C.-E.A. Winslow Day:
Proceedings of the June 3, 1977
Centenary Celebration

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Sponsored by Yale University, the City of New Haven, and the John B. Pierce Foundation, the C.-E.A. Winslow Day program consisted of speeches by Mr. Leonard Woodcock, President Emeritus, U.A.W., the Honorable Kenneth Gibson, Mayor of Newark, and Dr. Hector Acuña, Director, Pan American Health Organization; reminiscences of Ira Hiscock, Anna M.R. Lauder Professor Emeritus of Public Health, Mary Elizabeth Tennant, Associate Professor Emeritus of Nursing (Public Health), A. Pharo Gagge, Emeritus Fellow, John B. Pierce Foundation, and Mrs. Harriet Welch, Former President of the VNA of New Haven. The proceedings also included the presentation of gifts and the official C.-E.A. Winslow Day Proclamation.

On June 3, 1977, there gathered in the Mary Harkness Auditorium of the School of Medicine, guests, dignitaries, and alumni to celebrate the centenary of the birth of C.-E.A. Winslow. Sponsored by Yale, the City of New Haven, and the John B. Pierce Foundation, the program consisted of speeches, reminiscences of the life and times of Professor Winslow, presentations of gifts and proclamations, and a reception and dinner. Dr. Robert W. McCollum, Susan Dwight Bliss Professor of Epidemiology and Public Health and Chairman of the Department of Epidemiology and Public Health, presided at the festivities.

1. INTRODUCTION

Dr. McCollum: “We are here today to honor the memory of a remarkable man whose genius and versatility encompassed every discipline of public health. He was a writer of distinction, a teacher of renown, a man whose counsel was prized, a favored speaker before his colleagues, a world citizen in the realm of health, a great statesman, a man who was ‘always doing, never still’—an extraordinary man [1].

“He received his early and formative training from W.T. Sedgwick [2] at the Massachusetts Institute of Technology, where for twelve productive and happy years he refined his art and science. After a sojourn to New York, where he simultaneously held the positions as Professor of Biology in the City College of New York and Curator of Public Health at the American Museum of Natural History, he was called to Yale to occupy its first chair in public health. And here he remained for over forty-two years, as professor, chairman, and Emeritus Professor, bringing increasing distinction to his department, the Medical School, and to Yale.

“Among his many honors were the Mary Lasker Award of the American Public Health Association, the Lemuel Shattuck Medal of the Massachusetts Public Health Association, and the Léon Bernard Medal of the World Health Organization. Of the
many awards received, none pleased him more than the one named after his mentor, Sedgwick. To give a picture of Winslow the man, I should like to quote from Winslow's acceptance speech at that occasion:

'... the purpose of this award is not primarily to place each year a crown on the brow of a more or less worthy recipient. It is to keep the laurel green on the memory of a great pioneer in American public health and, above all, a human being whose personality, whose soul, was far more significant than any of his concrete achievements ... Intellectually, Sedgwick, as a pupil of [Newell] Martin, the associate of [Thomas] Huxley, was a child of the Victorian day—a day whose serene spaciousness, scientific reasonableness, and warm humanitarianism seems in these dark hours [of World War II] like some remote Golden Age of human history. Yet he had in him, too, a strong and essential mixture of the Puritan. He was never lulled into slackness by faith in automatic perfectionism. He knew that the world was a hard world and that progress comes only by ceaseless effort. He was alert to the call of duty "stern daughter of the Voice of God." The motive power in every hour of his life was service. He almost never used the word; but he made the tacit assumption that the aim of every human being was to "leave the world better and happier than he found it." After one long and intimate talk with me he said, "Well, Winslow, I think you can be a very useful man" ... This is perhaps, more than any other, the attitude of mind we must cultivate today' [3].

"Those of you here today will doubtless agree that C.-E.A. Winslow was indeed a 'useful' man." Dr. McCollum then presented Dr. Robert W. Berliner, Dean of the School of Medicine, the Honorable Frank Logue, Mayor of the City of New Haven, and Dr. Arthur DuBois, Director of the John B. Pierce Foundation, for words of welcome.

2. WORDS OF WELCOME

DR. BERLINER: "Throughout the years, Yale University has been very fortunate to have a distinguished faculty whose contributions and influence have extended far beyond the classroom, to the community, nation, and world. The medical school has shared in this wealth of outstanding leaders and innovators in therapeutic and preventive medicine and in the basic sciences, and C.-E.A. Winslow was such a leader. Dr. Winslow's entry into the field of public health was by way of the relatively new science of bacteriology, but from this base his interest and endeavors developed rapidly to encompass a much broader perspective of concerns related to health. Already a widely recognized scholar when he was appointed Anna M.R. Lauder Professor of Public Health in 1915, he brought a new dimension to the medical curriculum and developed additional academic programs that were the forerunners of graduate schools of public health in the United States and elsewhere. The present Department of Epidemiology and Public Health is the direct descendant of the department which Winslow developed, nurtured, and in which he served with such distinction."

MAYOR LOGUE: "Dr. Winslow's life stands as an example of the kind of life we wish we could lead. He was a man who served the community, not just in his academic capacity, but as a man of action. For twenty years he served as chairman of the New Haven Housing Authority, recognizing that shelter was as critically important to the quality of life as were other public health concerns" [4]. The Mayor then read the official "C.-E.A. Winslow Day Proclamation," which he presented to Yale "as a
WHEREAS: Charles-Edward Amory Winslow, founder and first chairman of the Department of Public Health at Yale University in 1915, made many major contributions to many different areas of public health over a long period of time; and

WHEREAS: As a laboratory and field investigator, social and health innovator, professor and writer, he represented the ultimate worker, teacher and statesman in public health during the first half of the 20th century; and

WHEREAS: The Department of Epidemiology and Public Health at Yale, the John B. Pierce Foundation, the City of New Haven and many distinguished Americans will celebrate the 100th anniversary of Winslow's birth on June 3, 1977.

NOW, THEREFORE, I, FRANK LOGUE, Mayor of the City of New Haven, Connecticut, do hereby proclaim Friday, June 3, 1977 as

C.-E.A. WINSLOW DAY

in New Haven, and urge all citizens to honor this outstanding American and long-time local civic leader who contributed so much as a world-renowned pioneer in public health.

Frank Logue
Mayor

FIG. 1. C.-E. A. Winslow Day Proclamation.

token of the City's appreciation and which symbolized the past, present, and future relationship between City, University, and School of Medicine." (See Fig. 1.) The Mayor also presented, for loan to the Department of Epidemiology and Public Health Library, two volumes of handwritten Board of Health minute books, dating from the year 1806. He selected one passage to read to the audience as follows:

'At a meeting of the Board of Health in the Town of New Haven holden at the office of Henry Daggett, Esq. on the 17th day of March 1806 . . .

'Henry Daggett, Esq. was (by ballot) elected President. Elisha Munson Clerk.

'Voted: That Noah Webster and Isaac Tomlinson be a Committee to fix the landmarks and boundary lines of the quarantine grounds.
'Voted: That Elizur [sic] Goodrich, Simeon Baldwin and John Barker Esquires be a Committee to devise a general scheme of regulations under the law "providing in case of sickness" and make the necessary arrangements for carrying the same into effect.

'Ordered: That the act "providing in case of sickness" be printed.

'Voted: To adjourn 'till March 20th at 7 O'Clock p.m.'

DR. DUBOIS: "On behalf of the Board of Directors of the John B. Pierce Foundation, I extend greetings to Yale University and all its members and guests who are celebrating the 100th birthday anniversary of Dr. Winslow. Mr. Walter Grant, who is President of the Foundation, sends you this message:

'As first Director of the John B. Pierce Laboratory during the years 1932 through 1947, Dr. Winslow provided the initial leadership and momentum to carry out the Foundation's purposes in research, education, scientific and technical work, and to initiate the felicitous partnership between our institutions.'

"I might add to Mr. Grant's welcome that the Pierce Foundation was able to assist in the research and teaching program in public health at Yale because Mr. Pierce, who was a rugged individualist and industrialist, had the foresight to write a will which enabled this type of work to be done. We are still working in this close cooperative way with Yale, so that the many scientists attracted to the Pierce Laboratory by its former Director, Dr. James Hardy, offer courses in the Department of Epidemiology and Public Health. We continue to carry on in the Winslow tradition, and are delighted to be here with you and to join in celebrating his birthday. You have heard from Yale University representing academe, from local government, and now we add the interest of industry, all to get a job done in the field of public health."

3. REMINISCENCES

Dr. McCollum acknowledged that he had never had the privilege of knowing Professor Winslow personally, but that he has had the good fortune of knowing and working with many of Professor Winslow's students, colleagues, and friends who speak with warmth, admiration, devotion, and even a little emotion of their many years of close association with this great man. "Since these memories are readily shared by those who knew Professor Winslow, and since over the years I have read many of his papers and monographs, I feel that I, too, knew Professor Winslow well. And for those of you who did not have the good fortune to know the Winslows, we have invited some who did to share their memories with us." Dr. McCollum then presented Dr. Ira Vaughan Hiscock, Anna M.R. Lauder Professor Emeritus of Public Health, Mary Elizabeth Tennant, Associate Professor Emeritus of Nursing (Public Health), A. Pharo Gagge, Professor Emeritus of Epidemiology and Emeritus Fellow of the John B. Pierce Foundation, and Harriet H. Welch, Former President of the Visiting Nurse Association of New Haven.

PROFESSOR HISCOCK: "This is a good community, a great University, and a happy day, marking a milestone. We are celebrating Winslow Day and rejoice in the honor and memory of Charles-Edward Amory Winslow and Anne Rogers Winslow, distinguished pioneer leaders in health care, at home and abroad. We are also honored, and our day brightened, by the presence of their distinguished daughter, Anne Winslow, well known for her magnificent achievements around the world for the
benefit of mankind. We emphasize especially, since her graduation from Vassar, her impressive contributions to the Carnegie Peace Program, United Nations, and League of Red Cross Societies.

