HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

I. S. Falk

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In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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CHRONOLOGY

1899	Born, Brooklyn, September 30
1915-1920	Yale University, Assistant in Department of Public Health
1920-1923	Yale University, Department of Public Health Instructor
1920	Yale University, Ph.B
1923	Yale University, Ph.D.
1923-1926	University of Chicago, Assistant Professor of Bacteriology
1926-1929	University of Chicago, Associate Professor of Bacteriology
1926-1927	Chicago Department of Health, Bureau of Child Welfare, Assistant Director
1929	University of Chicago, Professor of Bacteriology
1929-1936	Milbank Memorial Fund, Research Associate
1936-1941	Social Security Administration, Bureau of Research and Statistics, Chief of Health and Disability Studies; Assistant Director of the Bureau
1941-1954	Social Security Administration, Division of Research and Statistics, Director
1954-1955	World Bank, Adviser on Social Services
1956-1958	Republic of Panama and the United States Canal Zone, Consultant on health services, and social security
1958-1980	United Steelworkers of America, Consultant on health services

1961-1968	Yale University, School of Medicine, Professor of Public Health and Medical Care
1968-	Yale University, Professor Emeritus and Lecturer, Public Health and Medical Care
1968-1979	Community Health Care Center Plan, Inc., Executive Director and Vice Chairman of the Board
1968-1981	Committee for National Health Insurance, Chairman of the Technical Committee

MEMBERSHIPS and AFFILIATIONS

American Academy of Political and Social Sciences

Member

American Association for the Advancement of Science

Fellow

American Economics Association

Member

American Hospital Association

Member

American Public Health Association

Fellow, past Chairman, Medical Care Section, editorial board member

American Public Welfare Association

Member

American Statistical Association

Fellow

Group Health Association of America

Board Member (Honorary)

Industrial Relations Research Assocation

Member

Sigma Xi

Member

AWARDS

American Public Health Association

Centennial Award, Medical Care Section, 1972

American Public Health Association

Sedgwick Medical for Distinguished Service in Public Health, 1973

Association of University Programs in Health Administration

Distinguished Service Award, 1973

Congressional Selective Service Medal, 1946

Connecticut Hospital Association

Honorary Member, 1975

The Group Health Association Award

The Esselstyn Foundation Award

The Montefiore Hospital and Ernest P. Boas Memorial Fund Award, 1969

Orden de Vasco Nunez de Balboa (Panama), 1956

Ordre de Honneur et Merite (Haiti), 1953

BOOKS

Principles of Vital Statistics, 1923

The Newer Knowledge of Bacteriology and Immunology (coeditor), 1928

The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families (coauthor), 1933

Security Against Sickness, 1936

Disability Among Gainfully Occupied Persons (coauthor), 1945

Medical Care Insurance (coauthor), 1946

The Social Insurance Program in Haiti, 1951

The Social Services in the Economic Development of Malaya, 1955

Social Security in Panama, 1956

Health in Panama, 1957

Health Services and Facilities in the Canal Zone, 1958

Standards of Good Medical Care (with H. K. Schonfeld and J. F. Heston) four volumes, 1975

FALK:

I was born in Brooklyn, New York in 1899 in quite a large family of people who had come to this country two generations before. My father was an active business man, mainly in the insurance field. I grew up in a family in which there were some schisms, some differences in religious outlook. My mother was rather orthodox, my father was not a religious person. He was rather outside the field of religious beliefs. This had some bearing on my development.

I went to school--the grade schools and high school--in Brooklyn and completed my elementary education when I was quite young, fourteen or fifteen. Though pointed toward going on to professional education and career, my family were rather indisposed to see me enter college at that age, thinking that I was too young and that I ought to do something for a year or two or three. I stayed on in the high school for a year or so, an assistant to some of the teachers in physics and biology.

About the time I was fifteen, a cousin of mine who was being educated in the health and biology fields at Columbia University and the College of the City of New York suggested I might be interested in taking a job with one of their teachers whom they greatly admired and who was soon to become a professor of public health at Yale, to head a newly created department of

public health. He was collecting a very small staff and wanted someone to be a laboratory technician. As a result, through this cousin, I was asked to come in for an interview, with C-E.A. Winslow who had several appointments in the New York area: State Department of Health, Professor in City College, and, as I recall, at Columbia University. He also was head of the Department of Public Health at the American Museum of Natural History in New York which housed, in addition to many public health exhibits, the national bacterial culture collection.

So I went for an interview with him and he invited me to come to be his laboratory boy in New Haven and to take some preliminary training in his bacteriological laboratory at the Museum. Professor Charles-Edward Amory Winslow was already regarded as one of the most promising Americans in sanitary science and public health. He had made a very distinguished record in his years at the Massachusetts Institute of Technology where he was educated and trained under William Thompson Sedgwick, one of the outstanding men in public health in those days. I am here referring to 1915.

So I went to the Museum of Natural History for some months, was trained in elements of bacteriology, laboratory procedures, culture medium preparation, maintenance of cultures, dishwashing, et cetera, the usual things. I came to New Haven in September of 1915 when Doctor Winslow took office as the Professor of Public Health at Yale.

My background had been that of a bright youngster, an omnivorous reader, with diverse interests but somewhat uncertain as to what I wanted specifically and particularly to do: whether to go on in study of languages, history, English literature, the sciences, et cetera--youngster whose career outlooks were not formed.

I came to New Haven when Professor Winslow came here in September 1915 along with one of his former pupils in New York who was going to be an instructor on his staff, carrying some cases of the cultures that were to be maintained in his laboratory in New Haven.

For the next year or two I was a lab boy doing all the things I was asked to do, and all the things I had gotten some preparation for. Reading omnivorously in the biological sciences and public health and bacteriology, particularly in chemistry, physics, biology generally, genetics and working as a janitor and a dishwasher and a culture media preparer and all the usual things--what the Germans used to call in the laboratory the "diener."

After about two years of that, and reading extensively under Professor Winslow's guidance, I became a special student in one of the two undergraduate colleges at Yale. In those days there were two major undergraduate colleges: the Yale College proper known as the academic or "Ac" and the Sheffield Scientific School which was the science branch of undergraduate education at Yale. I was privileged to be admitted to Sheff as a special student because of the recommendation from Professor Winslow and others in the building where we were working and from the then Dean of Sheffield Scientific School who was a very distinguished biochemist and nutritionist in those days, Russell Henry Chittenden, who was very well known in the world of those years.

For the next two years I was privileged to attend such classes and courses as I wanted to, I had no fixed curriculum to observe. I could select what I wanted to do. With Professor Winslow's guidance and the privileges he gave me I could spend a substantial part of my time course taking where I concentrated very heavily in the sciences, biology, chemistry, physics, physical chemistry which intrigued me very greatly, physiological chemistry as we used to call

it, biochemistry as it came more generally to be known. At the end of about two years of such privileged, special education I matriculated as a freshman, and with the help of some advanced credits I was granted at the time for the courses I had attended and what I had done toward meeting the requirements of the courses, stayed on and completed my work for a bachelor's degree, a bachelor of philosophy degree, in 1920. I had first matriculated with an earlier class but during the war years I was part of the time in the armed services in officer's training and so on so that I was somewhat delayed in completing the requiements. At any rate I completed them and received my bachelor's degree in 1920.

By that time I had been assisting Professor Winslow not only in his laboratory work, culture maintenance, experimental work of many kinds, but also had begun to do some research on my own motion under Professor Winslow's guidance, and the guidance of other members of the science faculty, and assisting in the teaching in the Department of Public Health. It was not yet at that time a formal school of public health though shortly it became one as the result of conferences in which Professor Winslow was engaged with the other leaders in the public health world: MIT, Harvard, Michigan, Hopkins, Columbia, one or two more.

I can still remember participating as their office management boy when some of these great leaders of public health came together at a very important meeting here in New Haven, chaired by William Thompson Sedgwick, H. C. Welch, Victor Vaughan, William Hallock Park, etc., all top names you know.

As I was saying, I was assisting Professor Winslow and the other instructors of the department in the teaching of what was then called "The Principles of Public Health," the basic course given to the undergraduates of

the Yale colleges, graduate students of other departments, some medical students, people from state and local health departments--a very mixed group of people. Between scheduled sessions of the course I actually acted as an assistant instructor, not taken very seriously because obviously I was much younger than the people I was talking to. At all events, I cut my eyeteeth there so that in 1920 when I received my bachelor's degree, I was appointed an Instructor in Public Health. Thus I began my formal involvement in a career in public health.

I went on immediately afterward to work for a graduate degree, and in 1923 I took my degree of Doctor of Philosophy in the Yale Graduate School. My concentrations still were heavily in the laboratory. In fact, my doctoral dissertation was on laboratory studies on physical chemical measurements of bacteria as colloids and in related subjects.

When assisting in the teaching of public health I was teaching vital statistics, as we called it in those days, some aspects of microbiology, some elements in seminars in epidemiology, et cetera. I mention this diversity because this was the Winslow practice of developing graduate students in the tradition he had inherited from Sedgwick and others at MIT, Rosenau at Harvard, who were very broad gauged men of affairs in the sciences and in their applications and who believed it was more important to give their students foundations in various related fields rather than encourage them to become intensely specialized in particular narrow areas.

As a result, in those years, although I was primarily a lab person and working in what was then rather esoteric aspects of biochemistry, and physical chemistry applied to bacteriology and to immunological problems, I also was constantly engaged in public health administration, statistical and

epidemiological studies, community surveys, et cetera. This was the strength of my education and also its weakness--you were encouraged to achieve a broad foundation in what Winslow in the Sedgwick traditions meant by public health, so that you could then subsequently elect the areas in which you wished to concentrate. I was as much at home in various aspects of vital statistics, epidemiology, and public health administration as in the intricacies of biochemistry. I mention this because it has been the strength and weakness of my subsequent career that I tried to be aware of problems and needs in the many aspects of thus broadly-conceived public health, and from time to time I changed my areas of concentration but maintained threads of interest in the various areas so that I could be dividing my time between the physics lab or the bacteriology laboratory or working in the health department.

I stayed there at Yale until after I received my doctorate in June 1923. One of my major interests was in bacteriological studies for which Winslow saw no place for me here at Yale because we had extensive bacteriology departments in the medical school and in the Sheffield Scientific School. I accepted the invitation which came to me through Professor Winslow from Professor Edwin Oakes Jordan who was head of the Department of Hygiene and Bacteriology at the University of Chicago. I accepted that invitation because I thought the opportunity was good and very attractive. Professor Jordan had told Professor Winslow--I should mention that Jordan who was one of the senior educators in bacteriology in those days was also a Sedgwick man from MIT, a few years ahead of Winslow, and had grown up and developed in the Sedgwick traditions--that the University of Chicago had begun to be interested in developing a school of public health in conjunction with the Chicago City Department of Health. There had been some feeling out, and the outlook was

encouraging. If you are acquainted with the background of that area of the country you would know the names of Frank Billings and Ludvig Hektoen and others who were very active in public health affairs as well as in the medical sciences and who were very influential with the then Commissioner of Public Health, Dr. Herman Bundesen.

The invitation to go to the University of Chicago in 1923 was very attractive to me because of the opportunity to work with some very distinguished people in bacteriology, immunology, pathology, and so on, and also to participate in the program toward the development of a school of public health. (Parenthetically I should say that in those days the University of Chicago's medical interest was expressed on the South Side where the first two years of medicine were taught in the various departments of the University and the clinical branches of medicine were taught at Rush Medical College.) The plans were quite well along toward the development of a full and comprehensive medical school on the South Side and in what was later to become the Billings Hospital of the University's medical school and now the Pritzker School of Medicine. Fiscal support from the Rockefeller Foundation was substantially pledged. The University was beginning to recruit some of the key people for the clinical side of medicine while expanding and strengthening the preclinical years which were already there and had been operating for twenty years or more.

As a result I went to the University of Chicago in 1923 as an assistant professor in hygiene and bacteriology. Very soon thereafter I became involved in the emerging plans for public health development which has been taking form, in a very limited degree, because of the Jordan influence. So, I forget which year, I began to work also in the City Health Department. The

department was not in good or strong state. Doctor Bundesen, the Commissioner, was very anxious to strengthen the department, making it a more effective community institution and was very keen toward the development of the affiliation with the university--to give resource to the university and to expect strengthening of his city department by reason of help he could get from the university people. Consequently, not long after I was there I was appointed to--I think it was called--the section on surveys of the department of health of the city. I became a two hat man. Later I was Assistant Chief or Director of Maternal and Child Health, and some other department. I was shuffled around, working with many people in the university and in the community towards strengthening the City Department of Health and helping it become a clinical resource for public health education and training, and a laboratory in many ways for the prospective school of public health.

A number of distinguished people of the Public Health Service were brought into the city department. I remember some of them very well: Jack Geiger and others who were top drawer people of the Public Health Service, all detailed to the city department. Doctor Bundesen had been a strong supporter of cleaning out and improving the city department, which had had a bad reputation, and making it before very long one of the most highly regarded of the city departments of health in the United States. In fact, I think somewhere about that time he received the distinguished award of the American Public Health Association for that achievement. I found I had very distinguished colleagues to work within the City Department of Health as I did on the South Side in the university.

So I worked in various fields and had students and had some grant funds, some support funds, for a number of bacteriological studies, immunological

studies, and some graduate students working in broader fields of public health, statistical surveys. I remember a survey of heart disease in the Chicago area, extensive graduate student studies in maternal and child health--a series of such studies that were conducted in conjunction not only with the other people in the department of health but with the community agencies. We had very little contact in those days with the state department of health. It was not a distinguished department. Most of its people were envious of what was being done in the city, and they were not always cooperative. That was a limitation which we unfortunately had to accept in those days.

At all events, in 1923 to 1929 that was the course on which I proceeded. I moved up in rank from assistant professor, 1923 to 1926, to associate professor, 1926 to 1929, to a full professor in 1929.

In the interim a very grievous disappointment came to me. The clinical developments on the South Side proceeded very rapidly with very generous financial support from the Rockefeller Foundation and some others. The preclinical resources were strengthened and the clinical departments were developed. The Billings, the hospital construction, proceeded. Then to my very great disappointment it developed that the very ambitious program for what was going to become the full-fledged Billings Hospital and the University of Chicago Medical School began to outgrow its financial resources, or the prospects for its financial resources. Soon it became evident that they were going to use up, in the development of the full and comprehensive medical school, not only all the money in sight but a great deal more beyond that. The objective of developing the school of public health we had been designing in considerable detail was scratched--it evaporated. In 1928-1929 this became

quite clear. I found that I was spending a good deal of my time and energy towards a goal that was not going to be achieved.

This was a great disappointment to me as it was to Professor Jordan, Professor Norton, Bill Taliaferro who had been brought in as Professor of Parasitology, and to many others. We had to be realistic and accept what was clearly the outlook, that much that we had hoped to develop: a school of public health on a compromise design between the MIT-Harvard school of public health and the Hopkins school of hygiene and public health which had come into being in the interim combining the foundations in the basic sciences of public health with a superstructure involvement in the fields of epidemiology, public health administration, et cetera.

The Hopkins school, by the way, which had been developed in William H. Welch's pattern, became a very strong school in the basic sciences of public health but it was weak in the field of public health practice. It was rescued by bringing in visting professors like Wade Hampton Frost and Sir Arthur Newsholme was brought over from England for a few years to teach public health administration to Americans. There was excessive concentration on the basic sciences-bacteriology, immunology, genetics, nutrition and biochemistry and so on--with substantial neglect of the applied fields in public health--which was rectified a few years after the school's beginning. We were not going to make their mistakes in Chicago, but we never got the chance.

So in '27 and '28 I became increasingly involved in something that went back to my days as a student with Winslow. Let me explain. Winslow in his teaching beginning in 1915 had a glowing story to tell his students about the past achievements in public health and about its potential for the future. The bacteriological era in public health was closing (we thought) or had

reached a mature level. Health education was coming into the field. There were important achievements to mark the progress that was being made in public health in the United States and other countries. Winslow became early convinced (I don't know just when this came about in his thinking beginning some time before 1915 or 1916 and continuing into the 1920s) that new chapters were about to open as new opportunities in public health: new chapters that would have to lean very heavily on the concern of public health leadership for personal health. The achievements in sanitary science and environmental protection already had very strong foundations; a great deal more was to be done in these fields but there was a well-established base for further progress. At the same time, he was aware that, as measured by mortality rates, by morbidity rates, by various indexes of other kinds, infant mortality, maternal mortality, et cetera, public health was by no means achieving its full potential. It had concentrated heavily on the infectious diseases and their control, on environmental sanitation and its control, but had largely neglected personal health services needed to prevent illness in the first instance, primary prevention, and what could not yet be prevented from being contained, being controlled, to help keep people in good health, or in as good health as was feasible, and to give them longevity with as good health as could be achieveable, obtainable.

To Winslow this outlook meant that stronger development than had been foreseen or anticipated, or was foreseeable, in the effectiveness of applying whatever had already become possible (and what was ahead) in the fields of medical care by reason of the science revolution and its applications in clinical medicine from 1890 up to the 1920s. There had been some interruption in that process in 1914-1918 by reason of the European war and our involvement

in 1917-1918. The time had come when public health had to become increasingly involved in personal health services and not to be so completely concentrated on the community health services. This led into achieving an understanding of why the wonders of the then perceived developing fields of medical care were not being more extensively applied, why the potentials of the then modern medicine were not reaching millions of people, were not reaching them early in containing the progress of disease that could not be prevented.

Winslow's studies and perceptions led into the importance of economic barriers that were in the way, that stood between the potentials of medical care applied from practitioners in the private sector to people who needed those services, that didn't know how to get them, couldn't afford them if they could find them. This began to involve him increasingly in the field today we call medical economics. So far as I know Winslow was the first public health leader in the U.S.A. to recognize the importance of that potential. I absorbed some of that when I was a student and instructor under him, so that when in the later 1920s increasing concern began to be appreciated and recognized in the economic aspects of traditional and prospective public health, or what today we call medical care, I began to read in that field and follow what was happening.

This is by way of explaining why, when my disappointment began to be acute about the outlook at the University of Chicago, I was quite aware of an emerging program that was soon to become the Committee on the Cost of Medical Care. In '28 the committee had already been formed. (It was formed in '27.) I had seen their publications and had kept more or less informed of what was going on. That committee, which had a five year study program which had begun in 1927 and was to run until '32 with good fiscal support from various

foundations, was in difficulties. By late '28, early '29, they had used up two or two and a half years of their five year prospective lifetime and were not well along on their very elaborate program of studies. They therefore cast about for some way of strengthening their research undertakings toward meeting their very firmly committed target of completing their work by the end of 1932.

Because of some statistical studies I had published in the '20s and some writings I had done for various journals, I was approached as to whether I might take a leave of absence from the University of Chiago and come aboard and take charge of Committee's research program. A number of people who were active in the Committee on the Cost of Medical Care knew my writings in these fields, some of them knew me personally. (Winslow who was chairman of their executive committee, was abroad and had no part in this approach to me.) Haven Emerson was a member of the executive committee and took a very active part. Michael Davis, whose name you know, was also a member of the executive committee. One or two others on the committee were aware that I had been writing on statistical aspects of morbidity, mortality, outlooks for longevity, the relations between preventive health activities in childhood and its relation to subsequent longevity of people who were protected in infancy and childhood and those who were not. In fact, I received some considerable acknowledgements for contributions on genetics and eugenics because this was a field of intense controversy. It was a time when some British leaders in genetics were preaching that public health achievement was antagonistic to good health of the public because it was preserving the unfit. I published some studies that preventive medicine preserved the fitness of the fit and protected them against the damaging effects of scarlet fever and other diseases and some birth defects which left children damaged and injured so

that their subsequent health and longevity was reduced by reason of the nonprevention of these diseases. I demonstrated that the facts were exactly contrary to what was being alleged: if you prevented in infancy and early childhood, you were preserving fitness for future life.

At any rate, I was approached on whether I would take an appointment with the committee just about the time when I was in my most pessimistic mood about the outlook at the University of Chicago. I was interested. I went to some meetings of the executive committee and talked with them and they with me about the problems of the committee and its study program. After I reviewed the status quo, I had some thoughts about what could be done, really a rescue and development operation. They knew I had something of a reputation of being effective as a director of studies and that I had a fluent pen.

I asked the university if I could have a leave of absence: but after it appeared that I would have to go to the committee for two years or two and a half years, the administration at the university thought they could not approve that. So I resigned and took the appointment as Associate Director in charge of research with the Committee on the Cost of Medical Care.

