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ESTABLISHING A NATIONAL HEALTH PROGRAM

AUGUST 4 (legislative day, AUGUST 2), 1939.—Ordered to be printed

Mr. MURRAY, from the Committee on Education and Labor, submitted the following

PRELIMINARY REPORT

[On S. 1620]

The Committee on Education and Labor, to whom was referred the bill (S. 1620) to provide for the general welfare by enabling the several States to make more adequate provision for public health, prevention and control of disease, maternal and child health services, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance, and training of personnel; to amend the Social Security Act; and for other purposes, appointed a subcommittee to consider the bill.

This subcommittee, having studied this bill, held numerous public hearings and accumulated a large volume of testimony and supplementary information, reports that it is in agreement with the general purposes and objectives of this bill. However, the subcommittee wishes to give this legislation additional study and to consult further with representatives of lay organizations and of the professions concerned. The subcommittee intends to report out an amended bill at the next session of Congress.

I. THE NEED FOR A NATIONAL HEALTH PROGRAM

BACKGROUND OF THE BILL

The bill under consideration is the result of several years of preparatory study and discussion. The bill implements the national health program, the details of which are contained in the record of our testimony.

The national health program is a logical outgrowth of the movement which led to the enactment of the Social Security Act in 1935. The Committee on Economic Security, appointed by President Roosevelt in 1934, had developed the outlines of a health program as part of a general plan for economic and social security. Parts of that

health program were adopted in 1935; they are embodied in the Social Security Act as titles V (grants to States for maternal and child welfare) and VI (public health work). Other parts of that program, dealing with medical care, construction of hospitals, and compensation of disability, were reserved for further study.

In August 1935, directly after the passage of the Social Security Act, the President created by Executive order the Interdepartmental Committee to Coordinate Health and Welfare Activities. This Committee undertook an extensive survey of the health activities of the Federal Government, and subsequently, through one of its subcommittees, the Technical Committee on Medical Care, a study of the health needs of the Nation. In February 1938 a preliminary report from the Technical Committee was transmitted to the President and in July of that year a report with recommendations was submitted at the suggestion of the President, to a large public gathering known as the National Health Conference.

At that conference, some 200 representatives of citizens in all walks of life—labor, agriculture, industry, welfare, education, civic organizations, government, the professions, etc.—came together to consider and discuss the national health program submitted by the Technical Committee. There was expressed widespread support for the broad recommendations of the Committee and for its proposal that the Federal Government should take the initiative in laying out and going forward with a health program for the Nation.

During the remaining months of 1938 many details of the program were explored with lay and professional groups. A report and a number of recommendations were submitted by the Interdepartmental Committee to the President on January 12, 1939. These documents were transmitted to the Congress by the President with his message of January 23, 1939. The bill to implement the program was introduced by Senator Wagner on February 28, 1939.

Before turning to an analysis of the bill, we may advantageously review the health needs which exist in the United States and the opportunities for improvement of health. We shall also wish to examine some of the reasons why large numbers of people now receive inadequate services. This review will furnish a background against which to view the bill in proper perspective.

We do not intend to present exhaustively the evidence accumulated in the record of our hearings, but only to summarize some of the more general facts. The information at hand in the United States is unusually comprehensive; in addition to the customary sources of information, there is available the large volume of statistics compiled by the United States Public Health Service which conducted a National Health Survey in 1935–36. This canvass of illness, disability, and medical care among some 900,000 families, with over 2,500,000 persons, in 83 cities and 23 rural areas, is the most extensive health survey ever made in the United States.

OPPORTUNITIES FOR IMPROVEMENT OF HEALTH IN THE UNITED STATES

A large mass of evidence which has been presented before this committee shows convincingly that there are great opportunities to improve health conditions in this country, to reduce the toll of pain and suffering, to lessen disease and premature death, and to greatly

diminish the public and private burdens created by preventable sickness and disability. These opportunities exist notwithstanding the fact that health conditions have been steadily improving.

Our general death rate has been declining; the deaths from tuberculosis, diphtheria, and other diseases have been greatly reduced; infant mortality has been cut to nearly half of what it was about 25 years ago; and other great accomplishments have been achieved.

While all this, and more, redounds to the credit of public and private efforts which have been made to improve the Nation's health, urgent needs still exist and large opportunities are still ahead.

It is necessary to consider not only present achievements, but what can be done—what it is possible to do with the resources at our command. It is well known that the prevalence of disease and the length of life are related to economic status. Because of this country's relatively high standard of living, it is to be expected that our sickness and death rates should compare very favorably with those of other countries. While death rates were lower last year than ever before, this is no reason for failing to strive for further improvement, since the same statement could have been made concerning the rates of 5, 10, or 30 years ago.

However good our accomplishments compared with those of other countries or those of our own past, it is nevertheless true that the conditions of health in this country could be and should be very much better than they are. We are convinced, from the testimony presented before us, that if existing medical knowledge and skills were adequately marshaled and put to work, the prevalence of disease and disability could be greatly lessened, tens of thousands of deaths annually could be prevented, the average expectation of life could be appreciably increased, and our people could be rendered healthier, happier, and more productive.

The opportunities for improvement in health conditions become evident when we look beneath the surface of national death and sickness rates, and consider the rates for particular localities or groups in our population. Then it becomes apparent that these average rates, which may be highly encouraging, obscure rates for particular communities, population groups, or diseases which are disgracefully high. We then find how much less we are doing than we know how to do, how much suffering, disability and premature death persists which could be prevented by known and applicable methods. A few specific facts will illustrate the general truth.

Tuberculosis.—In 1938, 69,000 persons died of tuberculosis in the United States—almost 200 every day of the year. Most of these 69,000 died in the early adult and middle-age period when they should be carrying major responsibilities for their families and their communities. They died, as Mr. Homer Folks said, testifying on behalf of the State Charity Aid Association of New York, and the National Tuberculosis Association—

> from a cause which we do understand, from a cause which we can control, which we are very slowly approaching a control of, but which, if we only applied more fully what we now know, could be eliminated as any substantial cause of death in a very much shorter time than it otherwise will be.

While for the whole population tuberculosis ranks seventh as a cause of death, for the age group 15–45 years it is the second most important cause of death. Since for each death there are estimated

to be about 5 living cases, it is probably that in any one year there are approximately 420,000 individuals who have this disease which we should eliminate from our society.

The average death rate from tuberculosis conceals rates which are far higher than should be countenanced. Thus, to cite one example from the record of our hearings, although the death rate from tuberculosis in New York City was approximately 50 per 100,000 last year, there was at the same time in this city a health-center district of several hundred thousand people with a tuberculosis death rate of more than 250—five times the city average. This situation is by no means exceptional.

Venereal diseases.—There are more than 500,000 persons infected with syphilis and more than 1,000,000 infected with gonorrhea seeking treatement each year. Some 60,000 cases of congenital syphilis occur annually. The disease causes more than 50,000 deaths a year. We are told that at least 10 percent of first admissions to hospitals for mental disease are charged to syphilis. Yet, this disease is one which we know how to control—certainly we know how to reduce very greatly its prevalence by the application of well-established methods. The Congress has already passed legislation to encourage the development of venereal-disease control; but the funds made available will probably be sufficient only to make a beginning in this campaign.

Infant and maternal mortality.—Childbirth costs the lives of many mothers and babies every year. In 1937, nearly 11,000 mothers died in childbirth or from causes connected with childbearing, and, in that same year, over 68,000 babies died in the first month of life and there were over 73,000 stillbirths. Much of this loss of life, witnesses have told us, is needless, unnecessary, and preventable. We have been authoritatively advised that various studies and surveys made under professional auspices have shown that from one-half to two-thirds of the maternal deaths are preventable; that the stillbirths can be reduced possibly by two-fifths, and that the deaths of newborn infants can be reduced at least one-third and possibly one-half. All this would mean the saving each year of more than 60,000 lives.

The fact that infant and maternal mortality rates vary widely among the different States (see tables I, II and III, appendix) shows that much could be done to reduce the loss of life that now occurs. In New Jersey in 1937, only 39 infants out of every 1,000 born alive died during the first year of life; but 124 out of every 1,000 died in New Mexico, 121 in Arizona, 76 in South Carolina, 74 in Texas. In urban areas, the range was from a rate of 128 (infant deaths per 1,000 live births) in New Mexico to 14 in Nevada; in rural areas, from 135 in Arizona to 38 in Connecticut. In the same year, the average maternal mortality rate for the country was 49 deaths per 10,000 live births; but for every 10,000 live births, in Connecticut only 25 mothers died from causes connected with childbirth, in Nevada 92, and in South Carolina 77. In some counties the rate was as high as 200. In the words of Dr. M. Edward Davis, associate professor of obstetrics and gynecology, University of Chicago, who testified before us:

> The loss of life is only one measure of the effectiveness of our care. Far more difficult to evaluate and to tabulate are the thousands of mothers who suffer serious and irreparable injuries and are destined for a life of invalidism. These physical and mental wrecks disturb the orderly American family life, thereby contributing to some of the major social problems. Many thousands of babies are

injured as a result of abnormal, unattended, or poor conducted birth processes. Many of these children survive to fill our institutions for the subnormal and feeble-minded. These physical and mental defectives add to the ever-increasing load of tax-supported institutions. Thus the lack of proper medical and nursing care during pregnancy and labor may not only result in death, in needless suffering, and chronic invalidism, but in an increasing economic burden to society.

The record shows that each year nearly a quarter of a million women do not have the advantage of a physician's care at the time of delivery. This means also a quarter of a million infants with no medical attention at the most critical period of their lives. In rural areas, only 16 percent of births occur in hospitals, whereas in cities, 75 percent occur in hospitals. For the great majority of the 1,000,000 births attended each year in the homes by physicians, there is no qualified nurse to aid in caring for the mother and baby. In one State half of the babies dying receive no medical care.

Notwithstanding the progress that has been made in reducing the infant mortality rate, there has been but slight decline during the past 23 years of record in the death rate of infants dying during the first month of life. Nearly one-half of all deaths in the first month of life are among prematurely-born infants; the experts testified that with proper care of the mothers, many of these premature births could be prevented, and with proper care of the infants, a larger proportion could be saved.

Medical care for children.—Vastly more could be done than is being done to conserve the lives and health of children. In the period 1934–36, we had an average annual total of 91,000 deaths of children under 15 years of age from the acute communicable diseases, accidents, heart conditions, and tuberculosis. These figures represent only a small proportion of the total number of children who are affected by these diseases and conditions and who, though they recover, may have suffered permanent injury to their health. The proportion of these deaths that is preventable is not known accurately, but there is no doubt that many deaths and much subsequent ill health could be prevented by such measures as more adequate control of communicable disease, protection of the milk supply, and systematic health supervision, and by early diagnosis and prompt treatment of conditions that, without such treatment, tend to become serious or chronic. The National Health Survey found (in 83 cities) that of all children under 15 years of age having illnesses that disabled them for 7 days or more, 28 percent had had neither physician's nor hospital care, the proportion lacking such care being largest among those in the lower-income groups.

The Children's Bureau of the Department of Labor has estimated that there are several hundreds of thousands of children with rheumatic heart disease or with other conditions which are forerunners of this type of disease. These and many other classes of children need care which they are not receiving—care in hospitals and in convalescent homes which should be continued for long periods and which is expensive. The Bureau has estimated that if such care were given these children and given them early in their illness, probably 60 percent could be restored to normal life.

It was officially reported to us that in May 1939 there were more than 14,500 crippled children on the waiting lists of official State agencies to receive hospital care under the provisions of title V of

the Social Security Act. Nearly 13,000 of these children had not received care because of lack of funds to provide such care.

Dentistry.—Dental care is a necessary health service. Yet authoritative witnesses have testified that, by and large, only those in the upper income groups receive anything approaching adequate dental care, while the vast majority of the population receives meager and scanty attention, principally of an emergency nature only. According to the findings of the National Health Survey, in families of skilled, semiskilled, and unskilled workmen, the proportion of adults who had never received dental care was almost twice as high as in the families of white-collar workers. In a recent survey of families in California cities, the proportion of persons requiring but not receiving dental treatment was four times as high in families of the lowest income class as among the well-to-do.

Industrial hygiene.—Vastly more could be done than is now being done to prevent those diseases and premature deaths which occur among workers as a result of exposure to industrial hazards and to enforce regulations for the control of these hazards. A large and important group of organic diseases, especially significant in adult life, shows strikingly the effects of industrial exposure; the death rates are two and three times as high as in nonindustrial groups during the active working years of life. In the hazardous industries, where workers are exposed to harmful dusts, metals, gases, vapors, or other injurious substances, to excessive heat, humidity, sudden changes of temperature, defective lighting, or to noise, the effects on health and length of life are very serious. These effects may be noted in reduced efficiency, in long periods of illness and disability, and especially in cases of certain chronic diseases which strike men and women down prematurely.

