critics of that bill. The objections to 51 varieties of medical care which might have come to pass had the 1939 bill become law were remembered and therefore a national system is now advocated. Section 1111, making provisions for funds for research, was included as a result of medical criticism of this lack in the earlier bill.

The provisions for hospitalization benefits in our bill, as methods of administering an insurance plan, follow the points on which there was agreement at a joint meeting of representatives of the American Hospital Association, the Protestant Hospital Association, and the Catholic Hospital Association with members of the staff of the Social Security Board a year ago, as given in the approved summary of that meeting.

Of course, we do not consider the bill perfect. No bill ever is. Bills are usually improved as a result of criticisms which come out in discussions and hearings. But criticism to be helpful must be constructive. I must say I have been astounded by most of the criticism of this bill.

The attitude of the Committee of Physicians for the Improvement of Medical Care, of which Dr. Channing Frothinghaim of Boston is chairman, and Dr. John Peters of New Haven is secretary, is a notable exception. In a letter to Senator WAGNER, Dr. Peters said, and I quote:

"The Committee of Physicians for the Improvement of Medical Care wishes to congratulate you on the presentation of S. 1161, the Federal Social Insurance Contributions Act. The medical features of the bill seem to the committee broadly conceived in a spirit of service. With its general provisions, the committee is in accord. It provides a framework and a basis for discussion from which it is sincerely hoped that a constructive program for improved medical and health care of the American people may be developed. * * * The medical profession should accept the challenge. Its members have the expert knowledge required to implement the measure. This knowledge should be placed unreservedly at the disposal of the legislature."

A letter like this gives me courage to hope that a proper and effective bill can be worked out. This letter does not mean that the members of that committee approve everything in the bill. It does mean that they are willing to work with us constructively toward a common end in the public interest.

No one will question the right of anyone in this country to present to the public their point of view, in the most effective language possible—that is a constitutional privilege we all want to preserve. But it does seem reasonable to expect that those who speak for vital legislation of this kind should speak the truth—should do it impartially and objectively, instead of confusing the rank and file of physicians and the general public by a misconstruction of facts.

S. 1161 has been variously described as "socialistic," "communistic," and as "state medicine." What really is meant by "state medicine"? How often has it been actually defined? Actually, state medicine is a system of medical care paid for out of taxation, under which all physicians are salaried, all hospitals and health services are owned and controlled by the Government, and everyone receives medical care at Government (or State) expense. This is not at all what we have in mind. The bill Senator WAGNER and I are sponsoring merely sets up the machinery for distributing the costs of medical care through insurance. It does not interfere with the professional aspects of medical practice. It does not come between the patient and the physician.

The bill has been called un-American. What is un-American about enabling people to pay for their medical care? What is un-American about seeking to guard against the emergency of sickness through an insurance system? What is un-American about expanding medical care and improving the national health? All these advantages are guaranteed under the bill. If you have any doubt that the language of the bill means what I have just stated, you have only to suggest clearer and stronger language.

The Congress will have an interest in seeing that both the Surgeon General and the Social Security Board shall be responsible to the public good. Moreover, this will be no hand-out by the Government. The people who pay for medical care through their payroll deductions will have a lively interest in the type of administration rendered.

Public opinion has been registered again and again in favor of arrangements such as those embodied in S. 1161. The most recent poll by the American Institute of Public Opinion (the Gallup poll) asked the following question:

"At present, the social-security program provides benefits for old age, death, and unemployment. Would you favor changing the program to include payment of benefits for sickness, disability, doctor, and hospital bills?"

Well over half, 59 percent, answered "Yes." Only 29 percent said "No."

Under a democratic government we cannot afford to ignore a reasonable public demand.

The science of medicine has made tremendous strides forward. The distribution of medical care, its availability, has not kept pace with the complexities of modern industrial life. The public has become educated to know a great deal about what it can expect from modern science, modern medicine. It wants better medical care and better health at a price within its reach. It wants health services without burdensome costs which make such services inaccessible to large sections of our population. It wants some kind of a health-insurance system which will spread the costs and enable people to provide in advance for the sudden emergency of illness which often occurs when one is least prepared to meet it. It wants to avoid the necessity of depending upon charity by making provision in advance in times of employment and prosperity and thus procuring the best quality of medical care and hospitalization without imposing upon anyone. Here is an opportunity for the medical profession to contribute to the establishment of a system of health insurance which will make America the healthiest, in addition to being the most prosperous, Nation in the world. This is a program which calls for the intelligent cooperation of us all.