In passing I may add it was a troubled period at the University of Chicago at the time. The previous president of the University had retired. A new president had been brought in. He had been compelled to resign because of some personal difficulties and the university was in the process of choosing a new president. About the time I had to make a decision whether to stay at the university or to leave, a new president came in and he wasn't interested. The vice president was keenly interested in my staying on but he was locked into a restrained position by reason of the financial commitments that had already been made to the Rockefeller Foundation and to many of the faculty of going

ahead with the full development of the Billings Hospital. So I left.

At that time, in the autumn of 1929, the country was very prosperous, or so it seemed. This was before the stock market crash in October '29. My thought was that I would find it interesting to be extensively involved in the work of the Committee on the Cost of Medical Care. The study program and the outlook that it could probably be brought to fruition, this program could be a landmark in studying the economic aspects of health and disease and lay out a program for the future. Then, after a couple of years of that, if I found I had other interests I would turn to them.

I did have the opportunity to take some of my bacteriological work which was in progress at that time with me. The committee's headquarters were in Washington. Some of my friends and associates at what was then known as the Hygienic Laboratory of the Public Health Service, welcomed me, gave me a "desk" as they called it, a place to work and maintain cultures and do some experimental work in my leisure time, so I would keep a continuity in the laboratory field. As you may know, the Hygienic Laboratory had been the basic laboratory of the Public Health Service for fifty or seventy-five years. Distinguished bacteriologists and epidemiologists and related people were located there and made tremendously important contributions to public health, epidemiology, disease control, and so on. Doctor George McCoy, the Director, I had known for some years. A number of my former students of my Chicago days were already on the staff of the Hygienic Laboratory and I knew many of the people. They gave me a warm welcome to come and work there.

So I went to Washington in December of 1929 and took the reins of the program and the Committee on the Cost of Medical Care, with the commitment to try to complete in the remaining two and a half years or so this five year

program. I closed one chapter and began another.

You asked me to talk about the background of the Committee (the CCMC), how and why it came into being and about its status and its objectives. Bear with me while I summarize its historical background.

What came to be known as the Committee on the Cost of Medical Care had its beginnings in the middle 20s, when a number of people knowledgeable in the health field began to be concerned about the recent developments in the field of personal health care and medical care and where it was going and where it should be going. They were acutely aware of the almost revolutionary changes that had already occurred in the field of medicine and medical care, devolving from the developments in 1880, 1890, the turn of the century, and that for some years there had been a considerable lag in the development of medical education and training in this country. From the turn of the century until World War I many of the people who wanted a good education and training in medicine had been going to Europe--to Britain, to Scotland, to France, to Germany, to Austria-Hungary, to Italy--countries which had made much more extensive application of the developments in the underlying sciences in medicine. In this country in the early 1900s many of our medical schools were really a disgrace. There were very large numbers of them, many of them were little more than diploma mills supported principally by fees charged to students to pay local practitioners who acted as the preceptors or teachers. A revolution in the field of medical education had come about beginning in 1910 with the publication of the Flexner report. There were a few medical schools that were of very high grade: the Harvard school, Hopkins, Michigan, and a few others, but you could count them on the fingers your two hands.

The Flexner report had provided the evidence of the sad state of the

medical schools in this country, principally those that were not university affilitated, and presented a picture that was so very bad that it led very quickly to the closing out of a large proportion of the proprietary medical schools and their replacement by university supported or affiliated schools, and so on. They began to have full-time faculties or faculties that were drawn from such really qualified specialists as we had in this country. Quickly within two, three, four, or five years the picture changed and we began to have a growing number of medical schools that were really qualified to teach what was potentially available in the medical sciences and the medical arts. This led to the rapid development of specialization because the people who now began to be the teachers in medicine were well aware that they were no longer competent to have great knowledge and familiarity with the whole broad spectrum of what was then modern medicine and they began to teach in specialty fields. Rapidly our medical schools began to create a growing number of specialists to the derogation of the family physician and the general practitioner.

This was begun soon after the Flexner report of 1910 and went very rapidly until, say, 1918, when we became involved in the World War. Then there was an interlude during which not much new happened, but directly after the end of World War I the progressive development was resumed with very great rapidity. The further development of specialization came very rapidly. With specialization came fractionation in medical care, and increasing costs, and a prospective very rapid change in the functions of the hospital which previously had been of only limited importance, shall I say, in dealing with the problems of medical care before the rapid increase of specialization.

So, between 1920 and the next half a dozen years tremendously rapid

changes were occurring in the field of medical care, with the outlook that it would continue toward increasing concentration on specialists and simultaneous neglect of overall general care, or coordinated care, family care. This was happening nearly everywhere except perhaps in small towns and rural areas in the United States. By 1925 or 1926 a number of people began to be concerned: Where was all this going? What was the end point toward which it would move in a decade or two ahead? Also they were concerned that the increasing costs of highly specialized physician care, the increasingly complex and expensive hospital care...there was a danger that trends were creating increasingly high barriers against the receipt of medical care by the bulk of the population.

These concerned people--like Winslow, Michael Davis, Walton Hamilton, Victor Vaughan of Michigan, I forget all the names. Some of these people began to hold meetings and talk about their concerns and their fears. They would meet at annual meetings of the AMA, the APHA, or some other associations. They thought the time had come when we should have a general assessment of where we were in the United States at that time and where we were going, if the going is--as appeared--undirected, where it should be going, and what parts should be directed. Out of those meetings emerged a fifty-person committee in 1927. The focus was on the economics of the problems, but that was only a focus of convenience. They had a very broad perspective in mind for the studies. They found a number of foundations were interested in supporting this effort. But recognizing the complexity of what might be undertaken, they were sensible in foreseeing that they needed several years for the studies they contemplated. From those discussions emerged the Committee on the Cost of Medical Care and a five-year program of studies to assess what resources we had, and how they were being utilized and by whom,

what the outlooks were for the personnel needs of the future, and the economics of the problems, the dynamics, the organizational problems, et cetera.

The committee outlined a program with a commitment for a five year program of studies, not an action program but a survey, an assessment, and such counsels as might emerge from these studies. It was organized by bringing together approximately fifty people in public health, private practice of medicine, institutions and special interests such as the hospitals and clinics, ancillary aspects of medical care, pharmacy, teaching in the areas of economics and sociology. Then there were a number of people representing the public interest. Practically all of them were very well known, distinguished leaders in their areas and fields.

They were organized as a formal committee with Ray Lyman Wilbur, a former president of the AMA who had been Professor of Surgery and Dean of the medical school at Stanford, and who became president of Stanford, as chairman. Winslow was Chairman of the Executive Committee which included eight members, three of them named by the AMA from its top leadership. In addition to Winslow, Haven Emerson, Professor of Public Health at Columbia, George Follansbee, chairman of the Judicial Council of the AMA, Walton Hamilton, Professor of Economics in the law faculty of Yale, Walter Bower and Walter Steiner, distinguished physicians in Massachusetts and Connecticut, Michael Davis, a medical sociologist and economist, and Mrs. William K. Draper, a public member.

The membership in general was about fifty persons. They assembled a research staff. A good deal of this was a development generated by Harry Moore who had been a public health economist in the Public Health Service. He

really was the sparkplug in the development of this program. They laid out a very extensive program of studies of the existing resources and their apparent adequacy, their organizational pattern in medical care in private practice and in the public sector, the institutional aspect, et cetera, et cetera.

They planned a whole series of studies to find how medicine was being practiced, whom it was reaching and serving, whom it was not reaching and not serving, the costs involved, the sources of the funds, et cetera. Of the extensive series of studies planned, some were library studies, many of them were field studies, including extensive surveys of practices by the providers of health and medical services and utilization and financing by consumers. The most extensive study up to that time, a "longitudinal" household interview study was undertaken and was going to take a lot of money, a lot of staff, and five years. So this comprehensive program was laid out with collaborating studies by other agencies: the PHS, the AMA, the ADA, the Milbank Memorial Fund, the Julius Rosenwald Foundation, the National Bureau of Economic Research, etc.

But, as I remarked earlier, the staff studies went rather slowly. Some of them went very poorly in that though good underlying work was done every study before it was to be made public was extensively reviewed not only by the executive committee (which met monthly or nearly every month of the year) but also by the whole committee of fifty members. All kinds of controversies and differences developed. There were some long delays in resolving the problems. A stiff-necked position by some member of the committee or by some staff member complicated the inherent difficulties and the directoral function was not very effective in finding ways of facing the issues while also being tactful as well as constructive in the draft reports. I won't take time to

elaborate on that.

When I joined to take charge of the research program and staff at the end of 1929, two and a half years of the five years were gone. One or two or three publications had been issued other than the program of the committee. Five or six other studies that were more or less completed were in the doldrums. A half a dozen more studies to which the committee was committed were either in an early stage of gestation or had not even been started.

Through 1930, '31, we made a great deal of progress. We got the study program on a clearer and better track. We repeated a number of the studies that had been bogged down for need of additional or updated information, some delayed by editorial shortcomings, etc. and began to publish our reports on a regular schedule. The executive committee, as I mentioned earlier, met nearly monthly through the year. The full committee twice a year and gave very intense attention to the reports which were circulated to them in draft form, and to their involvement with the staff, and so on. It was a very carefully patterned program so that the committee was not just a showpiece or window dressing; it was a very extensively, actively involved organization. The executive committee gave an endless amount of time to the reports and meetings.

In early 1932 the study program was sufficiently well enough along so that it was likely that we could complete the agreed upon program of studies which had undergone some changes in the course of the preceding four years but in general had adhered to the planned undertakings. The committee could see that it was going to complete its study program substantially on time. Twenty-six major reports had been published, or were in press, or being readied for publication, and the staff Summary Report (to be released as Publication No. 27) was well along toward completion. The magnitude of the U.S.A. costs had

been established -- their characteristics, impacts, causes, financing, etc., and their significance for prevention of disease, diagnosis, treatment, the providers involved, etc., a veritable library of information -- a basis for planning. (In passing, I might point out that the current system of medical care costs in the USA, now published regularly by the federal agencies, uses the CCMC total expenditure figures as of 1929 as the benchmark for the national data.)

With the technical and field studies completed or approaching completion, the committee had to begin to give thought to what the committee would want to say about the results of this very extensive undertaking which had involved about a million dollars (a tremendous amount of money for that kind of undertaking in those years) and the significance of those results for the prospective medical care scene. Commitments had been given to about eight foundations that had made contributions and to ten, fifteen, or twenty professional and related associations that had collaborated with the committee in the performance of collateral studies and the publication of many reports. The committee decided that it had to produce its own report, assessing the findings from its studies and deciding what it would choose to do in the way of interpretation, and, whether or not to come up with recommendations for the future.

There were some mistakes made in the first attempts to have a committee report drafted for it. That's not of any consequence because it had no significance for the outcome. Finally, the committee undertook to draft its own report, with such assistance from the staff as it wished to have. Through their executive machinery they appointed a subcommittee of their own membership to act as a drafting committee and it proceeded to draft reports,

and feed out the drafts to the other members of the executive committee and at a subsequent point to the members of the full committee.

When the report did begin to take form in the middle of 1932, it was very clear that there were four or five major conclusions that had emerged, as the committee saw it, from the studies they had conducted and which needed to play the role of foundations for recommendations that they decided they would want to make. The draft reports began to become summarizations, interpretations, of the findings and their estimates of the significance of these findings for the current scene, for the prospective scene, and for the formulation of recommendations.

The drafting committee came up with a report which was to become "Medical Care for the American People, the Final Report of the Committee on the Costs of Medical Care."

Here is a copy of "The Final Report of the Committee on the Costs of Medical Care." A plural had come into that underscored word about midway in the course of the program because some of the physician members of the committee thought that, unfairly, the public was beginning to think this was a study of physicians and physician practices and cost and the criticisms that were taking form seemed to be criticisms of the doctor and the costs of his services. Various proposals were made to change the title of the committee, to make clear that this was a much broader undertaking than just looking at the private practitioners of medicine. After considering various alternatives, they made only one change; they added an "s" on the word "Cost." So it began as the Committee on the Cost of Medical Care and ended as the Committee on the Costs of Medical Care.

The committee came up in the draft that was produced with five major

recommendations and an extensive text surrounding each one, and considering many apects of each recommendation. Of these five recommendations, two received specially intensive attention and precipitated serious controversy. The first and most important recommendation was that the fragmentation of medicine -- its most inchoate structure, with the outlook for increasing specialization and fractionation and the rapid disappearance of the family physician, the general practitioner, and all the consequences that come from those developments -- dictated the need that in the future good medical care should become available through organized group practice, which would involve the generalists, the specialists and the ancillary supporting services in an organized, sensible, and related form, and preferably hospital based and regionally organized.

The other was the recommendation that, for the future, the costs of medical care should be met by groups of people over periods of time, a group payment concept, which seems like old hat to us today but it was not old hat in 1932. It was based on the extensive committee studies which showed the variable and unforeseeable, and, for the individual family, the unbudgetable nature of medical care costs but which are foreseeable and budgetable for large groups of people-group payment.

In many respects, were the major recommendations as subsequent consequences were to indicate that the future of medical care should be based on group practice for the availability, the delivery, the provision of care and its availability to the public; and group payment, whether by insurance or taxation or a combination of them, should be the main financial support for the future of medical care.

There were three other major recommendations. One was on the

strengthening of professional and technical education. Another was for the strengthening of public health in community activities. A fifth was on the coordination of these various types of developments that could be anticipated--they were quite sure to play an important role in the future in the development of medical care and which the committee thought were vital to the sensible development of the availabiity of medical care for the population for its appropriate and effective financial support, and for the effective availability and delivery of the service, personal as well as communitywide for the population as a whole.

The committee in general believed that these developments should come about primarily on a voluntary basis. There was some difference of opinion in the committee on that. Some members thought that, particularly group payment, should be open to voluntary insurance and to compulsory insurance depending upon how communities would choose in the future. They were a minority of the committee that reported reservations to the report and they were content to footnote their reservations.

There was a point here where the relations between the private sector and the public sector were involved that I should have brought up earlier. One has to keep in mind that 1925, 1926, 1927 when the committee came into being, medical care, personal health care, and, in general, community health care were primarily functions within the states, with only limited responsibilities and performances for the federal government in these fields. (The U.S. Public Health Service controlled at the borders the danger of the introduction of infectious diseases, plagues of various kinds; there were the problems of interstate commerce; there were the needs of the wards of the federal government--the armed services, the Indians, the District of Columbia, the

longshoremen, the harbor workers, and so on.) But in general this was a field for the states and their "police powers" rather than for the federal government. So, in general, the field of community health was in the hands of the state and local governmental agencies, supplemented by the various voluntary agencies in the public health and related fields. Personal health care, in general, was in the private sector and not in the public sector--except for a few marginal situations like dealing with tuberculosis and mental disease, certain limited undertakings of immunizations and so on, they were in the public sector, but they were the exceptions.

This period in the late 1920s was seemingly, one of great prosperity. The United States was flying toward the highest level of economic affluence and prosperity that it had ever known. It was a period in which there were very strong commitments in a broad spectrum of the population for reliance on voluntarism; people would do things for themselves. Except for the formal field of public health, otherwise it was not primarily the concern of government; it was primarily a concern of people in their private lives and in the private sectors of their lives. Yet it was not surprising that these recommendations, except for where public health was concerned and some recognition of the role of government in providing supports for the availability not only of community health but of personal health for the very poor, was not the responsibility of government. I would emphasize that the recommendations were primarily on what needed to be done toward the future of medical care through voluntary activities.

A few members of the committee disagreed. They said the committee should have stood neutral on voluntary versus governmental activity. They, nevertheless, went along with the majority but their views were noted in

procedurally agreed upon footnotes in the reports.

The committee's draft report was circulated and studied and discussed. At a general meeting of the committee it very soon developed that a minority of the fifty members of the committee disagreed very strongly with large portions of those recommendations, principally on group practice as the medium for the availability and provision of medical care, and on group payment for financing. Group practice they regarded as a threat to the independence and the sovereignty of professional people to make their own decisions how they wanted to pursue their careers, how they wanted to practice; group payment was a threatened challenge to the persistence of the fee-for-service as a principal means of payment for medical care. There were other disputes.

Nine members (eight of them M.D.s) elected to dissent on those two recommendations as well as in limited degrees on others. They wrote an independent report which became Minority Report #1. Their dissent was mainly that the future of medical practice should be left to the medical profession to plan, to guide, to control. They did not want dilution of their opportunities and their responsibilities through the participation of lay people. They took very strong positions against the potential intrusions of governmental groups and agencies in influencing or determining the organization of provision of medical care. They took strong exception to the group payment recommendation unless group payment remained voluntary, was elected by the profession and remained under the control of the profession through its medical societies, and there were other objections. In general, this was sounding off the position of the medical profession at that time, as they thought they represented it to preserve the sovereignty--not merely the independence but the sovereignty--of the medical profession in the field of

personal health care. By inference this would extend from the physicians to the nature, the roles, the functions, the performances of the hospitals and their ancillary facilities.

There was another minority report (No. 2) written by two dentist members of the committee. I won't spend much time on that because they weren't of one mind, they weren't sure of where they stood and they wanted to be on both sides of the issues.

There was another major report, called a "Statement" written by Walton Hamilton, which I thought was the best economic statement on medical care that had been written up to that point by anybody. He felt the committee had failed to meet its primary obligation because it had made too many compromises in the development of its major recommendations and in the development of the supports of their recommendations. Then there was also a personal statement by Edgar Sydenstricker in which, in effect, he took the same position as Walton Hamilton but did not spell it out.

The majority report, as the formal report of the committee, had the support of a majority of the physicians who were on the committee. The physicians who signed the Minority Report No. 1 were a minority of the total physicians of the committee. That's a point that has not always been clearly understood.

The majority report and the minority reports were released on October 31, 1932 at an important series of meetings at the New York Academy of Medicine.

When the report was released that day at the New York Academy of Medicine there was consternation because on the table laid out for the press, there was also a preprint of an editorial which was to be released and to be published in the Journal of the AMA, prepared by the then editor, Dr. Morris Fishbein,

in which he damned the majority report of the committee from here to kingdom come. He referred to it in blistering terms and he used the phrase which became famous, or infamous should I say, that on the one hand it lined up the foundations and what today we would call the dogooders, and on the other side were the solid people in the profession of medicine. And the report and its recommendations were: "Socialism and Communism, inciting to revolution."

That was the outcome. As I say, there was a consternation and, in a sense, the ceiling fell in October 31, 1932.

The plans that had been considered for a followup organization to publicize the recommendations, to serve to explain them, to assist groups in society to make use of the twenty-seven reports and this final report (which was Report #28) -- when this schismatic result appeared in October 1932 all that went down the drain because the AMA called a special meeting of its House of Delegates which formally endorsed the principal minority report.

The consequence was disastrous for the whole field of medical care because at that time there was no major group of force in the United States that could play a countervailing role to the prestigious American Medical Association and its House of Delegates. They were damning the recommendations of a majority of the committee and endorsing the potential monopolistic position of the medical profession to the exclusion of practically everybody else for the future development of health and medical care services in the United States. This was a time when the labor union movement, the AFL, was not interested in developments in this field. The labor union members on the committee in general were cool to it. There were no consumer representative agencies of sufficient moment to play a consequential role. The idea then of following up the report of the majority of the committee was dissolved and nothing came of

it.

The phrase I was hunting for a little while ago in Dr. Fishbein's editorial he consigned the majority report to "innocuous desuetude." So it came about, as ordered from 535 N. Dearborn Street in Chicago--except for one important factor. The committee had begun its work in 1927 when the country was rising toward what I cited earlier as the highest level of economic comfort and affluence that it had ever known in its history. Beginning with October 1929 when the stock market first began to break and crashed, and later by the time October 1932 had come about the country was plunging toward the worst economic depression of all recent times. Thus, the committee's work had started in 1927 on the upcurve toward prosperity and great economic resources, but it had ended in late '32 when the country's economy was winding toward a nearly total halt. The "innocuous desuetude" could not be accepted by a nation that was finding itself in very grievous circumstances.

