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W. MONTAGUE COBB, M.D.

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IT IS MY HONOR to represent, as a member of its National Medical Committee, the National Association for the Advancement of Colored People, in support of the National Health Bill, S.1606. The National Association, founded in 1909, has over 520,000 members, organized into 1200 branches, youth councils and college chapters in forty-three states. It is the oldest and largest organization devoted to the securing of equal rights and opportunities for the more than 14,000,000 citizens who constitute America's most disadvantaged tenth. In its constant attention to the job for which it was organized and to which it is unswervingly committed, the N.A.A.C.P. knows it is safeguarding the democratic privileges of *all* American citizens, and at the same time is defining America in terms of democracy to the rest of the world.[1] The Association approaches the problem of health in the interest of the common welfare.

Numerous comprehensive and detailed studies have adequately defined, proved and stressed the urgent need of proper medical care for all Americans. No program previously proposed or instituted has indicated ability to close the gap between advances in medical technology, on the one hand, and the social and economic arrangements by which medical services are made available, on the other.[2]

President Truman's message to Congress of November 19, 1945, marked the first time in our history that a full length presidential message has been devoted exclusively to the subject of health. This message reflected significantly both the importance of the problem and the exhaustive consideration which all its aspects had received. The President recommended legislation embodied in the present bill. This Association is most acutely aware of the need for such legislation in respect to that segment of the population which it primarily represents. It cannot be overemphasized, however, that health is not a racial problem, that the health conditions of Negroes are largely a reflection of their socio-economic circumstances, and that poor health in any segment of the population is a hazard to the nation as a whole.

In the seven years since February 1939 when the first National Health Bill, S. 1620, was introduced in the Senate, the salient facts about all phases of our national health have become public knowledge, so that topical reference to a few items will suffice to establish background for the National Association's advocacy of the present bill.

Even though health conditions in the country as a whole are far from satisfactory, the plight of the Negro is worse than that of the white. In 1940, the latest census year, the standardized death rate for the country was 8.2 per 1000 for whites and 14.0 for Negroes, a mortality rate 71 percent higher than the white. In 1930 the Negro excess was 82 percent. In that year, the Negro mortality in the Registration States was 81 percent higher than the white in rural areas and 95 percent higher in cities, a fact of special significance in view of the continued urban migration of Negroes.[3]

In 1940 the life expectation of Negroes at birth was about ten years less than that of whites, the expectancy being for males, 52.26 years in Negroes and 62.81 years in whites, and for females, 55.56 years in Negroes and 67.29 years in whites.[4]

The consistent population increase shown by the Negro in spite of the high mortality and morbidity he has suffered has been due chiefly to his high birth rate which in 1942 was 23.3 as compared with 20.7 for the white. But the reproductive process in the Negro is attended with almost double the rate of casualties that prevails in the white. In 1942 the Negro maternal death rate was 5.5 and the white 2.2; the Negro infant mortality rate was 64.2 and the white 37.3; and the stillbirth rate was 50.5 in the Negro and 25.5 in the white.[5]

In retrospect, this approximately current unfavorable health picture shows considerable improvement over the past. The Negro mortality rate has declined from 24.1 in 1910 to 14.8 in 1943.[4] Since 1910 Negro life expectancy has increased about ten years or 25 percent.[3] There has been significant decrease also in reproductive mortality.[6]

Under similar environmental conditions there should be no appreciable racial differences in mor-

tality or life expectation. The circumstances attending the arrival of the Negro in America as well as those under which he has lived here both connote an inherent constitutional hardihood. Certainly, a people which has contributed Paul Robeson, Jesse Owens, Joe Louis, Henry Armstrong and a galaxy of athletes of similar caliber, cannot be said to be genetically lacking in physical stamina.

The N.A.A.C.P. has two chief points of interest in the profile of Negro health just outlined, first, that the excess Negro mortality and concommitant morbidity are due to preventable causes, and second, that as improvements are achieved, the Negro generally lags behind the white, indicating that he does not share as rapidly or as fully in the application of medical advances, even though the general progress is far from optimal due to conditions the present bill is designed to correct.