"When Principles of Sanitary Science and the Public Health [5] appeared in 1902, some fifty years after the beginning of the modern campaign for public health in America, its author, William T. Sedgwick, wrote to his former student and colleague as follows: 'My dear Winslow, You have had a hand in the making of this book by your enthusiasm and criticism. May the disciple some day surpass the Master in this subject which we both enjoy' [6]. Sedgwick's anticipation for his professional son was more than realized, with benefits for millions around the world.

"I shall jump over the early years of Winslow's preparation, growth, experience, and happy marriage to Anne Winslow (herself a brilliant student of Sedgwick's), and pick up the story in June, 1914, when four members of the Lauder family wrote to Yale Secretary Anson Phelps Stokes Jr., expressing their desire to give Yale University Medical School a sum sufficient for the endowment of a Department of Public Health and the establishment of the Anna M.R. Lauder Chair of Public Health. The Lauder family also expressed their desire that the department 'be organized and maintained according to the most modern ideas pertaining to the subject.'

"After a thorough search, Winslow was appointed the first Anna M.R. Lauder Professor of Public Health, which chair he occupied until 1948, the date of his retirement.

"For over thirty years, Winslow taught at Yale. He assisted in the development of public health in Connecticut (fulfilling thereby another wish of the Lauder family), worked diligently and without remuneration in the State, was a member of the State Public Health Council, served as a member and chairman of many health agencies and boards, and was the director of the New Haven Housing Authority. During his tenure at Yale, his assistants included J.S. Falk, M. Allen Pond, William Willard, Paul Anderson, Philip Nelbach, John H. Watkins, Leonard Greenburgh, Philip S. Platt, and Robert Jordan—all of whom grew to internationally recognized leadership positions in public health [7]. Graduate students came from far and near, several on scholarships from the World Health Organization, foreign governments, and the Commonwealth, Milbank Memorial, and Kellogg Funds. Most of them became distinguished in the evolution of the modern public health campaign.

"Winslow cooperated and collaborated with department heads, faculty, deans, and other administrative officers of the University [8]; with state, local, and national agencies (including the United States Public Health Service, United States Children's Bureau, Connecticut State Medical Society, Connecticut Bar Association); and with governmental officials and voluntary agencies. Winslow also found time to serve as President of the American Public Health Association [9], and as chairman of APHA's Committees on Administrative Practice [10] and of the Hygiene of Housing, the Committee on the Costs of Medical Care [11], and the New York State Commission on Ventilation [12].

"Another important 'event' in the life of the Winslows was the weekly, evening seminars held in the Winslow home. This was a time of enjoyment, enlightenment, and 'mind-stretching.' Imagine if you will fireplace aglow, scholarly discussion, the friendly exchange of ideas, readings from the classics and moderns—even relaxation for those who preferred to listen more than participate. And through it all, the graciousness of Mrs. Winslow's hospitality. It was a memorable, pleasurable experience for us all.

"Professor Winslow was a tireless gentleman and teacher who made many deci-
sions quickly, read books rapidly, and who even wrote manuscripts, including his classic definition of public health [13], while in bed. He had little use for lazy scoundrels or 'inept bluffers.' In debate he could often carry even 'an adversary captive after the triumphant charriot of his rhetoric,' and as Solomon said, 'The soft tongue breaketh the bone.' His inspiration, faith, and spirit were boundless.

"In thinking of today and tomorrow, I have a strong feeling that Professor Winslow, and Dr. John R. Paul [14], are looking down with smiles of gratification as they view the success of the department that their tireless efforts helped to make world famous."

At the conclusion of Professor Hiscock's talk, Dr. McCollum announced recent plans for the relocation and enlargement of the Department of Epidemiology and Public Health Library. The blueprints and plans were presented to Professor Hiscock in May 1977, in commemoration of his 85th birthday. All were greatly pleased to learn that the new library, made possible in part by the generous donations of Professor Hiscock's former students, friends, and co-workers, would be called The Ira Vaughan Hiscock Library. The texts and journals, which now exceed the storage and shelf capacity of the present department library, the many books, monographs, reports, and memorabilia from Professor Hiscock's personal library, and the two Board of Health Minute books on loan from the City of New Haven will fill the commodious and spacious reading room and stack areas of the Hiscock Library.

MISS TENNANT: "It is an honor and privilege to participate in these centenary proceedings. I had the good fortune to be a student of Professor Winslow's at the first training camp for nurses held at Vassar College in 1918. The American Red Cross, Vassar College, and a group of prominent nurses and professors, Dr. Winslow among them, recruited college women to nursing in view of the critical shortage of both civilian and military nursing personnel. In June of that year, 350 college graduates from every state in the Union and from Canada arrived at Vassar College to begin study. Professor Winslow, as he did all his life, emphasized in his course the preventive and social aspects of public health. His final lecture was a charge to his students. He made us feel that we were capable of great achievement in nursing. It was the most inspiring appeal that I have ever heard from a teacher.

"Throughout his professional career, Professor Winslow was associated with nursing [15]. He was directly involved with the founding and development of the Yale School of Nursing and was a valued member of its teaching faculty [16]."

"In 1928 I was appointed to the Rockefeller Foundation staff and departed shortly thereafter for their Paris Office. Prior to my departure, however, I had the good fortune to spend three months at Yale, observing first-hand the teaching program at the School of Nursing. Here I renewed my friendship with Professor Winslow.

"In retrospect, my decision to become a Public Health Nurse was owing directly to Professor Winslow's inspiration, an inspiration that I and others who knew him have treasured these many years."

PROFESSOR GAGGE: "Professor Winslow was one of the early environmental activists, and a long time friend of Clarence Mott Woolley, Chairman of the American Radiator and Sanitary Standard Company and President of the John B. Pierce Foundation of New York, which was first established in 1924. In 1932, the Pierce Foundation had accumulated sufficient funds from the Pierce estate to build its first laboratory, '... to promote research in the general fields of heating, ventilation, and sanitation for the increase of knowledge to the end that the general hygiene and comfort of human beings and their habitations may be advanced.' Later in the year, Mr. Woolley invited Professor Winslow to be the director of the laboratory.

"A new director of a new venture is customarily given a grand tour, and Professor
Winslow was soon off to Europe to see the latest in the hygiene and living conditions for the housing of the laboring classes. One of the newest fields in Germany and Switzerland to impress him was the possible role of light and heavy ions, especially the negative ones, in improving the 'pleasantness' and 'health' of our environment. In fact, when I first met Professor Winslow in June 1933 (after recently having completed my doctorate in physics from Yale), he told me that he believed 'ions' to be as important to man's 'air conditioned' environment as vitamins were to bread. This was the basis for my first job at the Pierce.

"Of course, ions were just one small phase of Professor Winslow's initial objectives for the Laboratory. While in England in 1932, Professor Winslow brought from the British Heating and Ventilating Engineers a test instrument called an 'Eupathoscope' for estimating thermal comfort. Later, with Dr. Leonard Greenburg, he developed a 'thermo-integrator' and with both instruments began the long research road to the present [17].

"In the early eight years, from 1933 to 1941, I had the great pleasure and scientific stimulation of being a part of Winslow's and the Pierce's contribution to the scholarly literature [18]. All of our work covers the first ten years of the Laboratory's existence and they can even describe our principal projects today. What ever happened to our early studies of ions? Well, after two years of extensive experimenting we could find no correlation between positive or negative ions and 'comfort and well being.' As a 'biophysicist' I found myself soon in the new field of thermal physiology and the environmental sciences, which I began at the Pierce, continued while a member of the Army Air Corps during World War II, and concluded back at the Pierce, all as a result of Professor Winslow's guidance and extraordinary vision.

"Professor Winslow had recognized from the start that the Pierce Laboratory would give him a long desired opportunity of combining the engineering, medical, physical, biological, physiological and psychological sciences into a team approach for the study of man's response to his living environment. Many of you are familiar with his contributions to the American Public Health Association, but you may be less familiar with the fact that he was President of the American Society of Heating and Ventilating Engineers (1945) and was personally very active on their Technical Committees dating from 1933 [19].

"Much of our stimulation in those early days of the Laboratory came from the Russell Sage Foundation Laboratory at Cornell Medical School under the leadership of Professor Eugene F. DuBois, the father of our present Director, and of their biophysicist-physiologist Professor James D. Hardy, our director from 1962-1974, during which time we had a most phenomenal growth. I cannot omit mention of their tremendous support during the early prewar years and the many opportunities they provided to present our Pierce findings to other societies, such as the American Physiological Society.

"I cannot resist telling an incident that gives insight to Professor Winslow's great kindness, sensitive nature, and wonderful hospitality. During those first months at Pierce in 1933, Professor Winslow invited me for a Sunday evening supper at his large Prospect Street house. Being a southerner from Richmond, Virginia, I assumed that this would be a semi-formal occasion and appeared fashionably, 5 minutes late, in sport coat and slacks. When Professor Winslow opened the door there was a slight gasp. You see, he was dressed in a black dinner jacket as were all his other guests. Mrs. Winslow introduced me to the guests and I am pleased to report that my embarrassment was short lived: For a few minutes later Professor Winslow reappeared, also in sport coat and slacks!

"In looking back, Professor Winslow's sense of timeliness and vision, to see where
to go next, has always amazed me. I am proud to see how those first few years at the Pierce Laboratory have proved so profitable both to our national effort as well as to his many colleagues."

MRS. WELCH: “We speak today of Dr. and Mrs. Winslow because they were true partners in every sense of the word. They were compatible emotionally, compatible with each other's objectives, and they shared a common goal. It was my privilege to know Anne Rogers Winslow, and to be one of her host of admirers.

“Some of you may know that Mrs. Winslow was a microbiologist in her own right, having studied with Sedgwick at the Massachusetts Institute of Technology. And, as you already know, it was in Professor Sedgwick's laboratory that she met her future husband and partner [20].