November 1932 had been an election year. Franklin Delano Roosevelt, governor of New York, had been elected President and in March 1933 he was going to take office as President. About that time the banking system was practically at a standstill. Commerce, business, industry, and manufacturing, if not closed down were barely keeping going. Unemployment was rising at a rate which had been shocking all through 1930-31 and into 1932. The economy of the nation was in very serious straits. The states were unable to deal with the economic situation. Voluntary agencies were utterly incapable of dealing with the problems of the magnitude with which the nation was confronted; and concerns and approaches and hopes moved to Washingon. The unemployment rate had gone up from traditional levels of four, five, or six percent to the official figures of fifteen or twenty percent, and I didn't

know anybody who believed the rates were that low. They were very much higher than that in many communities; whole communities had come to a near standstill.

I was making the point that the committee had started in a period of rising affluence and ended in a period of deep and grave and threatening economic depression. The public had to turn to Washington for assistance of one kind and another to recapture the activity in the economy. The focus was on Washington. The Roosevelt administration and the Congress quickly developed a wide variety, indeed a broad spectrum, of emergency measures to deal with the emergency situation -- to assist the banking system to make funds available to commerce and industry, to support many kinds of activities that were in very serious difficulty and to find ways of making jobs available for people while trying to avoid the conflict with those who said, "Make jobs available but not in my field because we want my field reserved so that as the economy begins to pick up again, my company, my industry, my activity will have a second economic opportunity."

This was one of the very grave difficulties in the field of emergency measures. There were a number of programs developed that made jobs for people but some of them didn't command much respect because they were "made" jobs. There were additions to the Federal Emergency Relief Administration (FERA) the Civil Works Administration (CWA), The Works Progress Administration, (WPA) and the Public Works Administration (PWA) which was expected to build public buildings (which was very slow in getting under way because of inherent difficulties), and other emergency measures.

These developments extended into the field of medical care. The physicians of America had millions of patients they were serving who were without adequate means of paying for it. So physicians were in difficulty in

maintaining their offices. Many of the hospitals of the country didn't know whether they would be able to open their doors next month. They couldn't meet their bills. People needed the services but couldn't pay for them. Remember this was a time when private insurance was voluntary insurance and was in its infancy. The number of people who had any kind of health insurance was relatively miniscule. The Purchase of Medical Care Through Fixed Periodic Payment by Pierce Williams, a collaborating study published by the National Bureau of Economic Research, gave the numbers. It was important in particular kinds of outlying areas: mining, forestry, railroads, public utilities, but it was not yet for the general public. The voluntary health insurance movement that we came to know later on had just barely begun to exist, but it had not yet become pervasive.

Through the emergency programs the federal government provided some assistance, provided the funds especially through the FERA, for almost every aspect of personal health care except hospital care. (There was a reluctance to become involved with the hospitals.) At any rate without getting into the details of that period, the emergency measures made an important contribution toward getting the economy in motion again, or more effectively in motion, and in meeting many of the needs. This began soon after the President took office in March 1933. By 1934 these programs were going more or less well, with some lagging here and there and particularly in Public Works Administration.

About that time President Roosevelt decided he could relax a little about emergency measures, but he felt he should begin to tackle the problem in this country that, against another contingent, economic depression of this kind, we should not have to depend on emergency measures, emergency programs, difficult to organize, and less than efficient or effective in practive. This led him

and Harry Hopkins, who was a very close advisor of his, and a number of members of the President's cabinet who were knowledgeable about these matters to consider that the time had come for the United States to develop long-term, non-emergency measures for provision against economic adversity: the U.S.A. should do what other countries in Western Europe particularly, had undertaken ten, twenty, thirty, forty years ago to develop what had come to be known as social insurance for organized, systematic provisions against economic adversity, particularly those measures that deal with the risks that people in monetary economics have to live with, have to confront, in event of economic downturn.

By mid-1934 the President issued an executive order creating a cabinet level committee, the Committee on Economic Security, and directed it to explore more or less permanent measures to deal with the risks of economic insecurity, including the risks of loss of income arising out of illness and the costs of medical care. The cabinet committee was created near the end of June '34, and it went to work to produce a program for the President and the Congress. A comprehensive structure was created from among government people best prepared to participate, and from bringing in many nongovernment people who were knowledgeable about the problems that were going to have to be confronted by the cabinet level committee.

With respect to the field of health -- public health, personal health care, medical care, disability and the risks and losses and the economic burdens arising out of illness--two of us were asked to become members of the Cabinet Committee staff. Edgar Sydenstricker, who was chief of research at the Milbank Memorial Fund, with which I had been working between the end of the CCMC and this period, was asked to take charge for the staff of the

Cabinet Committee for the studies and whatever recommendations might emerge with respect to health and disability problems. He accepted on condition that I would join him. I did. So he and I were the primary staff members for these studies and program developments.

Associated with us, with the Cabinet Committee's approval, were a number of other persons, some from the public health field (e.g., Ira Hancock, Frank Walker, Tom Parran), some from medical economics, (Michael M. Davis, Nathan Sinai) and R.J. Leland, Chief, and A.M. Simons, associate from the Bureau of Medical Economics of the American Medical Association, etc. And we went to work on these problems of health and disability.

The cabinet Committee had advisory committees for the overall structure of the program, functioning directly under the Committee, and they had a Technical Board of very distinguished people and a series of actuarial consultants. On our suggestion because of the complexity of the public relations involved and the complexity of the technical problems, the Cabinet Committee set up a medical advisory committee with representatives from the various aspects of the medical profession, a public health advisory committee, a hospital advisory board, a dental advisory committee. Collaterally because of the proposals that were coming up in maternal and child health and welfare and related subjects, on recommendation from the people in the field, there was a committee on child welfare, a nursing advisory committee and so on.

So, as we were developing analyses and proposals we met with these various councils and committees and tried out our ideas. We had extensive discussions with them and some considerable disputes, particularly with the medical advisory committee whose members had been selected to represent the various fields of interest including top drawer people from the AMA and related

organizations, some of the specialty societies.

That was a very smart idea for public relations but it was a stupid idea for the purpose of getting the job done because there were utterly irreconcilable elements in the medical advisory committee. The outlook for getting any consensus was nil. Also, some of the committee members didn't play fair with us although it had been agreed that we would be working in camera until the time came for approved and agreed releases that the negotiations would be held on a confidential basis, the AMA people immediately broke that promise and began releasing the intramural discussions. This meant floods of telegrams and letters pouring in on the White House, on the members of the Cabinet Committee and on the chairmen and members of the Congressional committees that were going to have jurisdiction. This led to a complex and very uncomfortable situation.

At any rate we proceeded with the studies with the help of our ancillary staff, some of whom came directly from the AMA and the AHA and acted fairly. I wasn't referring to them; it was the members of the advisory councils and advisory committees who played games.

We proceeded to develop a program for federal support for a federal-state system of health services availability (I hesitate to say health insurance because latitudes would be given to the states as to what kinds of programs they might prefer or might want to enact) in addition to proposals for strengthening the public health services, federal and federal-state, and then the programs for disability insurance. We had to recognize that if you were proposing developments in the field of insurance you had to be aware of the interrelations among the insurances for the different risks. So when it looked as though the old age insurance was going to have to be a national

system, that the unemployment insurance and the public assistance provisions would have to be federal-state systems, the question was: What latitudes, what freedoms do we have in choosing how to deal with health and disability proposals? We had to come up with some conditioned proposals, depending on how some of our collateral groups were proceeding on the various other risks. We used to meet together and discuss them and deal with them as best we could.

When we came up with the proposal for a federal-state program in the health field, two things happened to us that were very significant. One is that we caught hell from the AMA and various other groups that didn't want any such thing as "government intrusion" in medical care; and we caught hell from the labor union people who didn't want any such thing saying, "You are going to come up with a program that will depend on state benefits, state insurance programs, you give them choices and so on. We, the labor union people, are going to have to fight these battles out in forty-eight different states. We don't want any of that. We want a straight national system."

On the other hand there were other national groups that said, "A national system in the health field! You are out of your minds. This is not for money payments, this is for service provisions. Service provisions have to be geared to the local scene, and local control, and local options."

We were on the horns of a dilemma. We had to opt for something so we developed a program on a federal-state basis, despite that some of our strongest potential supporters weren't going to like it.

When the Economic Security (later to be known as Social Security) bill was going into Congress with the various recommendations, the fact that in one session, 702 if I remember correctly, it was authorizing the prospective Social Security Board that was going to be created to continue further studies

in this, that, and in health insurance. Those three or four words tucked in at the end precipitated so many telegrams and so many telephone calls, and so much pressure from the medical world, obviously carefully orchestrated, that the chairmen of the House committee and the Senate committees really were so plagued by the opposition from the medical world that they said, "Look take your whole economic security bill away, we want no part of it," or words to that effect.

Secretary of Labor, Frances Perkins, as chairman of the Cabinet Committee, became frightened that the whole economic security program, as it was being called, would go down the drain because of the dispute about a prospective health insurance. So the matter was taken up by the President and he decided to take advantage of the fact that our medical advisory committee had asked for more time to study what Edgar Sydenstricker and I had put before them as our health program proposals. The President approved that delay. A draft of guidelines was given to Congress in a preliminary report; but our definitive reports on the health insurance proposals never were submitted to Congress; and by agreeing to moderate a few words in the bill bearing on further health insurance studies matters quieted down. The President through his personal physician, Doctor Ross McIntire, and through various influential physicians who were seeing him or Mrs. Roosevelt, were told that the health insurance proposals were being deferred and would be taken up after the other major aspects of the bill were out of the way. Frances Perkins had been afraid for her major interest, which was unemployment insurance, and the President was afraid for his major interest, which was old age benefits. Of course the Townsend movement--urging money give-aways to older persons--was threatening the whole Economic Security program in Congress. So the health insurance

program was deferred and did not see the light of day, until some years later.

The excuse was given that the health insurance studies had not been carried to the point that a bill was ready for submittal to Congress, which was partly but not quite true.

The public health recommendations did go to Congress, they were enacted as Title VI of the Social Security Act, substantially as we submitted them. The maternal and child health and welfare programs went in as Title V of the Act and were enacted practically unchanged.

WEEKS:

The remarkable thing to me is that you had such a short time in which to do all this work. As I remember it, the Committee was formed at the end of June and you were supposed to report in December.

FALK:

The committee on Economic Security was created by the President's Executive Order on June 29, 1934. Its report was scheduled to go to Congress in January. And we did complete our work on time. In the health field all that we were permitted to present to Congress, as I remarked earlier, was an outline of guiding principles, as they were called. The studies and draft reports had to be done very fast, on a crisis basis.

WEEKS:

I have just started to read Mr. Witte's book. He came right down to Washington directly from Wisconsin, didn't he?

FALK:

Yes. He had a background of working with Congressional members and committees. He did a very creditable job as executive director of the Cabinet Committee staff. In the health field, however, he was a source of great

annoyance to us because he thought of himself as knowledgeable in this field and that he could be more effective than we in relations with the AMA and other opponents. Did you know Ed Witte?

WEEKS:

No, I didn't know him.

FALK:

He offended us very badly because he would accept invitations to meet with the hierarchy of the AMA without our participation although we were in charge of the health and disability studies, or even without keeping us informed. Very soon situations developed where he was making--I hesitate to use the word--commitments, but participating in understandings that were in conflict with agreements and compromises Sydenstricker and I were reaching with our own advisory committees or our own staff.

In his book, in a number of places, the information he presents is quite correct as he knew it, but at many points it was by no means a correct picture of what was transpiring, what was planned, or what had been agreed upon. Since efforts to stop this Witte practice were not effective Sydenstricker and I, attending a Cabinet Committee meeting, presented our resignations. We said we couldn't go on this way. The Committee stepped in and straightened things out. It meant a hiatus because the whole staff group working on the health field was incommunicado with our own executive director.

WEEKS:

You and Sydenstricker had sort of an independent position there. Weren't you still on the payroll of the Milbank Memorial Fund?

FALK:

For about two months, when we were loaned by the Milbank Memorial Fund at

the request of the committee chairman. They put us on the committee staff payroll. My recollection is that the first I knew I was on a federal payroll was when I received a check. Ed Sydenstricker and I discussed this with Albert Milbank, president of the Fund.

Mr. Milbank didn't like the idea. Ed Sydenstricker and I were indifferent. So that stopped. I remember a discussion about sending the check back. Somebody we talked with in the administration office in Washington said, "For heaven sake, please don't do that. That can make life complicated for us!"

So we kept our checks for the first two months. For the rest we were on loan, unpaid volunteers, available to the Cabinet Committee from the Milbank Memorial Fund. We stayed with the Cabinet Committee until the Social Security Act was enacted in August 1935.

WEEKS:

During that time you mentioned Nate Sinai's name. Was he a consultant to the Committee at that time?

FALK:

No, he was an adjunct staff member. Nate had worked with us on the Committee on the Costs of Medical Care. He had started some of the early studies for the CCMC. In fact the largest study, the family survey, was published as from Falk, Klem, and Sinai. Nate started that study and did a notable job in organizing it, and went back to the University of Michigan from which he was on leave. In the Cabinet Committee field he was one of the adjunct members of the staff that Ed Sydenstricker and I pulled in. He was very helpful. He worked with us extensively and came up with what I thought were some of the best ideas developed.

I had a similar experience with Nate a few years later when he served as a consultant to our committee office under the Interdepartmental Committee that planned the (amended) program for incorporation in the Wagner bill of 1939.

WEEKS:

He did a survey for the Michigan Medical Society.

FALK:

He did the Windsor study and worked with the medical society extensively. Until a meeting in Washington (I forget what it was called), sort of a public informational meeting at which the preliminary plans of the Cabinet Committee were being presented when Nate got an agreement with (I forget his name) a high officer of the Michigan Medical Society, who was going to come on the program and take a position in support of the staff proposals. Someone else was invited to speak on the opposition point of view, but Nate's Michigan friend broke his agreement and spoke against the proposals. Nate was very much annoyed that his friends in the Michigan State Medical Society had--what shall I say?--reneged on him and it is my recollection he broke off working relations with them.

WEEKS:

Somewhere along there he acquired the reputation of being far left, didn't he? Was this because of his ideas of national health insurance?

FALK:

Not really. Nate was never far left. He was often a little bit left of center, as I knew him. Some people among the physicians, who didn't like that much liberalism, plastered him with the far-left reputation. I know they told all kinds of scandalous stories about him. As far as I knew they were never justified. Nate, in working with us in staff positions, was a moderating

influence when an issue came up that could be taking us left. Because of his Windsor medical program experience and his experience with the Michigan State Medical Society when developing a prepaying plan, Nate annoyed some of the physicians in Michigan because he didn't like the behavior of those he thought were abusing the plan. He was quite outspoken about it. Some of them retorted to Nate by plastering him with a reputation of being very far left. Some of the Michigan Society physicians didn't like some portions of the Sinai-Simons report on "The Way of Health Insurance" in Europe. As I knew him and saw him in many, many of these meetings and conferences of drafting tasks, he was a constructive moderate liberal.

WEEKS:

Odin Anderson speaks very, very highly of him.

FALK:

Odin was an associate of his.

WEEKS:

Odin was sort of a protege of his. He speaks very highly of him. One more name I'd like to mention without throwing you off your story. A person I have become more and more interested in since I picked up his autobiography on a remainders table not long ago, Senator Paul Douglas. Of course at this time he wasn't Senator but he was active in a lot of social movements, particularly unemployment insurance and that kind of thing. Did he act as a consultant to the Committee at this time?

FALK:

No. Was Paul a Senator at that time?

WEEKS:

No, I think he was elected to the Senate in about 1948 or 1946.

FALK:

Are you sure of that date?

WEEKS:

Almost certain. I may be off a year or two but it was in the '40s when he became Senator.

FALK:

Not in the '30s?

WEEKS:

I don't think so.

FALK:

I had known Paul when I was at the University of Chicago. He was on the faculty. Then he became involved in local political affairs. He was on the Board of Aldermen. Paul was very much interested in social insurance in general and was an active member of the American Association for Labor Legislation. So all of us who worked in the field of social insurance had contacts with Paul, as I did. For years his interest continued.

He was more interested, as you say, in unemployment insurance than in old age insurance so he gave some considerable attention to that. But he knew the health insurance field. Paul had studied it in Europe, the European systems. If I am recalling correctly, he wrote an extensive paper on the French system when it was first taking form. He knew the German system, the Austrian, and various of the others, the British system, and so on. In the years I was studying the social insurance programs in the European countries I use to find Paul a very helpful person with whom to discuss these matters.

Then, after he became Senator he had some continuing interest in this field. I don't remember very much about it beyond 1939 when the first major

amendments of the Social Security Act came up. When we were setting up the Social Security Board's advisory council called for to review the old age and survivors insurance, I can remember some discussions about whether Paul might become chairman of that council. That was, I think, in '39 or '40, right after the 1939 amendments of the Social Security Act. There were some reservations expressed about him as against those who were advocating that we should get Douglas Brown of Princeton as chairman. I don't know whether Paul was already a Senator. You thought not by '39 or '40?

WEEKS:

I have the impression he was Senator three terms. I think he lost in about '66, right after Medicare. That was the time Percy defeated him, I believe.

Another Wisconsin man besides Witte was Altmeyer. Of course we must mention Wilbur Cohen. He came in as Witte's assistant, didn't he? He was a very young man right out of school?

FALK:

Yes. I hurried over the structure of the Cabinet Committee and didn't even mention the name of the Cabinet Committee. Arthur Altmeyer already by that time was Assistant Secretary of Labor under Frances Perkins and had had extensive experience in the field, in workman's compensation in Wisconsin and so on. He was probably the most knowledgeable man on social insurance in the federal government at that time. We use to say that when choosing people for the Social Security Board you could count on the fingers of two hands the number of people who were qualified for any important appointments in this field. The United States, because of its historic aloofness from this whole

field of the social insurance, lacked a whole generation of people in the field. The European countries had hundreds who were experts. The German systems went back to 1882. The British system began with the first insurance acts of 1910-1911. The French system came along later, the late 1920s. Austria, Italy, Belgium, Denmark, the Scandinavian countries all had experts. In the U.S.--ten fingers would cover the experts. Paul Douglas was one of those whom we used to regard as very knowledgeable in this field as well as John B. Andrews of the American Association of Labor Legislation and several of the people who were associated with him, and then Abe Epstein came along and he became quite a knowledgeable person. Arthur Altmeyer technically was probably one of the most knowledgeable of all in this country. From the point of the administrative aspects of social insurance he was without a peer, I think. He actually was superb, with knowledge, good hard sense and good judgment.

At any rate when the Cabinet Committee was set up Arthur was chairman of the Technical Advisory Board and was really the top administrative person. Ed Witte was executive for staff, but Altmeyer was really the man who ran things and kept things going and directional. Frances Perkins leaned very heavily on him. Generally it was he who formulated the agenda. In the Congressional discussions he was absolutely the number one person, knowledgeable, skillful, tactically very competent, and responsible. He was very highly regarded by President Roosevelt.

Wilbur Cohen came along as an assistant to Ed Witte. I think he had just gotten his bachelor's degree. He got his christening as an assistant to Ed Witte and worked a good deal with many of the advisory committees and did a lot of the staff work. After the bill was enacted and became the Social

Security Act, Wilbur joined the staff of the Board as technical assistant to Arthur J. Altmeyer. Then after I joined the staff in '36...no, a little later than than, when I became chief of the Division of Health and Disability Studies, Wilbur was my assistant director and also technical assistant to Altmeyer.

The law said that the Social Security Board with three members was to be bipartisan -- not more than two of whom could be from the same political party. The first Board included Gilbert Winant, the one Republican, and the President appointed him chairman. He was a very competent and very able person. He had been heavily involved in the advisory committee for the Cabinet Committee.

Altmeyer was the second member of the Board, the third was a political appointee, Miles, a lawyer from Arkansas.

In the Presidential election in 1936, when the Republican cadidates came out against Social Security, Winant thought this was a potentially embarrassing position for him as an identified Republican member of the Board whose party's candidate was carrying on a campaign, a "dog tag" system, for the country and so on. Winant resigned and left to become the Associate Director of the International Labour office in Geneva, as I remember it. Later he was appointed Ambassador to the Court of St. James.

Altmeyer succeeded him as chairman and remained Chairman of the Board until it was abolished and was replaced by a commission of Social Security. I forgot the year. Altmeyer, as Chairman of the Board, and even when Winant was Chairman the first year or two, when they were tackling the very difficult and complex problems of creating a very important, major, new government agency, had to start from scratch. They had to recruit, educate, and train the

personnel for what became a vast system. Winant was a big help in a lot of that. Altmeyer was the genius that made the planning possible and potentially effective.