The technical experts have told us that at age 20, the expectation of life of men engaged in industrial pursuits is 42 years. That is, they may expect on the average to attain the age of 62. On the other hand those who are not engaged in industry may expect at age 20 an additional 50 years. There is, therefore, a difference of about 8 years in the average expectation of the two groups.

Differences in the sickness or death rates among occupational groups should not be charged altogether to the specific effects of industry; other factors associated with occupations play large roles, such as economic status, race, education, and so on. Yet it may be true that if a single item were to be selected among the determining factors in the health of men and women, occupation would probably lead all others.

It has been estimated that about 1,000,000 persons are exposed to hazardous silica or silica-containing dust in the United States. It has been further estimated that of this number 250,000 have silicosis in some stage of the disease. It is well known that individuals with silicosis are abnormally susceptible to tuberculosis; the latter disease is about 10 times more common among those who have silicosis than among the general population.

The industrial hygiene protection of women was especially urged upon us by the National Women's Trade Union League of America whose Southern representative, Miss Mollie Dowd, appeared before our committee:

Our interest in the maternal- and infant-care program, however, does not permit us to lose sight of the fact that maternity is not the only health problem of women workers. According to the national health survey, conducted by the Public Health Service, women workers of all ages experience more sickness than do male workers of all ages. In a study of the members of industrial sick-benefit associations, most of which pay benefits only for diseases common to both men and women, it was shown that women workers had 50 percent more disabling illness lasting for more than 1 week than did male workers. In other studies of industrial workers, it has been shown that women workers have more absences from work because of sickness than do male workers, and that this is true for all causes, except accidents. For example, respiratory diseases among women workers cause an absence rate 75 percent higher than among males, and digestive diseases caused more than twice as many absences among the women as among the men.

Women workers are exposed to many occupational hazards. In the shoe industry, for example, it was found in Massachusetts that women workers are usually susceptible to benzol poisoning. In 1936 one-fifth of the occupational diseases investigated by the Massachusetts Department of Labor occurred among women workers.

The National Women's Trade Union League is deeply interested in the development of industrial hygiene services.

It is clear from these few citations, and from much more in the record, that there is urgent need for an extensive program of industrial hygiene to reduce occupational health hazards.

Rural health needs.—Any program to promote better national health must give special emphasis to the needs of rural areas. In general, incomes are lower in rural than in urban areas; consequently, the populations in rural areas are served by fewer physicians and by more limited health facilities of various sorts than are the urban populations.

There are approximately 160,000 physicians in active practice in this country, an average of 1 physician to about 807 persons. However, as material submitted by the American Medical Association shows, there are large differences among the States in the ratios of physicians to population. The States which are mainly agricultural have fewer physicians, compared to population, than those States which are mainly urban and industrial.

There are still approximately 800 counties in which there is no public health nursing service for rural mothers and families. In 18 States, the average rural population served by a public health nurse is between 10,000 and 20,000; in 5 States the ratio is 1 nurse for between 20,000 and 30,000 persons; in 2 States the ratio exceeds 1 to 30,000. The average for cities is now approximately 1 public health nurse for every 5,000 people.

Infant mortality rates are higher in rural than in urban areas (table II, appendix).

For years, many urban communities have had child health centers. Until the passage of the Social Security Act, relatively few such centers for advice and aid were available to rural mothers. While the establishment of such centers has been encouraged by provisions of the Social Security Act, as yet there are still vast areas in rural sections where facilities of this sort are almost nonexistent. Of 2,451 rural counties, only 26 percent are provided with a child health center, and only 14 percent with a prenatal clinic.

General hospitals, which are so important for the treatment of serious illness, are found predominately in urban centers. The counties of the United States which do not contain a registered general hospital are usually characterized by rural population, remoteness from metropolitan centers, and low incomes.

The acute health needs of rural areas were called to our attention by Mr. M. L. Wilson, Acting Secretary of Agriculture:

> The problem (necessary medical care, etc.) is particularly acute in rural areas, and States predominantly agricultural are least able to provide for this type of care.

He also called to our attention the special problems of the destitute and needy rural population:

> The experience of the (Farm Security) Administration has indicated that a very substantial factor in the rehabilitation of the needy rural population involves the health of the families. No plan of economic rehabilitation can succeed without taking account of the necessity of restoring and maintaining good health in the persons who must operate the farm unit and who are depending upon it for support. In some measure, the Farm Security Administration has attempted to meet the health needs of families under its care by advancing funds in the forms of loans or grants. However, the program of the Administration and the funds available to it have not permitted any substantial inroad into the problem of health rehabilitation in rural areas. Many families who are not now receiving assistance from the Farm Security Administration or who are getting only subsistence grants might be rehabilitated, if serious health conditions could first be ameliorated. A national health program could play an important part in assisting the activities of the Farm Security Administration by clearing up the health problems, which, in a great number of families, make economic rehabilitation an impossibility.

Public health service.—The financial aid given to the States by the Federal Government for public health work under title VI of the Social Security Act has made possible a greater advance in the provision of basic public health services than ever before within a comparable period. On January 1, 1935, only 594 out of some 3,000 counties in the country were receiving health services under whole-time county or district health units; at the close of 1938, the number of counties so served had increased to 1,371—more than double. Over the period 1937–38, there was an increase of 1,720 in the number of full-time public health nurses employed by State and local agencies. Nevertheless, over one-half of the counties in the country are still not served by full-time health officers on a county or district basis, and approximately the same proportion of our cities are still without full-time health officers. At present some 745 counties have no public health nursing service. Although the technical experts estimate that one public health nurse to 2,000 persons is necessary to provide a minimum adequate level of service, the average population per nurse for the country as a whole is about 6,000.

States expend through their health departments, on the average, about 11 cents annually per capita, while some State appropriations fall as low as 3 cents. Many local official health organizations have budgets amounting to no more than a few cents per capita. Health departments are fairly high on the scale when their annual appropriations reach 50 cents per capita. Few health departments, mainly in large cities, have budgets that approximate $1 per capita. With small budgets, adequate community public health services are out of the question.

General hospitals.—Year after year, hospitals play an increasingly important part in providing the physician with facilities for the diagnosis and treatment of disease. No plan for promoting the Nation's health can be considered complete or effective that does not give due consideration to the adequacy of hospital facilities.

There is wide variation among the States in the availability of hospital facilities. As regards general hospitals, the number of

available beds varies among the States (not counting the District of Columbia) from a maximum of 5.2 to a minimum of 1.3 per 1,000 population, with an average for the country as a whole of 3.1 beds per 1,000 persons (table IV, appendix). The amount of general hospital care actually received ranges from a maximum of 1.4 days of care per person per year in one State to a low of 0.20 days in another State. Adequate standards for general hospitalization, we are told by the professional experts, call for an average of 4.5 beds in general hospitals for every 1,000 persons in the population. Only 3 States and the District of Columbia at present exceed this standard. To bring all the States up to this widely accepted standard of adequacy would require approximately 180,000 additional beds.

Mental-disease hospitals and institutions.—Responsibility for institutional care of persons with mental disorders has been almost wholly assumed by the State and local governments. Approximately 96 percent of all beds in mental-disease hospitals are in Government hospitals of this type. Over 85 percent of the income of these hospitals is from taxes, and the ability of the individual patient to pay for care is not an important factor influencing the receipt of this type of care.

Great differences exist among the States in the availability of beds in mental institutions (table IV, appendix); the States with the most adequate provision have nearly seven beds per 1,000 persons; those with the fewest beds have about two per 1,000 persons.

About one-fourth of the population lives in the 12 States with the highest ratios of mental hospital beds to population; in these 12 States there is an average of 4.8 beds per 1,000 population. That these States do not have facilities in excess of need is demonstrated by the fact that their hospitals have occupancy rates as large as or larger than their rated capacities. If the ratio of 4.8 beds per 1,000 persons is taken as a reasonable standard for the entire country, an addition of 130,000 beds would be required to bring the remaining States up to this standard.

Tuberculosis hospitals and institutions.—Professional standards specify a need for tuberculosis hospital facilities in the ratio of 2 beds per annual death from this disease. Only 8 States have 2 or more beds per annual death, while 27 States have less than 1. To bring facilities of the whole country up to the standard (allowing for a continued reduction of deaths) would require the addition of about 50,000 beds.

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This brief review of inadequacies and of possibilities for improvement of health is not intended to be a complete catalog; we have tried only to touch a few high spots in the mass of evidence laid before us by the witnesses who have testified, and contained in the documents that have been filed with us. The evidence on needs, in urban and in rural areas, is overwhelming, as may be evident to anyone who will examine the record.

CAUSES OF INADEQUATE HEALTH SERVICES

There are various factors which explain why large proportions of the population fail to receive the medical and health services they need. So far as community services are concerned, there is often a

lack of understanding or experience as to the benefits to be derived from public health and related services and, perhaps more important, there is lack of financial resources. So far as services for individuals are concerned, there is, among other factors, ignorance as to the benefits of modern medical care, reliance upon unsuitable methods of care, distance from practitioners and facilities, etc. But while these particular factors play a part in the case of services for individuals, we are convinced from the evidence placed before us that the major reason is lack of financial ability on the part of large proportions of the population—as individuals, as groups, or as members of communities—to meet the costs of needed services.

The ability and the inability to purchase individual health services depend very largely upon income, upon the size of the sickness bills, the uncertain frequency with which they come, and the methods by which these costs are financed. Many who could buy medical care on some budget basis find it difficult to purchase service on the customary basis of paying at the time when the need for care arises.

The need for medical care by a family is uneven and unpredictable. In one year little medical service or none may be required. In another year the family may suffer one or more sicknesses among its members and may require medical services costing large amounts. No particular family knows, any week, any month, or any year, whether it will be among the fortunate or among the unfortunate. An operation for appendicitis may easily mean hospital and medical bills of $200 or more. A case of cancer may require medical treatment costing several hundreds of dollars. Millions of persons with small or moderate incomes find it difficult or impossible to meet such medical costs.

The fact that sickness so often strikes without warning, the variation and uncertainty of the costs which it will bring, vitally affect the ability of families of small or moderate incomes to meet these costs and to purchase adequate care. In the words of Mr. Matthew Woll, vice president of the American Federation of Labor, testifying before us on behalf of millions of wage earners in that organization:

> No one is more conscious of the importance of good health than the worker. Upon the maintenance of health depends his job and his living. A period of illness or an injury may mean not only the staggering costs of medical care but the temporary or permanent loss of job and income.
>
> Inability to pay for adequate medical care has often meant permanent undermining of health—and, therefore, loss of earning capacity. Life itself either partially or totally, is tied up with adequate medical care. The group I represent, approximately 5,000,000 of wage earners, and those dependent on them, have never had adequate medical care, so that they were free to have a doctor whenever needed. We do not have the medical or the living conditions that would avert disease. When sickness comes we wait, hoping its development may be checked and expense avoided. Because of need for economy, children's diseases and afflictions are neglected, mothers are made invalids, premature old age cuts off useful persons' lives, adults in their prime drop at their work.

This is not a problem of the industrial wage earners alone; it is equally a problem of our rural population. Mr. Edward A. O'Neal, president of the American Farm Bureau Federation, testified as to the extensive survey made by the large organization which he represented. He said:

> The studies of our committee further confirm other studies showing the inadequacy of the health and medical facilities available to farm people. Great numbers of farm people are unable to obtain adequate medical and hospital care

for their families. The costs of medical care are all too often out of line with the ability of farm people to pay.

Statements to the same effect were made by representatives of other major consumer groups, including the National Farmers' Union, the Congress of Industrial Organizations, and the General Federation of Women's Clubs.

Families with small or modest incomes—whether living on the farm or in the city—are on the whole less well able to take care of their needs for medical care than of other needs; the costs of food, shelter, clothing, etc., regularly and constantly press their claims upon the family income and these costs are predictable even for individual families. But when sickness comes, it brings with it costs or expenses which are of an extraordinary character and for which generally no advance provision has been made by the individual family. Accordingly, medical care tends to fall in the same category as luxuries so far as its claims upon family income are concerned. Variations in sickness costs are so great that a large proportion of self-supporting families could not—if they tried—individually budget against these costs.

The limited ability of people to meet sickness costs is reflected in the amount and variety of services they receive. The National Health Survey showed that the average number of physicians' calls per case of disabling illness is considerably higher among the well-to-do than among the poor. The study made by the Committee on the Costs of Medical Care, undertaken in 1928 before the depression set in, showed that the well-to-do received 3 times as many services from physicians, that 6 times as many in each 100 received dental care, that 2½ times as many had health examinations as in the families with incomes under $1,200 a year.