Diseases for which the cause and mode of transmission or development are known, and for which a specific control program has been established are preventable. Nearly all diseases showing excess mortality in the Negro fall into this category. High occurrence of these conditions is also associated with any group of low economic status where there is ignorance, overcrowding, poor nutrition, bad sanitation and lack of medical care.

The National Health Survey of 1935-36 found that the amount of disability per person due to illnesses which incapacitated for a week or longer was 43 percent higher in the Negro than in the white population. The higher disability rate for Negroes was due chiefly to chronic diseases which disabled the average Negro eight days per year compared with five days for the average white person. The higher rate was observed for all disease groups. Pneumonia was almost twice as frequent in Negroes as in whites and certain chronic diseases—the cardiovascular-renal group, rheumatism, and asthma and hay fever—were of significantly higher rate.[7]

The Survey noted that improvement of standard of living associated with a rising income increased the health status of Negroes as measured by various indicia of illness. The average Negro in the non-relief class experienced only one half the disability per year as the Negro on relief. The Survey concluded that low economic status, rather than inherent racial characteristics in reaction to disease appeared to account principally for the higher disability rate in Negroes.[7]

In the light of these facts, the N.A.A.C.P. has a natural and vital interest in any measures which make for the improvement of the general health, particularly that of the economically poorly circumstanced. The first part of S.1606, Title I, Part A, providing for measures against venereal diseases and tuberculosis deals with preventable conditions associated with low economic status which unduly ravage Negroes. The tuberculosis mortality rate in the Negro is more than three times that in the white. It has been stated that syphilis occurs six times more frequently in Negroes than in whites.[8] Because of the unfortunate tendency on the part of many, including even some health officials, to make invidious racial implications from such data, it is desirable to quote a statement from H. H. Hazen's authoritative monograph, "Syphilis in the Negro."[9]

"The problem transcends racial boundaries. Where the Negro syphilis rate is high the rate in the white group as well is likely to be unusually high. One finds, by comparison of these areas with those having lower rates for both Negro and white, that a less vigorous effort has been made to control the disease. Treatment facilities in the areas of high prevalence prove to have been inadequate and largely inaccessible. Likewise, the public is not well informed on the value of early and adequate treatment in arresting the disease and in preventing its spread." And he reaches the conclusion that the most outstanding characteristic of these areas of high prevalence is a low economic status in a large proportion of the population. . . .

"Despite the alliance of syphilis and poverty, syphilis has receded wherever the people have been informed of the methods of prevention, detection, and cure, and meanwhile, provided with facilities for obtaining treatment irrespective of their financial status."

The same spirit of cooperation from the people has been manifest in the application of newer techniques for the control of tuberculosis. Communities tend to welcome such measures as mass x-ray surveys when they have been made to understand the objectives.

Tuberculosis mortality in white adults has declined at a more rapid pace than the total death rate from the beginning of the century through 1943, the last year of available data. This was true

also in Negro adults until 1935. From 1935 through 1937 the rate of decline was essentially the same as that of the total death rate, but beginning with 1938 and for each subsequent year the decline in tuberculosis mortality has been less than that of deaths from all causes.[10] This would indicate that since 1938, progress against tuberculosis mortality in the Negro has not been as satisfactory as against deaths from all other causes combined.

Title I, Part B providing for grants to states for maternal and child health services, like Part A, deals with a phase of health where the Negro has vital need. In this group, between 1915 and 1942 maternal mortality rate had been reduced from 10.6 to 5.5; infant mortality from 181.2 to 64.2; stillbirths from 73.4 (1922) to 50.5. Yet, as already stated these final figures are approximately twice the comparable rates for the white.

More than four fifths of Negro babies are born in the Southern States; two thirds are born in rural areas; four fifths are born in States where per capita income is below the national average. The wholehearted acceptance by the Negro of health facilities so far made available warrants all possible development and expansion of activities which will bring Negro mothers safely through childbirth and Negro infants safely through the first year of life.[11]

Title I, Part C of the bill, dealing with grants to states for medical care of needy persons, is an obvious necessity, which appears to be universally recognized, as one of the chief opponents of the bill, the American Medical Association, in its National Health Program of February 23, 1946, recommends that for medical care of the needy, local funds be supplemented "with the assistance of federal funds when necessary."[12]

Title I of the bill referring to grants to states for health services and specifically to provisions for venereal diseases, tuberculosis, maternal and child welfare, and the care of the indigent, appears in all its subdivisions to cover vital areas of need for medical care in our country today. The need for the measures provided for in this title is particularly acute among our Negro citizens.