Not many years passed before Arthur Altmeyer was considered the most skillful, the most effective, administrator in the United States government. The Social Security Board got its operations under way on schedule, on time, despite the newness and the novelty of the programs, despite their vastness, had done recruitment with great skill and perceptiveness, and the training programs were effective. Many complicated problems had to be ironed out between the first enacted law of 1935 and the amendments that were finally effective in 1939, between the time when account numbers had to be distributed, life-time accounts inaugurated, taxes, payroll taxes, were going to begin to be collected and when benefits were going to become due. It was Altmeyer's genius that got the ship put together, got it on course, got it sailing quite smoothly. Rarely has a program approaching such magnitude in the United States been put together so well. There never was a scandal or a major fraud. This was Altmeyer's movement.

Altmeyer was a tough administrator. In his quiet way he could be tough, but he could also be very gentle and very patient. When I was a Bureau director, he had 22,000 employees in that system in the various bureaus and regional offices. He was largely, mainly responsible for getting those many thousands of people to understand that their task was to administer the programs according to the law and its regulations but never to forget that the purpose of the Social Sercurity program was to be helpful to people. It was that balance that was the focus of the man.

WEEKS:

I think it pretty well carries through now. I have only been in a Social Security office two or three times as a beneficiary. I have been amazed at the courtesy, and the thoughtfulness, and the patience they have. Quite often you have to wait. I have observed other people waiting who have problems, and they are worried, yet the clerks seem to take time, have patience and understanding. I am quite impressed with it.

FALK:

It is interesting to hear you say that because the thousands of people that are involved in not only the Washington offices, but the regional and local offices let that become a form of religion with them. The genius of Altmeyer made that possible while never forgetting the overriding rule that this is a program of law and that you have to abide by the law and live by the law and by its regulations and balance that against the fact that this is a program to serve people. You have to be a bureaucrat to appreciate that kind of achievement. Arthur Altmeyer had that ability.

WEEKS:

You spent many years in Social Security. Can we find a chain of events? I think the next step after the law was enacted was ... wasn't there an interdepartmental group that got together to discuss how all the various social programs could be brought into...?

FALK:

You see, the Interdepartmental Committee to Coordinate the Health and Welfare Activities of the Social Security Program was established by the President when he signed the Social Security Act because the Social Security Program involved existing agencies in various departments of the government. The Social Security Board was a new, independent agency reporting directly to

the President. The Social Security Act also involved many other agencies: the Public Health Service, which was in the Treasury Department; the Children's Bureau, which was in the Labor Department; the tax collection and accounting of wages earned which was in the Treasury Department; the relations with all the states who would be administering the public assistance programs; the vocational rehabilitation agency, which was a section in the Interior Department etc. There was a very large scale problem of coordination.

After the Act became law and the programs got started, some of them had one year, two years, three years for the preparatory steps and for implementing. The Interdepartmental Committee got around to the health field in 1937 under the chairmanship of Josephine Roche, Assistant Secretary of the Treasury Department, who had been in charge of the Public Health Services. She had been the alternate to the Secretary of the Treasury in the Cabinet Committee on Economic Security and had thought (along with Harry Hopkins) that the health insurance was the most important need though the old age program and umemployment insurance had been more urgent. Both Roche and Hopkins had argued that more people were distressed, more people were in financial difficulty by reason of the costs of illness and the effects of disability than because of other major risks. They had been disappointed that the health insurance programs had gotten deferred, laid aside, filed away.

So right after that the Interdepartmental Committee had helped to get the general organizational arrangements among the different departments of the government in working order for the Social Security Act, they turned to the health field and set up a subcommittee to review what had been proposed but not enacted in 1935 and to reassess the scene.

A committee of five of us was appointed. Martha Eliot of the Children's

Bureau was chairman, Goerge Perrott, Clifford Waller, and Joe Mountin, of the Public Health Service and I, from the Social Security Board, were the five members of this subcommittee. So we started out on a reassessment, a review. We had our own differences to straighten out and to invent some new elements and then to bring the result of our work back to the Interdepartmental Committee for review and discussion and some modifications. Finally, when a series of program proposals had been agreed upon, the committee got a clearance from the President and an authorization to submit the proposals to a national conference. That's how the National Health Conference of 1938 came about on invitation from the President. There we presented our new proposals on public health, maternal and child health, medical care, disability insurance, and hospital and other facility construction, etc. before a large assembly of people from many walks of life--from the professions of medicine, public health, hospital administration, etc.; public representatives --governors, municipal authorities and others from voluntary agencies, etc. from many parts of the country in a three day conference in Washington.

Out of that conference and its assessment emerged a series of proposals and some amendments of what our five member subcommittee had submitted to the Interdepartmental Committee which led to the first new comprehensive legislation in the health field, the Wagner Health Bill of 1939, a bill that dealt with many aspects of the whole health field. It was the first such program to receive public hearings in Congress--under a subcommittee of the Senate Committee on Labor and Education.

WEEKS:

Wagner had previously introduced some other labor legislation hadn't he?

FALK:

Wagner had preceded the Social Security Act with broad national labor legislation, an unemployment insurance program as well as public aid for housing bills and even "social" legislation. He was in many respects a legislative pioneer.

WEEKS:

Was he in a sense the administration's front in this case?

FALK:

He was a Senator from New York when Roosevelt was governor. They were very close colleagues and personal friends. They had a great deal of respect for each other and worked very closely and smoothly together. Wagner was very knowledgeable in a variety of social fields.

WEEKS:

Did you have anything to do with writing that bill?

FALK:

Yes. It was drafted under the direction of our five-member subcommittee and I personally participated extensively in the drafting.

WEEKS:

This is part of the chain I was trying to develop. I was hoping to get you to talk about this and about the Wagner-Murray-Dingell bills, and then finally the Murray-Dingell, and so on. It seems that your hand was in there all the time.

FALK:

I would have been disappointed if I hadn't had the privilege of having my hand in. Yes, I wrote a good deal of the report for the Interdepartmental Committee, not all of it, but a good deal of it. At some points many other people participated. But somebody has to sit there and draft it and amend it,

and so on. In the drafting of the Wagner bill I don't remember how much of it I actually wrote myself, but a considerable portion of it. Some of my colleagues in that five member committee did a good deal of the drafting in the maternal and child health aspects of it, but on some parts of it I produced the drafts then lots of people would get their hands in on it.

WEEKS:

Was Wilbur your assistant at this time, or was it a different time that he was your assistant?

FALK:

I don't remember Wilbur Cohen being involved in the preparations for the National Health Conference though he might have been. As a technical assistant to Arthur Altmeyer, the chairman of the Social Security Board, Wilbur had to be kept informed of everything, just as Martha Eliot had to keep the Children's Bureau informed and as the PHS people had to keep the SG informed. If he had ideas to submit, he was invited in, but I don't remember him being an active participant in the development of the 1939 Wagner bill. Many people were involved because it was a comprehensive program bill.

WEEKS:

I ran across a statement the other day that I can't verify. Back in this period it must have been about 1936, Governor Frank Murphy is supposed to have come to Roosevelt and asked for money to build hospitals in rural Michigan.

FALK:

I remember that very well. He wanted money from Harold Ickes who was administrator of the PWA, the Public Works Administration. Ickes, as well, was Secretary of Interior. Murphy had seen the President and had been referred to Ickes. Murphy was Governor at that time, wasn't he?

WEEKS:

He was just finishing his term.

FALK:

As I remember, Mr. Ickes had discussed Murphy's proposal with Josephine Roche, Assistant Secretary of Tresury, in charge of the P.H.S. and who had been active in the health planning program. I got to know about it through a call from Josephine Roche telling me about it and would I come to a meeting with her and Governor Murphy and Mr. Ickes. Also there was Abe Fortas, the Undersecretary of Interior under Ickes. I think he was also general counsel.

Josephine was bothered about it, because the program, as Frank Murphy proposed it, was for money for the construction and equipment of hospitals, but he wasn't asking money for their operation. If he had brought that up, he had already been advised against it. I don't remember that detail but I know that it was development, construction, and equipment money, not maintenance. I know that he had one or more talks with Josephine Roche. I know the proposal in a vague sort of way, but not more than that.

I remember that meeting in Mr. Ickes' office because I had the very unhappy task to say, "This is no go, because the very communities for which the Governor wants the help for these small rural hospitals are , in general, communities that don't have hospitals because they can't support them. What will you do with these hospitals if you build them? How will you maintain them? Let's give some thought to whence the money is to come to support them, especially in their initial operating years, if they are not affluent suburbs of well-to-do communities."

We had a long session in which I was the most unpopular person in that room because I said there were various ways in which proposals could be

devised for support funds. I don't recall now why Govenor Murphy was opposed to it, whether he had been told he couldn't get it, or what. I do remember I was getting dashes of cold water every time I brought that up. I said that if the construction and equipment grant funds have to be conditioned on some kind of a community means test, you must come along with something that guarantees support of the operating expenses, but I couldn't get any support for that. After the Governor left to keep another appointment (with the President) Mr. Ickes and Abe Fortas and Josephine Roche and I continued the discussion. It very soon developed that I was the oddball man in that picture because I said I wanted to see maintenance money in this proposal, at least for a while, even if only for a brief period of time. Put it on a liquidating basis. Otherwise you are going to get some phrase that some journalist coined, "some empty mausoleums." I can still remember that unhappy experience.

I can remember saying, "If you will give me a signal to do so I'll be glad to draft several alternative proposals for some federal grants to serve, if you like, for declining maintenance support."

I don't remember why the answer was, "No." I don't know whether the President had already turned it down or was intending to do so.

However, I remember Mr. Ickes saying to me, "You are uncomfortable about this."

I said, "I am very unhappy about it. I hate to be in the position of saying no to an obviously otherwise desirable program."

He said, "Forget it and rest comfortably. I have no intention of approving as PWA administrator a program of this kind unless the people who are advocating will come to me and propose maintenance money."

This was in the mid-30s, wasn't it?

WEEKS:

It had to be no later than 1936.

FALK:

It was probably during the period between the Social Security enactment and something else that was going to come along and lead to another hospital construction support program, as later in the Wagner bill, S.1620 of the 79th Congress.

WEEKS:

I have seen this incident mentioned in only one place, possibly it was in some statement you made in previous testimony.

FALK:

I remember it because it was an unhappy experience. It was out of character for me in many respects. Murphy went to the Supreme Court didn't he?

WEEKS:

Yes. Also at one time he went to the Philippines as Governor-General didn't he? I have forgotten in what order they came. Also he was Attorney General at one time. He died quite young. The next in sequence was....

FALK:

The hearings on the Wagner bill, the first Congressional hearings in this whole field. That was a disaster. The hearings were held by a subcommittee of the Committee on Education and Labor. Senator Jim Murray of Montana was the chairman. Wagner's bill had been referred to that committee. Wagner was not a member of this committee, but Murray gave him the courtesy as the author of the legislation of being the first witness. He gave some very strong testimony. But the meeting room was stacked with the opponents of the legislation. Some very curious bedfellows on that one: the AMA, the state

medical society people, particularly from New York state and they were a disaster---I say that, chuckling about it, because there were some very amusing situations that developed in cross-examination by Senator Wagner of opposing witnesses.

Haven Emerson, who had been one of the strongest proponents of our public health program in the Social Security Act, testified in opposition to this program. He thought national financial help for public health or medical care was not needed, and he was afraid of government controls! Haven Emerson was two or three different people at two or three different cycles in his life, I found. At that moment, this was 1939, he was in his antigovernment phase. He was afraid basically that, if the public health agencies became responsible for personal health services, that would involve them in medical care expenditures and monies so much larger than the amounts available for community health services that the medical care programs would swamp the public health programs and put them off in the dust bin somewhere. So he was opposed to any programs--however developed, however inspired, as in this case through federal support grants--that would encourage the health agencies being made responsible for or becoming involved in personal health programs. So we had this strange picture of some of the most reactionary members of the New York State Medical Society and Haven Emerson in bed together.

It was a ludicrous performance because the first group of fellows who came to testify at that hearing saying they spoke for the AMA hadn't read the bill and didn't know its content. They had some speeches that had been prepared for them by somebody else, I suppose in Chicago, and they made fools of themselves. To the extend they didn't, Senator Wagner did it for them. They charged that through government support it would be getting its hand on the

medical schools and their curricula, and in the practices of doctors and their relationships with patients, and so on and so forth.

Wagner cross-examined some of these people. He took very serious offense because they talked at length about the intruding or damaging hand of government and of government money in universities and medical schools. He was a long-time trustee of Cornell University and very proud of the record of New York State money in supporting Cornell University and the Cornell University Medical School in New York City. He made fools of these people by challenging them to cite a single case, one or two cases, or a single case, in which the government money that Cornell University received intruded into curriculum control, faculty control, or medical school practices. He made fools of them to the point that a large audience there, no matter how serious it was, was boisterous in laughing at the asinine performance.

Except for an initial day of sensible hearings from the farm groups and needs, the hearings got off to a bad start, as indicated. Subsequently the successive hearings which stretched on from April to July were solid and comprehensive for the most part, with testimony from a wide variety of witnesses--from federal agencies, from management, labor, MCH, public welfare, voluntary health agencies, etc. Later witnesses for the AMA and other professionals gave solid testimony opposing this bill to counter the testimony from many who supported it.

What mattered really was that the subcommittee...(Jim Murray was chairman of the subcommittee, Elbert Thomas of Utah was chairman of the full committee. Vic Donahue of Ohio, Allen Ellender of Louisiana, young Bob LaFollette of Wisconsin were the other subcommittee members.) The subcommittee found soon after the hearings that among the members of the

subcommittee La Follette was cool for reason peculiar to his Wisconsin background and Ellender was openly antagonistic. When they approached the member of the full committee it was very evident that Jim Murray couldn't get this bill reported out. So I wrote the committee report for them and that was the end of it.

The significant point is this 1939 Wagner bill was the first major bill to have public hearings on the health benefit programs developed under the Interdepartmental Committee that hinged their program to a federal-state pattern. It proposed federal grants-in-aid giving the states very wide latitude to follow any reasonable course they wished, what kind of a program to develop, whether a state program of "socialized medicine" or a prepayment plan or a voluntary insurance plan or a mixture of voluntary and compulsory--all kinds of latitude were left in the bill for the states to elect. Nevertheless, the vocal opponents would have none of it. Thus, the outcome of the hearings on this bill began to be a turning point between our proposals for federal grants-in-aid to state programs as against a straight national program.

WEEKS:

In the first Wagner-Murray-Dingell bill you went to a national...?

FALKS:

In the first Wagner-Murray-Dingell we were still adhering to a federal-state program but not with all the latitude in the Wagner bill.

Later, when we became impressed with the weakness of the federal state approach for medical care and the successful operations of OASI on a national basis we shifted to a national health insurance pattern.

Then that takes us into the '40s.

WEEKS:

Before we get into the '40s, may I interrupt a moment? The Federal Security Agency was established in '39, I think, with Paul McNutt as administrator. Somewhere I have read--of course nobody at that time knew whether Roosevelt wanted to run again in 1940, did they?

FALK:

Perhaps the only one who knew was Franklin D. Roosevelt. (Maybe Eleanor knew? Maybe Harry Hopkins knew?)

WEEKS:

Someone has said possibly Roosevelt didn't want to push health legislation too much because McNutt might get credit and he might be an opponent for the Democratic nomination in '40 if Roosevelt decided to run again. That's kind of an extended conjecture.

FALK:

There's no doubt there was a mixed situation and I didn't know very much about it. It was plain, however, that McNutt was grooming himself for the nomination; he was playing all kinds of games to do it. The initial story (I didn't know how authentic it was) was that President Roosevelt appointed McNutt to head the Federal Security Agency on Harry Hopkins' advice. Harry's strategy allegedly was that anyone you put in to run the Federal Security Agency is going to come out with a black eye because of the inherently controversial programs incorporated into the Agency and that would dispose of him that way. McNutt obviously didn't want to be disposed of so he began trotting around public speech-making everywhere. He had been head of the veterans' American Legion and he used that in many different ways.

At a critical point in the time schedule McNutt was going to make a speech

in New York on an amended form of the health insurance program, and if I recall correctly, on Social Security. It had not been "cleared" or reviewed by the White House, or the PHS or Social Security. He never made it. After he had released it to the press he got a call from the White House and he didn't make the speech.

Later the story was it had been drafted for him in the AMA headquarters. I can't vouch for the truth of that but I know that it was one that might have been written in the AMA headquarters. It reportedly was not written in the Federal Security Agency.

Some people in the Agency learned about that speech the morning of the day he was to make it in the late afternoon or in the evening. Word about it and its content was carried to the White House. The President didn't like it and, I was told, he reached Mr. McNutt somewhere en route to New York and directed him not to make the speech, and he didn't. That's what started these rumors that the President was saving the health insurance for his next campaign if he decided to run again.

WEEKS:

To follow this a little further, when Roosevelt did decide to run, he didn't make a strong stand in 1940 for health insurance, did he?

FALK:

He made a first major move for health insurance when he proposed in his budget message of January 5, 1942 a national hospital prepayment program as an expansion of old age and survivors insurance. That was his first feel out. Most people don't seem to know there was such a program, but there was in 1942.

WEEKS:

That was after the 1940 election?

FALK:

Yes, at near mid-term. Also little known, we achieved agreement with the hospital people about specifications for prepayment of hospital costs if an administration program would be submitted and enacted by Congress. This was accomplished in joint meetings with representatives of the American, Protestant, and Catholic hospital associations on, September 3-4, 1942. Dr. Basil MacLean, the president of AHA and I acted as cochairmen; and, with about a dozen representatives from the hospital associations and about an equal number from the federal agencies participating, we hammered out "agreed" major specifications--though with understanding that these were preliminary and tentative and were not to be regarded as advocacy by the hospital people.

WEEKS:

Considering the chain of Wagner-Murray-Dingell bills. Were you involved in writing them? Was there much change in them as the various bills came along?

FALK:

In general what happened was first the transitional move from the Wagner '39 bill to the Wagner-Murray-Dingell bills which were comprehensive bills covering almost all aspects of the Social Security program.

WEEKS:

Were they proposed amendments to the Social Security Act?

FALK:

Yes, amendments to the Social Security Act though the 1943 bill (S 1161 of the 78th Congress) provided for administration of the medical care benefits by the Surgeon General of the P.H.S. It also introduced some major new elements like the disability insurance programs (temporary disability program,

permanent total disability program). In various subsequent bills there were other health benefits, maternal and child benefits, and so on, public health expansion. Most of the Wagner-Murray-Dingell bills--I don't say this to boast--were written mainly on the health and Social Security aspects by me and Wilbur Cohen and by some members of the general counsel's office. The maternal and child health and welfare programs were written mainly by Martha Eliot and others in the Children's Bureau. As to the financial sections...all of us were involved in that, drafting and redrafting.

Note that by the time of the 1943 bill we had discarded the federal grant-in-aid approach and gone to a "straight national" pattern for medical care insurance--locking it with the national OASI.

By the time we got to those bills I was the Director of the Bureau of Research and Statistics and all of these fields were within my jurisdiction and responsibilities. We had to involve many people. I had become the Assistant Director when Walton Hamilton the first director of the Bureau, retired and returned to the Yale Law School. Ewan Clague, the assistant director, was moved up as the Director and I moved into Ewan's slot as Assistant Director. I think that was in '39 or '40, I forgot the date. Then when Clague accepted the appointment of Commissioner of Labor Statistics and moved to the Department of Labor, I was commandeered into the position of Director. I fought that one, I didn't want it, but I didn't have a choice. The situation was very difficult because there were some other people being recommended that Arthur Altmeyer and the board did not want. So Arthur twisted my arm and said, "I am signing the orders, and that's all there is to that."

So I became the Acting Director of the Bureau I think it was in 1940, then

the full Director in sometime '41.

WEEKS:

These Wagner-Murray-Dingell bills kept appearing every Congress until Wagner's resignation. He resigned in about '48 or '47, didn't he? He died about '49, didn't he?

FALK:

You remember better than I.

WEEKS:

It isn't that important. Then it switched over and became the Murray-Dingell bill.

FALK:

You may be right.

WEEKS:

I was just wondering about a gap there between Wagner's death and the Forand bill which came in the '50s, didn't it?