The care that women receive in pregnancy and childbirth, and the chances of mother and baby living, vary directly with economic circumstance. A recent study in one State showed that 92 percent of women in families with incomes of $2,000 or more received prenatal care, whereas, only 57 percent of the women in families on relief received such care. In one city, for which we have the statistics for 1930, the infant-mortality rate in families with an annual income below $500 was 168 per 1,000, while the rate in families above the $3,000 income level was only 30.

Limited ability to pay sickness costs is also reflected in limited ability to build, support, and utilize hospitals. We have already called attention to the large variations among the States in the ratios of hospital beds to population. It will be noted (table IV, appendix) that, by and large, these variations are related to wealth (measured, in the present instance, by per capita income). It may also be noted that the amount of care received in general hospitals and the amount expended for services furnished by such hospitals also show tremendous variations among the States, and that, in general, these variations are parallel with the average per capita incomes in the States (table V, appendix). On the average, the people of the United States receive about 0.8 of a day of general hospital care per person a year; but in some States the figure is higher than 1.3 and, at the other extreme, as low as 0.2; per capita expenditures for this type of

service run approximately parallel with the volume of service. From one extreme to the other among the States, there is about a 6:1 ratio in services received and more than a 10:1 ratio in expenditures.

A witness representing the American Medical Association furnished statistics for a recent period showing that among one-fourth of the States with the highest percentages of population filing income tax returns, there was an average of 1 general hospital bed for every 261 persons in the population and, on the average, these beds were being used to 65.5 percent of their capacity. Among one-fourth of the States at the other end of the economic scale, there were 549 persons per general hospital bed and the average occupancy rate of these hospital beds was only 52 percent. (General hospitals are generally considered to be well utilized when they run at 80–85 percent occupancy.) The poorer areas, which probably have more sickness, have fewer beds and use them less.

The fact that a considerable proportion of general hospitals are being used to far less than their capacity in some places does not alter the basic need for additional facilities, or for facilities within the financial resources of particular groups of people, in other communities.

The burdens of sickness costs are also revealed in other ways, as illustrated in the following passage from Mr. Jacob Baker, president of the United Federal Workers of America (Congress of Industrial Organizations), who testified before our committee:

> The personal-loan departments of commercial banks find that much of these loans are for medical services, this accounting for 30 percent of the personal loans of the National City Bank.
>
> All workers' debts rest in large degree on physical disability. The loss of earning power due to sickness, as well as the cost of medical care, add to the debt burden of workers * * *.
>
> The largest single cause of debt, so far as we have any information about, the chief reason that people go into debt, the chief debts that hang over them, the chief concern that they have to settle when they borrow from a credit union to straighten out their affairs is medical costs. That, it seems to me, is a very important thing, because as we observe it among Federal workers, we find that it is an overhanging old worry as a result of medical debt that, coupled with the loss of energy and ability and physical strength due to illness, the two taken together result in lowered morale, lowered working ability, and recurrent illness.

The limited ability of people to meet sickness costs under present-day methods of paying when sickness occurs is one of the principal reasons for the inability of many families to purchase needed medical care; many of these families would be able to meet these needs if they had the opportunity to purchase medical care on a group basis and through regular periodic payments. The effect of these economic difficulties is seen in the insufficient services received by people of small means. The testimony on this point from the National Health Survey is quite extensive. Although this survey was conducted by the United States Public Health Service in 1935–36, during a period of economic depression, the statistics only confirm on a large scale the evidence cited from the Committee on the Costs of Medical Care which made a similar survey, in the years 1928–31 under the chairmanship of Dr. Ray Lyman Wilbur, a past president of the American Medical Association, president of Leland Stanford University, and President Hoover's Secretary of the Interior.

The present method of paying for medical treatment, that is to say, paying for service when the need actually arises, not only lessens the financial ability of persons with small or moderate incomes to purchase medical care but often causes them to assume financial burdens which they can carry only with difficulty or which they cannot carry at all. On the average, families spend 4 to 5 percent of income for medical care, this proportion being fairly constant for large groups of families, whatever the annual income. However, in any one year a majority of families will incur medical costs of less than the average, while a small proportion will be forced to assume medical costs amounting to large proportions of their year's incomes. Thus, the average is misleading as to the problem that has to be faced by individual families. As President Roosevelt said in his message of January 23, 1939:

> The average level of health or the average cost of sickness has little meaning for those who now must meet personal catastrophes. To know that a stream is 4 feet deep on the average is of little help to those who drown in the places where it is 10 feet deep.

The irregular and unpredictable occurrence of sickness, and consequently of expenses for medical treatment, tends to create a new class of dependent or needy persons, so that, in addition to the indigent, people everywhere are beginning to characterize a large proportion of our population as the "medically indigent" or the "medically needy." These are persons who are self-supporting in every respect but as regards need for elaborate or expensive medical care; they include tens of millions of people, on farms and in cities, above the relief level. Yet, though these are people who need no public assistance for their ordinary support, their health and medical needs are as much the concern of Government as are the needs of the indigent.

Just how large a proportion of the population is unable to afford the cost of adequate medical care cannot be stated with complete confidence. But there is no doubt that, with the present income distribution of the population, the proportion is very large. This was strikingly illustrated in evidence submitted to us by Dr. R. G. Leland, Director of the Bureau of Medical Economics, testifying on behalf of the American Medical Association.

Dr. Leland furnished us with a chart which summarizes relationships between medical services and economic status (Chart XXIX—Factual Data on Medical Economics). This chart refers to the "indigent" as a community responsibility for all their medical services; to families with incomes above $3,000 as being "self-sustaining—no special arrangements needed." Between these two extremes, the chart divides the population into two groups, those "Below $1,500" and those "$3,000 to $1,500," and it shows that in varying degree these people range from, at one extreme, being for the most part self-sustaining so far as minor illness is concerned to, at the other extreme, presenting serious economic problems when confronted by the service needs of chronic illness. All who are in income classes between the indigent and the $3,000 level are shown in this chart as needing economic help—in one degree or other—according to the seriousness of the illness. And for chronic illness the problem is labeled as more of an economic than of a medical nature. It is noted in the text accompanying the chart that the income limits are not hard and fast, but need adjustment according to cost of living, number in the family, etc.

The significance of this chart prepared by the American Medical Association becomes plain when we recall the income distribution of our population. The latest estimates made available to us show that the indigent and the border-line persons in families with incomes under $800 a year include between 40,000,000 and 50,000,000 persons. If we move up the scale to the $1,500 level, we account for another 30,000,000 to 40,000,000 persons. And when we move up to the $3,000 level, we account for over 90 percent of the entire population. More than 90 percent of the population are in the groups with annual family incomes below $3,000 a year, and about 75 percent are between the indigent and the $3,000 level. Thus, it is evident that most of the American people are either in the one group whose medical care is wholly a community responsibility (the indigent) or in the other group whose medical costs present grave economic problems.

The long history of this subject shows that these problems do not solve themselves by being ignored; neither do they cease to exist by being either ignored or denied. Nor, as a long history of special studies makes plain, are these problems new or the result of an economic depression. They were with us in the 1920's, as Dr. Wilbur's Committee on the Costs of Medical Care fully recognized, and they are still with us today. These problems must be faced squarely and solved on a basis which not only safeguards the quality of medical care but also preserves the dignity and self-respect of the people who are to be served.

We have already noted the attitude of wage earners and their representatives toward these problems. We wish also to cite only one excerpt from a farm representative, touching on the same point. The following passages are from the testimony of Mrs. H. W. Ahart, president, Associated Women of the American Farm Bureau Federation:

> Our organizations have definitely expressed themselves on the problem of obtaining adequate medical care for our rural people.
>
> We desire to obtain this medical care at terms commensurate with the ability of our farmers and their families to pay for its costs.
>
> Rural people are traditionally proud and desire to pay their way insofar as it is humanly and practically possible.
>
> We recognize the fact that our health services are inadequate, not because of the capacity to produce but of the capacity to distribute, and that the greater use of preventive and curative services which modern medicine has made available waits on the purchasing power rather than on the need of community or individual.

It is well known that the medical profession, the hospitals, and other practitioners and agencies have been accustomed to shoulder a substantial part of the burden of providing medical care without charge to those unable to pay for it. Physicians, hospitals, and others are giving a tremendous volume of service without charge to the indigent and to others unable to pay for medical care, and many charges to those supposedly able to pay are not collected. To some extent, physicians recoup for this free service by charging the well-to-do in proportion to their means, but many physicians, serving a clientele with small or modest incomes, find themselves swamped with calls and demands for free care and many are unable to earn incomes reason-

ably commensurate with their training, ability, and their own financial needs.

We cannot emphasize too strongly, or say too often, that when we speak of inadequate medical care, of insufficient services received by large numbers of people, or of the economic problems in paying for care, we are not criticizing the physicians or the hospitals or others who furnish service. They have long been performing humanitarian services deserving the highest praise. It is not the responsibility of doctors or hospitals or related groups that large sectors of the population have limited economic resources. We know well enough how cooperatively and how sympathetically doctors, hospitals, and others contribute, as best they can, toward solving the financial problems of their patients. Both we and the professions are trying to see an existing problem in its proper proportions in order that we and they together can devise a good solution.

When the evidence shows how many millions of people have insufficient means to purchase the care they need, it is referring not to people who have applied for care and been denied it but to people who do not receive, or who receive insufficiently, the care they need.

Voluntary organizations of many kinds, lay and professional, civic, welfare, fraternal, religious, charitable, philanthropic, or educational, have made such large contributions to the health and the welfare of our people, to their medical care and toward a solution of medical economic problems, that it is quite unnecessary to review the subject. Every informed citizen knows of the vital role which such voluntary organizations have played in the development of our professions, our hospitals, and our facilities generally, and of the prominent part they have played in helping to moderate or solve the economic problems created by sickness for millions of people. And every right-thinking citizen will insist that in a health program for the future there shall be adequate provision for the continued vigorous activity of the voluntary organizations.

There is no escaping the fact that the costs of sickness are a heavy burden on large portions of our population, that modern medical care is of necessity elaborate and expensive in many cases of serious illness, that the costs may be out of reach for people with small incomes, and that the burden should not be left so largely on the practitioners, hospitals, and voluntary organizations as it is today. We must provide substantial solutions, as we believe we can, which will be beneficial alike to patients, to the entire public, to practitioners, to the hospitals, and to the related institutions and organizations.

The public and professional desire and readiness to solve some of these problems through group payment of costs is well known in nearly all parts of the country. The rapid expansion of insurance against hospital costs and other sickness costs, of the risk-spreading arrangements of tax-supported services and facilities, of the loan and insurance plans being developed for farm groups by the Farm Security Administration—these and numerous other developments show the readiness of the public and the professions, of official and nonofficial agencies, to look realistically at the economic problems of sickness and to develop solutions in a practical way.

DISABILITY INSURANCE

Title XIV of the bill provides for Federal grants to the States to aid them in developing systems of temporary disability compensation.

The National Health Survey found that on a given day 2.4 percent of all gainful workers of ages 15 to 64 are disabled on account of illness or accident, and are unable to perform their accustomed work. This is equivalent to an average of 8.6 days of disability per worker per year. The testimony shows that if account is taken of many others who are no longer numbered among the gainful workers, because of chronic disease, impairments or disability, these figures are considerably larger. It has been estimated that the total loss of earnings among gainful workers on account of disability, both temporary and permanent, is in excess of $1,000,000,000 a year.

If every worker were disabled for 8 or 9 days a year and were to lose a week's wages on this account, there would be no grave problem. The real problem arises from the fact that disability for the individual worker is not predictable, and that in any one year while most workers will lose no time or only a few days from work on account of illness, some will be disabled for several weeks, some for months on end, and some will be so injured by disease or accident as to be unable ever again to earn a living.

As an economic hazard to the security and well-being of employed persons and their families, disability is probably second only to the hazard of unemployment. In years of little unemployment, sickness and disability is probably the leading cause of dependency.

The program of social security which this country has established is incomplete without protection of the individual against the risk of losing his earning power because of disability. At present, in all but one of the States, if a worker is injured in an industrial accident, he is entitled under the workmen's compensation laws not only to medical care but also to cash benefits to partially replace earnings or earning power or to support his dependents. Under the unemployment compensation laws in all the States, if an insured individual loses his job he is entitled, at least for a limited period, to unemployment benefits until he can find another job. Under the old-age-insurance program, gainful workers are assured pensions when they reach 65 and retire from work.

The lack of protection against wage loss from disability is a serious gap in this system of defense against the hazards to security. It is obviously inconsistent to provide compensation in lieu of wages to workers who become unemployed because of lack of a job, but to provide no compensation to workers who are unemployed because of illness; it is obviously inconsistent to provide pensions to workers who are no longer able to earn their living on account of old age, but to make no provision for workers who become permanently disabled before they reach old age.