With the plans for the administration of the S.1606, the N.A.A.C.P. must have certain vital concerns. About 79 percent of our Negro population are concentrated in the 17 Southern States where they comprise approximately one fourth of the total population. Another 18 percent live in the three Middle Atlantic and five North Central States, making a total of 97 percent in these 25 states. Until very recently about 90 percent of those living in the South were rural dwellers in contrast to 80 percent urbanization of those living in the North.[9] These facts of regional and rural and urban concentration would entail variations in the mechanics, but not the principles of procedure in implementing the bill as it would affect the Negro.

The N.A.A.C.P. is concerned that, irrespective of the means by which it would be planned to implement the bill in any locality, there should be no discrimination against any citizens because of race, creed, color or national origin. It is concerned that in the provisions for training of the large new personnel that will be needed for State and local health work, Negroes be integrated into the program at all levels, administrative as well as professional, without respect to section of the country.

The Association is further concerned that in the needs for medical care and facilities to be determined by the respective states, the same standards should be used for such determination for all political subdivisions of the states and for all citizens.

Title II of the bill, referring to prepaid personal health service benefits, appears to have many progressive features in keeping with democratic practice. The provisions for a national advisory council and local advisory councils on which both the professions and the public would have representation extends representation to areas where it has not extended before, and affords an opportunity to the public and to groups of the professions, which hitherto have not had such opportunity, to work for the improvement of both the national health and that of their own communities. The Association does not find, as has been frequently alleged, that the traditional free choice of physician by patient, and patient by physician, has been impaired by the provisions of the bill. Section 205, (A) specifically states in effect that any physician, dentist, or nurse legally qualified to practice in a state shall be qualified to furnish services. Section 205, (B) states very clearly that every person entitled to receive general medical, or general dental benefits shall be permitted to select, from among participating practitioners, those from whom he shall receive such benefit subject

to the consent of the practitioner or group of practitioners selected, and every such individual and every group of such individuals shall be permitted to make such selection through a representative of his or their own choosing and to change such selections. The remaining provisions of this section all are directed at ensuring not only that achieved medical standards be maintained, but shall be advanced. It is further specifically stated that "payment shall be adequate, especially in terms of annual income or its equivalent and by reference to annual income customarily received among physicians, dentists or nurses having regard for age, specialization, and type of community; and payment shall be commensurate with skill, experience and responsibility involved in furnishing the service." Were it not for the fact that fees can be paid in a variety of ways it would still be impossible for the Association to see any way whereby medical care, even under the bill, could be extended to those particularly economically underprivileged areas where it is most sorely needed.

In the past it has been impossible for physicians to remain long in either rural or urban areas where they are needed most, because of lack of facilities on the one hand and the fact that the population was too poor to afford them an adequate income on the other. The Hill-Burton Hospital Construction Bill, S.191, which has been passed by the Senate and which has received endorsement of the American Medical Association, would provide a means for the construction of lacking facilities. S.1606, for the first time, offers a means whereby the necessary professional personnel could be paid in such areas. As has been repeatedly pointed out in earlier testimony, no form of voluntary prepayment medical insurance could be of benefit to these people, because they could not afford it. In this connection it should be emphasized that the furor over free choice of physicians can have no meaning for millions of Negroes as well as of millions of whites in poor economic circumstances, because down the years these people have been without any medical services whatever. Ofttimes when such services have been available they have been the indifferent services of physicians who do not want them as patients or similarly unsatisfactory services of crowded clinics.