“Her contributions to the Board Members Organization of the Connecticut Public Health Nursing Agencies, which she helped found, were many, and for many years BMO served as a forum for members to discuss common problems and concerns. BMO served as the prototype for our recently inaugurated Association of Community Health Service Agencies, which now focuses on today's changing health needs, state and federal health legislation, and the organization and delivery of health services in the state.

“Mrs. Winslow was a strong advocate for continuing education for the public health nurse, for health education and promotion, and for consumer rights. Because Professor Winslow and Mrs. Winslow were respected authorities, and gifted lecturers, they were much in demand as speakers. Mrs. Winslow, for example, lectured throughout the United States, and in Canada, Puerto Rico, and Switzerland. What Mary Gardner [21] was to the public health nurse, Mrs. Winslow was to the Board members of public health nursing associations.

“Mrs. Winslow was the second President of the New Haven Visiting Nurse Association and served in this capacity from 1927–1937. She continued as a Board member during my term of office (1958–1964), during which time she was elected an honorary life member.

“She was a friend of Mrs. Franklin Delano Roosevelt, Harriet Lauder Greenway [22], and Mary Breckinridge [23]. She was a gracious hostess, and entertained dignitary and student alike with 'a cup of tea, a dainty sandwich, and sweets.' She was also 'a mother image' when a student needed special attention, and a 'true friend' when we sought her advice and counsel.

“Mrs. Winslow's graciousness and inner beauty reflected her genteel background and heritage. Few women influenced so many youths, and few have left their imprint on young spirits. She made a lasting impression on everyone who was privileged to know her. She was an inspiration to me, and her warm presence has been an influence in my life. To know her was to love her.”

4. MEDICAL CARE

DR. MCCOLLUM: "We cannot possibly cover all of the public health disciplines to which Professor Winslow contributed [24], and so we have chosen three which are representative of his concern, commitment, and farsightedness: medical care, the city, and international health. Our first speaker is Professor I.S. Falk, one of Winslow's first students at Yale. As did Winslow, Professor Falk began his distinguished career in bacteriology. After a professorship in bacteriology at the University of Chicago, Falk in 1927 was asked by Winslow, then vice-chairman of the Committee on the Costs of Medical Care, to become the director of the research staff of the Committee, a position Falk was subsequently to accept. From CCMC [25], Falk continued his
research into the organization, delivery, and financing of health in the United States, which led him to the Office of Research and Statistics of the Social Security Administration, the United States’ Steelworkers, and to Yale’s Department of Epidemiology and Public Health as its first Professor of Public Health in Medical Care. Dr. Falk is now Emeritus Professor of Public Health [26] and, as was true of his mentor, will simply not slow down to enjoy retirement. He is not only in constant demand as a consultant and expert witness before Congressional committees, not only the chairman of the technical committee which prepared the fundamental principles and framework for the most comprehensive of the national health insurance bills currently being debated, but is the Executive Director of Connecticut’s first health maintenance organization, the Community Health Care Center Plan. And, as you shall see, Professor Falk is as eloquent as he is indefatigable.”

PROFESSOR FALK: “The economics of medical care—now receiving much public attention—was among the many and diverse fields in which Winslow pioneered. As early as 1915, when he was called to Yale, he was already teaching the importance for public health of dealing with economic barriers to medical care.

“By the mid-1920s, the medical care system of the country was heading toward grave difficulties from the increasing complexities of newly developing medical specializations and from rising medical costs. In 1926–27, Winslow was one of a small group of experts that organized the Committee on the Costs of Medical Care for a comprehensive five-year program of studies of national medical practices, needs and costs; and, as Chairman of its Executive Committee, he guided it throughout its course. He was grievously disappointed when in late 1932 the Committee’s Final Report [27] which advocated a broad national health and medical care program came to disaster. Most of its main proposals for improvement of medical care clearly intended mainly voluntary actions of local communities. Nevertheless, disaster resulted mainly because the leadership of ‘organized medicine’ dissented from the Committee’s recommendations for development of group practice and group payment for medical care and, instead, committed the medical organization to solo practice of physicians and to fee-for-service financing of the services.

“Later in the 1930s, when the nation was in deep economic depression and health and medical care needs far exceeded the capacities of state and local governments and of voluntary agencies, the Federal Government was compelled to assume national leadership for both community-wide and personal health services. At the National Health Conference of 1938, Winslow spoke in support of a national program which included proposals for Federal grants that would encourage broad health program developments and that would permit the states to elect either voluntary or compulsory medical care insurance systems [28]. He spoke eloquently, striving to avoid a persisting schism between those who advocated continuing professional dominance and those who sought practical achievements through collaboration of professional, non-professional, and governmental leaderships. That was the occasion of Winslow’s conversion from main reliance on voluntarism to overt support of national governmental action. From that time on, he never wavered in giving active support to proposals for a substantial role for government in safeguarding and advancing the availability of medical care services for the population.

“Between 1938 and his last active years in the 1950s, Winslow supported governmental and private leaders in advocating an effective national health program, including national health insurance. But they were years of stalemate and frustration because of inability to resolve or to compromise differences among groups with conflict of interests and objectives. While stalemate persisted, the technology of
medical care continued to make unprecedented progress. The organizational and economic aspects of medical care drifted steadily toward an oncoming crisis, caught up in controversy between professional insistence on controls and dominances, on the one hand, and consumer interests on the other. Nor was crisis avoided when Medicare and Medicaid were enacted in 1965, giving some help to the aged and the poor but failing to deal with the needs of most of the population who were neither the aged nor the poor, and creating new difficulties for medical care in general.

“In 1968–69, the drift had gone so long and so far that the deficiencies in medical care practice and the escalation of its costs had reached intolerable levels. The late Walter Reuther, then President of the United Auto Workers union, and his colleagues at UAW, led the organization of the Committee for National Health Insurance. It brought together about 100 leaders from many walks of life to engage in formulating a newer system of proposals to deal with the needs for the better availability of medical care and for the better performance of the medical care system. The Health Security Program which took form quickly became the leading proposal for national health insurance and invited a plethora of adapted and countervailing proposals on the Congressional stage.

“Since Walter Reuther’s tragic death in a plane accident in 1970, the Health Security Program has been led by Leonard Woodcock who succeeded him as President of UAW. Here is the prototype of the best in labor union leadership which devotes itself to winning for all members of our society what it seeks for its own membership—a good life, good and safe jobs, and broad economic security, good housing for the family, with well protected civil rights and without avoidable discriminations—with health and well-being—all within the framework and the resources of our democratic society. And a leadership whose perspective does not stop at our shores but undertakes to contribute what it can to advance the well-being of people everywhere.

“Such a leader is Leonard Woodcock. His activities, at home and abroad, have heralded him not merely a statesman in labor-union leadership but also a wise national and international counsellor for the welfare of people generally. In these respects, his devotion and skillful efforts for the improvement of health services and the advancement of national health and well-being are truly in the Winslow tradition. His orientation derives not from the perspectives of the public health professional but from the deprivations and the needs of people who hope for better community and personal health services which are within our reach but are not yet within their grasp.

I am greatly pleased to introduce Leonard Woodcock, until a fortnight ago President and now President Emeritus of the United Auto Workers, to address us on ‘A Health Security Program for the People of the United States’.”

MR. WOODCOCK: “It is traditional in most professional fields to call upon a fellow professional to assess the contributions and praise the accomplishments of a leader in that field. I hope that it is significant that this distinguished body has called upon a layman to help commemorate Dr. Charles-Edward Amory Winslow on the occasion of the 100th anniversary of his birth. I hope that it is significant in a very specific way that honors his memory. More than twenty years ago, Professor Winslow spoke of the desirability in health education of a two-way process. He said, ‘Cooperative analysis of our health problems is not merely a subtle form of salesmanship of a predetermined program. The program itself is far sounder if worked out in an honest and open discussion, in which the experts and the public participate, than if it is prepared by the expert alone in his ivory tower.’ In being here today, I feel that in some sense I am accepting Professor Winslow’s invitation.
"I may say that I am especially grateful to have such an invitation from so distinguished a professional. In my experience in discussing health care issues, above all the need for a comprehensive, universal national health insurance program, I have not always sensed so warm a welcome from all health care professionals and their national associations.

"In dealing with so complex a career as that of Professor Winslow's one can only acknowledge its many-sidedness and develop at best a single theme. In the year of his death, the American Journal of Public Health chose to characterize Professor Winslow's life and career under 14 separate headings, with brief tributes from as many of his fellow professionals. He was characterized by the Journal as an administrative practice pioneer, association leader, bacteriologist, foe of the slum, health educator, historian, interpreter of the voluntary agency, medical care statesman, mental hygienist, nursing mentor, occupational hygienist, public health engineer, teacher, and world citizen. I suppose that any one of these might serve as the theme of extended remarks, but there are two very specific aspects of his career that seem to me to link his concerns most personally with my own.

"The first of these is certainly well known to you. When Yale University established the Department of Public Health in 1915, Dr. Winslow was appointed Anna M.R. Lauder Professor of Public Health and Chairman of the Department, and served in that capacity until his retirement in 1945. The link may not be so obvious. But when the Committee for National Health Insurance was established, one of its first tasks was to appoint a Technical Committee to draft proposed legislation. To head that effort, our Committee turned to Yale and chose as the first and only Chairman of that Technical Committee, Professor I.S. Falk. His work has given substance and distinction to our efforts.

"The second concerns Winslow's work as a pioneer in the field that has come to be called medical economics. He was one of the few who developed the Committee on the Costs of Medical Care in 1927 and helped to guide it through the five years culminating in the formulation of the first definitive national health program in 1932. That program urged organized group medical practice and group payment of medical care costs when those ideas were both new and highly controversial. The work of that Committee and its report and recommendations stand today as a landmark for those of us who have been working for the past nine years to shape and define and help bring into being an honest and genuine national health program. It is a landmark that reminds us of how far we have come and how far we have yet to go. And with all due respect to the efforts of the men and women who have labored mightily to bring about reform under the various laws that we have seen in the past decade, I must state that it seems to me that we still have more to do than we have yet done.