To afford protection against the risk of disability, both temporary and permanent, a certain amount of voluntary disability insurance has developed in this country. However, the vast majority of employed persons have no substantial protection against disability and there is little basis for believing that the situation in the future will be in any way greatly altered unless appropriate governmental action is taken. In other words, if adequate protection against the

risk of disability is to be developed, insurance must be made obligatory as we have already done in the case of protection against unemployment and old age.

THE NEED FOR FEDERAL ACTION

The purpose and objective of S. 1620 is to aid the States in improving health conditions and services in the United States and in establishing systems of insurance against wage loss from temporary disability.

This bill does not propose a new departure or a new type of activity for the Federal Government. Participation in health services by the Federal Government is as old as the Nation itself. Federal cooperation with the States in safeguarding health and strengthening State and local health services has an unbroken history of 150 years. The bill before us proposes only to lay out a long-range and systematic program as a basis for carrying on old and traditional activities in a sound and efficient manner.

The first interest of an enlightened government is the well-being of its citizens, and health is a fundamental element in well-being. We regard it as self-evident that the health of our citizens is of basic concern to the Federal Government. The most important asset of our Nation is the health of our citizens, for upon health and vigor depends their economic capacity to be productive. It follows that the Federal Government should take every proper step to safeguard the health, both mental and physical, of its citizens, and to see to it that there is available to every citizen those health and medical services which are necessary for the prevention and cure of disease, and the promotion of the fullest practical measure of health and well-being.

It is our opinion that the administration and operation of health services should be left to the local communities and to the States, and that the Federal Government should not control or dictate to the local communities or States in the management of these functions. But the Federal Government cannot be indifferent to remediable deficiencies or inadequacies in the provision of services that are necessary to health. It should take steps to aid the States and, through them, the local communities, in the provision of necessary health services to their inhabitants. The primary opportunity for the Federal Government is to give financial and technical aid to the States.

Just as health is the most precious possession of the individual, so is a healthy citizenry the most precious possession of a nation. 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. Only the Federal Government can take steps toward assuring at least basic opportunities for health among the citizens of the several States. There is a vicious circle in our society, wherein

ill health leads to poverty and poverty to ill health and the lack of services essential to health. If this vicious circle is to be broken, action by the Federal Government is essential.

Disease germs and the economic effects of sickness do not respect State lines. The opportunities for the spread of disease are increased by modern methods of transportation and by the mobility of population. The citizens of one State cannot be safe from communicable disease so long as such disease prevails among the citizens of other States. One State cannot stamp out tuberculosis among its people unless the disease is also stamped out in neighboring States. One State cannot meet all the costs of improved health services and cannot protect itself against the burdens of dependency caused by sickness, disability, or premature death unless other States also participate in a common effort against disease. But together, and with the aid of the Federal Government, an effective and concerted war can be waged against disease.

The Federal Government is now providing aid to the States for a variety of purposes having to do with the general welfare and with health. Grants to the States are now being made for the provision of assistance to the needy aged, dependent children, and blind, for vocational rehabilitation, for the strengthening and developing of public health and maternal and child health and welfare services, for the provision of health services to crippled children, and for the control of venereal diseases. There are as strong reasons for Federal assistance, financial and technical, to the States for health services as for any other objective of social endeavor.

A national health program is not merely an emergency program—any more than the health problems of today are emergency problems. On the contrary, a sound program must deal with a problem of large magnitude which will be solved only by years of sustained effort. The accumulated neglects of many years must be overcome and careful plans must be laid to wage a ceaseless and unremitting war against disease.

A long-range health program offers a challenge not only to our humanitarian impulses but to our economic judgment; it offers an opportunity to balance the health budget of the Nation.

We are spending about three and a quarter billion dollars or more each year for health services and medical care. Our workers probably lose over a billion dollars a year in wages that are unearned because of disability. Premature death of wage earners brings losses in our human capital which have been authoritatively estimated as amounting to over $5,000,000,000 a year. Altogether, sickness and disability lay upon the national economy, a toll, in costs and losses, of something like ten billions a year.

As a result of these costs and losses, there is a staggering public burden for dependency and relief. One State alone expends $22,000,000 per year for home relief of families made dependent by illness of the breadwinner.

Cooperative Federal-State health and assistance programs now in operation only emphasize the need for a carefully planned, well-coordinated, long-range health program, adequately financed, so as to assure that we will make those efforts and expenditures that will bring the maximum return, especially in the prevention of disease

and disability. It is to such a balancing of the health budget that the national health program and the present legislation is directed.

The public hearings on S. 1620 held by our committee provided an opportunity not only for us to be furnished a large volume of information but also to hear the opinions of groups and individuals interested in health services and in the public welfare. The committee cannot fail to be greatly impressed by the large number of highly responsible organizations and agencies whose representatives testified in support of the bill and urged action by the Federal Government.

The public hearings have shown that there is broad and substantial support now for Federal legislation to strengthen, extend, and improve the health services of our people. Scarcely a witness raised objection against the objectives of the bill, though representatives of some organizations presented serious criticisms, some of which we shall discuss specifically later.

The committee believes that the bill offers a basis for constructive developments. We do not at this time have solutions for all of the problems which have developed in the study of the bill, but we are confident that solutions will be found as we proceed with our study and as we continue to receive critical advice and assistance which we welcome from public and professional groups and individuals who have assured us of their cooperation.

II. Principles Underlying the Bill

Before turning to a review of the bill and to a consideration of any special problems arising out of its analysis, we wish to comment on some important general features.

S. 1620 proposes to implement the national health program by building upon the framework of health services constructed under the Social Security Act. To that end, it amends several titles of the act, to enlarge and broaden their scope, and adds three new titles. There would then result the outlines of a general program, with five principal elements: (1) Maternal, infant, and child health and welfare services; (2) general public health services; (3) construction of needed hospitals and related facilities; (4) general medical care; and (5) compensation for disability wage loss. We shall refer later to the questions of providing compensation for permanent as well as for temporary disability, and of making a beginning toward the control of industrial hazards. S. 1620 offers the basis for a balanced, long-range program.

A few general characteristics of the proposals embodied in the bill deserve special mention.

Federal-State cooperative programs.—In its general pattern, S. 1620 undertakes to implement the national health program through the method of Federal grants-in-aid to the States. In this, and in many other respects, the bill follows the procedures developed and tested during the past 4 years in various titles of the Social Security Act. This pattern tends to give great latitude to the States in the development of their own plans. The program is flexible and adjustable to the different needs which exist in the several States, and is endorsed by the American Public Health Association, whose membership covers the State and local, as well as Federal, public health professional workers

of the country. Mr. Abel Wolman, president of the association, testified (in part) as follows:

We believe that wide latitude should be allowed to the States in the definition of the population to be served, and in the method of providing these public health, medical, and hospital services. The Wagner Act agrees with that major essential principle.

Perhaps I ought to stop a moment to emphasize that fact, that the act, regardless of whatever other disabilities it may have, certainly makes careful provision on what we believe to be a democratic basis for that evolution of the program in its essential features and in all of its parts should rest upon the local people and should not be handed down from above by the Federal Government. We are happy to say that in most of the essentials the Wagner bill provides for that kind of development, without which we believe there would be considerable risk in future performance.

The testimony submitted at our hearings leaves no doubt as to the success that has attended the Federal-State cooperative health programs operating under titles V and VI of the Social Security Act. We quote a few excerpts on this point.

Dr. Felix J. Underwood, secretary, State board of health, Jackson, Miss.:

It has been my privilege and responsibility for a number of years to act as chairman of one of the important committees formulating regulations, authorized under this act for its administration.

I have taken my responsibility seriously, I have read the reports from every State in regard to the operation of these titles. I am familiar with the comments made by the committees of the various State medical associations, and I can say to you, without fear of contradiction by anyone professionally qualified to object, that there has been universal commendation of the administration of these titles by the Public Health Service and the Federal Children's Bureau. There has been no complaint from any State health administrator coming to my attention, nor in my deliberate judgment has there ever been any justification for complaint of coercion of the States by the responsible Federal agencies or any attempt at federalization or regimentation of public-health work or workers in my State or any other State.

Every State plan for the protection of the health and lives of the people of Mississippi since 1921 has been originated and approved by the State board of health and the medical advisory group, and no plan has been amended or changed by the Federal agencies. I do not know of a single instance in which an officer of the Public Health Service or the Children's Bureau has been detailed to any State except upon the expressed request of the State health authority.

In fact, Mr. Chairman, in my own experience, because of the limited personnel available to these Federal agencies, I have often had extreme difficulty in obtaining badly needed technical assistance when I have urgently requested it.

If every State and local governmental agency could have had the experience extending over many years that has been enjoyed by the State health authorities in dealing with the Children's Bureau and the Public Health Service, "the wolf cry of bureaucracy and Federal domination and control" would never have been raised.

Dr. A. T. McCormack, State health commissioner, Louisville, Ky., and retiring president of the Conference of State and Provincial Health Authorities of North America:

I am very happy to be able to report to this committee that in the operation of titles V and VI there has been, and can be, no adverse criticism, no criticism that is justifiable, and there has been none from any responsible authority. The reason for that is perfectly simple.

* * * In regard to the cooperation with the States with both of them, and each of them (the Children's Bureau and the Public Health Service), there has never been the slightest intimation of coercion, or an imposed control at any time in any State.

The State health authorities, through the local agencies in the State, originate the plans, they develop them. As a rule, they are accepted without change or amendment by the Federal authority, because they recognize that those charged

with the responsibility for the actual administration of so important a function as the protection of the public health are not going to attempt to do, by and large, a foolish thing * * *.

Senator ELLENDER. You found the attitude of the Health Department here at Washington to be cooperative, as you said, and there is no effort made on its part to try to make you adopt this plan or that plan because the other State has it?

Dr. MCCORMACK. There has never been any such suggestion. Not only has there never been such suggestion but no officer of the Public Health Service has come into the State of Kentucky, except at my invitation, since I have been State health commissioner.

These views expressed by State health officers are completely confirmed by the testimony of the Federal administrative officers: Dr. Thomas Parran, Surgeon General, United States Public Health Service:

The Public Health Service has had a background of dealing with the States for almost 50 years. We have had no difficulty in administering title VI with the States; there has been no suggestion of Federal domination and Federal control. There has been, I think, one of the finest examples of Federal and State cooperation in administering title VI, and I may say also title V of the Social Security Act.

Miss Katharine Lenroot, Chief, Children's Bureau, Department of Labor:

The amendments proposed in S. 1620 would build upon the foundation which has been laid in more than 3 years of Federal-State cooperation under these provisions, in which all States, Alaska, Hawaii, and the District of Columbia have participated.

I want to speak here of the very excellent cooperation that we have had from all of the States. All of them were in a position to submit plans for maternal and child-health services very promptly after the passage of the 1935 act. Not only in our Federal and State relationships but also in the relationships among the Federal agencies, and particularly between the Public Health Service and the Children's Bureau, both of which are dealing with State health departments, we have had the most cordial and harmonious relationships all the way through from the very beginning and have consulted freely and fully on all points which would affect common policies.

The Federal-State cooperative program contemplated in titles V and VI, as amended by this bill, follows the practices and the experience already accumulated under these titles of the Social Security Act. The fundamental latitudes now left to the States in the development and operation of plans are retained. Corresponding latitudes are also provided for the States under the new titles (XII, XIII, and XIV) which this bill proposes to add to the Social Security Act. This is especially notable in the case of title XIII (grants to States for medical care), in which nothing in the bill limits the freedom of each State to determine the scope of services, the population to be covered, or the methods of financing a plan which may be approved under this title.

It may be emphasized that the operation of health or medical care programs under this bill is a State and not a Federal obligation. The bill does not propose to set up a Federal system of medical care; it undertakes only to encourage and aid the States in setting up their own programs. Neither—as seemed to be thought by some witnesses—does the bill set up a Federal system of health insurance or of State medicine or of socialized medicine, nor does it require any State to set up any particular type of medical service. The role of the Federal Government remains—as it is now—to give financial and technical aid to the States.

Operation by the States.—We cannot emphasize too strongly that the Federal Government does not become the operating agency for health services under this bill; plans for health services, medical care and temporary disability compensation would be administered and furnished by the States through State plans of their own devising and design. The intent has been to lay down in the bill only such standards and provisions as are necessary to assure that Federal funds will be used by the States for the intended purposes and with reasonable economy and efficiency.

Approval of State plans.—Attention is especially directed to the fact that each title of the bill not only stipulates the provisions which must be contained in a State plan submitted for approval, but also specifies that the Federal administrative agency "shall approve any plan which fulfills the conditions specified * * *." In other words, it is intended that the States shall be advised in advance of the conditions which they must meet in order to qualify for Federal grants-in-aid and shall also be assured that if their plans meet these conditions their plans will be approved.

