cine." And Dr. Walter Bauer, chief of medicine of the Massachusetts General Hospital, says, "I don't see how we can provide good medicine without group practice."

Group practice arrangements are increasing substantially in number, particularly in the West and Midwest. Taking the United States as a whole, there were 368 group practice units in 1946. By 1959 the total number of group practice clinics had reached 1,154.

Group practice will continue to grow in response to the technical advances in medicine and resulting specialization. We believe this development to be so important in relation to efficient utilization of medical manpower and to providing the best possible quality of medicine that every possible effort should be made to stimulate an even faster rate of growth in group practice.

We have been particularly impressed by the achievements of group practice where the medical teams contract directly with groups of consumers to provide comprehensive health services on a prepaid basis. Quite literally, the consumer pays so much per month to the medical group to keep him well. Under this type of arrangement, the medical group has an incentive to practice preventive medicine because the patient who becomes sick becomes the financial as well as the medical responsibility of the prepaid health plan.

Contrast this with the typical insured plan which only reimburses the patient when he becomes sick. These sickness insurance programs typically exclude payment for preventive care and physical examinations. Under such programs the doctor assumes no financial responsibility because his services are paid by a third party. Early diagnosis and treatment are, in fact, effectively deterred in the typical sickness insurance plan through the use of "deductibles and coinsurance."

That "an ounce of prevention is worth a pound of cure" has been well documented in the Federal employees health benefits program.

Just as you find lower rates of surgery for the comprehensive, direct service, group practice, prepayment plans, so you will also find lower hospitalization rates under these plans.

Federal employees enrolled in Blue Cross had 865 nonmaternity hospital days per 1,000 subscribers in the contract year 1962–63. Those electing the commercial insurance program had 767 hospital days, and those choosing the comprehensive plans had only 430 hospital days.

In view of the many advantages of group practice and particularly of group practice coupled with prepayment, we believe the objective of H.R. 9256—to assure the availability of credit for group practice plans—deserves wholehearted support.

In fact, we believe Congress should do much more to promote the growth of more rational methods of organizing health services. Therefore, we ask specifically that the Congress soon give consideration to the need for additional support and encouragement for group practice prepayment plans through grants in aid for construction of necessary facilities and initial staffing similar to the Community Mental Health Centers Act as amended in the 1965 session of the 89th Congress.

Mr. Chairman, I appreciate this opportunity to present the support of the AFL–CIO for H.R. 9256. Thank you.

Mr. BARRETT. At this point in the record I would like to introduce a statement for the record by our colleague, Mr. Moorhead who could not be here today. He is introducing two statements in support of H.R. 9256 by Dr. Dean A. Clark, director, program in Medical and Hospital Administration at the University of Pittsburgh, School of Public Health, and Dr. Leslie A. Falk of Pittsburgh, Pa.

(The statements referred to follow:)