"In the light of a long and productive career such as that of Professor Winslow the nine years I have referred to is not a long time. Perhaps it seems longer than it was, given the special peculiarities of those nine years. These administrations that had no viable social or economic policies and the programs that meant most to us labored under the direction of a succession of do-nothings, enemies of the activities they were directing. Today, of course, as we continue to press for a total program, we are under obligation to respond to certain interim or transitional proposals for reform of the current system.

"We have testified in support of the Carter Administration's hospital cost containment proposal, H.R. 6575, within the framework of our belief that it is at best a modest proposal, no more than an appropriate beginning. We who advocate and have advocated complete reform of the current health care system are bound to
recognize that fact. Certainly hospital costs, which constitute over 40 percent of health care costs, should be contained and may be contained at least temporarily, as the experience of the Economic Stabilization Program showed.

“The bill, however, does not go far enough. It should be extended to include similar cost controls on increases in nursing home revenues. There are about 15,000 nursing homes providing some level of nursing care. Over half of the revenues of these institutions comes from Medicaid and Medicare. 80% of the nursing homes are private for profit operations. This contrasts with 10% of the short-term general hospitals. It is hardly surprising therefore that nursing home expenditures in the last two years increased almost a third more rapidly than even hospital expenditures. In fiscal 1975 over 1974 their expenditures increased 31.9%. In fiscal 1976 over 1975 their expenditures increased by 16.8%.

“It is hard to accept that these apparently unwarranted increases are due to excessive costs in providing patient care. On the contrary the voluminous testimony before Senator Moss’ Senate Subcommittee on the Aging and a number of in-depth state investigations, particularly in New York State, demonstrated that much of the care was substandard, callous and shocking. And many of the expenditures charged to public programs were for the personal profit and aggrandizement of the operators and had no relevance to patient care.

“Another basic problem is that, even in a limited period of time, restricting a cost containment program to hospitals will force up other system costs, such as physician fees and hospital outpatient charges. We are, naturally, concerned if temporary constraints on hospital costs are secured at the expense of increased cost escalation in out-of-pocket expenditures by consumers.

“One important and positive proposal of the bill is that limiting hospital capital expenditures. The Institute of Medicine of the National Academy of Sciences has told us that ‘There are significant surpluses of short-term hospital beds and that they are contributing significantly to rising hospital care costs’ [29]. It is time we had an effective national program limiting excess beds, and this is a good start. A standard of 4 beds per thousand population is probably a generous one. The allocation of beds based strictly on population probably needs to be tuned more finely so that areas of special need are able to get a greater proportion of the closed-end budget of new capital expenditures.

“But we believe that this section of the proposed legislation does not go far enough in dealing with the problem of existing excess beds which may be staffed or partially staffed although lying empty, or which may be occupied by patients who could be taken care of equally well in less intensive facilities or at home. Therefore, provisions should be added for local health systems agencies and state planning agencies to designate specific beds as “excess” and to mandate proportionate reductions in hospital reimbursement by all payers to those hospitals designated as having excess beds.

“That the present escalation of hospital costs makes no sense is well illustrated by the situation we face in Michigan. We are being asked to accept an average Blue Cross-Blue Shield premium increase of 12.4%. The current premium for a Chrysler worker with a family is already $147.05 per month, plus some $20 a month for dental coverage. This proposed increase comes at the same time that we are told that Blues’ subscribers in Michigan are using fewer hospital days per 1,000 than in the previous year. Hospital bed occupancy is down from the previous year. Average medical-surgical length of stay is also decreasing. Our members cannot understand how when fewer hospital services are being provided and fewer days of care are being used, costs continue to rise, apparently without regard to these factors.
Hospital technology and numbers of employees have been increasing rapidly each year with little consideration shown for the cost-to-benefit ratio of such expenditures. The number of employees per 100 patients in community hospitals has increased nationally from 252 in 1970 to 339 in 1975. In industry, as we know it, new technology is usually associated with lower unit costs. That is not the case in hospitals, where new technology is usually purchased not primarily to do the old job at a lower cost, but rather to do jobs in greater depth regardless of the price per unit of services and the volume of work performed.

We believe, therefore, that the Administration’s cost containment proposal is a necessary first step which will have limited usefulness in beginning to contain costs in one segment of the health economy. Because, however, it does not deal with all segments of the system and because it is transitional, it is not likely to have long term effect unless it is followed in short order by comprehensive legislation which will deal with the basic problems which require restructuring and refinancing of our health care system.

On May 16, 1977, at the UAW Convention in Los Angeles, President Carter indicated he recognized the limitations in the Administration’s first health care proposals and was committed to introduce comprehensive national health insurance legislation early next year.

We are often asked why the UAW has put so much effort into securing the passage of comprehensive national health insurance when our members already have among the best health insurance programs in the nation. But we know that we are not getting a sufficient quantity and quality of care for the exorbitant prices we are already paying.

We saw too and were frightened in 1975 by the specter of some thirty million Americans who lost their health insurance coverage when they lost their jobs. Tens of millions of Americans, including those who are union members, cannot afford the benefits the UAW has been able to negotiate. Millions of other Americans cannot get adequate care even if they have basic private and public health insurance. This is because care is not accessible in many of our urban and rural areas and because there are legions of specialists and sub-specialists and not enough family doctors.

Those who provide care are not accountable to those who pay for it. Too much of our collective bargaining monies go to pay hospitals and doctors, and our health is not being proportionately improved. And by most reliable estimates some forty million Americans under the age of 65 do not have adequate access to our health care system.

The health care issue has high priority for us for two other reasons. First, through our contracts with employers we represent probably the largest nongovernmental expenditures for health insurance. Last year alone negotiated UAW health care premiums were in excess of $1 1/2 billion. Second, to the UAW this is a part of our interest in the whole health care field for we are concerned about the health of the nation. We do not believe our member families live on an island apart from the rest of the population. Disease and social unrest are contagious. We are governed by the conviction that a better life for all members of our society makes possible a better life for those who labor in it.

This of course goes to numerous social problems beyond those in the traditional health care fields. We have a deep and continuing interest in occupational and environmental health. The barrage of new knowledge about the effect of occupational hazards on the health of workers which has come to attention in recent years has convinced us that much of the fruits of preventive medicine can be reaped by improving the workplace. The UAW has increased its professional staff, its commit-
teemen services and its legislative efforts in this area. Our members wholeheartedly support this program. Those knowledgeable of Dr. Winslow's writings would know this is wholly compatible with what he advocated so many years earlier.

"Nine years ago our many concerns about health problems crystallized. The UAW leadership recognized that our ability at the collective bargaining table to improve benefits, quality and access to decent health care was being more and more circumscribed. We recognized that costs were on the verge of getting completely out of hand. The problems as we understood them were in the health care system and in the society. We decided then the time had come to organize a broad national coalition, which became the Committee for National Health Insurance, and which has been working to develop a program containing the essential principles necessary for reform of services and refinancing of costs.

"We call it the Health Security program and it has been introduced in every Congress since the 91st. We intend to do our utmost to help the members of the 95th Congress enact a national health insurance bill based on principles contained in the Health Security program.

"There is no doubt that a great problem in our educational efforts has been the myth created by former President Nixon and carried on by former President Ford that we can't afford national health insurance—that it costs too much. When you consider the fact that in fiscal year 1976, we Americans spent an average of $638 for every man, woman and child for health care, you can understand that we are already over-spending without any national health insurance.

"As a nation, we spent $139 billion in fiscal year 1976 for health services without any national health insurance program. This is more than the total for national defense and it is rising much faster than defense costs, even with the B-1 bomber included. According to the Congressional Budget Office, by fiscal 1981 Congress will have to appropriate $13 billion more for Medicare and Medicaid alone than was appropriated in fiscal 1976. This is with no national health plan.

"We spend more of our Gross National Product for health than any European country, and they all have national health programs.

"So I am sure it was perfectly clear to Mr. Nixon that he had chosen the right audience when he appeared before the American Medical Association and criticized the Health Security bill as being too costly. He knew and Mr. Ford knew that the national health insurance costs they referred to were federal costs representing transfers from private premiums, state and local taxes and direct patient payments, and were not new costs.

"Under the Nixon and Ford Administrations, national health expenditures doubled from $69 billion in fiscal year 1969 to $139 billion in fiscal year 1976, while we tinkered with the costly and defective system but declined to institute meaningful controls and reforms.

"It is possible to go on and to cite numbers and assumptions and counter-assumptions. One assumption is, however, generally accepted. Health services will continue to absorb an increasing share of our nation's resources until such time as we have a national health insurance program which deals concurrently with reform of services and refinancing of costs.

"We believe the problem this nation faces in reforming our health care system is fairly simple. It is a problem of values, of priorities, not one of resources. We are the richest nation in the world. We spend more on personal health services than probably any other country. We have richly talented medical and scientific professionals who
have won more Nobel Prizes in medicine than any other nation. We have a splendid set of health care institutions; and in the face of this we continue to have a sick health care system.

"We believe that it is simply inconceivable that a nation with the assets just described is not able to provide access to full health services to all its citizens. When 61 other nations find it possible, no rational person can maintain it is beyond our grasp.

"There are two basic approaches in the national health insurance bills now before the Congress. The first is contained in the AMA’s bill and others like it. It asks the Congress to pass a law requiring employers to offer private health insurance plans to employees. In this respect, at least, the AMA has risen above principle and departed from its long-standing insistence on voluntarism. In other respects, the AMA remains consistent. There are no cost controls in the program, no quality safeguards, no incentives for reforms of the health care delivery system. And for the poor and near-poor, there are degrading and costly means tests based on sharing of premium costs according to tax liability. As a matter of fact, there are 91 different pigeonholes that poor individuals or families might fit into to decide how much of the health insurance premiums they must pay and how much the Federal Treasury will pay.