Quality of medical care.—Maintenance of high standards of quality and improvement for the future are among the fundamental objectives of the bill. By strengthening the financial support of health programs, by enabling more people to receive medical care and earlier in the course of their illnesses, by supporting the construction, maintenance, and use of modern hospitals, health centers, clinics, and related facilities, by providing more substantial funds with which to pay for medical services, by directly encouraging the training of personnel, and by other provisions—by these and related means the bill offers new support and new encouragement for standards of quality.

Furthermore, the bill requires that State plans to be approved for Federal aid must make various substantial provisions to safeguard quality of care. The bill provides for administration of State plans by personnel selected on a merit basis, and makes appropriate provision for other methods of administration, including "methods of establishing and maintaining standards of medical and institutional care and of remuneration for such care, such methods to be prescribed by the State agency administering the plan after consultation with such professional advisory committees as the State agency may establish." In addition, cooperation and working agreements are required among the different public authorities in the States administering related programs. Furthermore, the Federal and State administrative authorities are authorized to create advisory councils, to advise them in administration of their programs.

We do not lose sight of the basic fact that quality of medical care is primarily a professional problem. We are confident that the provisions of the bill can be carried out so as to furnish a new stimulus to advance the quality of medical care. The bill offers new opportunities for all those agencies, especially the professional agencies, which have already made notable contributions to advance further the quality of service.

Variable grants-in-aid.—Attention is directed to the provisions in titles V, VI, XII, and XIII that the Federal grants-in-aid shall vary according to the financial resources of the several States. This is no fundamental departure from the present provisions of titles V and VI of the Social Security Act. It seems not to be generally known that

variable-matching grants have been part of these health titles of the act from the beginning. Under title V of the present act, part of the sums allotted to the States must be matched by them, but another part is allotted on the basis of the financial need of the States without matching. In title VI of the Social Security Act, there is no statutory requirement for any matching, and in allotting funds to the States the Surgeon General is required to take into account their financial needs. The variable-matching provisions of S. 1620 carry these policies further and undertake to place upon a more explicit and more systematic basis the original intent of Congress that grants-in-aid for health purposes under the Social Security Act shall be adjusted to the financial needs of the States.

Temporary and permanent disability compensation.—The committee calls attention that S. 1620 undertakes through title XIV to provide for the compensation of workers deprived of their earning capacity by reason of temporary disablement. The bill does not deal with permanent disablement, although provision against this contingency was included among the recommendations of the Interdepartmental Committee transmitted to the Congress by the President on January 23, 1939. As we have already indicated, there are close interrelations between provisions to safeguard workers against temporary and permanent disablement. The committee therefore cannot ignore the problems created by permanent disability when it studies measures to deal with temporary disability, despite the fact that proposals for permanent disability benefits were not specifically included in the bill under consideration. A system for permanent disability compensation must be reasonably related to old-age insurance, and such a system has been under consideration by another committee of the Senate studying amendments to title II (old-age insurance) of the Social Security Act. Developments in this field and the need for permanent-disability compensation legislation will be considered carefully by our committee in connection with title XIV of S. 1620.

Finances and the rate of expansion.—S. 1620 levies no pay-roll or other taxes. As will appear later, it increases the expenditures now authorized for health purposes under the Social Security Act from $17,075,000 to $98,250,000 for the first fiscal year of the program, and to larger sums in succeeding years (in addition to authorizing so much as the Congress may deem necessary for various specified purposes, as shown in the analysis). Though the proposed authorizations for the first year are larger by about $81,000,000 than those in titles V and VI of the present act, and therefore represent a relatively large expansion, they are not unreasonable in light of the job waiting to be done. Whether the actual sums proposed in the bill, should be specifically endorsed, the committee is not prepared to say at this time. Nor has the committee yet had adequate opportunity to determine the precise rate at which the program should expand after the first year. These are questions which require much further study.

III. Principal Provisions of the Bill

S. 1620 amends three titles of the Social Security Act (V, VI, and XI) and adds three new titles (XII, XIII, and XIV). Title V of the act (grants to States for maternal and child welfare) is in five parts, and section 2 of the bill amends parts 1, 2, and 5. Section 3 amends

title VI (public health work). Section 4 amends the act by addition of title XII (grants to States for hospitals and health centers), title XIII (grants to States for medical care), and title XIV (grants to States for disability compensation). Section 5 makes miscellaneous amendments to title XI (general provisions).

MATERNAL AND CHILD WELFARE

Title V of the Social Security Act is at present divided into five parts. The present bill amends parts 1, 2, and 5, as indicated in the summary which follows.

Part 1 of this title deals with grants-in-aid to the States for maternal and child-health services. As amended by section 2 of S. 1620, appropriations are authorized to assist the States to promote the health of mothers and children and to improve medical services in maternity and infancy. Special emphasis is placed upon the needs of rural areas and of people living in areas suffering from severe economic distress. Appropriations are authorized up to the amounts shown in the accompanying tabulation where, for each title, the proposed authorizations are compared with authorizations now contained in the Social Security Act (sec. 501).

Any sums which may be appropriated by Congress within the limits authorized by the bill are to be distributed among the States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for extending and improving maternal and child-health services. These allotments shall ~~be~~ determined by the Chief of the Children's Bureau on the basis of the total number of births in the latest fiscal year for which statistics are available, the number of mothers and children who are in need of services, special problems of maternal and child health existing in the States, and the financial resources of the States (sec. 502).

If a State plan is to be approved it must comply with certain stipulated conditions in order to assure that the Federal grants-in-aid to the States shall be expended for the purpose for which they are intended and with reasonable economy and efficiency. It is specified that a State plan must provide for financial participation by the State and for a program which shall be State-wide, or which shall be progressively extended so as to be in effect in all areas in need of the services by the end of the fiscal year ending June 30, 1945. It is required that the plan shall be administered by the State health agency (or that this agency shall supervise any part of the plan administered by another State agency or by a political subdivision of the State) and that the State health agency shall be authorized to promulgate such rules and regulations as are necessary for the efficient operation of the services. The Chief of the Children's Bureau is authorized to require the inclusion in the State plan of safeguards which will insure methods of administration necessary for the maintenance of high standards of medical and institutional care and of remuneration for such care, personnel standards of administration on a merit basis, and such other safeguards as are necessary for the efficient operation of the plan. The State plan must also contain provisions for the making of periodic reports by the State health agency to the Chief of the Children's Bureau and for the creation of a State advisory council (or councils) composed of members of the professions and

agencies, public and private, furnishing services under the plan, and of other persons who are experts in the field. Finally, the plan must provide for administrative cooperation and, when necessary, for working agreements between the State health agency and other public agencies administering closely related services (sec. 503).

The bill proposes a somewhat different method for the allotment and payment of grants-in-aid to the States from that now contained in the Social Security Act. Instead of the present provision, which includes a 50–50 matching fund and a "free" fund, the latter allotted according to the financial needs of the States for assistance in carrying out their plans (after taking into consideration the number of live births), the bill proposes that allotments shall be made by the Chief of the Children's Bureau in accordance with a matching formula which takes account of the financial resources of the States. Under this formula the Federal Government would contribute grants ranging from 33⅓ to 66⅔ percent of the total amounts to be expended under the State plans, depending upon the matching ratio determined for each State by its relative financial resources (Secs. 502 and 504).

If any State fails to comply with the terms of the approved plan, the Chief of the Children's Bureau shall, after reasonable notice and opportunity for hearing, notify the State that further payments will be suspended until compliance occurs (sec. 505).

The Chief of the Children's Bureau is authorized to establish a Federal advisory council (or councils) to advise with respect to carrying out the purposes of this part of title V. The Chief of the Children's Bureau, with the approval of the Secretary of Labor, is authorized to make and publish necessary rules and regulations to carry out this part of the title (secs. 506 and 507).

Part 2 of title V deals with grants-in-aid to the States to enable them to develop medical services for children and services for crippled and other physically handicapped children. As in the case of part 1, emphasis is placed upon the needs of rural areas and of areas suffering from severe economic distress. The appropriating section authorizes the annual appropriation of amounts which begin with $13,000,000 for the fiscal year 1940 and to increase progressively through 1942. For each fiscal year thereafter there is authorized the appropriation of a sum sufficient to carry out the purposes of this part of title V (sec. 511).

Any sums which may be appropriated by the Congress for this part of the title are to be allotted to the States by the Chief of the Children's Bureau after taking into consideration the child population, the number of children in need of the services, special problems of medical care for children, and the financial resources of the several States. As shown in the accompanying table, the appropriations which are authorized are to be allotted separately for medical care of children and for services to crippled and physically handicapped children in need of special care (sec. 512).

State plans under part 2 must meet requirements substantially similar to those stipulated with respect to maternal and child-health services, with minor variations necessary for the particular purposes of this part of the title. For example: Though it is required in part 1 that a State plan shall provide for administration by the State health agency (or for supervision by the State health agency of any part of the plan administered by another State agency or by a political sub-

division of the State), account is taken of the fact that in some States programs which come within the field of part 2 are already in operation and are administered by a State agency other than the health agency. Accordingly, there is a special provision that where some agency other than the State health agency is already charged by State law to administer a program which may come within the objectives of this part of title V, and where it is already carrying out a substantial program of medical care for children or services for crippled children, an appropriate plan may be submitted and approved except that administration by the State health agency shall become effective by the fiscal year ending June 30, 1945. This provision is designed to encourage and accelerate the administrative integration of health programs in the States (sec. 513).

Federal grants-in-aid are to be made under conditions and arrangements similar to those covering payments for maternal and child-health services. State expenditures for the institutional care of children with mental disease, mental defectiveness, epilepsy, or tuberculosis are counted in the funds matched by Federal grants (under this part of the title) only as they exceed the average annual amounts spent in the last 3 years for these purposes (sec. 514).

The further provisions concerning the operation of State plans, the establishment of a Federal advisory council (or councils) and the rule-making power of the Chief of the Children's Bureau are similar to the corresponding provisions for part 1 of this title (secs. 515, 516, and 517).

Part 5 of title V is amended to increase to $2,500,000 the sum which is authorized to be appropriated for the administrative expenses of the Children's Bureau for the fiscal year 1940, in administering the provisions of the title and in making such studies, investigations, and demonstrations, and such provisions for the training of personnel as will improve the quality of services and promote the efficient administration of the title; thereafter, so much is authorized as is sufficient for the purposes (sec. 541).

PUBLIC HEALTH WORK

Title VI of the Social Security Act is amended so as to make more extensive provisions for State and local public health services and for investigations by the Public Health Service. The provisions of the title are adjusted to the general pattern already outlined for the amendments to title V.

Part 1, providing for public-health work, authorizes appropriations to provide grants-in-aid to the States to enable them to extend and improve their public-health services, especially in rural or economically distressed areas. Special emphasis is given to tuberculosis, malaria, pneumonia, cancer, mental health, and industrial hygiene; but the scope of public-health work is not limited to these special fields. Existing law authorizes the appropriation of $8,000,000 a year for grants to the States. S. 1620 authorizes appropriations, beginning with $15,000,000 for the fiscal year 1940, for increased amounts for the 2 succeeding years and thereafter for so much as the Congress may consider necessary to carry out the purposes of this part of title VI (sec. 601).

The Surgeon General of the Public Health Service, in allotting to the States the sums appropriated by Congress, is required to take into consideration the population, the number of individuals in need of the services, the special health problems, and the financial resources of the several States (sec. 602).

The provisions relating to the approval of State plans are similar in these amendments of title VI to those governing plans with respect to maternal and child-health services in title V outlined above. As in part 1 of title V, the State plan is required to be administered by the State health agency (sec. 603).

The provisions for payments to the States, the operation of State plans, authority to establish a Federal advisory council (or councils), authority to make and publish necessary rules and regulations are also similar to the corresponding provisions in title V. The appropriation of $1,500,000 is authorized for the fiscal year 1940 for administration, studies, demonstrations, training of personnel, etc., and thereafter a sum sufficient for these purposes. Miscellaneous provisions authorize such administrative reorganization within the Public Health Service as may be necessary for efficient administration (secs. 604–608).

Title VI of the Social Security Act authorizes the appropriation of $2,000,000 a year for expenditure by the Public Health Service for the investigation of disease and problems of sanitation. This part of the title now becomes part 2 of title VI and authorizes the appropriation of $3,000,000 for the fiscal year 1940, slightly larger appropriations for the next 2 years, and thereafter so much as the Congress may consider necessary (sec. 611).

GRANTS TO STATES FOR HOSPITALS AND HEALTH CENTERS

Section 4 of the bill amends the Social Security Act by adding a new title (XII) to provide grants to the States to enable them to construct and improve needed hospitals and to assist them in defraying the operating costs of these institutions during the first 3 years of operation. Again, special emphasis is placed upon the needs of rural and economically distressed areas. The appropriations which are authorized are divided between those which may be used to assist the States in the construction and improvement of general hospitals and those intended for mental and tuberculosis hospitals, as shown in the accompanying table. All payments to the States are contingent upon the States having in effect plans approved by the Surgeon General of the Public Health Service (sec. 1201).