FALK:

I forgot the dates. Aime Forand succeeded Dingell on the Way and Means Committee. Aime Forand was the next ranking man, so that after Dingell's death Aime Forand took over. We went through a series of adjustments of the bills because there were differences of opinion as to whether a bill would have a better political outlook if it did or if it did not include medical benefits, or if it were limited to hospital benefits. Aime Forand was of two minds about that, as were many people. I wasn't. We had the problem over and over again. I thought we would spare ourselves nothing by leaving out the physician benefits of the program and think thereby we would persuade the AMA out of the picture. I was confident that kind of strategy on tactic wan't

going to work. They were much too sophisticated to know if you let, as they put it, the camel get his nose under the tent, how long would it be before you had physician benefits?

So those bills went back and forth, I forget--without looking them up--which one preceded which one, and which one followed.

WEEKS:

I think it was Nelson Cruikshank who told me that Aime Forand was reluctant to introduce this bill in the first place. Then the labor union some way got him some publicity in the Providence, R.I. newspaper. He was so pleased with the good publicity he got that he became quite enthusiastic about it.

FALK:

If Nelson says that, it's probably correct because he was closer to Aime Forand than I was. I don't remember the details of when the bill was of this scope or that scope. I would have to refresh my memory. There is no point in my guessing. I know that it went both ways and at some point when people were addressing comments to bills in this field they weren't always clear that they were talking about this bill or its successor bill or its preceding bill because they came very close together. Then the bills moved out of the hands of Murray, Dingell, and Forand into other people's hands both in the Senate and the House.

WEEKS:

At that time Senator Kennedy became interested too, didn't he?

FALK:

Jack Kennedy. Yes, Jack Kennedy and...

WEEKS:

Anderson and King?

FALK:

Before Anderson and King, Green and two or three other people brought in bills. A drug and medicine bill, a hospital benefits bill.

WEEKS:

There were so many bills it's almost impossible to keep them straight. I was wondering, we have skipped Hill-Burton, that came in there in '46, of course which is little different. That came in before the Forand bill, didn't it?

FALK:

Oh, yes. It was during the Wagner-Murray-Dingell legislation period. The separate hospital construction bill was introduced in '45 and was referred to Senator Murray's committee, the Committee on Labor and Education. Lister Hill was chairman of the subcommittee on that bill for executive committee review in the Senate (not public hearings). The situation was somewhat complicated because the bill had been introduced in the Senate by Hill and Burton. Before the bill came up for review Burton had been appointed to the Supreme Court so that when the bill was to go through executive hearings and mark-up, it was all on the Senate side and Hill could handle it alone because Burton was no longer there. I remember those executive sessions very well, having been heavily involved in that.

You see, the Hill-Burton bill was a bill-drafter's rehash of the hospital construction program that had been Title XII in the Wagner National Health Act of 1939, S.1620. It also drew on S.3230, 76th Congress--the Wagner-George "National Health Act of 1940"— which provided for both construction and early-year maintenance support grants, and which was favorably reported by

Senator Murray (Committee on Education and Labor) in Report No. 1558, April 30, 1940 but which was not enacted. It was subsequently in the Wagner-Murray-Dingell bill.

Vane Hoge, Louis Reed, and others in the Public Health Service, George Bugbee from the AHA, and others participated in a subcommittee of Murray's subcommittee under Lister Hill's chairmanship with Murray sitting in. It was in difficulties because the financial proposals in it, the federal distribution of funds to the states were unacceptable to the states represented in the subcommittee mainly by Senator Allen Ellender of Louisiana. LaFollette was on that committee and Bob Taft, they also were opposed for different reasons. Lister Hill was in a quandary what to do about it. He and Murray put their heads together. They called me one day and told me the situation behind the scene. Would I figure out some kind of financing arrangement that would make the bill potentially acceptable? Bob Taft had said that there was no point in giving a lot of federal money to the rich states but OK to give it to the poor states. LaFollette had said, "Which are the rich states? None of us is rich enough to deal with this problem."

Allen Ellender said, "Why should we give money to New York State and Massachusetts in order to build hospitals? They have got all the hospitals they can use and more. We need them down in poor little Louisiana."

I can remember pulling some of my staff together and saying, "I am not altogether happy with some of the provisions the PHS and the AHA have put in this bill. I liked it better the way we had it in the 1939 Wagner bill or in the Wagner-George 1940 bill or the Wagner-Murray Dingell bill, but that's past history. Let's see what we can do to straighten this out." So we drafted a whole series of alternative financing provisions. Tom Parran, who was Surgeon

General at this time, sat in on some of those sessions and Vane Hoge who did most of the detail work in the Public Health Service didn't like some of my ideas--without getting into the technical or policy details of why they didn't.

The main problem was to get a financial formulation that would be applicable to the perspectives of rich states and poor states, big states and small states, and so on, because the needs and issues were diverse. The key problem critically was that the drafters had been working with specifications that were based on fixed formulae grants. You couldn't get enough flexibility in the programs with provisions of that kind. So, two or three people of my staff who were very knowledgeable in this field (we had been working extensively on diverse federal grant patterns for public assistance and health programs) really put their heads together and explored with me and said, "We'll have to put together a variable plan formula that is peculiarly adaptable to the hospital field."

Of course, in the hospital field there were two different categories of variables that produce coinciding results: the question of the need of the state or the community for federal aid in general, and the question what the community need is for hospital care. The key to that problem is that, if the community, state-wide or part of a state is poor, generally it has fewer hospital beds, and it has higher need for support of care. If it is a well-to-do area, a well-to-do community, it has a more generous supply of hospitals, more generous support of them, and less need for general federal support. So we said let's play with that kind of formula.

We tried various approaches to variable grant formulae and finally came up with a particular variant that was accepted by the subcommittee and enacted. It is a peculiar formula. I have never really understood why it was

accepted. The second or third time at the executive sessions of the subcommittee we had a list of the states on a blackboard and showed how this formula would work; when we got through with a presentation Lister Hill took a canvass of the committee--the subcommittee was there and some other members of the full committee. He asked, "How many here understand what we have been talking about?"

One hand went up. That was Bob Taft's. He said, "Because I know what he means when he says a square of the allotment percentage derived according to the factors required to be considered."

I am sure I am diverting you. This is how the Hill-Burton formula came into being with its famous (or infamous) square formula. It was the first major piece of legislation postwar that went through the Congress with practically unanimous consent with a basic financing formula that almost nobody in the Congress understood.

WEEKS:

Couldn't you say, though, that the southern states knew they were going to get more out of it?

FALK:

They saw that on the background. We had formulae through which the states with per capita income equal to or above the national average would get lesser shares of the federal appropriations and other graduations would be for states with less than national per capita income. That was the compromise formula, but we had to work in that square in order to get big enough grants to the poorest states, granting them the credit, so to speak, in the formula (a) because they had more financial need for hospitals than the richer states and (b) they had more need for hospital care. So we squared the formula. Alanson

Willcox had been sitting in. He was the assistant general counsel for the PHS in the Federal Security Agency. He drafted the report from the Lister Hill-Murray committee. If you go back and read that report sometime, if you haven't done it recently, you'll find some very skillful writing. It went through the full Senate Committee, the Senate and the House in a breeze. That was in '46. It was not only the first major health legislation enacted after the war but it had another nearly unique quality. It was the first bill enacted by Congress with a grant formula since the days of 1870 or 1880 or 1890 when variable grant formulae were used in the land grant and related acts.

WEEKS:

Do you think this is why Medicaid came up the same way, with a variable grant?

FALK:

They began using it on all kinds of bills. The famous name I want to mention, a fellow whose ingenuity made that formula possible was a member of my staff named Daniel Gerig, whom I never forget to give credit for it.

WEEKS:

Daniel...?

FALK:

Daniel G-E-R-I-G. He later left us to go to the International Labour Office.

WEEKS:

Someone had said that Bob Taft was very eager to have state administration of the Hill-Burton funds. Do you remember his making point of it at that time?

FALK:

There was no question about that but that view was also expressed by other

members of the subcommittee and of the full Senate committee. In these hearings that the federal role was going to be to make money available under prescribed conditions as to a state plan requirement, and so on, the regional factor that we had to persuade Bob Taft to accept in the executive committee sessions, the quality standards that had to be observed in the state plans, the no interference rule by the federal government in the state personnel and this and that in the state agencies. The states would make application certifying that they would observe these various conditions.

WEEKS:

Did the communities have to participate also?

FALK:

No. Not financially, but the applicant had to have the non-federal share of the cost and had to agree to various preconditions for construction and for subsequent operations.

WEEKS:

Would the federal government grant enough money to build a hospital or would they grant only enough...

FALK:

A certain sharing proportion. The states could determine that proportion within specified limits. The states got the federal money. The state could say that the community that was going to build a hospital would have to find the money, not the state agency. A state could say that we get so many million federal dollars according to the formula, we have applications for so much money, any applicant that meets such and such conditions can get up to (not to exceed 50%, let's say) of their expected costs from this federal grant pool, or 40%, or 33%. Some states had a 50% formula, I don't think there were

any higher than that. Connecticut had a 33% provision. That was a variable with the state, dependent on how best to spread the federal grant which they got by federal formula among the applicants whom the state agency could properly approve. I think no state went above 50%. I am not sure whether it was permitted or not. It has been so long since I last read the original bill. Not less than 25%, I think. Then whoever was the applicant, whether it was a local government agency or a civic group or whatever applied to the state agency. The state put no money into it except for their own administrative expenses. I think that was not reimbursed originally. Later the act was amended to earmark a portion of the money for public health centers, clinics, and so on, for ambulatory facilities. I forget the details of that. They may have had to pay their own administrative expenses. I forget; I am sorry, '46 is quite a while ago.

WEEKS:

It was quite a step forward in federal support...

FALK:

There were two provisions that caused trouble, one immediately and another later. The first was President Truman's objection that an advisory council of nongovernment persons could override the Surgeon General on some provisions for approval or nonapproval of applicants. The President thought it was at least bad policy and possibly unconstitutional. When he signed the bill into law he said he had first considered a veto, then accepted the bill but announced he would ask Congress later to amend the act.

The other element in that bill that got into real trouble was the provision that allowed federal grants despite "equal but separate" operation of aided institutions. Until the Supreme Court's adverse decision came on

that, the bill remained intact except for amendments later.

The bill provided for support for hospitals and public health centers. The term "public health centers," if I am correctly recalling the phrase was, as I recall, an invention from George Bugbee and/or Bob Taft, I have forgotten. They didn't want to use a word like "clinic." The public health center was so defined as to be quite broad, it could deal with ambulatory care in general as well as preventive, immunization, and even some clinical services. The AMA and various state medical societies and county medical societies didn't like that provision. We got it through the committee almost intact, but once the act was in force as a law and funds began to be available the objectives from the private medical profession greatly increased; they didn't like it. The Public Health Service chickened out on it so that for all practical purposes they killed that part of the statute by inaction. They earmarked no money for it, and they were cold to approving applications for it. They weren't going to get into a hassle with the AMA or the state and county medical societies, who were fearful that somebody would raise some money and would then have a free clinic going or a low pay clinic or all the other things private practitioners didn't like.

It wasn't until, I forget, about 1950 or '52, '54, quite a while, before there was enough pressure upon the Congressional committees to implement that original intent of this aspect of the Hill-Burton Act. The way Congress did it was by insisting upon earmarking a portion of the funds appropriated for the Hill-Burton program, earmarking a portion to be used exclusively for ambulatory facilities. The states had to use the money as prescribed or lose it. Anybody who opposed an application for money in that field then had to deal with the state agency that said, "We can't turn these people down, the

money is there." That came four, five, six or eight years later. There was an awful battle about it, I can still remember that, but I can't remember how long that battle raged.

In general, except for the separate but equal provision, the Act was flawless at least in providing federal grants to the states for applications under the state program, with no required matching by the states but with a carefully developed set of conditions which the state and the federal agency would be required to see that the applicant met. It was not until about 1970 that we got the beginning of a new battle about the Hill-Burton Act, about the availability of "free" services from Hill-Burton aided hospitals or other facilities for people who couldn't pay the charges. That's going on right now. This includes an outrageous performance by the federal bureaucracy because they have blatantly amended the contract agreements under which grants were received by applicants and spent by them by putting on the federally-aided applicant requirements that go beyond what were contracted when the original aid was awarded.

WEEKS:

There must have been some foreshadowing of that because I remember one hospital that had a Hill-Burton grant back in the sixties. I can remember talking with their financial man. They were deliberately entering charity as an item in their financial statements.

FALK:

That's correct. You see, the act and the original regulations provided that an eligible shall be a community institution, serve the community, and--I forget how it's phrased but the substance of it is--give free care, for persons who needed it but couldn't pay up to the service and fiscal capacity

of the institution. Up to. So every Hill-Burton aided facility was obligated to be open to the community, the poor, the ghetto, the neglected people, and to give them care at reduced cost, or at no charge to them, up to the fiscal capacity of the institution to do that, and up to its service capacity. "Up to." They were the key words in those grant contracts. I know about that because I have been having to live with it in recent years.

Various suits were entered against the Public Health Service, against various Hill-Burton aided hospitals, and against various other aided institutions by disaffected groups who felt that their poor, their blacks, their Hispanics their this and that go to the emergency room or what not and the institution says: Who's paying for this? What's your prepayment? Have you got Blue Cross? Is the city or the state paying? If not we can't take care of you. And they didn't.

There were complaints against them on the ground, when some knowledgeable person got hold of this, that this was a Hill-Burton institution. It was obligated to be available in the community, and obligated to provide free care open-end. But it wasn't. It was obligated to provide care at reduced cost or free up to its fiscal capacity. An institution had the right to say what its fiscal capacity was. It could say, for example, that it could earmark 10% of its operating costs to be absorbed, and so on, but that it couldn't do 50%. If the hospital had the misfortune to be located in an area where it had a very large potential population of people unable to pay, it couldn't do all that was expected or demanded of it. I am saying that as apology for some institutions, others just didn't want to do it. Some couldn't; some wouldn't.

A number of law suits were entered in various communities, and here and there. In general the Public Health Service lost those cases, the courts

having found, in many cases, that the hospitals had not met the declared or implied requirements under the Hill-Burton Act. In a number of cases that was quite true. There were a number of other cases that were marginal because the act and the regulations were rather vague about what that "up to" meant. The PHS then about two or was it three years ago--this is 1980 we are talking about, it was about '76 or '77--issued a series of regulations spelling out the obligation. They had gotten plastered because they lost the court cases, whether rightly or wrongly is arguable. After some of the "lost" court cases, they decided at PHS they would get out of that pass by spelling out precisely what those requirements would be and aided institutions accepted the specification. But more recently they spelled them out again and leaned way over in spelling out the magnitude of the obligation for care to be provided at reduced cost or at no cost. They wrote the regulations so that institutions that got their grants before Hill-Burton amendments of 1960 something or other, I forget what year, did not have a change in those words about obligations up to certain levels, but now they made the obligations almost blanket. Therefore there were two categories of Hill-Burton aided institutions, some got their Hill-Burton aid before a certain date when the law and regulations said one thing, and some who got their grants after a certain date when the regulations had been amended. Thus it created a controversy. That's before the courts right now.

At the Community Health Center Plan here in New Haven we had Hill-Burton aid in the "up to" period and then suddenly we were confronted with an obligation to provide practically unlimited free care. We said, "We can't take care of the halt, the lame, the blind for the whole state of Connecticut by reason of the $300,000 grant we got years ago. We weren't obligated to do

that. We were obligated to do 'up to' our fiscal capacity." Our fiscal capacity we estimated at this and that and cleared that with the state agency which had the authority to do so. We thought we were decent citizens behaving competently. We won't know until we see how the court case comes out.

The AHA brought suit in the Chicago Federal District Court, lost, and appealed it. It's up before the Federal Appeals Court.

WEEKS:

These are important things about Hill-Burton that are not usually discussed.

FALK:

Now, Hill-Burton is really out, repealed under the Planning Act. However, there were twenty year obligations under those contracts for those who had received Hill-Burton grants.

WEEKS:

We had a very good Hill-Burton program in Michigan. I am trying to think of the name of the man who directed it. He worked himself to death. He worked about twenty hours a day working out of the state agency and in inspecting the hospitals they were building under the Hill-Burton aid. Joe Homminga was his name, a Dutch name, Joe Homminga. I think he literally worked himself to death. He was just a dynamo. He was going everywhere, seeing everything, sitting in on all the meetings at which contracts were let. He was everywhere.

FALK:

I did know the people in those days. I don't remember many of them now.

WEEKS:

Of course Sy Gottlieb, do you know Sy Gottlieb? He's the head of the

Greater Detroit Area Hospital Council. He was the first Hill-Burton director in Michigan and then after a short time he came to the University of Michigan. He was there under McNerney when they did the McNerney study.

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FALK:

Let's leave Hill-Burton and go back a bit in time. With reference to the Committee on the Costs of Medical Care, I focused my discussion towards the Committee's final report which was the definitive document and which laid out a program for the desirable developments of the future. For the convenience of students and scholars of that period who may be interested in those studies I would call attention to the fact that when we were completing the work of CCMC we worked toward the preparation of two volumes. One, of course was the Committee's own Final Report. The other was a staff volume prepared to summarize all of the studies in which the Committee had engaged in its five year program; it included summarizations and interpretations of the whole medical care scene in the United States as the setting for the particular studies conducted by the CCMC staff and the collaborating institutions. The staff volume, a 600+ page book which was Report #27, paired with the Committee's report which is Report #28, is referred to at many points in the Committee's report as "The Summary Volume." It's actual title was The Costs of Medical Case: A Summary of Investigations on the Economic Aspects of the Prevention and Care of Illness. Its authors, of course, were the whole Committee staff and the staffs of many collaborating institutions. The volume itself is identified as having been prepared by I. S. Falk, C. Rufus Rorem, and Martha D. Ring, all members of the Committee staff with a foreword by Ray Lyman Wilbur, chairman of the Committee, and published by the University of

Chicago Press, actually a few months after the Committee's report was released, namely in early 1933. It is a very useful volume for people who may be interested in knowing and becoming familiar not merely with the Committee's specific twenty-six other reports but the whole USA medical care scene at that time.

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You referred to the fact that you were aware that I at various times had engaged in studies and activities in other countries. I would mention that for a number of years beginning in the 1920s and on into the 1930s and subsequent years, my wife and I, and when the children were young, they too, used our summers for trips to various European countries. These were, in our earlier years in the 20s and so on, vacation trips, tourist performances, bicycle trips through England to visit the cathedrals, bicycle trips in France and in other countries.

But some of these foreign excursions were combinations of summer vacations and performances in respect to particular studies which I was interested in or in which I already was engaged. I would cite in the latter category three examples: at various times in the late 1920s and early 1930s I became interested in the history and evolution and performance of social insurances in the European countries. I was aware that this was a field with a large and complex history going back to the Middle Ages, but in their modern forms beginning at least with the development of the first social insurance programs in Germany in 1881, 1882, or 1883 which had been followed by parallel, corresponding developments in most of the western European countries. They were important to those countries and their experience, it seemed to me, was potentially important to us in the United States against such time as we might

have reason to explore the possible applications of social insurances to the problem in the United States.

Accordingly, beginning in about 1927 or 1928, I began to read on the history of social insurance in Europe. Then as time marched on and the outlook was beginning to suggest that we might have reason to consider social insurance program developments in the United States I began to work more seriously on the history, the evolution, and the developments in European countries. We had had some social insurance developments in this country beginning soon after the turn of the century when particularly the American Association of Labor Legislation (AALL) undertook the development of what we have come to call workman's compensation, as a substitute for employer's liability under the common law. It's of interest that after the Association succeeded in winning the adoption of workman's compensation laws first in some states and then in nearly all of the states and in the federal government, they engaged in a campaign for the parallel development of health insurance in the United States. Between about 1910 and 1916, 1917, 1918 the AALL sponsored a national campaign for the adoption of what they called a "model bill" for state health insurance programs in the United States to deal with the problems of non-work connected illness, disability, and medical care. That campaign, which in its early stages was strongly supported by spokesmen for the American Medical Association as well as the AALL and many other groups finally floundered when the onset of World War I exposed the campaign to the destructive slogan of "Made in Germany," particularly under the attacks led by the chief statistician of the Prudential Life Insurance Company, who became a very famous figure in that campaign. I am referring to Frederick L. Hoffman. Others were involved. The AMA reversed its position and opposed the program

in various states that were considering health insurance legislation. The program failed of enactment...it did pass in one house or another of one or two states, as I recall, but in general came to a close and died when United States became involved in World War I and was no longer displaying interest in a program of that kind.