"The other basic approach to national health insurance involves a tax-financed program with budgeting of health expenditures. The fact that most hospital bills are now paid on a cost-plus basis has generated a blank check environment for the financing of hospital care. The fact that most physicians negotiate only with themselves what their fees should be and how often their services should be utilized by their patients makes the medical marketplace even more advantageous for suppliers than the oil or coffee producers.

"Under the Health Security bill’s budgeting procedures, hospitals and doctors would both be paid negotiated amounts based on annual budgets determined in advance. Participating providers would be required to accept payment from the program as payment in full; they could not charge patients additional amounts. Physicians would be entitled to reasonable fees or other methods of payment; but the amounts would be negotiated by the insurance program personnel on the local level and the representatives of the physicians. Hospitals would present prospective budgets relating both to their own internal and external services, and to other hospitals in the same area so that duplication of expensive and under-utilized services would be controlled. Needed but presently unavailable services, such as hospital-based home care, could be rapidly developed.

"The Health Security bill would be financed by a combination of payroll and general revenue taxes. The Medicare tax would be shifted into this program since everyone, including the elderly, would be covered. Employers would pay three-and-one-half percent of payroll. This is well within the percentage of payroll which large employers are now paying for comparable coverage under private group plans, and even small employers’ contributions are approaching this figure. The self-employed would pay 2.5 percent up to $24,000 income—or a maximum of about $600 for comprehensive coverage. The individual and payroll taxes would be matched by federal general revenues.

"Because the Health Security bill has provisions for system reform, because it eliminates the duplication of advertising, selling and administration and profits from hundreds of competing insurance companies, because it has budgeting and strict cost control, there is every indication that it could actually conserve billions of dollars
within a few years and certainly reduce sharply the runaway inflation that is so plaguing the health care system.

"Under a Health Security bill, we would substitute new and earmarked taxes for what people are now spending, and the country should save money. At the same time, access to quality care for all would be provided in a way consistent with the self-respect and dignity of the individual.

"During his campaign, President Carter made an exception for national health insurance in his pledge not to increase total federal expenditures as a percentage of gross national product. He said that he might be willing to add one or two percent of the GNP to federal spending to pay for a national health insurance program. That could mean some $18–$36 billion at the outset of a program that began in 1980, for example.

"We now have high hopes that we are beginning to see the light at the end of the tunnel. In addressing the UAW Convention on May 16th, President Carter indicated that he understands the problems in health care and said, 'We must move immediately to start bringing health care costs under control.' And he also stated the Administration is aiming to submit legislative proposals for national health insurance 'early next year.' We believe that the proper kind of program for America can be based on the principles enunciated by the President in April 1976 in an address to the Student National Medical Association. The major points President Carter made in 1976 included the following principles:

1. Coverage must be universal and mandatory. Every citizen must be entitled to the same level of comprehensive benefits.

2. Barriers to early and preventive care must be reduced in order to lower the need for hospitalization.

3. Benefits should be insured by a combination of resources: employer and employee shared payroll taxes and general tax revenues.

4. Uniform standards and levels of quality and payment must be approved for the nation as part of rational health planning.

5. Strong and clear cost and quality controls must be built into the program.

6. Rates for institutional care and physicians' charges must be set in advance.

7. Consumer representation in the development and administration of the health program should be assured.

8. Incentives for reorganization of delivery must be an essential part of the payment mechanism.

9. National priorities of need and feasibility should determine the stages of the system's implementation.

"Those are certainly principles with which, and within which, we can work together to bring to reality an idea whose time has surely come.

"I quoted Professor Winslow earlier about the usefulness of cooperative analysis and the superiority of programs that were prepared in that fashion over those emanating from an ivory tower. National health insurance is no ivory tower idea. Our program has been hammered out in the cooperative fashion that Professor Winslow advocated and has been tested, again and again, in public discussion. We do not fear such discussion, indeed we have pressed for it at every opportunity.

"In his essay 'The Idler,' Samuel Johnson wrote: 'To do nothing every man is ashamed and to do much, almost every man is unwilling or afraid. Innumerable
expedients have therefore been invented to produce motion without labor and employment without solicitude."

“We believe the time has come to abandon expediency, identify aimless motion, and to take needed action without fear.”

5. THE AMERICAN CITY

DR. MCCOLLUM: “C.-E.A. Winslow was a busy faculty member and he was also a busy citizen of New Haven. There were no town-gown problems as far as he was concerned. Professor Winslow considered the community to be his laboratory and concern about the community his responsibility. He considered decent housing an important contribution to the health of its citizens. And his concerns are equally valid today.” Dr. McCollum then called upon Mayor Logue to introduce the Honorable Kenneth Gibson, Mayor of Newark, New Jersey.

MAYOR LOGUE: “I think the circumstances of Mayor Gibson’s trip to New Haven is an eloquent statement as to what a day in the life of a mayor is really like. The City of Newark is currently renegotiating a contract with its police officers. These negotiations broke off at 5 A.M. this morning! With very little sleep, he was back at his desk and, a few hours later, he is here in New Haven to honor a commitment. His presence here indicates the stuff Mayor Gibson is made of. It is no wonder that he was recently elected chairman of the United States Conference of Mayors. Kenneth Gibson exemplified the best in municipal leadership.”

MAYOR GIBSON: “We are here today to honor the life and accomplishments of a man of vision, who, far more than most, looked beyond his own time and space and sought to achieve what should be rather than what was.

“Professor Winslow felt a kinship with engineers, believing that their training attracted and produced men with the quality of intellectual honesty and willingness to accept facts which are fundamental in science, social affairs, and character. As a planner concerned with housing and the urban environment much that we have accomplished today is owing to Professor Winslow’s genius.

“I too feel a kinship with Professor Winslow, not only because I am an engineer, but because we are both advocates for urban America. And as an advocate, I have often speculated about the future of American cities. What will our cities be like in the next decade? Bluetown and Redtown are two possibilities.

“Bluetown is characterized by evidence of human, physical, and economic development. Business, labor, government, and community leaders work cooperatively, planning and change is humanitarian, and public schools are as good as if not better than in the suburbs. I also see our cities as innovative and exciting laboratories, where new ideas and programs are readily demonstrated. I also see old buildings and neighborhoods preserved, rehabilitated, and diversified; clean streets; efficient and economic rapid and surface transportation; abundant investment opportunities for private capital unencumbered by bureaucratic red tape; programs for job training, placement, and counseling; our youth employed; and the fiscal health of our town secure and prospects bright. Discrimination and problems related to race have not been yet eliminated, but race is not a problem to be solved by minorities alone because whites in Bluetown comprise 45% of the city’s population. A final vision is that the state and federal governments, recognizing that Bluetown is a regional center for commerce, the arts, communications, entertainment, and education, contribute monies for the upkeep of these important and enriching regional services. I am an optimist. But I also envision another city emerging.

“Redtown has a population that is overwhelmingly poor. Its citizens are mostly the
elderly and the young. They are poorly educated, largely untrained, and require a substantial level of public care. Because housing is old and substandard, the incidence of fires and displacement is high; because many are unemployed, crime is omnipresent; and because welfare and health costs are excessive the rates of treatable illnesses and chronic disorders is also high. In Redtown human and corporate flight is significant, property abandonment substantial, the pathology of race and poverty extensive, government leadership narrow-minded and short-sighted, business timid and defensive, and those with clout and leadership skills corrupt. The economic health of Redtown is grim: Taxes are high, services are poor, and the financial future appears unsalvageable.

“How paradoxical that we are moving quietly and simultaneously toward both models. In some of our cities there is rebirth, revitalization, and renewal. In others there is no hope at all. Hope seems to be dependent upon our understanding of history, how well we address the problems of race, and money. In recent months, I have watched with interest several notable analysts and planners jump aboard President Carter’s bandwagon for fiscal conservatism. Some have said that we must limit federal spending in order to improve the economy. According to these analysts, the ‘give-away’ programs to the cities must be limited. Indeed, cities should no longer depend upon Washington at all; rather, they must ‘clean up their own act.’

"Of course, the analysts should be saying just the opposite. At no time has intergovernmental cooperation and planning been more necessary. Those of us at the street level, who occupy city halls, must work cooperatively with Washington to solve certain crucial issues. For example, we must learn how to deal with the fact that the budgets of our cities will become smaller. There will be less money and fewer jobs in our future cities. And our task will be to make such cities better managed, more responsive, and liveable with less money available to do the job. We can reduce services and costs to the bare minimum, but in so doing, I submit that we will have arrived in Redtown.

"We must also learn how to enhance the special character of each city and make them more livable, attractive, and suitable for social and economic development. To achieve this goal, we must assure that our cities are competitive with the suburbs—that schools, housing, and services are equal to or surpassing those that exist in the surrounding environs.

"A final need is for us to plan comprehensively. Changing demographic patterns, fluctuating job opportunities, reduced budgets, continued demands for services—all will have a profound effect on our urban environment. We must become more efficient, cost-effective, and better managed, but the rub is that we cannot do it alone. We need to effect a trilateral, cooperative relationship with labor, business, and local government. But the federal government must play the most significant role.

"To arrive in Bluetown rather than Redtown, our national government, without hesitation or equivocation, must confront and resolve the national crisis of unemployment and develop rational and equally humane policies respecting energy, health, transportation, housing, and welfare. We need the money, but we also need the direction and leadership to achieve goals that can only be forthcoming from Washington.

"Five years from now, ten years from now, our cities may become national nightmares. They may also become centers of social and economic rejuvenation. I do not know which will be our fate any more than Professor Winslow did. But I do know that we must individually and collectively call upon his vision, enthusiasm, dedication, and concern for the human condition in order to develop a national
commitment that will make our cities places that encourage rather than destroy humanity.”