For the purposes of this title, the term "hospital" is given a broad meaning, to include health, diagnostic, and treatment centers, institutions, and related facilities (sec. 1209).

Any sums which may be appropriated by the Congress for the purposes of this title are to be allotted by the Surgeon General after taking into consideration the needed additional hospitals of, and the financial resources in, the several States (sec. 1202).

A State plan, to be approved, must provide for financial participation by the State and for administration of the plan by the State health agency (or for supervision by the State health agency of any part of the plan administered by another State agency or by a political subdivision of the State). In addition, the State plan must provide

safeguards to assure continued public ownership of hospital facilities, equipment, etc., constructed or improved through Federal grants-in-aid and to assure satisfactory title, location, design, construction, and equipment. Administrative safeguards similar to those provided for under titles V and VI must also be established and it is required that the State agency shall have authority to make necessary rules and regulations and shall make such reports as the Surgeon General may require. The plan must also provide a system of financial support which will give reasonable assurance for the continued operation and maintenance of hospitals constructed or improved under this program and it must contain provisions guaranteeing to workers employed in the construction of the hospitals the prevailing wage in the locality for work of a similar nature. The Surgeon General is authorized to utilize the Public Works Administration (or, upon termination thereof, any other appropriate agency designated by the President) to review the title, location, plans, and specifications and to supervise the awarding and performance of contracts for the construction of hospitals assisted under the provisions of this title (sec. 1203).

The construction of needed mental and tuberculosis hospitals is already commonly an activity of a State agency, but not necessarily of the State health agency. In order that programs for the construction of such hospitals shall not be impeded, it is provided that a State plan submitted for approval under title XII is exempted from certain specified administrative requirements during the fiscal years 1940 and 1941 (clause 11, subsec. 1203 (a)).

Payments to the States are to be made on the same basis as applies to payments under titles V and VI, with the additional provision that the Federal grants-in-aid toward the operating costs of added facilities shall be at fixed rates; $300 a year per added bed in general and tuberculosis hospitals, and $150 per added bed for mental hospitals during the first year of their operation; two-thirds of these amounts, respectively, for their second year of operation; and one-third of these amounts, respectively, for the third year of operation (sec. 1204).

Title XII also contains provisions concerning the operation of State plans, the creation of a Federal advisory council or councils, and for the making and publishing of necessary rules and regulations, all of which correspond to the provisions of titles V and VI, the Federal administrative authority being assigned to the Surgeon General of the Public Health Service (secs. 1205–1207).

The appropriation of $1,000,000 to the Public Health Service is authorized for the fiscal year 1940 for the administration of this title, and for each fiscal year thereafter a sum sufficient for the administration of the title. There is also an authorization for the appropriation of a sum sufficient to carry out the functions vested by this title in the Public Works Administration or a successor agency (sec. 1208).

GRANTS TO STATES FOR MEDICAL CARE

Section 4 of the bill further amends the Social Security Act by adding a new title (XIII) to provide Federal grants-in-aid to the States to enable them to extend and improve medical care, especially in rural areas and among individuals suffering from severe economic distress. The sum of $35,000,000 is authorized to be appropriated for the fiscal year 1940, and thereafter such sums as the Congress

may consider necessary. Any sums authorized under these appropriations are to be distributed to the States submitting plans approved by the Social Security Board (sec. 1301).

If the sum appropriated for the fiscal year 1940 is insufficient to meet the total payments for that year, the total amount available is to be allotted among the States by the Social Security Board after taking into consideration the population, the number of individuals in need of the services, the special health problems, and the financial resources of the several States (sec. 1302).

The approval of State plans is conditioned upon stipulations like those already reviewed in connection with the preceding titles, except that administration of the State plan is not exclusively restricted to the State health agency (sec. 1303).

Payments to the States are to be made on the basis of the same variable matching formula applying to payments under other titles of the bill. No Federal grants are to be made in respect to so much of the State expenditures as are in excess of $20 a year per individual eligible for medical care under the proposed plan, or so much as are expenditures for the institutional care of cases of mental disease, mental defectiveness, epilepsy, and tuberculosis (sec. 1304).

Federal payments are to be suspended if any State fails to comply with requirements specified in the title (sec. 1305).

The administration of the title is vested in the Social Security Board. The Board is authorized to create a Federal advisory council (or councils) to advise it with respect to the administration of this title, and to make and publish rules and regulations necessary for efficient administration. One million dollars is authorized to be appropriated for the fiscal year 1940 to meet the administrative expenses of the Board, and for each fiscal year thereafter a sum sufficient for such purposes (Secs. 1306–1308).

GRANTS TO STATES FOR TEMPORARY DISABILITY COMPENSATION

Section 4 of the bill also adds a third new title to the Social Security Act, title XIV, to assist the States in the development, maintenance and administration of plans of temporary disability compensation. The appropriation of $10,000,000 is authorized for the fiscal year 1940, and of such sums for the fiscal years thereafter as may be necessary to carry out the purposes of the title. Sums appropriated by the Congress under these authorizations are to be distributed to the States having plans for temporary disability compensation approved by the Social Security Board (sec. 1401).

State plans to be approved for grants-in-aid under this title are required to be based upon State laws which meet a number of conditions explicitly laid down in the title. The State law must provide for: Administration and payment of disability compensation through a single State agency, or through more than one where this may be consistent with efficient administration of the State plan; methods of administration necessary for efficient operation; opportunity for fair hearing before an impartial tribunal for individuals whose benefit claims are denied; cooperation and working agreements with State agencies administering related programs or services; the making of such reports to the Social Security Board as may be required and necessary, etc. No plan for disability compensation is to be approved by

the Social Security Board for any State which does not have a plan or plans, approved under other titles of the bill, such as will assure that reasonably adequate medical services, including preventive services, are available to minimize disability among persons covered by the temporary disability compensation plan of the State. Payments will cease when the plan fails to meet the stipulated conditions (sec. 1402).

Grants to the States which have approved plans would amount to one-third of the sums expended as temporary disability compensation plus one-third of the costs of administration found by the Board to be necessary for proper and efficient administration of the plan. The method of computing and paying such amounts is similar to the provisions of the assistance titles in the present Social Security Act (sec. 1403). The appropriation of $250,000 for the fiscal year 1940 is authorized to cover the Board's administrative expenses, and for each fiscal year thereafter a sum sufficient for such purposes (sec. 1404).

GENERAL PROVISIONS

Section 5 of the bill amends title XI of the Social Security Act which contains miscellaneous provisions. The terms "State" and "United States" are amended to include Puerto Rico when used in the titles amended or added by this bill (subsecs. 1101 (a) (1), (2)).

Section 1101 is further amended by the addition of a new subsection to define the term "financial resources." This clause specifies that the financial resources of the several States shall be measured by per capita income, as determined jointly by the Secretary of Commerce, the Secretary of Labor, and the Chairman of the Social Security Board, on the basis of the latest available satisfactory data for a 3-year period. The measurement of financial resources shall be expressed in a series of matching proportions for the purpose of making grants-in-aid to the States under titles V, VI, XII, and XIII of this bill. For titles V, VI, and XII, these matching percentages shall range from a maximum of 66⅔ percent for the State with the lowest financial resources to a minimum of 33⅓ percent for the State with the highest financial resources; for title XIII, the maximum is to be 50 percent and the minimum 16⅔ percent. This amendment to title XI lays down the pattern for variable matching grants applicable to all the titles which involve such variable grants; it is the basis upon which the bill undertakes to provide that the grants-in-aid to the States shall be adjusted to the relative financial resources of the States (subsec. 1101 (e)).

Present appropriations for health purposes under the Social Security Act and appropriations proposed to be authorized by S. 1620

Purpose	Present authorization under the Social Security Act	Proposed authorization under S. 1620 [1]			
		Fiscal year 1940	Fiscal year 1941	Fiscal year 1942	Succeeding years
Title V:					
Part 1: Maternal and child-health services	$3,800,000	$8,000,000	$20,000,000	$35,000,000	(2)
Part 2: Medical services for children, including crippled children	2,850,000	[3] 13,000,000	[3] 25,000,000	35,000,000	(2)
Part 5: Administration, investigations, and demonstrations, etc	425,000	2,500,000	(2)	(2)	(2)
Title VI—Public health work and investigations:					
Part 1:					
Payments to States	8,000,000	15,000,000	25,000,000	60,000,000	(2)
Administration, studies, demonstrations, etc		1,500,000	(2)	(2)	(2)
Part 2: Investigations	2,000,000	3,000,000	3,500,000	4,000,000	(2)
Title XII:					
Grants for general hospitals		8,000,000	50,000,000	100,000,000	(2)
Grants for mental and tuberculosis hospitals		(2)	(2)	(2)	(2)
Administration, etc.					
Public Health Service		1,000,000	(2)	(2)	(2)
Public Works Administration (etc.)		(2)	(2)	(2)	(2)
Title XIII:					
Grants for medical care		35,000,000	(2)	(2)	(2)
Administration		1,000,000	(2)	(2)	(2)
Title XIV:					
Grants for temporary disability compensation		10,000,000		(2)	(2)
Administration		250,000	(2)	(2)	(2)
Total	17,075,000	[4] 98,250,000			

[1] These amounts replace, and are not additional to, the amounts authorized by the Social Security Act.
[2] A sum sufficient to carry out the purposes of (this part of) this title.
[3] Of which $4,000,000 in the fiscal year 1940, $5,000,000 in the fiscal year 1941, and so much as the Chief of the Children's Bureau deems necessary in succeeding years, are to be allotted "for service to crippled children and other physically handicapped children in need of special care."
[4] Total of limited expenditures authorized.

IV. Some Special Problems Raised in the Hearings

The hearings have developed many problems which deserve and will receive the careful consideration of the committee. We do not undertake to discuss all of them at this time; we wish to comment briefly on a few which are of wide interest.

1. *Federal aid to States.*—Some witnesses have objected to the grant-in-aid pattern embodied in the bill. They have urged that there should be a Federal officer with authority to approve aid to some States in dire need of assistance and withhold it from other States with lesser need. However, the questioning by the committee brought out that the more closely these witnesses inspected the procedures necessary for an equitable grant-in-aid program, the closer they approached to just such a pattern as is embodied in the bill—with some divergence of opinion as to the amounts of money to be authorized or as to the details of the standards to be followed in making allotments.

The amount of Federal aid under a Federal-State cooperative program should be measured by the size or degree of the need for such aid. There can be no objection to this principle. It would be unsound, however, to assign to an administrative officer, except in

some unusual emergency and only for the duration of such an emergency, the authority to give or to withhold grants-in-aid at his sole discretion. The orderly processes of government require that the Congress shall determine, in clear and unequivocal language, the conditions and circumstances under which Federal aid may be available to each State and the formulas which shall determine the amount of such aid. In a Federal-State cooperative program, each State is entitled to equal opportunity to make its showing of need and to equal opportunity for aid according to its need for such aid.

The procedures stipulated in the bill follow the precedents laid down for the administration of Federal grants-in-aid under the Social Security Act and under other acts which experience has shown are practicable and equitable. The testimony to which we have already referred shows that the Federal-State cooperative program under the health titles (V and VI) has operated smoothly and without domination of the States by the Federal Government. The details of the procedures may require amendment, and we are studying them carefully.

2. *Variable grants and matching proportions.*—We have already called attention to the fact that the bill provides for variable instead of uniform Federal-State proportions in the grants-in-aid. This provision rests upon the sound principle, adopted in 1935, in titles V and VI of the Social Security Act, that Federal aid to the States should be adjusted to the financial resources of the States and to their relative inability to meet their health problems. The formulas for the measurement of State financial resources and for the determination of variable matching proportions present many complex problems which we have not yet had adequate opportunity to explore. Studies on these points are still in progress.

Our attention has been called to problems which may arise because of the different limits specified in the bill for the range of matching proportions applicable to the several titles. Health services which may be developed under the several titles need to be intimately correlated in the States and localities, and administrative difficulties may arise if there are financial advantages or disadvantages in providing a particular service preferentially under one title or another. Further study may show that it is advisable to use a single range of matching proportions in all titles dealing with health and medical services.

3. *Income limit of the population to be aided.*—The appropriation sections of titles V, VI, XII, and XIII of the bill include as being especially among the purposes of the authorization to assist rural areas and areas (or, in title XIII, individuals) suffering from severe economic distress. Some witnesses would go further in this direction; they recommend that the bill be amended so as to limit exclusively to "needy" or to "medically needy" persons the health services financially aided by grants-in-aid contemplated by this bill. It has not always been made clear, however, precisely how one or the other of these groups is to be defined, without limiting the effectiveness of health programs in the States so as to defeat the purpose of the bill to improve the health of the population. We have already reviewed the overwhelming body of evidence submitted at our hearings, showing that medical costs may be burdensome and that medical care is inadequate for tens of millions of our people in income brackets above the level of those who are in receipt of any form of public aid or assistance.