Major objection to the bill from the medical profession has been voiced by the American Medical Association, consequently the counterproposals of this organization have been studied with great interest. In the considered judgment of the Association these counterproposals are far inferior to the proposals of the National Health Bill. The American Medical Association's proposal, as stated in its Journal of February 23, 1946, recognizes apparently that some form of prepayment medical insurance is necessary, and that it is the determination of the American people to obtain such insurance. There may be said, therefore, to be general agreement that prepayment medical insurance is both necessary and desirable. Operating upon the sound and time tested insurance principle that a large number of insured will permit a greater coverage in services, smaller premiums and less administrative expense than will smaller groups of insured persons, the National Health Bill proposes that the entire population earning an income be taxed a small percentage of earnings, (percentage to be determined), which shall provide ultimately for complete coverage of medical services with a similar provision for the medical care of the indigent. The American Medical Association proposes that on a trial and error basis various forms of voluntary prepayment medical care plans be tried out until optimal procedures are determined by experience. It further proposes that regional plans shall be locally determined. Already it has been evident that all such plans so far proposed have the weakness that they are available to the relatively small groups who are able to pay for them and have but limited coverage and high premiums, so that still the people who need medical care most are not able to provide for it. The American Medical Association's proposal then blandly suggests that the indigent, who are not able to be provided for through some prepayment medical care plan, or local public funds, should be cared for by federal funds. Where the Federal Government would obtain these funds the American Medical Association does not indicate. The voluntary prepayment plans are particularly little available to the poorly circumstanced of the American population of whom Negroes constitute the largest group. In addition, where these plans have already appeared and are operating, besides being little available to Negroes on an economic basis, they have been closed to them by reason of racial discrimination as well. The law has been the best safeguard of the under-

privileged throughout our history. Therefore, the Association firmly believes that equal justice in the securing of adequate medical care for all citizens would be better obtained by national legislation to that end than by other means.

The Association affirms that the profession of separate, but equal facilities for the care of Negro population in those areas where that population is concentrated has always been a myth, and would prove again to be a myth should it be attempted. Specifically the Association wishes to declare against the principle in the application of this bill to the development of separate hospitals, separate health centers, separate training programs, and separate public health programs. We wish to declare emphatically for the elimination of the entire racial separation practice in the construction of any new facilities, and in the operation of all new plans for the distribution of medical care and for the integration of Negro professional personnel into all levels of the plan according to qualification. Recent experience with attempts to assure adequate professional personnel through the separate system of professional education have proved how sterile and ineffective is this plan. It has resulted in there being not only inadequate numbers of general practitioners, (and nurses), but also of specialists in the respective fields.

The Association's study of this bill indicates that it might be possible for the administration of the program to be assigned through private auspices, particularly state and local medical societies. This Association would be unequivocably and unalterably opposed to any arrangement of this kind. In many states, including the entire south and the District of Columbia, local medical societies have consistently barred Negro physicians from membership, and the American Medical Association, through the technicality of not admitting to its membership physicians who are not members of their local societies, has extended the effect of this racial discrimination. This Association, therefore, would see no outlook but the perpetuation of these discriminatory practices in the administration of a national health program and advocates that the administration be entirely in the hands of responsible public officials.

In the summary it may be stated that from the point of view of the N.A.A.C.P., S.1606, for the first time in our history, provides a means whereby the economic barrier to the extension of medical care to the millions of American citizens who so sorely need, but cannot afford such care, may be overcome. It provides a means, further, whereby the tragedy of economic collapse brought upon families by expensive illness may be averted. This plan appears conceived upon the soundest possible basis, namely, the distribution of cost over the entire earning population so that maximum coverage for all may be achieved while administrative expenses are held to a minimum. The Association would like to note the endorsement of this bill by the Medico-Chirurgical Society of the District of Columbia. This organization, of 188 physicians, is the oldest Negro medical organization, and the largest local society of this group. This body was formed in 1884 as the result of the determined refusal of the Medical Society of the District of Columbia, supported and confirmed by the American Medical Association, to admit qualified Negro physicians to membership. These physicians individually and collectively are a prosperous group, but they have seen in the National Health Bill the same advantages for the American people which the Association has briefly described.

In closing, the N.A.A.C.P. regards S.1606 as one of the most progressive and potentially beneficial pieces of legislation of recent years. It is sorely needed by the great majority of Americans, but it is most acutely needed by our 14 million American Negro citizens. The Association unqualifiedly endorses this bill and strongly urges its passage.

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