6. INTERNATIONAL HEALTH

DR. MCCOLLUM: “Professor Winslow was often described as a world citizen and international statesman on matters relating to health. Loyal to his own nation, he was a discerning interpreter of the contributions of other nations and of international bodies like the League of Nations [30] and the World Health Organization. President Carter in his message to the World Health Assembly meeting in Geneva last month [31] emphasized the desirability and need for greater attention on the part of the United States to health problems in the developing nations and the cooperation and contribution by the United States in supplying the technology and training essential to better define problems and provide effective solutions. These words echo sentiments expressed by Winslow in earlier days. They are no less significant today.

“To introduce the annual Winslow speaker, I am pleased to call upon Dr. Edward M. Cohart, C.-E.A. Winslow Professor of Public Health. The Winslow chair was established at Yale from funds donated by an anonymous friend of the department. Dr. Cohart is the first occupant of the Winslow chair, which he has held with a devotion and scholarly dedication which Professor Winslow would have expected and admired.”

DR. COHART: “Professor Winslow had a long history of concern with problems of international health, dating back to 1917 and the Red Cross Mission to Russia [32]. Between World War I and II, he had served as a member of the Board of Directors of the International Health Division of the Rockefeller Foundation [33] and as an Expert Assessor of the Health Committee of the League of Nations [34]. During World War II, he wrote a paper on International Organization for Health for the Commission to Study the Organization of Peace [35]. In this document, he emphasized that after the war there would be urgent and immediate need for: (1) feeding the hungry, (2) caring for the sick, (3) controlling epidemic disease, (4) providing the essentials of community sanitation, and (5) protecting the health of mothers and children. He maintained that the only way to avoid postwar catastrophe from lack of services to meet these needs was to ‘develop an international world order which can effectively apply the results of modern medical science’ not only to the immediate postwar problems but also to the longer run health concerns of the international community of nations.

“In early 1948, Dr. Winslow wrote an account of the beginnings of the World Health Organization (International Conciliation, March 1948, Carnegie Endowment for International Peace) from the resolution submitted in San Francisco in 1945 by Brazil and China requesting that ‘a general Conference be convened within the next four months for the purpose of establishing an international organization’ to the establishment of an Interim Commission of the World Health Organization in July 1946 and the formal birth of WHO in February 1948. The Pan American Health Organization became the Regional Office for the Americas of WHO in 1949.

“The Pan American Health Organization was founded as the International Sanitary Bureau in 1902. I am sure we all participate with its Director General in celebrating the 75th anniversary of its birth and its many accomplishments over the years.

“Dr. Hector Acuña, the Director of the Pan American Health Organization is Mexican by birth. He received his medical education in Mexico and worked in international health for many years in Mexico’s Ministry of Health and Welfare,
eventually becoming Medical Director of its Office for Interamerican Cooperation in Public Health.

“In 1954 Dr. Acuña became a member of the Pan American Sanitary Bureau in which he served for the next 8 years as medical advisor to a number of Latin American countries. He also served for two years in WHO’s Regional Office for the Eastern Mediterranean where he was Chief Medical Advisor to Pakistan. He returned to Mexico in 1964 and held several private and public posts until 1971, when he was appointed Director of International Affairs in the Ministry of Health and Welfare. In 1974 Dr. Acuña was elected by the members of the 19th Pan American Sanitary Conference to his present position as Director of the Pan American Health Organization. One final biographical note that we consider very important. Dr. Acuña received his Master of Public Health degree in 1951 from Yale.

“Dr. Acuña, it is with great pleasure that I welcome an old friend back to Yale.”

DR. ACUNA: “I feel greatly honored to have been invited by Professor Ira V. Hiscock to share memories with you of Professor Charles-Edward Amory Winslow on the occasion of the centennial of his birth. I first met this illustrious man at Yale, in 1949, when I was preparing for my master’s degree in public health. All who came into contact with him, read his books, or discussed his opinions, knew him to be not only a dedicated scientist, a thinker of deep foresight, and a man of diverse interests, ideals and strong convictions, but also a humanitarian and a true internationalist with a broad perception of the great issues of the era. Indeed, many of his writings have a nearly prophetic ring, when placed in their time context.

“Professor Winslow was a prolific writer who covered an amazing variety of topics with equal ease. He was just as conversant with international health problems as with problems of ventilation in schools. He could take in one stride the widest issues and the most minute details.

“A quick look at his bibliography reveals the broad range of his interests, from mental health, physiology, nursing, health education, bacteriology, to industry or health insurance. In this rich flow of ideas, theories, demonstrations, and scientific knowledge, we find recurring trends that give some insight into the progression of Dr. Winslow’s thinking and work.

“Today, I would like to dwell on two specific themes in Professor Winslow’s writings, which highlight his scientific approach to public health and his repeated plea for international solidarity.

“Allow me first to draw your attention to a very important book that Dr. Winslow wrote at age 54, and which was published in 1931. I refer to Health on the Farm and in the Village [36]. This book is not a well-known opus and has too often been overlooked by the scientific community. Hardly any reference to it is encountered in bibliographies on the subject and seldom is it mentioned in award and memorial events. This omission may be attributed to the attention calling urban and industrial problems of the time. Yet that brilliantly written book from such a mature and sophisticated scientific researcher represents a landmark in the history of public health.

“From the first paragraph of the foreword, we are left musing on Dr. Winslow’s words: ‘I conceive the problem of rural health as the most vital of the entire field of public health.’ Throughout the study, Winslow the scientist analyzes the bacteriological, epidemiological, nutritional, administrative and housing problems of the village, as well as the villagers’ and physicians’ social behaviors, while Winslow the statesman draws immediate conclusions from the far-reaching consequence of poor rural health.
“Dr. Winslow perceived that rural health coverage could not be handled as a mere extension or adaptation of urban medical care. Rural health had its own pathology and clinical patterns which required different types of health personnel and delivery techniques from those of urban medical care; entailing a different community response. Rather than adapting urban solutions to rural problems, Dr. Winslow searched for countryside techniques and grass-root ways of acting to provide health services to rural populations. He underlined key problems and suggested valid solutions.

“A true follower of Edwin Chadwick, this era’s pioneer in the field of public health, Professor Winslow once more denounced the association of poverty and disease, underlining health deprivations in rural slums and the collective responsibility of society to solve these inadequacies. In his detailed analysis of the costs of rural health services, he subscribed to the idea of the late Hermann M. Biggs—acclaimed for his notable contributions to the cause of public health in the United States—that ‘public health is purchasable,’ and clearly established this principle’s corollary that ‘without money you cannot purchase public health.’ Moreover, Dr. Winslow demonstrated that the per capita costs of rural health services were higher than those of urban health services for achievement of similar results.

“Professor Winslow proposed two possible remedial actions: one concerned the reduction in costs of rural health services through utilization of appropriately trained rural manpower and use of unsophisticated techniques; the other dealt with the establishment of a combination of health insurance and tax-supported health services.

“In Health on the Farm and in the Village, Professor Winslow returned to his often expressed concern about the community. Community participation had to be the first resource since the health of the community is the ultimate goal of health services. The extent of his belief in this involvement was such that he saw the whole area of public health as a community enterprise. This belief is crystallized in his remembered definition: ‘Public Health is the science of preventing disease, prolonging life and efficiency through organized community effort.’ Professor Winslow consistently related all health initiatives or programs to community involvement. His later works increasingly outlined the new types of personnel envisioned and the new technologies that would bring the community to full and active participation. It is no wonder that some 50 years later we are struck by the pertinence of his proposals.

“Having covered the first point of my presentation, I would like now to turn to Dr. Winslow’s involvement in international public health.

“At the turn of the century, 75 years ago in December 1902, delegates from Costa Rica, Cuba, Chile, Mexico and the United States of America, met in Washington, D.C., to establish the International Sanitary Bureau, which was later to become the Pan American Health Organization and the Regional Office of the World Health Organization for the Americas. The following week, at the annual meeting of the American Public Health Association, in New Orleans, Louisiana, Dr. Winslow, then age 25, was elected to membership in the American Public Health Association. This marked the beginning of an international career for Dr. Winslow, who progressively immersed himself in major international public health issues. Whether in his capacity as consultant, delegate to the League of Nations and to the World Health Assembly, or expert on public health matters, Professor Winslow soon became the most vocal advocate of international cooperation in health. His well remembered sentence, ‘We are all members of one another,’ at the opening of the Fifth World Health Assembly in 1952, stamped his imprint on the World Health Organization.
"It would be interesting to know how many of Dr. Winslow's ideas actually influenced the steering of the Health Committee of the League of Nations and later of the World Health Organization, and how many of his earlier views were modified or expanded, following his international service.

"In 1951 Professor Winslow made his most important contribution to the publications of the World Health Organization. His monograph *The Cost of Sickness and the Price of Health* [37] established a permanent landmark in analyses of public health programs in developing countries. Most of the topics in this monograph reflect his early concerns about costs, manpower and technology in rural America.

"For 50 years the League of Nations, the World Health Organization and the Pan American Health Organization have tackled those very issues confronted by Dr. Winslow.

"The Pan American Health Organization’s objectives today fall along lines of action similar to those suggested by Professor Winslow. Prefacing the final strategy adopted by PAHO in public health, an assessment of the past decade’s achievements was recently undertaken which showed that, despite current progress in medicine, health care could not be made available to rural and marginal populations without instigating drastic changes in the coverage of services. A 1972 survey had shown that 40 percent of the 300 million inhabitants of Latin America and the Caribbean had no access to health services. The underserved populations were mainly in distant rural areas or in periurban slums. If things remained as they were, the demographic growth, particularly high in the above two areas, would sharply increase the number of underserved inhabitants during the next decade. By 1980, the rural population of Latin America and the Caribbean would reach 145 million and that of urban slums 50 million.