Any useful definition of the "medically needy" must recognize that a large proportion of the entire population may be greatly burdened by sickness costs, and may, at any time, be among the "medically needy" even though otherwise self-supporting. Furthermore, many health problems transcend geographical or economic or social boundaries, and some health services must obviously be made available on a community-wide basis to all families and be paid for from general tax funds.

Other witnesses, representing large groups of the population, have emphasized the inadequate services received by self-supporting families and individuals of small incomes; they have recommended that the bill be amended to require, as a condition for receipt of Federal aid, specific health-insurance programs in the States to meet the needs of self-supporting persons with incomes up to $3,000 or an even higher limit.

Although we have not completed our study of these conflicting recommendations, the bill would appear to follow a fundamentally sound principle when it leaves to the States the decision as to the population groups to be served by their plans. A sound formula must be a flexible one. This seems to be especially important in view of the diverse conditions existing in the several States and the varying needs to be met. In every title, the bill requires the States to participate in financing the costs of the services and it may, therefore, be safely assumed that the States will reach careful conclusions as to the populations to be served by their plans. The special emphasis on the needs of rural areas and of areas or individuals suffering from severe economic distress is sound. But this provision establishes no exclusive groups to be aided nor does it place any drastic restraint on the States; it only supports the basic principle of leaving wide latitude to the States in utilizing Federal aid for the solution of their health problems.

4. *Medical education and research.*—In several sections of the bill which authorize appropriations, the training of personnel is included among the stated purposes. Some witnesses have construed this to apply only to the training of administrative personnel, though there is no such explicit provision. In any case, they have urged that medical education and research are of fundamental importance to the advancement of health services, that nongovernmental support for these activities is, and is increasingly becoming, inadequate, and that the bill should make substantial provision for the Federal support of professional education, administrative training, and research. The committee has these suggestions under consideration.

5. *Health education of the public.*—Several witnesses have testified as to the importance of health education for the public and that extensive provision should be made to support development in this field. Although the bill intends, under titles V, VI, and XIII, to encourage and aid health education, the committee is prepared to make the intention clear and specific.

6. *Administrative provisions.*—The bill has been criticized on the ground that the several parts are to be administered by multiple Federal agencies. A number of witnesses have urged that the health provisions, which are closely related to each other, should be administered by one Federal agency or that specific provision should be

made for cooperation and coordination among the several Federal agencies. Some have advised that the bill be amended to provide for a Federal Department of Health in which should be consolidated all health activities of the Federal Government.

Some witnesses have recommended that title XIII should be administered by the Public Health Service instead of the Social Security Board and the committee is giving careful consideration to this proposal.

The reorganization bill was before the Congress when S. 1620 was introduced by Senator Wagner. He called attention, in his statement made at the committee's first public hearing, to the need for coordination among the Federal agencies which would be given administrative responsibilities, but expressed the view that such proposals be given continued study pending the outcome of the reorganization bill. More recently, the Reorganization Act has been passed and the President's Reorganization Plan No. I has come into effect. This plan created the Federal Security Agency and coordinated the Public Health Service and the Social Security Board, two of the three administrative authorities specified by S. 1620. Thus, the administration of all parts of the bill except title V dealing with maternal and child welfare, is brought under one administrative agency.

The relationship which should obtain, in administering health programs, between the authorities within the Federal Security Agency and the Children's Bureau of the Department of Labor which administeres title V, and between them and other Federal agencies dealing with closely related matters, and the coordinating arrangements which should be provided by legislative or by executive authority, require further study.

A closely related question concerns the authorization to create Federal advisory councils for the three Federal administrative authorities. Representatives of the governmental agencies as well as of private groups have recommended that the bill be amended to provide for a single Federal advisory council or a national health council including both professional and public representatives, to be established jointly by the agencies charged with administration. All comments appear to be in agreement on this point. Corresponding recommendations advising amendment of the bill to require single councils at the State level are also before us.

Another closely related matter is the recommendation that the bill be amended to provide for joint periodic consultation of the Federal administrative authorities with a conference of those officers of the States who are responsible for administration of State plans.

These and similar suggested amendments, important for the efficient operation of the Federal-State cooperative programs proposed by the bill, are receiving careful study.

7. *Protection of minority population groups.*—It has been urged upon our committee by witnesses who have testified at our hearings that there should be explicit provisions added to the bill to safeguard the interests of minority groups in the population. It has been suggested that the approval of State plans should require that in States where separate health facilities are maintained for separate races there shall be no discrimination, by reason of race, creed, or color, against any group of people in the provision of services to be received, remuneration for services furnished, or payment of benefits. Our committee

believes that there should be just and equitable allocation of funds according to the needs for services, and will study carefully the amendments suggested to carry out these purposes.

8. *Scope of services under State plans.*—It has been urged upon the committee by some witnesses that the bill should be amended to require that various specific kinds of services be explicitly included among the services that are to be furnished under State plans aided by Federal grants. The committee hesitates, at this time, to commit itself to this policy. In the first place, we are disinclined to add to the bill any stipulations, unless we are sure these are essential to carry out the purposes of the bill, that would limit the latitude that should be left to the States to design their own programs. In the second place, the specification of some kinds of services recommended by some witnesses invites the specification of other kinds which may seem to be equally important to others. There is no practical end to such a process. The relative importance of the services furnished by different types of practitioners, institutions, and facilities cannot be uniformly evaluated; they must be weighed in terms of the people to be served, the conditions that exist in the States and communities, the funds available, the public demand, and other factors. The committee believes it should give further study to the suggested changes.

9. *Eligibility of practitioners under State plans.*—Some witnesses have recommended that explicit provision be made in the bill as to the eligibility of various schools of practitioners to furnish services under approved State plans.

Various schools of practitioners are recognized and licensed under the laws of the States to furnish general or limited medical services. The committee is impressed by the fact that the licensing and regulation of practitioners in medicine and allied fields have always been within the jurisdiction of the States, and not of the Federal Government. We are inclined to believe that the powers of the States in these matters should be left as at present and, therefore, that the bill should not include any specifications on these points, except a provision to the effect that nothing in the bill should be construed as infringing upon the authority of each State to continue to regulate the practice of the healing arts.

10. *Cooperation with representative groups.*—There is some confusion as to the intent of the bill on the point that the States should utilize and encourage cooperative arrangements with practitioner and welfare groups and organizations.

The desirable objective is stated by the provision in each title which requires that a State plan to be approved shall "provide for an advisory council or councils composed of members of the professions and agencies, public and private, that furnish services under the State plan, and other persons informed on the need for, or provision of, * * * services * * *." Some witnesses who have raised this point have commended clause (6) of subection 503 (a) of the Social Security Act, which specifies that a State plan must "provide for cooperation with medical, nursing, and welfare groups and organizations." The committee has heard no objection to adding or substituting a provision equivalent to this clause.

11. *Construction of needed hospitals.*—Fears have been expressed, at the hearings, in the press, and in professional circles, that the hospital-

construction program contemplated in title XII may lead to the building of public hospitals in communities where they are not needed or where nongovernmental hospitals are already adequately serving, or may in the future adequately serve, community needs. The title is not intended to lead to any such unsound activity. Before any new hospital construction is undertaken, the available beds in qualified, existing, nongovernmental and governmental hospitals should be used, provided the type of service meets accepted standards and the charges for the use of such beds are reasonable. Section 1201 declares that sums authorized to be appropriated are for the construction and improvement of "needed" hospitals and section 1202 provides that the Surgeon General shall make allotments to the States in accordance with rules and regulations, taking into consideration for the several States "the needed additional hospitals."

When we say that there are serious hospital deficiencies in many parts of the United States and for large groups of the population, we are not losing sight of the splendid facilities which have been developed through private as well as through governmental activities. We have no intention whatever of endorsing any proposal that would encourage the building of hospitals where adequate facilities exist or that would encourage the building of public hospitals where private hospital construction would in the normal course of events meet community needs. On the contrary, private activity, construction, and support of hospital services is a sound and estimable community service. There are, however, areas of the country and large groups of people whose needs for hospitalization are inadequately met and will, by all available evidence, continue to be unmet unless State and local public resources, assisted by the Federal Government, are utilized to deal with the problem. Farm organizations have testified that such conditions are especially evident in many rural areas. Where qualified hospitals exist but are inadequately used, because they cannot finance the care of persons who require but cannot pay for service, the first necessity is to encourage use of these facilities by solving the financial problems. But where qualified hospitals do not exist or are insufficient, there is need for additional construction.

There is no issue between the intent of the bill and the views of those who believe there should be additional safeguards against unnecessary or undesirable hospital construction. Our committee intends to prepare amendments to title XII to assure that Federal aid under this title will require unequivocally clear showing of need through impartial State and local surveys, and clear satisfaction of Federal requirements that such needs exist, in addition to reasonable demonstration as to future continuing support of the hospitals.

In this connection, we are studying the methods of financing needed hospital construction and we expect to have further conferences with representatives of hospital organizations to discuss various problems concerning hospital needs and services.

12. *Payment for services furnished by nongovernmental hospitals and other agencies.*—There has been much discussion of this point. The committee is aware of the extensive current practices whereby State and local governments pay for services rendered by nongovernmental hospitals, nursing agencies, etc., to needy persons. It is one of the primary purposes of the bill to assist the States in meeting the costs of medical services needed by their citizens and thereby to assist the

people in receiving more adequate care. Obviously, the more extensive use of qualified existing hospitals, public and private, is one of the simple and direct methods of achieving this objective. As we have already said, empty beds in qualified hospitals should be filled in communities where the need for service exists and is not being met. The same principle applies to the use of nongovernmental nursing and other agencies.

There is nothing in titles V, VI, or XIII—the titles which deal with Federal aid for health or medical services—that would limit any State plan in paying for services furnished by nongovernmental as well as by governmental hospitals and agencies. Federal aid would be available toward such expenditures. In similar circumstances, nongovernmental hospitals and agencies are being extensively used in State plans operating under title V of the Social Security Act. The Children's Bureau testified at our hearings that the States are purchasing services for crippled children from 601 hospitals, of which 512 are private, nongovernmental, and 89 governmental hospitals. Federal aid is assisting in paying for these services, and we have no intention of altering these practices.

The intention of the bill to aid in the use of existing facilities is evident not only in the absence of any prohibition against the use of nongovernmental facilities, but also in the provision requiring representation on the State advisory council or councils "of members of the professions and agencies, public and private, that furnish services under the plan * * *." However, in order that all doubts and fears on this score may be resolved, the committee is agreed that the bill should be amended by addition of positive provisions that qualified hospitals and agencies, both public and private, may be utilized in the State plans.

V. The Problem of Industrial Health and Safety Hazards

We have already called attention to the health problems of industrial workers and to the importance of enforcing regulations for the control of health and safety hazards in industrial establishments. The activities of the Federal and State Governments need to be greatly expanded and strengthened so that the health of the workers may be better safeguarded and improved. Furthermore, there is need to strengthen the administration of workmen's compensation laws in the States. To these ends, we are giving careful consideration to the adoption of an additional title (XV) which has been recommended to the committee. In doing so, we would be attempting to provide an effective working arrangement as between conflicting recommendations which have been submitted to the committee.

This additional title follows the general pattern of other titles of the bill. It authorizes the appropriation of $1,000,000 for the fiscal year 1940, $2,000,000 for the year 1941, $3,000,000 for the year 1942, and a sum sufficient to carry out the purposes of the title for each fiscal year thereafter. These sums are to be allotted to the States to assist them in extending and improving their activities in the control of working conditions and practices involving health and safety hazards in industrial establishments, in the development and enforcement of pertinent regulations, and in assisting them in the administration of workmen's compensation laws. The money is to be al-

lotted by the Secretary of Labor to States having approved State plans, after taking into consideration the population, the number of employed wage earners, the special industrial hazards and need for assistance in the enforcement of workmen's compensation laws, and the financial resources of the States.

State plans would be required under title XV to meet stipulations similar to those summarized above for the other titles, except for variations appropriate to the purposes of this title. A State plan to be approved would have to provide for administration by the State labor department or other agency charged with administration of general labor laws, or for the supervision by the labor department of any part of the plan administered by another public agency, State or local. Provisions concerning payments to States, operation of State plans, authorization for the Secretary of Labor to create an advisory council or councils and to make and publish necessary rules and regulations follow the pattern common to the bill. The sum of $150,000 is authorized to be appropriated for the fiscal year 1940, for the administration of this title by the Department of Labor, and a sum sufficient for these purposes for each fiscal year thereafter.