I refer to these episodes because interest in social insurances had its modern beginnings in this country with those activities of the American Association of Labor Legislation. As I remarked earlier, I knew the history of those experiences and wanted to learn more about the background of the subject, so I began some studies in, I think, 1927 or 1928. I pursued them through the next five, six, seven years by more intensive readings, and by more intensive studies in a number of selected countries. I prepared draft manuscripts reviewing histories in Britain, France, Germany, Denmark, and other countries. From time to time I sent drafts of those manuscripts to governmental and private experts in the several countries for critical review. When visiting those countries in the summers of those years I had conferences with the people to whom the draft manuscripts had been sent, including the administrators of various programs from whom I could obtain not only general, constructive, critical comments but also a great deal of technical information.

That series of studies and visits to European countries culminated in 1936 when I drew the manuscripts together and put them into a setting of the emerging scene in the United States having regard for the experience of the CCMC and its studies. By 1936 the emerging programs in the United States extended to the emergency measures of the 1933-34-35 period and the work of the (Cabinet) Committee on Economic Security in 1934-35 and the enactment of

the Social Security Act in August of '35. All of that is summarized in the volume titled Security Against Sickness: A Study of Health Insurance which was published by Doubleday in 1936 with the fiscal support of the Milbank Memorial Fund with which I was at that time still associated.

I would like to mention in connection with foreign studies a more or less parallel experience in the period 1933-1934 on up until 1937, when, at the invitation of the Health Section of the League of Nations, I undertook for them a study that they had asked me to undertake as part of their development at the League of the international epidemiological service they were developing and which was crystalized in large measure by Edgar Sydenstricker of the Milbank Memorial Fund.

I had long been interested in the development of systems of indices for the measurement and evaluation of health conditions and public health activities in the United States that had been sponsored and supported by the American Public Health Association through some of its leading standing committees. They had developed so-called "appraisal forms" and other methods of making comparative studies among the cities of the United States for the evaluation of needs and of activities to meet those needs. It seemed to me that a parallel development on an international scale might come to be a useful tool. The Health Section of the League asked me to pursue that. I did.

I developed a series of tentative systems of indices for measuring circumstances, conditions, needs, and program activities in countries with which the Health Section of the League of Nations was participating. As a result of my preliminary studies and reviews by Dr. Ludwig Reichman who was head of that section in the League of Nations, and the various staff members there, in the summer visit to Geneva in 1936, I think was the date, and with

the help of Dr. Knud Stouman, a staff member, made available by the Health Section of the League, we crystalized the information I had put together into a systematic listing of indices in a number of European countries and to engage in such revisions of them as the experience suggested. The material was published in the Quarterly Bulletin of the Health Section of the League of Nations and utilized quite extensively in the international surveillances and evaluations of health conditions, needs, and practices. Subsequently, because of Professor Winslow's interest, Dr. Stouman came to the United States and participated with me in the testing of these indices in New Haven to see what might need to be done to the system to adapt it to community comparisons within the United States. The result of those studies were also published, as I recall, in the Quarterly Bulletin of the Milbank Memorial Fund. These were very illuminating experiences for me in those years. I was very glad that I had had the opportunity to engage in them.

One other set of experiences in studies abroad: When I left the Social Security Administration in 1954, I left to take an appointment with the World Bank joining their missions then being organized to go to Malaya and Singapore to engage in a study of national economic development, one of a long series of such undertakings sponsored by the World Bank. My participation in the mission was to be the advisor on the social services and to be responsible for the studies on health and welfare and social insurances and related matters within the scope of the economic development program to be studied and formulated by that mission.

I was troubled that in addition the design of the mission intended that social services should also include the whole field of education. That staggered me because I was not particularly experienced in that field. I was

aware that it would involve a large and very complex series of studies, and most particularly because while the health problems were in many respects the best known among important difficulties in those areas of southeast Asia, it was also well known that the possibly approaching independence of Malaya from the British Empire was intensely involved with the public demand for relevant education opportunities in the multilingual and the multi-ethnic society. However, I agreed to take the assignment particularly since it was agreed that Mrs. Falk would accompany me and would participate in some sectors of my obligations, especially with respect to the field of education.

We, therefore, went to Malaya and Singapore and engaged in a series of studies and participated in the development of the final report which was prepared by the mission and transmitted to London and the authorities in Malaya and Singapore to lay out the basis for the economic development of those areas in southeast Asia. As anticipated, the problems were very complex and the need for dealing with them was becoming increasingly acute. Quite as anticipated the needs were particularly acute with respect to the development of stronger programs in the health field and in the fields of education. We were pleased that the analyses developed in our studies and the proposals to which they led were in large measure very quickly implemented in Malaya and in Singapore and played an important and substantial role in the further planning of the economic development of those areas. The report was published by the World Bank in a volume entitled The Economic Development of Malaya: The Report of a Mission Organized by the International Bank for Reconstruction and Development published for the bank by the Johns Hopkins Press in 1955.

The experience of working with the World Bank mission until the completion of the report in '55 led to my being asked by the World Bank and some of the

associated countries to participate in similar studies in some of the other countries with which the World Bank was involved in providing means of support for economic development. Of those opportunities the one in which I engaged was a joint one of the World Bank and the Republic of Panama. So I went to that area to engage in studies of the health programs first and then subsequently their health insurance and social insurance system generally. That was a very interesting experience which led me to undertake something about which I still shudder. Namely, it was the survey and summarization and evaluation and redesign of the health care system of the whole country.

The public health hospital and medical care system of Panama was in the main a mixture of public programs and private activities as was generally the case in underdeveloped countries of the world and in developing countries of the world. In Panama the scope of the program was particularly important and complex because of the developments that had stemmed from the days when control of communicable diseases made the digging of the Panama Canal possible. Panama had the reputation of being in many respects the most forward in Central America and in northern areas of Latin America for a leadership role in the development of health programs. Unfortunately, over the years since the beginning days of the Panama Canal, the program had suffered many neglects and setbacks. The World Bank, considering whether or not to invest further in the support of the economic development of the country was much concerned to have assurances that the health needs of the country were being, or would be, met so as to support rather than to discourage effective economic development. We engaged, with Mrs. Falk's participation and help, in a very comprehensive survey of the health resources of the country and evaluation of their adequacy and effectiveness, and in the

design of an extensive series of program improvements.

It was a rather singular experience because of the timing. A new election and inauguration of the president and the election and seating of the parliament of Panama came along before we had finished the studies. Nevertheless, because of close association with the leading presidential candidate before he was elected, the results of the study were made available in preliminary form and most of our recommendations were enacted by their legislature and implemented by the new administration before the report had been completed! That was an experience that one treasures but doesn't expect to have repeated.

The studies of the health system of Panama were compiled in a very extensive report published by the Republic of Panama and the World Bank. This led to a review of a limited health insurance system which they had and which was in difficulties, and also the possible development of an old age pension or old age social security system. That too led to a series of reports which were published by the Republic of Panama. In the final stages, the pension program involved getting the actuarial assistance of Robert Myers who was the senior actuary in the Social Security Administration of the United States.

The health program was extensively revised and, I believe, improved. In some respects it provided models for the health program activities in other Latin American countries under the sponsorship of the international organization and the WHO.

Hardly were those studies completed when I was asked to make an evaluation study of the health program of the U.S. Canal Zone, with which I had had to deal because of the close relations between the Canal Zone and the Republic of Panama. That became a study to review the activities there, which on the

whole were in excellent shape, except that the key institution in the Canal Zone was the Gorgas Hospital, which had long since ceased to be an effective institution. It had become incapable of overcoming the difficulties of adapting to the changing nature of the technology of health services. That study was completed and led to the publication of the report by the Canal Zone government; and it completed my obligations to engage in studies in that part of the continent.

From time to time I have engaged in other foreign studies. I might mention in passing that at one point when still in the Social Security Administration, I was asked to do a study of health conditions and needs in Haiti, a study requested by the Haiti government through the U.S. State Department and the Department of HEW. I did engage in extensive studies there. That involved parallel studies in Dominica and in other places in the Caribbean. They led finally to the development of a program for rehabilitating many of the health activities and finally the design of at least the first step towards a social insurance program for Haiti. That first step was concerned with health and medical aspects of workman's compensation and the design and operation of health services through an institution called "Idash" which was an acronym for the name of their health insurance program facility. It involved not only the design of their Idash health center program and facility but also the training of personnel to become the administrative staff. I brought a selected number of individuals to the United States and Canada where they engaged in education and training programs. They then went back to Haiti to bring the program into force.

I was very pleased that in that troubled country a beginning was made toward the development of a useful social service. Because of their very

limited resources I had to discourage rather than encourage their development of more elaborate social insurance programs. I was pleased that they took my advice both on what should be undertaken and what should not. Unfortunately the political instability in Haiti resulted in a political turnover; the then president of Haiti, when I was working there, General Paul Magloire was overthrown. He was succeeded by Doctor Duvalier, known as "Papa Doc," who became first president then president for life, and in more recent years, has been succeeded by his son, who at this date is president for life in Haiti. The country is going through very great difficulties because it is beyond question the economically poorest independent country in this part of the world, perhaps in the world. It is in very grave difficulties because of its poverty, its lack of resources and the alleged indiscipline in the administration of the affairs of the country.

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We have dealt with repeated references to the Wagner-Murray-Dingell bills of the 1940s and on into the 1950s proposing at first government grant-in-aid programs for the support of health and related undertakings, then later an amendment of the bill to propose what Arthur Altmeyer used to call "a straight national program" of health insurance patterned on the national old age and survivors insurance rather than on a federal-state program.

The impasse on the Wagner-Murray-Dingell bills persisted year after year with very extensive activities in support and opposition of the bills and breeding the development and introduction of a wide variety of counter measures or alternate measures by people who thought they knew how to break the impasse--by suggesting some modification of the Wagner-Murray-Dingell bills or substituting pieces of the bill rather than the comprehensive measure

that was making very little progress through the committees of the House and the Senate. Many of these measures were intended to be quite sharp by means test or insurance company alternatives to the social insurance proposals of the W-M-D bills.

The impasse continuing year after year led me to begin to think about possible ways of breaking it. In 1949, '50, and '51 I spent a great deal of time on an alternative that seemed to me might have the possibility of achieving at least a beginning in the direction of the medical care provisions of the W-M-D bills. I mentioned in passing that a historian or a political scientist writing on this subject has noted the fact that twice before somebody had suggested that instead of a comprehensive national health insurance it might be wiser or more feasible to start with some piece of the program. I am referring to Peter Corning's monograph, The Evolution of Medicare: From Idea to Law. He refers to the fact that back in 1937 Dr. Thomas Parran the Surgeon General of the Public Health Service, had made such a suggestion. Among the pieces that might be used to start a legislative program might be to start with the beneficiaries of the Social Security program rather than the population covered or embraced within the coverage of the Social Security program. That received no further attention because it was regarded by the Interdepartmental Committee to Coordinate Health and Welfare Activities as merely an expression of the cautious approach that was characteristic of the Public Health Service in undertaking new program developments. Peter Corning also mentions that somewhere someone called his attention to a file paper prepared in 1944 by Merrill Murray, who was one of the staff experts on unemployment insurance and old age insurance, a similar proposal. I knew the Parran proposal because I was at the meeting when he

suggested it, but as I have said it was one of a number of alternative measures that he proposed really for consideration by the Interdepartmental Committee which gained no support. The Merrill Murray memorandum I had never known about and had never seen. I don't know precisely what its origin was or its content.

In the late forties I was doing my own thinking about how to break the impasse and explore the possibilities of having a paid-up health insurance for the beneficiaries of the Social Security system particularly, but not limited to the aged, recognizing that it might later extend to the disabled when they might become beneficiaries. (They weren't yet under the Social Security program at the time.) But it could extend to survivors of covered and insured persons. I undertook, with members of my staff of the Bureau of Research and Statistics, a systematic exploration of how such a compromise proposal might be designed, what its specifications could be, what its scope and potential impact and effectiveness might be, what such a proposal might cost, and how it would fit within the framework of financial measures such as payroll taxes, general revenue support, or otherwise. We worked out the specifications systematically and developed the design of the program and the cost estimates rather quietly and with very little about this work known throughout the Social Security Administration.

When we arrived at the state where we had a systematic presentation available, I showed a copy of it to Wilbur Cohen who was technical assistant to the Social Security Commissioner. He in turn called this possible program development to Mr. Oscar Ewing who was the Federal Security Administrator at the time. Mr. Ewing seized upon it very vigorously. He had been displaying indications of his presidential ambitions and was very much concerned with the

possibilities of broadening the scope of the social insurance program in the United States, particularly with reference to what might be done in the health insurance field. He had been less than enthusiastic about the participation in the debates and battles over the Wagner-Murray-Dingell bill. He indicated he thought that this was potentially a useful, perhaps even a promising alternative approach to be pursued. When he read the draft report and asked me to confer with him about it, he explored it, had various members of his immediate staff and the general counsel review it. He then also made drafts of it available to some other people outside of federal government, people he knew well, whose judgment he respected.

Attention to the proposal became quite extensive, long before I thought it was ready for general public discussion. However, the development and spread couldn't be contained, so Mr. Ewing submitted the program for review by the responsible authorities in the federal government: the Bureau of the Budget, various other departments of the government, Treasury and others, and made copies available to some of the staff in the White House.

President Truman was a little cool to act on this possibility because the Magnuson Commission on the Health Needs of the Nation was approaching completion of its studies and Mr. Truman, I was told, was reluctant to inject a new set of proposals into the political scene since it might intrude into the field he had delegated to that Commission. But he did authorize the Bureau of the Budget to in turn authorize Mr. Ewing to proceed to make the program public and to make the design of the program available to possible sponsors of legislation in the Congress.

Accordingly, in the middle of 1951, Mr. Ewing released the content of the program to a press conference and a bill was prepared and was made available

to Senators Murray and Hubert Humphrey, and to Representatives Dingell, and Celler and through them in turn to others. The proposal was that beneficiaries, primarily old age beneficiaries, of the Social Security program should become eligible for a paid-up program of health benefits rather broadly designed to extend to hospital and physician and some collateral services. The cost of the program was to be met by a relatively small adjustment of the payroll taxes that were being paid by employers and employees covered by the Old Age and Survivors Insurance program.

The program on the whole was very well received except by the American Medical Association and some related health professional organizations and by some wings of the insurance industry. It was quite well received by most of the insurance industry, the Blue Cross Association and a number of others who had long been plagued by the difficulties of embracing within their insurance programs the aged, the people who have the greatest need for health care, and, generally speaking, the least means for obtaining health insurance through employment or through their own fiscal resources. Insurance carriers in very broad measure thought they would be greatly relieved to be free of an obligation to extend their insurance carrier functions to the aged.

The bills began to be kicked around in the Congressional committees and as the program came into controversy, counter measures and alternative measures appeared on the scene, many of them. Alternatives were developed but as supports grew gradually between 1952 and 1956 and '58 there came into being indications that this was approaching enactment. It led to very vigorous counter measures from some who were strongly opposed to expansion of the Social Security system and led finally--skipping a lot of intermediate steps--to the development of an expanded means test programs as an alternative

to a paid-up insurance program.

Finally it led in '60, '61, '62, to the development of the Kerr-Mills program which was intended to broaden the availability of public assistance medical care so that it would extend to the medically indigent and not be limited to the indigent in need of money payments for support. That program enacted in 1960, if I remember correctly, was expected to be very effective because (within the framework of the Kerr-Mills program) the financial support to the states from the federal government was very considerably increased and broadened--to buy the supports of the states--so that they could undertake broadened public assistance medical care programs with very little additional cost to them, the additional cost coming from the increased federal grants-in-aid to the states.

That program was very successful in being picked up and developed rapidly in six, seven, eight, or nine relatively wealthy states that could put up their matching funds. Otherwise it was a general disaster which quickly became evident. Most of the states could not afford to take advantage of the program's opportunities even though the federal grant support had been very considerably increased. Within two or three years it was evident that 70, 80, 90% of the federal money was going to five, six, or seven of the wealthiest states in the country and only a miniscule portion of the federal aid was going to the states in which the needs were greatest, the proportions of the population who were needy with respect to health services were largest but which those states could least afford to support financially.

I mentioned the catastrophies of the Kerr-Mills program because through 1961, 1962, 1963 its failure with respect to the limitations I just mentioned led to expediting, augmenting, accelerating the acceptability of the paid-up

insurance concept that was going to become Medicare in 1965 first through the discussions and debates centered on Aime Forand's bills, and later on the King-Anderson bills, compromises would be enacted in 1965.

I have written elsewhere (in various published papers) about the good and the bad in the Medicare enactment of 1965 and I am not going to recap all that here. There is no doubt it has made major contributions for the medical care of the aged (and, later on, for the disabled). But some of the compromises and some overt stupidities it embraced were almost unbelievable and they plague the medical care scene to this day: e.g., separation of hospital care (Title XVIII-A) from medical care (Title XVIII-B); open-end "signed blank check" financial guarantees to hospitals, physicians, etc.; substantially no quality controls; exclusion of preventive services, etc.

Also, the most serious blunder was the compromise with the AMA in accepting what is Section 1 of Title XVIII--the abnegation of all federal authority to effect systems improvements, a compromise which, if it couldn't be avoided <u>then</u>, should have been suspended--and surely won--within another year or two (in light of the growing pressures politically for the program). That compromise, which I thought was undesirable, unwarranted, and premature, has been responsible, in my opinion for the greatest weaknesses and failures in the Medicare program to this date despite the good and useful and constructive services which did become available otherwise through the Medicare program.

The simultaneous enactment of Title XIX (Medicaid) which had been proposed by the AMA and others (as an alternative to paid-up insurance benefits)--a "clever" move by Wilbur Mills--was minor because most of its main provisions were already "in place" in the open-end statutes and regulations of the Public Assistance operations. The same applies to the MCH enactments that were part

of the 1965 law.

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You have asked me to say something about my experience in developing a group practice prepayment plan of the kind that is now being called Health Maintenance Organization (HMO). By way of background, let me point out that while many who would now come into the HMO field think it all began with the enactment of the HMO law in 1973 seemingly unaware that for many years what we today are calling HMOs were in operation or in developmental stages as prepayment plans in many parts of the country. The beginning of interest in this field goes back a hundred years or thereabouts through the development of group practice prepayment plans in many parts of the country, in many areas, particularly in the outlying areas of industries that had to develop their medical care services lest they be unable to have an adequate and durable labor force. The development of such programs by the railroads, some of the railroads when they were developing their rights of way across the continent, the developments in mining, lumbering, power development areas, all of which were confronted by the needs for having an integral and stable health and medical care service available in their area of operation. The monograph by Pierce Williams, to which I referred earlier, was a summarization of those developments in the days of the CCMC.

Subsequently a good deal of public attention was focused on undertakings to provide prepayment programs for hospital care in the Baylor experiment, the development in one place and another. Some of these became viable programs, some suffered infant mortality by reason of bad design or overt opposition from local physicians, medical societies, et cetera, that feared the

competition from such plans. There were court cases and issues and many quarrels. Nevertheless group practice prepayment plans had come into being and had proved themselves capable of successful and effective operation. Attention is often focused as though the idea of what we today call an HMO began with the Ross-Loos Clinic practice in Los Angeles in 1927-8-9. It was unlike the industrially sponsored plans many of which had been studied and reported on by the CCMC in its program years 1927 to 1932. Open community plans, were relatively new. Justifiably the Ross-Loos is often cited as the first such program. It was a pioneer plan and it got into great difficulty with the local (Los Angeles) medical society which fortunately was not sustained. Doctors Ross and Loos were given a new opportunity to proceed when the Judicial Council of the AMA sent the case back for review (allegedly) by reason of failure by the local county society to observe appropriate procedural obligations.

The Kaiser plan which quickly became one of the most important operations in this field began with the early development of a single employer plan when Henry Kaiser found he needed medical care provisions for employees in building an aqueduct across the desert in the West and later when he was engaging in his great dam construction developments, and, finally, during World War II when he undertook his program of steel development at Fontana, et cetera, and the building of ships in the San Francisco Bay area, in the Portland area, and so on. During the wartime the Kaiser plans were single industry plans. They were part of federally subsidized, federally supported, federally financed, urgent programs. At the end of the war, when Mr. Kaiser was closing out the shipyards and some related activities, he faced the question whether to phase

out his medical care program. Because of the urgent need for the program in the communities with large in-migrated populations and a shortage of doctors and so on, he decided instead to test whether the program might be continued and opened to the community, and the public generally. The latter view prevailed and the Kaiser plans, as open community group practice prepayment plans came into being and quickly demonstrated very successful operation. They have flourished in the San Francisco area, the Portland area, then in the Los Angeles area, and subsequently in Hawaii, Colorado, Ohio, and elsewhere (most recently in Washington, D.C.).