"In 1972, the Ministers of Health of this Hemisphere met in Santiago, Chile, and approved the Ten-Year Health Plan for the Americas, by which countries committed themselves to bringing basic health care to all peoples within a decade. This goal could not be attained within the framework of health services of the period; drastic changes were needed in our approach to health care. Although the Pan American Health Organization had foreseen them and called public attention to the radical measures that were necessary, two or three years went by before the magnitude of such changes could be assessed; because they affected the core concept of health care delivery, the structure of health services and the manpower and technology involved.

"Simultaneously, the countries were gaining experience in the strengthening of rural health services and between 1975 and 1977 a joint effort between these countries and the Pan American Health Organization resulted in a new strategy for the extension of health service coverage.

"This strategy is based on the fact that different populations present a continuum of health needs of varying complexity, ranging from basic health care that can be undertaken efficiently with simple resources and inexpensive techniques to complex services that require highly trained personnel, sophisticated equipment and advanced technology. We recognized that these needs could be met by a continuum of resources, organized into a system of progressive levels of care, as I am about to describe.

"Most of the simple and pressing health needs felt by the community can be satisfied by the community itself provided that it reaches a minimum of organization, and its leaders and voluntary and traditional health workers receive training, assistance, and support from the peripheral echelons of the system.

"The more complex needs of the population will require efficient coordination
between community resources and the network of existing health services. By efficient coordination, we mean management of patients through the different levels of care, so as to ensure comprehensive and high quality medical care with effective communications between these levels, for the training and supervision of personnel, and for the technical and logistical support required. In addition to the combined efforts of the community and the institutions, corresponding actions need to be taken in other sectors such as agriculture, labor, education and housing.

"In this proposed health system the major difficulties lie in the area of primary health care, in which three challenging issues have been identified. The first challenge is the participation by the community, meaning that the community should take an active part in the identification of its needs, in the decision-making, the organization and control of community services and the delivery of primary health care. Community participation in health requires definite support from the health services system. It implies that, within a short period of time, a whole network of health outposts—and this is the second of the challenges I was talking about—should be installed and equipped, communications established and staff trained and supervised to act as an articulation between the community and the health system. I would like to dwell a little longer on the third challenge, namely technology, because it is of a different nature from those just described. The concept of community participation and strengthening of health services presupposes the utilization of an appropriate technology.

"Presently available medical technology was developed through the years in the industrialized countries. It has been adopted by developing countries without significant modification and has now become so universal that no one today thinks of questioning it. Not only are hardware and software—the two components of technology—inseparable, but they often engender other advanced technologies in related areas. This makes it almost impossible to accept one set of techniques and reject another so that the technological package must be accepted as a whole. No alternatives are presently available to the so-called 'advanced technology.'

"The effects of advanced technology are particularly visible in the clinical field. In the area of diagnosis it has totally replaced the traditional methods, which were less precise perhaps, but far more simple and less costly. In fact, technology has become so inextricably intertwined with our clinical behavior and with the organizational patterns of modern medicine that it is almost impossible to distinguish one from the other.

"Although the effects of medical technology are the most apparent, those of other built-in technologies which may not be as obvious have, nevertheless, farther reaching consequences. I refer to educational technology which has a wide impact on the future behavior of health personnel, and to administrative and managerial technologies that invariably mold our mental image of the health services and their financing.

"In developing countries, the advanced technology is relatively well adapted to the more complex levels of care. On the contrary, most of the presently available technology clashes with our concepts of primary care and community participation. Because of its rigidity, technology could be the major obstacle to any radical change in the health services during the coming years.

"As no alternatives are yet available, the developing countries will have to establish a new policy on health technology. The first measure will be to scrutinize carefully all direct transfers of technology, remembering that Professor Winslow, though a highly sophisticated scientist, repeatedly advised against the indiscriminate use of technology.
"The second and most important measure will be the development in the countries of Latin America and the Caribbean of an 'appropriate technology' to meet the real needs of the majority of the population and the real needs of the health services. Special attention will be given to those techniques that may help bridge the gap between informal community health care mechanisms and those of the formal network of health services. As is often the case, it will be necessary, as a first step, to utilize intermediary technology, particularly in administration and planning, to identify priorities and steer research towards the areas where the new technology is most needed.

"In cooperation with the countries, PAHO is presently studying means for developing appropriate technology and the criteria it should follow. The desired technology should be low cost and utilize local materials and labor; it should be compatible with the cultural characteristics of the population, be fully understandable by the operators, and, if possible, by the users as well. It should be replicable in as many locations and situations as required by the coverage of health services.

"In summary, what we intend to develop is an autochthonous solution that will contribute to the self-confidence and self-reliance of the populations. To illustrate this last point, we used to favor in the past, in rural areas, the filtration of water through Berkefeld filters. However, these filters had to be imported, purchased and carefully maintained. We are now promoting successfully an alternative method which uses local sand and charcoal filters installed in pottery jars. The imported filters were certainly safer, when used, but they kept villages dependent on an external commodity, whereas the pottery jar filters, though more cumbersome, may be reproduced locally at no cost and contribute to the self-reliance of the community.

"In concluding, I would like to share with you my views on the role to be played by PAHO, academic institutions and other international organizations in the promotion of technical cooperation as opposed to technical assistance.

"In developing appropriate technology, PAHO and WHO cooperate with the countries in changing the traditional patterns of international exchanges. The Organization is progressively phasing out the mechanisms of technical assistance, through which very often advanced technology was indiscriminately applied in the countries.

"In contrast to this attitude, PAHO is moving towards mechanisms of technical cooperation by which the countries can exchange their experiences and mutually assist each other. Some results have already been obtained, particularly in the fields of elementary care, basic pharmacopoeia, and training of auxiliary personnel.

"What is needed now is the development of methodology rather than technology. Once the methodology is mastered, the technology will be produced. We realize that the development of universally valid methodologies is a far more difficult intellectual and scientific enterprise than the mere exporting of technology. It is, however, an enterprise without national boundaries and which has no vested interests to limit international cooperation. The role of the international scientific community, as I see it, is to recognize this area of research and devote some of its researchers' knowledge, time and resources to the more basic needs of rural and marginal communities.

"In the last few years we have come to realize that the most elementary health problems of the most deprived populations called for the simplest health services activities. This made it all the more difficult to reach an adequate solution. We believe it is time to apply our most penetrating analysis to the problems that weigh most on our populations. Thus we would follow the example of Professor Winslow, who, at the peak of his career, put his talent and time at the service of the health of his homeland's farmers."
7. CONCLUSION

DR. MCCOLLUM: "We have had a full and busy day and it remains only to thank those who helped make this celebration such a success. Several of the many are especially deserving of credit: Marianne Mazan, I.S. Falk, Kay Howe, Eric Mood, Marge Noyes, Martha Everett, Jennifer Harvey, Fran Nankee, Connie Payne, and Louis Kaplan.

"Of the many words written about C.-E.A. Winslow and that he himself wrote, I have selected two passages as representative of his career and his life and times. The first is Haven Emerson's [38] tribute to Winslow written a month after Winslow's death, and the second is the conclusion to one of Winslow's most memorable papers, 'Poverty and disease.' Emerson wrote:

'There he sat, our chairman over the years, nudging progress in public health. His respect for the realities of finance, politics, legislation, and contemporary public opinion restrained with reluctance his basic and enduring confidence in the limitless will for an ever-advancing human welfare which was his determination and purpose in life. His every attitude and response, his vivid concern as a professional practitioner of human biology set the tone of argument, project, and program' [39].

And Winslow himself wrote this:

"Since the days of John Simon [40], the public health movement has had a history of approximately one century. I have fought in the ranks of the health army for nearly half of those hundred years. You and I have determined that men should not sicken and die from polluted water, from malaria-breeding swamps, from epidemics of diphtheria, from tuberculosis. Those battles have been, in large measure, won. We must now determine that men shall not be physically and emotionally crippled by malnutrition, by lack of medical care, by social insecurity. If there are better ways than public housing, and sickness insurance, and social security let us find them. If not, let us move forward. . . . I urge those who do not agree with me to mend their ways; and those who do agree with me to go forward with hope and courage" [41].

"Ladies and Gentlemen, thank you for helping us to commemorate C.-E.A. Winslow Day." A reception and dinner followed, during which George A. Silver presented a spirited and poignant toast, responded to eloquently and graciously by Miss Anne Winslow, daughter of Professor and Mrs. Winslow, and at which the Dean of the School of Nursing, Donna Diers, read a telegram in tribute to Dr. Winslow.

REFERENCES

1. The C.-E.A. Winslow Papers, extending for over 250 linear feet, have been deposited in the "Contemporary Medical Care and Health Policy Collection" of Manuscripts and Archives, Yale University Library. Articles about Winslow have been mostly of a memorial nature. See, Ira V. Hiscock, "Charles-Edward Amory Winslow, February 4, 1877–January 8, 1957," Journal of Bacteriology 1957, 73, 295–96; "Charles-Edward Amory Winslow, 1877–1957," American Journal of Public Health 1957, 47, 153–67; John F. Fulton, "C.-E.A. Winslow, Leader in Public Health," Science 1957, 125, 1236; and Reginald M. Atwater, "C.-E.A. Winslow: An appreciation of a great statesman," American Journal of Public Health 1957, 47, 1065–70. Two additional monographs have valuable material about Winslow's contribution to epidemiology and medical care: Roy M. Acheson, "The epidemiology of Charles-Edward Amory Winslow," Journal of Epidemiology 1970, 91, 1–18, and Arthur J. Viseltear, Emergence of the Medical Care Section of the American Public Health Association, 1926–1948: A Chapter in the History of Medical Care in the United States (Washington: American Public Health Association, 1972).
2. William Thompson Sedgwick (1855–1921). Biologist, epidemiologist, educator, born in West Hartford, Connecticut. Sheffield Scientific School, Yale University, B.S. (1877); Johns Hopkins University, Ph.D. (1881); subsequently Professor and Head, Department of Biology and Public Health, M.I.T. (1883–1921). Revered teacher and mentor of Winslow. See, C.-E.A. Winslow, "William Thompson Sedgwick, 1855–1921," Journal of Bacteriology 1921, 6, 255–62 and E.O. Jordan, G.C. Whipple, and C.-E.A. Winslow, William Thompson Sedgwick; A Pioneer of Public Health (New York: Yale University Press, 1924).