Concurrently, title VI of the bill would be amended so as to avoid duplication with title XV; grants toward the activities of the public-health agencies would apply to "industrial hygiene except such activities for the control of industrial health and safety hazards as are authorized in title XV." Accordingly, the development of industrial hygiene knowledge and skills, the performance of studies of occupational disease, disability and hazards to health, and activities relating to the general health of the worker which are among the functions of health departments would remain within the scope of title VI—Public Health Work and Investigations. The study and control of working conditions and practices involving health and safety hazards in industrial establishments, the development and enforcement of pertinent regulations, and the strengthening of workmen's compensation laws would be aided as the activities of the labor departments. There would, of course, need to be coordination: at the Federal level, between the Department of Labor, the Public Health Service, and the Social Security Board; and at the State level, between the labor, health, and related departments. Federal coordination in this field becomes part of the general problem raised by other titles of the bill and to which we have referred; State coordination is covered by requirements stipulated as conditions of approval for State plans.

VI. Conclusion

S. 1620 has received wide support from large and representative organizations. Its objectives are noncontroversial. Our Government is dedicated to promoting the welfare of the people and the protection and improvement of health and well-being. Making available to all of the people the great life-saving services which modern medicine has to offer is an objective which every right-thinking citizen supports.

The committee is convinced that Federal legislation along the general lines followed by S. 1620, based upon Federal-State cooperative programs, is necessary to strengthen the health services of the Nation and to make provision for the progressive and effective im-

provement of health conditions in all parts of the country and among all groups of people. The needs are large and an adequate program to put knowledge and skill more effectively to work will involve considerable expenditures of funds. The program must therefore be worked out with great care. We are confident that such a program can be worked out and that the expenditures will be sound national investments which will bring large returns. The role of the Federal Government should be primarily to give technical and financial aid to the States.

A critical analysis of the present provisions of S. 1620 shows a number of points at which its specific purposes can be more clearly stated and its provisions improved. The committee has not yet reached any conclusions concerning the precise rate at which Federal appropriations should be increased, but the committee is agreed on the general principle that the proportion of Federal assistance should be greater to those States in which there is the greatest need for the services contemplated under the bill. The committee is prepared to augment the provisions of the bill—if additional provisions are needed—to assure that the amount of Federal assistance would in no instance be in excess of clearly demonstrated need.

Some misunderstandings seem to have arisen and criticisms have been expressed concerning parts of the bill. Some witnesses have assumed that it would bring about revolutionary or dangerous changes in medical care. We think these fears are unwarranted, but we will welcome further suggestions as to specific amendments which may safeguard the objectives of the bill. Medical science has reached a commendable status in this country. The bill should encourage the further evolutionary development of medical science, teaching, and practice.

The committee has received the assurances of many lay and professional groups that they will be prepared to furnish further information and suggestions. We expect to consult further with representatives of these groups.

We have not yet had adequate time to make exhaustive study of all of the problems involved in the legislation proposed by S. 1620. The committee will continue its study of S. 1620 so that a definitive report on the proposed legislation can be submitted soon after the beginning of the next session of the Congress.

VII. Appendix

Table I.—*Infant mortality: United States, 1937*

	Rate per 1,000 live births		*Rate per 1,000 live births*
New Mexico	124	Tennessee	61
Arizona	121	Florida	60
South Carolina	76	Kentucky	59
Texas	74	Mississippi	59
Colorado	73	Missouri	57
Virginia	70	Oklahoma	57
North Carolina	66	Wyoming	56
Louisiana	66	Arkansas	54
Maine	65	California	54
Delaware	64	United States	54
Alabama	62	North Dakota	52
Georgia	62	Montana	51
West Virginia	62	South Dakota	51
District of Columbia	61	Indiana	50
Maryland	61	Ohio	50

TABLE 1.—*Infant mortality: United States, 1937*—Continued

	Rate per 1,000 live births
Pennsylvania	50
Vermont	49
Michigan	48
New Hampshire	48
Rhode Island	48
New York	45
Idaho	44
Iowa	44
Kansas	44
Massachusetts	44
Illinois	43
Wisconsin	43
Nebraska	42
Oregon	42
Minnesota	41
Utah	41
Connecticut	40
Nevada	40
Washington	40
New Jersey	39

Source: Reports of the U. S. Bureau of the Census.

TABLE II.—*Infant mortality in the United States: 1937 (infant deaths per 1,000 live births)*

	Urban
New Mexico	128
South Carolina	99
Arizona	90
North Carolina	90
Texas	81
Louisiana	80
Alabama	78
Mississippi	78
Virginia	75
West Virginia	75
Tennessee	74
Georgia	72
Arkansas	70
Maine	68
Colorado	66
Kentucky	63
Oklahoma	62
District of Columbia	61
Maryland	60
Florida	58
Indiana	57
Missouri	53
United States	52
Iowa	52
Vermont	52
Ohio	51
Pennsylvania	51
Kansas	50
Delaware	49
Michigan	48
Rhode Island	47
New Hampshire	46
Wyoming	46
California	45
South Dakota	45
New York	45
Massachusetts	44
Idaho	42
Illinois	42
Montana	42
North Dakota	42
Wisconsin	42
Connecticut	41
Utah	41
Nebraska	41
Minnesota	39
New Jersey	38
Oregon	38
Washington	37
Nevada	14

	Rural
Arizona	135
New Mexico	123
Delaware	83
Colorado	79
South Carolina	72
California	70
Texas	70
Virginia	68
Maine	64
Maryland	63
Florida	61
North Carolina	60
West Virginia	59
Missouri	59
Louisiana	58
Alabama	58
Georgia	58
Kentucky	58
Wyoming	58
Mississippi	57
United States	57
Tennessee	56
Montana	55
North Dakota	55
Oklahoma	54
Rhode Island	54
South Dakota	53
Arkansas	52
Pennsylvania	50
New Hampshire	50
Vermont	49
Ohio	47
New York	47
Illinois	47
Michigan	47
Wisconsin	45
Oregon	45
New Jersey	45
Massachusetts	44
Idaho	44
Washington	44
Nevada	44
Nebraska	43
Minnesota	43

TABLE II.—*Infant mortality in the United States: 1937 (infant deaths per 1,000 live births*—Continued

	Rural		Rural
Utah	42	Iowa	39
Indiana	42	Connecticut	38
Kansas	41		

Source: Reports of the U. S. Bureau of the Census.

TABLE III.—*Maternal mortality in the United States: 1937*

	Deaths assigned to pregnancy and childbirth per 10,000 live births		Deaths assigned to pregnancy and childbirth per 10,000 live births
Nevada	92	Massachusetts	46
South Carolina	77	Ohio	46
Georgia	74	Washington	46
Louisiana	72	Idaho	45
Mississippi	71	Iowa	45
Arkansas	68	New Hampshire	45
Florida	68	Kansas	43
Maine	66	Maryland	42
Alabama	63	California	41
Tennessee	61	Nebraska	41
District of Columbia	58	New York	40
Texas	57	South Dakota	40
Vermont	57	Oregon	40
Arizona	54	Delaware	39
Colorado	54	Illinois	39
North Carolina	54	Wyoming	38
Virginia	54	Rhode Island	38
Oklahoma	52	New Jersey	38
Missouri	51	Montana	37
New Mexico	50	Michigan	36
West Virginia	50	Wisconsin	36
United States	49	Indiana	35
Pennsylvania	48	Utah	33
Kentucky	47	Minnesota	31
North Dakota	47	Connecticut	25

Source: Reports of the U. S. Bureau of the Census.

TABLE IV.—*Distribution of hospital beds per 1,000 population according to medical type of hospital, by States arrayed in descending order of per capita income*

State	Beds per 1,000 population			
	General	Tuberculosis	Mental	Total
United States	3.14	0.55	4.12	7.81
District of Columbia	5.34	1.11	.91	7.36
New York	4.58	.80	6.87	12.25
Delaware	3.10	.86	5.97	9.93
Nevada	4.23		3.29	7.52
Connecticut	3.62	1.11	5.42	10.15
California	4.42	.72	4.60	9.83
Arizona	3.61	1.39	2.18	7.18
Rhode Island	4.44	1.15	5.01	10.60
Wyoming	2.86	.14	3.89	6.89
Illinois	3.53	.50	4.61	8.64
New Jersey	3.42	.91	5.09	9.42
Massachusetts	5.23	.99	6.40	12.62
Wisconsin	3.73	.73	5.43	9.89
Maryland	4.09	.74	5.02	9.85
Montana	4.98	.37	3.53	8.88
Michigan	3.54	.83	4.31	8.68
Pennsylvania	3.48	.42	4.02	7.92
Ohio	2.84	.49	4.04	7.37
Washington	3.76	.61	4.58	8.95
Indiana	2.23	.44	3.45	6.12
Colorado	4.33	1.60	4.43	10.36
Minnesota	4.12	.78	5.07	9.97
New Hampshire	4.03	.47	5.18	9.67

TABLE IV.—*Distribution of hospital beds per 1,000 population according to medical type of hospital, by States arrayed in descending order of per capita income*—Con.

State	Beds per 1,000 population			
	General	Tuberculosis	Mental	Total
Oregon	3.68	.56	4.82	9.06
Utah	3.40	----------	2.68	6.08
Idaho	2.84	----------	2.96	5.80
Maine	3.18	.57	4.29	8.04
New Mexico	3.23	.91	2.03	6.17
Kansas	2.60	.23	3.71	6.54
Vermont	3.00	.53	5.64	9.17
Missouri	2.78	.50	3.53	6.81
Iowa	2.73	.31	4.14	7.18
Florida	2.72	.36	2.92	6.00
Texas	1.98	.35	2.41	4.74
Nebraska	3.19	.12	3.90	7.21
West Virginia	2.66	.41	2.13	5.20
Louisiana	2.63	.15	3.46	6.24
Virginia	2.04	.45	3.82	6.31
Oklahoma	1.67	.32	3.24	5.23
North Dakota	3.04	.57	4.35	7.96
South Dakota	2.63	.28	3.45	6.36
Georgia	1.55	.19	2.48	4.22
North Carolina	1.86	.45	2.18	4.49
Kentucky	1.69	.23	2.41	4.33
Tennessee	1.67	.37	2.43	4.47
South Carolina	1.60	.31	2.58	4.49
Alabama	1.39	.14	2.10	3.63
Arkansas	1.26	.35	1.96	3.57
Mississippi	1.26	.24	2.22	3.72

Source: Compiled from material presented to the subcommittee by Surgeon General Parran, of the U. S. Public Health Service.

TABLE V.—*Patient-days of care per 1,000 persons and estimated annual per-capita payments for care in general hospitals,*[1] *by States, arrayed in descending order of per-capita income*

State	Patient-days of care per 1,000 persons	Annual payment per capita	State	Patient-days of care per 1,000 persons	Annual payment per capita
United States	780.04	$3.37	Utah	804.55	3.05
			Idaho	576.74	2.31
District of Columbia	1,361.04	6.38	Maine	763.69	3.10
New York	1,286.13	6.53	New Mexico	554.42	1.75
Delaware	790.13	3.57	Kansas	570.61	2.14
Nevada	925.15	7.04	Vermont	734.77	2.56
Connecticut	960.61	4.51	Missouri	683.43	2.75
California	1,173.11	5.67	Iowa	598.27	2.38
Arizona	777.84	3.03	Florida	514.93	2.37
Rhode Island	1,300.81	5.70	Texas	394.51	1.65
Wyoming	565.36	2.81	Nebraska	718.49	2.36
Illinois	865.10	3.20	West Virginia	566.78	2.16
New Jersey	873.97	4.33	Louisiana	725.04	1.99
Massachusetts	1,340.83	7.05	Virginia	499.35	1.73
Wisconsin	858.36	3.68	Oklahoma	301.40	1.36
Maryland	1,106.30	3.76	North Dakota	656.07	1.98
Montana	1,067.24	3.64	South Dakota	484.21	1.87
Michigan	988.52	4.72	Georgia	343.47	1.64
Pennsylvania	883.81	3.07	North Carolina	434.93	1.55
Ohio	735.75	3.30	Kentucky	366.00	1.42
Washington	870.45	3.34	Tennessee	386.57	1.70
Indiana	533.11	2.20	South Carolina	395.37	1.17
Colorado	974.70	4.49	Alabama	285.32	1.08
Minnesota	993.70	4.16	Arkansas	207.63	1.74
New Hampshire	947.57	3.87	Mississippi	209.65	.67
Oregon	915.88	3.02			

[1] Excluding all mental and tuberculosis hospitals, infirmary units of institutions, and all other hospitals of Federal control.

Source: Material presented to the subcommittee by Surgeon General Parran, of the U. S. Public Health Service.