By the late sixties or early seventies, instead of the half million or million persons who had some kind of prepaid health program in the days of CCMC, there were now several millions of persons who had access to such programs, particularly in California, plans that were aping the Kaiser plan, and the Group Health Association in Washington, D.C., the co-op plan in the Puget Sound area, et cetera. The HIP plan in New York City at first had a quarter million then a half million and now 800,000 or more subscribers. There were altogether perhaps ten, fifteen, twenty maybe thirty group practice prepayment plans rivaling the nongroup practice program of the Blue Cross and the Blue Shield Associations and the insurance companies. The latter had grown very rapidly first before and then especially during World War II and thereafter when court decisions permitted employer to charge the costs incurred for employee plans as a cost of doing business so that it was tax exempt to the employers and so that the payments for benefits were tax exempt to the employees. (In negotiations between management and labor the courts had declared some years before health insurance programs were properly a subject of labor-management negotiation.)

Long before these developments I have referred to, the question of group practice prepayment plans really came to the fore as part of the major recommendations developed by the Committee on the Costs of Medical Care. You will recall that two of the five major recommendations of the majority CCMC report dealt respectively with the need for group payment to deal with the otherwise unbudgetable costs of medical care, and group practice for the effective and efficient way to provide comprehensive medical care with effective utilization of various categories of personnel. Instead, if you look at the final report of the CCMC, you will find that two chapters in that report are as good a description of the need for and the design of group practice prepayment plans as anything that has been written since then. That was in 1932.

The minority report of the CCMC dissented very strongly from group payment and group practice. In some respects that dissent was supportive of activities throughout the country in the medical and related professions to discourage the development of group practice prepayment plans. That's between the CCMC 1932 report and, say, the 1960s and later. The growth of such plans was much slower than many of us had expected it would be. The difficulties of developing the plans were inherent in the development of prepayment group practice plans. The additional difficulties created for the development of such plans by the opposition, from the AMA and other sources, had a good deal to do with the fact that the growth was very slow. That has often been used as an argument to say, "See, the public doesn't accept these programs, doesn't want them, or they are not feasible and should be discouraged."

Nevertheless, in these intervening years, the growing complexities of the medical care scene and the cost escalations have repeatedly dictated again and

again the need for programs like the Kaiser plan, or the HIP in New York or others, programs that make comprehensive care of good quality, readily available at costs that moderate if not wholly contain the escalation of medical care costs.

In the course of those years between, say, 1930 and the 1960's I had often been troubled by the slow development of what seemed to me a highly desirable new and improved pattern for the availability and the effective cost containment of medical care. I came to the conclusion a number of years ago that there was another important reason for the persisting opposition of the medical profession to such developments other than the obstructive legislation in some twenty or thirty states which the AMA had sponsored during those years and which made it very difficult in those states to develop such newer programs. The other major reason was that the group practice prepayment programs had with two major exceptions remained apart from the medical education and training system in this country. The physicians, generally speaking, who were in practice and had no background in this field--they had been educated and trained in the group practice settings of their education in medical schools and teaching hospitals, then went out in practice solo on a fee-for-service basis. The medical education system had made no effective moves toward preparing their prospective next generation of physicians for roles in organizing comprehensive group practice such as these newer plans would require. We continuously lacked a whole generation of physicians exposed to the consideration that they might seek to develop their careers in a group practice setting.

There was some change after World War II when many physicians came out of the armed services where they had had experience in group practice, extensive

group practice. Some thought it was a very distasteful experience and wanted no further part of it. Many others immediately on being mustered out from the armed services sought out how to join existing groups or to develop new groups whether in their own specialty or in multispecialty practices.

In general, I thought the failure of the education system to prepare their students, interns, residents, and fellows for the needs in this field was one of the important deficiencies. Accordingly I gave some assistance here and there to the encouragement of medical schools, to teaching hospital institutions and to medical centers, to become involved in this field. I had this very much in mind when I was approached about coming to join the faculty at the Yale Medical School (which includes the Yale School of Public Health). One of the objectives I would have would be whether I could look forward to a role in developing a group practice payment plan in affiliation with, under the sponsorship of, or even its ownership by the education system.

In the years beginning with 1958 I engaged (as a consultant on health studies for the United Steelworkers of America) in a comprehensive survey of health care programs and benefits in the U.S. steel industry and then went on, with the union and the employer representatives, to plan group practice prepayment in steel industry concentration areas. In one place and another I focused on joint or affiliated programs with teaching medical centers as with the University of Pittsburgh Medical Center and the Johns Hopkins Hospital. Though these did not come into being, the labor union and the industry leaders became more knowledgeable about prepaid group practice plans and increasingly supportive of their development.

When discussing the invitation to come to Yale I quickly learned that the likelihood of Yale University or of its medical school or of its medical

center sponsoring such a program was out of the quesion. The medical institution was very conservative and wanted no expansion of its obligations to community service other than service useful toward satisfying its clinical teaching needs.

The alternative was whether Yale would give me encouragement, if I came here, to develop a community program in affiliation or in association with the medical center, to draw upon its resources. On this I was encouraged. The then director of the hospital, Dr. Albert Snoke, and the then dean of the medical school, Dr. Vernon Lippard, were quite friendly to this idea. Their only reservation was: Would I, please, move slowly?

So shortly after coming to New Haven in '61, I began the preparatory studies, what today we would call the feasibility studies, to assess who in the community, had what kind of prepayment, what the costs of medical care were, what the outlooks of the labor unions and other groups in this community were. I was given a good deal of encouragement to go ahead. So I drew together quite a number of people from the faculty of the school of public health and the medical school, the nursing school, the law school, and so on, to participate with me in the design and development of a program.

We got some grant support from HEW and engaged in a whole series of feasibility studies with labor unions and employers, and with many other groups in the community, to find out what the circumstances were and what the outlook was. Out of this came a good deal of encouragement, so that between 1961 and 1971, with help from various kinds of grants and support funds from HEW and then from some foundations like the Ford Foundation, the Robert Wood Johnson Foundation, and so on we went forward with the development of a group practice prepayment program under the auspices of a community corporation, a

nonprofit corporation created in New Haven by a special act of the Connecticut legislature to overcome the obstructive legislation that was on the books of this state. In the course of time, we completed the preparations for support from community groups, with labor union people, some leading employers, and others; and developed a formal affiliation agreement between the newly created corporation under its special legislative act and the Yale-New Haven Medical Center. The agreement was that the resources of the medical center would be available to a group practice prepayment plan in a broad measure at first when the plan might have limited resources, and subsequently more extensive specialty support services--hospital beds, et cetera--when the plan would become operational.

Between 1967, when we received our charter from the state legislature in form of a Special Act and 1971, we succeeded in finding a suitable site, raising the funds, completing with the help of an emergingly interested architect, Bruce Arneill, to design the facilities for comprehensive care, and constructing the building with some Hill-Burton aid (a small portion of the cost assisted by Hill-Burton funds)--but financial support mainly from local banks. We developed the Community Health Care Center facility and its equipment, recruited the staff first by drawing on people who were in the Yale University faculty, some from the full-time faculty, some from the clinical faculty, all of whom had hospital privileges and faculty appointments and around whom we developed a recruitment of a more expanded staff. Its size grew with the growing enrollment of the plan.

We had had some years for the developmental stage and very strong support from the Central Labor Council and its constituent labor unions, and some quiet, covert, but meaningful support from some employers (who preferred not

to appear in the public scene but were very helpful in those years when we had some strong opposition from the professional associations in this area and in the state.) We were able to get some of the major "organized" companies to commit themselves in their labor-management agreements as these came up for renewal or reconsideration to inclusion of "dual choice clauses" for their employees when there would be a group practice prepayment plan available operationally in the community.

Those preparations having been made, in October 1971 the plan was ready to become operational and it had actually a thousand enrollees. Before the end of the year we had some five thousand, recruited mainly from larger establishments which had the dual choice clause previously negotiated. That program has grown. As of today the program is in its tenth year of operation and has about 27,000 enrollees.

In 1971 when this plan in New Haven first became operational, in many parts of the country discussions were gaining force for the development of such programs. Plans were springing up here and there; some were stillborn; some became operational and went forward more or less successfully. This was a period in which the escalation of costs was becoming in many respects the single most discussed aspect of medical care in the United States. The escalation of costs was becoming staggering to millions of people and was carrying needed medical care beyond the reach of millions. This circumstance and the increasing knowledge and recognition that not only were quality standards being observed but major costs were being contained successfully in the Kaiser plans, in the Ross-Loos plan, in the Puget Sound plan, in the GHA in Washington, D.C., et cetera. There was a potential for dealing with the needed system improvement and the cost containment through the group practice

prepayment plan model that could not otherwise be available in this country except through drastic and controversial development of a comprehensive national health insurance program.

This led several people to consider federal legislation to support the development of such group practice prepayment plans. After some other trials legislation was introduced principally by Chairman Paul Rogers of the House Interstate and Foreign Commerce Committee and Doctor William Roy, a physician and lawyer member of the Ways and Means Committee, who sponsored a bill known as the Roy-Rogers or the Rogers-Roy HMO bill. The HMO name had come into the picture because Dr. Paul Ellwood of InterStudy in Milwaukee had persuaded President Nixon first and then some of his staff people two or three years before, I think it was 1970, that there was urgent need for the growth of Health Maintenance Organizations with emphasis on the prevention of disease as well as on the care of nonpreventable disease. As a matter of fact, the acceptance of this by President Nixon and some of the staff people of the Department of HEW later cooled off when they heard from some opponents of such programs. Anyway, the idea, using Ellwood's nomenclature, Health Maintenance Organization, or HMO's, came into the legislative scene most importantly through the Roy-Rogers bill in 1971, as I recall. It was immediately enmeshed in intense controversy. It took two or three years to get the bill out. By the time it was reported out favorable and was passed by the House. In the Senate a corresponding but more comprehensive bill sponsored by Senator Edward Kennedy and many associates had very strong support and had been passed in the Senate before the Roy-Rogers bill was passed in the House.

However, when it appeared that the House bill was likely to be enacted, and its opponents began to see they couldn't strangle it, they pursued the

tactic of loading it with a wide variety of more exacting specifications and requirements under the guise that they were accepting the potential development of group practice prepayment plans, but they wanted to be sure these were awfully good ones that would live up to the high standards that would be expected of them. This came to be known as a Christmas tree bill. Although some of the excessive requirements were avoided in the last stages, the bill was finally passed in December '73. It had been accepted on the Senate side in lieu of the more comprehensive Kennedy bill and was accepted by the President who signed it in December 1973.

There was a provision in the passed bill that it (including some grants supports for newly developing programs) would come into force ninety days after approval by the President. It was, however, going to take two to three years before essential regulations were issued by what was on the whole an inept, federal staff.

We here in New Haven in the CHCP, the Community Health Center Plan, having become operational in October '71, were already a going program by the time the HMO Act was signed by the President. In general, our program structure and design and scope of benefits, et cetera, were fully in comport with the main requirements of the HMO Act, indeed went further because we had some benefit provisions that were optional and not required by the HMO Act. Therefore, soon after the act was signed by the President, we considered applying for federal qualification assessing what changes, all of them very minor, would need to be made in structure, in benefit provisions, et cetera. Then, under authority of the board of directors we did make application. After going through the rigamaroles that were involved we become federally qualified in October of '75. Indeed, we were the first plan in the United

States to become fully qualified under the federal law. Later that point came into some dispute because through some misunderstanding the next generation of personnel in the HMO administrative office thought that our federal qualification had been what is called transitional qualification, not a full qualification. That dispute was never resolved. We had full qualification having made such changes as the statutes and regulations required and had the approval not only of our board of directors but also of the state insurance commissioner under whose jurisdiction we operate in the state of Connecticut.

So we came into being as an operating program in October '71 and a federally qualified institution in October '75 under the HMO Act. We went forward in the development of the program from the 1,000 enrollees that we had on the day we started with four full time physicians and a long list of part-time specialists and their supporting staffs. We drew as much as we needed on the resources of the medical center under the affiliation agreement which had been negotiated in 1968.

With two exceptions, we were as far as I knew, the first group practice prepayment plan to be formally affiliated with a medical teaching institution for the reasons I indicated earlier. Two exceptions, one was a very real one, Dr. Russell Lee's affiliation of his clinic with Stanford University Medical School and the university proper which was later dissolved when Stanford decided to develop its own program. The other was a program in New York City by a labor union which had made an agreement to participate and work with New York Medical College and Hospitals. Despite the fact that Dr. George Baehr medical director of the HIP program, had tried from the very beginning of that program and had looked forward to achieving association with the five or six medical schools of the New York area for the same reasons that I was ambitious

to develop a program in affiliation with a teaching system of medical care in New Haven. It had not succeeded in New York because the local physicians who were alumni of those medical schools wanted nothing of this sort to happen; they succeeded in dampening the support and provided overt opposition. Doctor Baehr did get one affiliation, with the Cornell University Medical College, but it survived only about sixty or ninety days as I recall, before the alumni got it repealed. They were only the two I mention that I knew of in which the education system had become participants in the development of physicians and other personnel for a group practice prepayment plan.

Here at Yale we were going to try it. Some people thought I was foolhardy in trying this here because the Yale Medical School was notable as probably the most conservative medical center in the United States. My argument was that that was exactly why that was the best place to make the effort because they were going to have to change. They have changed somewhat, not very much. So our affiliation did mean a certain amount of exchange with the undergraduates in the medical school and in public health, and in teaching arrangements, but only in a limited measure. Yale Medical School and Yale-New Haven Medical Center have been moving toward increasingly more technological developments but is not very sure about what its future should be with respect to the education and training and physicians other than for the superspecialities. I don't know how that is going to come out.

At any rate, I saw the plan into being with all its warts and shortcomings, particularly the accumulating debt which was inherently involved in developing a group practice plan. In such a plan you have to have comprehensive resources and facilities, comprehensive services, long before you have got the enrollment that will support it, then gradually look to

achieving the economics of scale with the growth of enrollment. As I remarked earlier, we started with 1,000 enrollees and now in our tenth year we have about 27,000. I designed the plan targeted towards a maximum of 30,000, thinking that when that level was being approached the plan should go into a regional program of developing secondary and satellite facilities. This year (I having retired as Executive Director in November 1979) my successor, John A. Nelson, is engaged in the design of the first satellite facility.

The program has had fiscal difficulties of many kinds, some from the escalation of costs, some from the almost disastrous lag in the development of federal regulations for the HMO program, a lag which for a while slowed down and nearly halted our enrollment activities. Employers were unsure what their privileges and obligations would be until the federal regulations had been issued, particularly in respect to the mandatory obligations placed upon employers to make a qualified HMO of one kind or another available to their employees. Twenty-two months elapsed between the time the law said the program was to be in effect, before the regulations were published bearing on the question of mandatory obligations on employers (Congress having failed to provide a guideline in the statute and/or in its committee reports with respect to inter-relations with the National Labor Relations Act). That was a near disaster for programs like ours that were just getting along in spite of our financial obligations, but were essentially dependent upon the growth of enrollment towards a true financial breakeven.

The program is now operational, more or less successfully, and has stimulated the development of other plans in this area. When we came into being, this was the first in the state of Connecticut. It was the first federally qualified HMO with a formal affiliation with a teaching, training

center. In our early planning and developmental stages, especially after we achieved our affiliation agreement with the Yale-New Haven Medical Center in 1968, we had visitors from medical education institutions up and down the East Coast and from other parts of the country to know how we had gone about and succeeded in getting such an agreement and how we were using it and how we hoped to use it. Others in New York, Philadelphia, Baltimore, and various other cities derived some benefit from our experience and we hoped we helped them to avoid some of the wounding experiences that we had gone through. The Harvard plan people were wrestling with the development of their program about the same time we were. They came to talk with me and some of my associates about the relationships that might be desirable between the operating plan and the university and its medical school and hospital affiliations and so on. They generated possibly a more successful program because the Harvard Medical School and medical center and the Harvard University were more agreeable to lending their name and assuming sponsorship responsibilities and providing financial aid than we were able to get from the Yale people here. On the other hand they had more difficulties with their initial enrollment activities. They actually became operational before we did, a year or two years before, which I liked to think was because they had larger resources available to them. We had to find or create all our resources. We've got an operating program. Now in Connecticut, 1980-1981 there is coming into being a group practice prepayment program in the Bridgeport area, there's another such plan in the Hartford area, another in the Stamford area which is an extension of one that has been developed in Westchester County. Independent Practice Associations and various non-group practice plans, IPAs, are already operational in the state so that we have something like ten HMOs of one design

or another now in the state of Connecticut where not many years ago we had at first none and then one.

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About some other post-Medicare activities:

On the enactment of the Medicare legislation in mid-year 1965 there was something in the nature of elation over this landmark legislation, which reflected efforts that had been proceeding for fifteen or twenty years. The United States now had a health insurance system national in scope though limited, in its first enactment, to the aged--national health insurance for a ten percent sector of the population. It had admitted and recognized limitation, yet had the promise of making more and better medical care available to this part of the population which was among the most neglected portions of the population so far as their medical care and health services were concerned. It is specially important that this was in the social insurance pattern and was free of means testing and was in the nature of providing lifetime paid up insurance to persons who qualify for old age benefits. Later there were some extensions to be coming along with respect to the disabled, those with terminal kidney disorders, etc. But that was still in the future.

The satisfaction of this achievement was quite broad. Within a year when the effective date for the program was approaching, the benefits which were promised under the program were actually made available, as the British say, on the appointed day. This was a very great achievement on the part of the people who were responsible for the administrative developments of the program notably Robert Ball, then Commissioner of Social Security, and his associates

who did a magnificent job of making all the benefits of the program effective on that appointed day. I emphasize this point because many people talk about the needs to phase in, or to stage in, a comprehensive program as though they obviously were unaware that programs of this kind in other countries as well as here have been implemented on an appointed day for all aspects of the program. I will return to this point later because it will become part of an important and major controversy in the national health insurance discussions of more recent years.

The elation as I referred to it upon the enactment of Medicare was, however, short-lived. Many people knowledgeable in this field soon began to point out that the program, whatever its strength and its promise, had some very serious limitations. I commented on this earlier but I would like to emphasize three points here. The first point was the restrictions on the potentials of the program that was written into the first section of the Medicare Act, which for all practical purposes guaranteed that no administration of the program was being given any authority to make, or to encourage, or to intrude into any possible needed changes of the medical care system. The second point was that in light of the relatively low cost estimates that had preceded enactment there were many who had doubts that those estimates would prove to be valid, pointed out that there were practically no cost containment provisions written into the bill or contained in the Act and that the costs had already begun to spread the estimates. Third, that the provisions of the bill, and what was contained in the Act, dealt in only very limited fashion, almost minimal fashion, with safeguards necessary to ensure that the quality of the care to be provided under the program and paid for out of public funds. These were important elements for

consideration for those who thought that the Medicare legislation had been enacted with too many, and perhaps, unnecessary compromises to achieve its passage in the House and Senate of the Congress of the United States.

Within two or three years some of the limitations of the Medicare program began to become evident and concern began to be expressed that it was not enough to live with the Medicare program. It was necessary to go on toward the planning and development of a more comprehensive program for more of the population and with provisions that would protect the program against its potential weaknesses.

The Medicare program was enacted simultaneously with a new revised Medicaid program for the poor. Now many were concerned about needs of the population that was neither aged nor poor. Eighty percent of the population, more or less was between those two extreme groups. What should be done to make more and better, and more conveniently financed, programs available for the population in general?

By 1967 and 1968 this concern began to take form in one quarter or another. One of the most active expressions on the need for something vigorous came from Walter Reuther then President of the United Auto Workers of America as expressed in his Bronfman lecture at that American Public Health Association annual meeting in November 1968. So enthusiastically was that speech of his received not only in the APHA but much more widely in the public that he went forward with his moves to create a committee of fifty or a hundred representing various sectors of society and people in various walks of life who had an interest in health programming in this country to come together and plan further some appropriate form of a national health insurance. Mr Reuther and others--in the labor movement, among employer

groups, among members of Congress--began rapidly to develop committee which became known as the Committee (of one hundred) for National Health Insurance (CNHI).