China and the Cairo Parley

EXTENSION OF REMARKS

OF

HON. CHARLES O. ANDREWS

OF FLORIDA

IN THE SENATE OF THE UNITED STATES

Tuesday, December 21 (legislative day of Wednesday, December 15), 1943

Mr. ANDREWS. Mr. President, I ask unanimous consent to have printed in the Appendix of the RECORD an article entitled "Chinese Regaining Prestige as Result of Cairo Parley" from the very able mind and pen of James D. White, Associated Press writer, published in the Washington Star of December 19, 1943. Mr. White has recently spent 10 years in the Chinese Republic, and of course speaks with authority.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

CHINESE REGAINING PRESTIGE AS RESULT OF CAIRO PARLEY

(By James D. White)

(Mr. White spent 10 years in China as a correspondent, was repatriated in 1942, and recently interviewed repatriates returning on the *Gripsholm*.)

Flying back to Chungking from the Cairo conference, Generalissimo and Mme. Chiang Kai-shek carried more with them than the tri-partite agreement to strip Japan of the fruits of a half century of conquest.

The conference with President Roosevelt and Prime Minister Churchill meant more than that to Chiang, to his Government and to the Chinese people.

It was Chiang's first meeting with other chiefs of state. It confirmed the generalissimo in his role—if there have been recent doubts—as China's unchallenged national leader in war and in the peace to follow.

It was full Allied recognition of China's place as a great power, today and tomorrow.

Prestige, commonly known as "face," means much in the Orient.

REBUILDS CHINA'S PRESTIGE

The Cairo conference was the latest of a series of events which have helped to rebuild the prestige of both China and her generalissimo from the low to which it had fallen through the fortunes of war.

Americans coming most recently from Japanese-dominated Asia—repatriates on the exchange ship *Gripsholm*—express the opinion.

They say that the Cairo conference will do more than any other single factor to give the Chinese greater confidence in themselves, their allies and the future.

This is a big order.

China fought alone for more than 4 years. Chiang and many other Chinese warned repeatedly that Japan would attack the democracies of the west. After Pearl Harbor the Chinese watched with bitterness as their predictions came true—bastions of the British Empire crumbled before the Japanese and the United States and Britain could not prevent the conquest of the Philippines and the Dutch East Inides.

Allied prestige fell to an all-time low in Chungking as the Burma road was lost and China's last great supply contact with the outside world fell into Japanese hands.

CHINESE SAW CHANGE

Chiang's own prestige fell in the minds of some Chinese. The old rift between his Government and the Communists was exhumed.

Then in August 1942, American marines landed on Guadalcanal in the South Pacific. Though this was 4,460 miles from Chungking, the Chinese knew it was the beginning of the long road back to Tokyo.

The United States Army established its Fourteenth Air Force in China and almost for the first time Chinese soldiers fought with strong air support. With such help they have just turned the Japanese invaders back at Changteh in what is called the fiercest fighting in China since the battle of Shanghai in 1937.

The first big Allied gesture toward China was when the United States and Britain voluntarily relinquished their extra-territorial rights in Chna whereby their nationals were responsible to their own laws and courts rather than to Chinese.

But this fell flat in the eyes of the Chinese, according to Gripsholm repatriates. In the first place, these rights had not been fully enjoyed in Japanese-occupied China, where the majority of Allied economic interests and personnel were concentrated in the treaty ports, like Shanghai.

JAPS BEAT US TO DRAW

Furthermore the Japanese beat us to the draw on this move and not only "relinquished" their own extraterritorial rights but handed back to puppet Chinese regimes the International Settlement in Shanghai, the foreign concessions at Hankow, Shanghai, Tientsin, and elsewhere, and the diplomatic quarter in Peiping.

To the Chinese, say repatriates, it looked as though the allies were belatedly giving up what they no longer possessed.

But it was a different story when the American Congress repealed the Chinese exclusion laws. This had not been done by the time these repatriates left occupied China but word had got around that it was going to be done and the Chinese were talking about it.

Repatriates say that the Chinese are quietly jubilant that America is voluntarily wiping out what the Chinese always considered to be an affront to their national and racial honor.

The Chinese think of it as one more sign that America considers China and her people capable of pulling their own weight in the world to come.

Then China was asked to sign the four-power declaration at Moscow. To Chungking this meant that China was going places and was on her way.

Repatriates report, too, that the Chinese were somewhat surprised—and pleasantly