By 1968 it was launched, supported by contributions from labor groups, from church groups, from civic groups, from education groups, a wide diversity of people who had representation on this committee which approached having a hundred members and who provided support funds on a voluntary basis.

A number of members of Congress were invited to join the committee, some invited themselves into the committee. Mr. Reuther and his associates and some of us were careful to ensure that there were equal numbers of Republicans and Democrats among the members of legislative bodies so as to protect the committee from any charge of political bias. The committee set up subcommittees, among others a technical committee which drafted a set of principles which was announced by the Committee for National Health Insurance and made the acceptance of those principles the only precondition to membership in the committee.

The technical subcommittee, in which I had been asked to serve as chairman, was then directed to proceed to draft beyond the statement of guiding principles a specific program for national health insurance that would meet the objectives of the statement of principles. Those principles called for a program that would undertake to make available to the population comprehensive personal health care services of good quality with the availability to extend to all persons while avoiding deductibles and copayment so that there would be no financial barriers between those in need of care, or who were seeking care, and those who would be available to provide the care. The financing was to come from national resources, with provisions for such

improvements in the availability of the care as might be achieved by encouraging organized provision of the services through group practice and otherwise and with the public financing geared to such provisions as might be necessary to contain or at least to restrain the escalations of costs. Accordingly in the course of something between a year and two years of intensive work the Technical Committee developed a design of specifications while available legal consultants converted those specifications into a draft bill. It came to be known as the Health Security Program and the Health Security bill.

I should explain that the provisions for cost containment--costs had already become alarming to millions of people throughout the country--were to be implemented by the intent that the program of national health insurance designed in this bill should undertake to have the program operate within the concept of a national budget. Practically all activities of the United States, certainly in the public sector, function under budgets. Budgeted amount are intended to set the boundaries on the commitments of the undertakings. The health field has been operating on an open-end basis, and cost containment has been foreign to it in general. Here the intent was that the available funds for a national health insurance should be operated within the framework of a national budget as determined by national policy considerations, and that escalations of the costs should stay within the boundaries of the escalation of the economy as a whole. More specifically that the escalation of the national health insurance programs cost shall be bounded by remaining in a fixed proportion to the gross national product.

Shortly after the bill was released and became available it precipitated a storm--exclamations of pleasure from those who supported its proposals and a

storm of displeasure from those who disagreed. Further, it brought on a flood of alternative legislative proposals quite directly after it was introduced in the Senate by Senator Edward Kennedy and many associates, and in the House by various members of the House committees so, after the first year or two it came to be known principally first as the Kennedy-Griffiths bill and then as the Kennedy-Corman bill from the names of the principal sponsors in the Senate and the House.

Introductions of other legislation took the forms of many kinds of alternatives, some that used portions or pieces of the Health Security bill, some that submitted countervailing proposals. Particularly there was the fact that the Health Security bill contemplated a governmental system from a top drawer government administrative board down through regional and local administrative agencies and the availability of advisory councils of various kinds at each level of contemplated administration.

I won't go into the details of the bill because it's a large and comprehensive document which spelled out the benefits that were to be available to the entire population of the United States. Those who would be qualified to be participating providers include: the personal providers as physicians and others, or institutional providers as hospitals and others, each category being required to meet specifications on their professional and technical qualifications and agreeing to provide the designated and specified services without any direct charging to patients at the time services are made available by the provider. Provision was also made for systematic review of activities and for the earmarking of portions of the funds to be appropriate for the program for various kinds of systems improvements such as to ensure the availability of funds for providers that were in short supply toward

meeting the benefit obligations of the bill, or that were in short supply in certain areas and regions particularly poverty areas of the cities of the country, subsidy provisions for encouraging the development of organized group practice prepayment plans; and for the experimental development of home care services, badly in need of expansion in the United States, etc. The details apart, the bill received very extensive attention as did some of the countervailing proposals that came from those who didn't like the idea of a governmentally developed program or a publicly administered program or who thought that if health insurance were to come into being it should be done in stages or in phases, bits and pieces at a time. Parenthetically I might say that people who advocated such developments were never clear to explain how categorical or a limited portion or pieces of the program undertaken could serve to effect system improvements.

Most of the bills that came as rival bills also neglected need for cost containment provision.

Between 1971 and 1972 and the years before 1976, the controversial discussions of the Health Security program went apace, quite in the pattern of the national health insurance debates that we had had for the twenty years or more preceding.

In 1976 a new element came into this picture when Mr. Jimmy Carter announced his candidacy for the President of the United States. In his pre-election addresses, papers, speeches, etc., he announced, among other things, that he was in favor of a national health insurance program. In some of his addresses he came very close to endorsing the general specifications of the Health Security program. In one or two of his addresses it seemed almost as though the Health Security Program people might have written his speech for

him. There were only two important exceptions. One, that the program might have to be phased in rather than implemented all at once; and second, that there might have to be provision for an appropriate, suitable place for the insurance industry with appropriate regulation within the framework of the health insurance administration. The language he used did not seem to precipitate unacceptable compromises. However, between the early and the ending pre-election period a new element came into the picture when it appeared that some of Mr. Carter's advisers were telling him that there was something incompatible between his commitment to a national health insurance program development that might be quite costly and his promise or commitments toward seeking a balanced budget yearly in his four year term of office. The apparent issues between these two positions not resolved and many people following developments in this field were left in a quandary.

After Carter's election when discussions were resumed between the Committee for National Health Insurance and the White House, difficulties emerged. It soon appeared, first, that Mr. Carter and his advisers were fearful that the Health Security Program would cost too much to be embraced within his program toward a balanced budget by 1981 or by 1982. Second, new interpretations were being placed upon what Mr. Carter might have meant in his pre-election period by "phasing in" the program and what he might have meant by a suitable place or an appropriate place, an adequate place for the insurance industry. Highly conflicting explanations were given.

Hitherto, phasing or staging had meant, in this field, you enact or you commit yourself to a program and within that program you indicate the dates at which various elements of the program might be brought into effect. It now turned out that Mr. Carter's advisers, or some of his staff, argued he had

meant something quite different, that you would enact just a first phase of the program and, after suitable experience had been gathered with that, you would consider what the subsequent phases would be and when--in which years. Similarly it soon developed that the place for the insurance industry meant something much more, meant a good deal more, than had been understood from his pre-election speeches. He really meant, it now appeared, very extensive operation or responsibility, but also minimal control or guidelines or policy assurances, and other assurances on those who would be given the opportunity or privilege of participating in salesmanship, financing and/or administration. Further, an initial phase proposal began to take the form of a program: (a) for cost containment on hospital costs, but not on the costs of other major elements in the health services picture and that this was something to be undertaken legislatively quite independently of undertakings with respect to the enactment of the first phase, and only a first phase, of a national health insurance program.

These conflicts of interpretation were extensively discussed between the spokesmen of the Committee for National Health Insurance and the White House staff. There was much concern in the CNHI because they began to suspect that there had been either some grievous misunderstandings when it was thought that the President and his staff and the CNHI had mutually agreed, had mutual understandings, or whether there were changes of perspectives on the part of the President and his administrative people. Attempts were made to clear up these differences or misunderstandings. A compromise was achieved with respect to revising the Health Security Program to make provision for the insurance industry to have a meaningful role in the operation of the program. The CHNI people recognized (I as chairman of the Technical Committee had had

to point out) this had become necessary because the escalation of medical care costs between the time when the Health Security Program was first designed and its financing was worked out--the escalation had become so severe over the years that had intervened--that the initial financing proposals could no longer be regarded as practical. The original program had contemplated that 50% of the program's financial needs would be raised through earmarked taxes and 50% would come as matching funds from the general revenues of the U.S. Treasury. At the time, 50% from the Treasury as on-budget costs meant some twenty odd billion dollars, and had seemed like a manageable proposal. But now with the escalations that had occurred, with medical care costs practically doubling or little more than doubling every five years, fifty billions of dollars from general revenues, particularly now when the economy was suffering from the effects of the actions taken by OPEC on oil prices, began to seem like an unacceptable burden on the federal budget. Accordingly, a meaningful place for the insurance industry really began to mean that the principal source of financing the program would probably have to be through some off budget financing such as mandating health insurance coverage and payments on employers on behalf of employees, this to be supplemented by public funds financing for persons that cannot be reached through the labor force and employer-employee relations.

Accordingly agreements were reached between the CNHI and the President, the Secretary of HEW, and the White House staff for a revision of the Health Security program to make provision for mandating on employers and effecting a major share of the financing through employers and their insurance carriers, and providing for major administrative functions to be carried by the insurance industry. This was not a happy compromise on the part of the CNHI

but seemed to be an unavoidable one. The committee, therefore, proceeded to direct its Technical Committee to rework the Health Security bill to meet those new understandings.

While this was in progress, however, it began to appear that a greater difficulty stood in the way of an agreed undertaking from the interpretation being placed by the White House staff and the HEW staff on phasing. The draft proposals and draft bills that began to appear from the HEW staff and the White House staff precipitated consternation in CNHI; they extended only to a first phase program, which as a matter of fact soon began to take the form of really a program of limited scope on the pattern of a catastrophic insurance coverage for people who first made expenditures of say, $2500 or $3000 per family, substantially in a pattern not greatly dissimilar from the catastrophic insurance proposals that had been taking form under Senator Long, Senator Talmadge, Senator Ribicoff, and others in the Finance Committee of the U.S. Senate. There were rumors that a political "deal" had been made.

This kind of a phasing was utterly and totally unacceptable to the CNHI and to their supporting groups. Many of them immediately recognized that a very limited program of the kind being contemplated by the President and his staff would mean a very limited undertaking that could not possibly achieve comprehensiveness because of the catastrophic payment underlying it and because of the dangers that catastrophic insurance would bar cost containments. Indeed, on the contrary, it would carry the threat of escalating the expansion and increase of costs. Also, a first phase program gave no assurances toward comprehensiveness of either the benefits or the coverage except on and through an uncertain schedule of future years and future legislative enactments. Accordingly, the CNHI and the Administration

agreed to disagree. The President sent his limited program bill to the legislators who would sponsor it and the CNHI proceeded to complete the drafting of the revised bill which now in May '79 was released under the title of "The Health Care for All Americans Act."

At this time, post-election 1980, the president's hospital cost containment bill is dying, if not dead. His first phase health insurance program is dying, if not dead. The Health Care for All American Act faces the uncertain future of what will happen to it and about it when the next Congress convenes with a more conservative Republican control in the Senate than it has had for some years and an uncertain control in the House which still has a Democratic majority but an uncertain political color. As 1981 approaches the CNHI is preparing to consider a reassessment and a redesign of its program in support of the development of a national health insurance of the kind and dimension that it has hitherto sponsored.

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In passing I mentioned that among the major reports produced in the Committee on the Costs of Medical Care one of the staff members essentially involved was C. Rufus Rorem. I had known him slightly before that when both he and I were on the faculty of the University of Chicago although we were in very different fields. I was in hygiene and bacteriology and he in political science and business administration. He had gone into the fields of interest of the Julius Rosenwald Fund, particularly the division directed by Michael M. Davis. When the Committee on the Cost of Medical Care was getting under way, Rorem was made available to the committee through the influence of Dr. Davis, first, as I recall, on a consultant basis, but subsequently after I joined the

committee as a regular staff member, but some division of his time between the committee and the Julius Rosenwald Fund.

He worked extensively with me and other members of the staff particularly in the studies of group practice, group clinics, and also in the whole area of hospital programs, hospital development, hospital costs and financing, etc. He became in many respects one of the most valued and productive members of the CCMC staff. His productivity was extraordinary. He had great capacity for saying "yes" or "no" to undertaking something, but if he did undertake something he agreed upon a time schedule and never in the years I worked with him did he ever fail to meet a date that had been agreed upon. This was one of his outstanding characteristics, of productivity on time.

Near the end of the CCMC days when we undertook to put together the staff summary volume to which I alluded earlier, he in many respects was the most important colleague that I could muster to work with me on that, both because of the breadth and scope of the undertaking, and also because we were going to be working against a deadline and on a very tight schedule. You will note that I referred to him as the first author associated with me, and then with Martha Ring who was our editorial person. His contributions are best expressed by the large portions he drafted and prepared for that volume and the great extent--I can assure you he participated with me and Martha Ring in the review and careful scrutiny of everything else that was to be contained in that volume.

While doing so much to make the work of the CCMC both productive and incisive and completed on time, he was also doing a number of related studies: those on group practice, his Saskatchewan study, and various and miscellaneous hospital cost studies. He was also participating in various

study activities associated with Michael Davis at the Julius Rosenwald Fund. So, shortly after the CCMC closed its door and its books, he was able to move on quite rapidly to develop and to complete a number of the cost studies that are associated with his name in the period when he was working with Davis at the Rosenwald Fund, and to undertake a nationally significant program of catalyzing in various communities the development of what we now call Blue Cross hospital insurance programs.

After the Rosenwald Fund closed out its activities in this field Rorem went on to other undertakings and made signal contributions in Philadelphia and Pittsburgh in his regional planning and other activities of which the records are readily available.

I scarcely need to embellish what I have said except to add that he's an admirable person to know as an individual, and a joy to work with.

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You asked me to comment about by views of the American Medical Association. It is sometimes praised and often damned. It is praised for the good things it has done and is doing with respect to surveillance of medical care, support of appropriate standards of licensure and medical performance by physicians and others, the support of research programs, and many other kinds of activities in the medical care field. It's often praised and with good reason with special reference of its work in respect to standards for good medical care, for the restraints on quackery, charlatanism, and misuses and abuses of licensure, etc. This is well known among people who work in this field. I yield to no one in admiration of the good they have done and are doing, and what more may be expected from them in these respects.

All of this, however is in large measure outside the scope of my immediate activities of many years. Within the framework of the fields in which I have worked specifically, I have had more occasion to damn the AMA of its policies that I have regarded as unsocial if not antisocial which have hampered, indeed frustrated, what has seemed to me to be the desirable developments in the field of health services and medical care. I don't limit this only to the personal health services field. I am mindful of the obstructionist tactics that the AMA has practiced for many years in the development of the publicly supported communitywide services. They have an almost unbroken record of having done the wrong things in those respects. They have an equally unbroken record of bad judgments and bad leadership with respect to the overall, general development of the availability of personal health services. I don't have to review for you the history of their record with respect to the limitations on public health departments or on private agencies that have tried to be useful in the communitywide health field. Their obstruction with respect to the selection of promising people to work in those fields, their opposition to the development of anything they thought was a challenge from the public sector to enter the fields that they had thought were the private preserve of the physician in the private sector, are other instances.

There is, to be sure, justification for those whose vested interest is in the private sector to undertake to defend and protect it. But we have a right to expect such positions to be taken with care and with needs to assure that protection of interest in the private sector as against undertakings in the public sector is not without concern for the needs of society in general, particularly if the private sector is not succeeding, or indeed, is failing to meet the needs of the public and the only alternative is undertakings in the

public sector. I don't expatiate on that because the record in those respects is very clear for anyone to read. If one needs to read not only the editorial comments in the newspapers or the general reading journals, one has only to turn to the carefully written record of the AMA's own history. I have in mind a book which is on my shelf: The AMA: Voice of American Medicine by James B. Burrow, published by the Johns Hopkins Press in 1963; also the more limited book, Professional Power and American Medicine: The Economics of the American Medical Association by Elton Rayack, published by the World Publishing Company in 1967. There are a half a dozen other books of the same kind on my shelves and I suppose there are many more in any good library.

It is a record which with respect to the role of the AMA and the public and private sectors I think is a disgrace for a learned profession.

Coming to the fields in which I have had a more direct and immediate contact with the AMA, my most serious criticism is that in October 1932 the AMA had the opportunity, through its representatives on the CCMC, to play a constructive role in the understanding and evaluation and design of the future course of developments, a constructive role with their colleagues on the Committee on the Costs of Medical Care, their colleagues who were physicians, dentists, or hospital administrators or others in the social sciences, or public representatives. By no stretch of the imagination, certainly by no stretch of my imagination, can I conceive how they possibly could have taken a less productive and a less constructive, and a less intelligent position than they took through the pressures on their representatives on the committee to participate in the development of the minority report #1 of the CCMC or the position they took in their House of Delegates shortly thereafter in endorsing that minority report. At that time the AMA had a clear choice of a road to

follow in the development of the design and the rules under which medical care would develop in the United States.

They had the examples that had been followed by the British Medical Association, by the medical association of France, by the medical association in Canada, when confronted with somewhat similar situations. It was as though they were deaf, dumb, and blind--or, their senses apart--they were indifferent to the experience of other medical associations in seeking to provide any constructive or useful guidance but chose instead to stand pat and even obstruct which is clearly evidence in the role they played through their representatives in the development of that minority report, in the urgings on other people to join with them, and in the positions they took in the AMA House of Delegates. Their role to be more concerned with that provision in the AMA charter concerned with the economics of the private medical profession as distinguished from the ethics of the medical profession to which they have often turned for a refuge.

In the years that followed, the AMA has been, with an occasional exception, on what I regard as the wrong side of the tracks, on the wrong course of the road, having taken the wrong fork in the road, instead of participating with other members of society in the support of constructive developments for the general public good as distinguished from what most people regard as the selfish, economic, and sovereignty interests of the medical profession.

They had, to be sure, played a very useful and constructive role back in the early decades of this century which led to the development of the Flexner studies through the joint support of the AMA and the Carnegie Corporation. The construction nature of the Flexner report was in 1910 in U.S.A. and in

Canada in 1911, of course.

There that chapter closed, from then on the AMA has been dominated more by fears and trepidations and what they regarded as the insecurities of their economic interests as against the weighed and weighted interests of the public need. With respect to the role of the states, the transferred roles to the federal government, the AMA has a long history of almost systematic and almost without exception obstructive tactics on the role of the federal government. There, perhaps, is as good as example of an institution which regards the federal government of the United States as a foreign agency whose interest is unwelcome and undesirable to the public good.

You can see this in the roles they played when the federal government was concerned about the development of then needed increases in the numbers of physicians, the needed increase in the support of our medical and other professional schools, the needed support for various minority and economically disadvantaged groups that should be enabled to study for medicine and for the other professional pursuits, or in the AMA's positions as to a role for the federal government in supporting improvement of the availability and the delivery of medical care consistently for years from the 1930s on to this day. The only encouraging exception that I know is that it would seem as though the AMA is nearly ready to admit that HMOs have a useful role to play in the United States, though they may qualify this by urging there should be no federal financial aid.

There have been times when the AMA has been supportive of good and promising developments in the hospitals of this country. One has to look carefully to see when they were supporting a hospital per se or when they were supporting the hospital as a doctor's workshop. With that kind of episode, as

with many others, so that many people who are not distraught in their circumspections scrutinize closely what motivates the AMA when they seem to be doing something people like.

Their history of obstructionism in the development of federal programs perhaps is more outstanding in very recent years--perhaps because it is more recent--than with respect to state governmental agencies. Overall I am reminded of something that one of their former very well-known and efficient leaders said to me some years ago. He was explaining why the AMA was opposed to this and that in the public sector, or in the combined public and private sectors.

Dr. Morris Fishbein the editor of the Journal of the AMA, said to me, "Dr. Falk, we are not really opposed to this. We just think we have a role to make it go slowly".

I said to him, "How slow is slowly?"

He said, "As slow as we can make it go".

I don't recall this for this record lightly, because it was an expression of one who became in a measure a disavowed leader of the AMA, but because it so precisely and correctly summarizes the development and pursuit of policies by the AMA over a period--from my personal experience I can say--of at least a half a century.

I return by saying that if it were pertinent I could say some additional kindly things about the AMA, but I hope I will not be pressed in that exercise.

Interviews in New Haven

December 11 & 12, 1980

Editor's Note

Dr. Falk's technical and professional papers, manuscripts, correspondence, etc., have been deposited in the archives of the Yale University Library where (classified and indexed) they are part of the Contemporary Medical Care and Health Policy Collection and may be consulted.

The archives collection lacks the papers that reflect Dr. Falk's activities as an official of the Social Security Board (and Social Security Administration), 1936-1954, having become part of the official U.S. Government files. They are identified and described in part in the Social Security Administration (Office of Research and Statistics) Research Report No. 30, Social Security Sources in Federal Records 1934-1950 by Abe Bortz, 1968, U.S. Government Printing Office.

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