3. "Sedgwick Memorial Medal for 1942 Awarded to Dr. C.-E.A. Winslow," American Journal of Public Health 1942, 32, 1416–17.

4. See Winslow's "Housing as a public health problem," ibid. 1937, 27, 56–61, "Opportunities and responsibilities of the health officer in connection with the Federal Housing Acts," ibid. 1938, 28, 1269–76, and "What is New Haven's housing problem?" Housing Advocate 1938, 1, 8–10.

5. W.T. Sedgwick, Principles of Sanitary Science and the Public Health With Special Reference to the Causation and Prevention of Infectious Disease (N.Y.: Macmillan, 1905).

6. In Winslow MSS, 32/2.

7. Falk, for example, taught at the University of Chicago and Yale, was Director of Research, Office of Research and Statistics, Social Security Administration, and is currently Executive Director, Community Health Care Center Plan, New Haven; Pond taught at Yale, was Assistant Surgeon General, United States Public Health Service, and is now Professor of Public Health, University of Pittsburgh; Willard is Dean, School of Medicine, University of Alabama; Anderson is Chairman, Department of Epidemiology and Biostatistics, University of Oklahoma; Nelbach is Executive Vice President, American Association for World Health, N.Y.C.; Watkins was a distinguished biometrician who taught at Yale before his untimely death; Greenburgh, now retired, was Executive Director, Division of Industrial Hygiene, New York State Department of Labor; Platt, also retired, was Director, National Society for the Prevention of the Blind, N.Y.C.; and Jordan, also retired, was Administrative Associate, Commonwealth Fund, N.Y.C.

8. For Winslow's philosophy about public health education, see his "The place of public health in a University," Science 1925, 62, 335–38 and "Department of Public Health, Yale University," (pp. 1–11) in Methods and Problems of Medical Education. Tenth Series (N.Y.: The Rockefeller Foundation, 1928).

9. See Winslow's presidential address, "Public health at the crossroads," American Journal of Public Health 1926, 15, 1075–85.

10. For Committee on Administrative Practice Papers, see Winslow MSS, 1/1/c. See, also, "Fifteen years of the Committee on Administrative Practice," American Journal of Public Health 1935, 25, 1296–1320.

11. For Committee on the Costs of Medical Care, see Winslow MSS, 11/5.

12. For New York State Ventilation Commission, see Winslow MSS, 12/14 and Winslow's "The practical significance of the work of the New York State Commission of Ventilation," Journal of Outdoor Life 1923, 20, 15–17.

13. "Public health is the science and art of preventing disease, prolonging life, and promoting physical and mental health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health." See Winslow's "Untilled fields of public health," Science N.S., 1920, 51, 22–33.

14. John Rodman Paul (1893–1971) Clinical epidemiologist and leading researcher in poliomyelitis. Princeton, B.A. (1915); Johns Hopkins, M.D. (1919); Director, Ayer Clinical Laboratory, Pennsylvania Hospital (1922–28); Yale School of Medicine (1928–66) as Professor and Chairman, Section of Preventive Medicine (1940–57), Professor of Epidemiology and Preventive Medicine (1958–61), and Professor Emeritus and Director, WHO Serum Bank (1961–66). Recipient of many awards and honors: United States Medal of Freedom (1946), Howard T. Ricketts Award (1954), Charles V. Chapin Award (1959) Kober Medal of the Association of American Physicians, D.Sc. (Hon.), University of Chicago, and John Phillips Memorial Award of the American College of Physicians (1963). Prolific writer of scientific articles and author of A History of Poliomyelitis (New Haven: Yale University Press, 1971).

15. See Winslow's "Report of Committee on Nursing Education," The Nation's Health 1922, 4, 1–8; Nursing and Nursing Education in the United States: Report of the Committee for the Study of Nursing Education (New York: Macmillan, 1923); "Nursing education: its past, and its future," Modern Hospital 1925, 25, 237–40; and "The nursing problem," New England Journal of Medicine 1929, 200, 267–70.

16. For information about Yale School of Nursing, see Winslow MSS (Addition, 1975).

17. See Winslow and L. Greenburg, "The thermo-integrator . . . .", Transactions of the Society of Heating and Ventilation Engineers 1935, 41, 149–55.

18. See, for example, Winslow, A.P. Gagge, and L.P. Herrington, "Thermal interchange between the human body and its atmospheric environment," American Journal of Hygiene 1937, 26, 84–102, ibid., "Physiological reactions of the human body to various atmospheric humidities," American Journal of Physiology 1937, 120, 288–99 and "The influence of air removal upon health losses from the clothed human body," ibid. 1939, 127, 505–18.

19. See Winslow MSS, 6/8.
20. Mrs. Winslow was co-author of two of her husband's papers and helped with countless others. Professor Winslow inscribed his first paper to Mrs. Winslow as follows: "I inscribe this first copy of the first essay... to you, to whom all that I do and all that I am belongs." Winslow MSS, 32/3.

21. Mary Sewell Gardner (1876–1961). Pioneer of public health nursing was born in Providence, Rhode Island. R.N., M.A. from Newport (R.I.) Hospital; Director, Providence District Nursing Association; recipient of Walter Burns Saunders Medal (1931); Fellow, American Public Health Association; Honorary President, National Organization for Public Health Nursing. Author of standard textbook in public health nursing (1916) which went into two editions, referred to by Winslow as "an inspiration and rallying point for a whole profession."

22. Harriet Lauder Greenway, prominent member of the Lauder family who, in 1914, donated $400,000 for the establishment of a Department of Public Health. Wife of Dr. James Greenway, founder and director of the Department of University Health, Yale University.

23. Mary Breckinridge (1881–1965). Nurse-midwife. Native of Tennessee, but spent entire adult life in Kentucky. Graduate of St. Luke's Hospital, N.Y.C. Surveyed health needs of the hill people in Kentucky. Studied midwifery in England and established Committee for Mothers and Babies in Hyden, Kentucky. Director, Frontier Nursing Service. See Ernest Poole, Nurses on Horseback (New York: Macmillan, 1932).

24. In 1957, editors of the American Journal of Public Health paid tribute to the memory of Winslow with a memorial number in which fourteen of his colleagues wrote about Winslow's many contributions to the various disciplines of public health. The areas covered were: administrative practice, the American Public Health Association, bacteriology, urban problems, health education, history, voluntary agencies, medical care, mental hygiene, nursing, occupational health, public health engineering, international health, pedagogy. See American Journal of Public Health 1957, 47, 153–67.

25. See "The Committee on the Costs of Medical Care—25 years of progress," ibid. 1958, 48, 979–1002, and L.S. Falk, "Medical Care in the U.S.A., 1932–1972; Problems, Proposals and Programs from the Committee on the Costs of Medical Care to the Committee for National Health Insurance," Milbank Memorial Fund Quarterly/Health and Society 1973, 51, 1–32.

26. Professor Falk has recently designated Yale's "Contemporary Medical Care and Health Policy Collection" as the eventual depository for his personal papers and manuscripts.

27. Medical Care for the American People. Final Report of the Committee on the Costs of Medical Care. Publication No. 28 (Chicago: University of Chicago Press, 1932). The Final Report has recently been republished by Arno Press (1972).

28. See Winslow MSS, 12/12 and 12/(Addition, 1975). See also Viseltar, op. cit. (n. 1), p. 7.

29. Institute of Medicine, Controlling the Supply of Hospital Beds; A Policy Statement (Washington, D.C.: National Academy of Sciences, 1976).

30. See Winslow MSS, 7/19.

31. "President's Message to the President and the Members of the World Assembly Meeting in Geneva, Switzerland, May 5, 1977," Weekly Compilation of Presidential Papers May 16, 1977, 13, 686.

32. See Winslow MSS, 24/5.

33. Ibid., 9/37.

34. Ibid., 7/6.

35. Winslow, International Organization for Health (New York: Committee to Study the Organization of Peace, 1944). See, also, "International co-operation in the service of health," Annals of the American Academy of Political and Social Science 1951, 273, 192–200.

36. Winslow, Health on the Farm and in the Village (New York: Macmillan, 1931).

37. Winslow, The Cost of Sickness and the Price of Health. World Health Monograph Series, No. 7 (Geneva: World Health Organization, 1951).

38. Haven Emerson (1874–1957). Clinician, public health administrator, educator. College of Physicians and Surgeons, M.D. (1899). General medical practice and clinical research and teaching (1899–1913); Sanitary Superintendent and Commissioner of Health, N.Y.C. (1914–17); University teaching at Columbia University as Professor of Public Health Administration (1920–49). Recipient of Sedgwick Medal (1935) and Lasker Award (1949). President of the American Public Health Association (1933–34). Author of numerous papers and survey reports on clinical medicine, poliomyelitis, public health, tuberculosis, etc. See Selected Papers of Haven Emerson (Battle Creek: W.K. Kellogg Foundation, 1949).

39. Haven Emerson, "C.-E.A. Winslow: Administrative Practice Pioneer," American Journal of Public Health, 1957, 47, 154.

40. John Simon (1816–1904). First Medical Officer of Health of the City of London (1848); later medical officer to Privy Council. Principal author of numerous public health reports and sanitary surveys depicting health and disease in Victorian England. See his Public Health Reports (1887) and English Sanitary Institutions (1890).

41. Winslow, "Poverty and disease," American Journal of Public Health 1948, 38, 173–84. See also Viseltar, op. cit. (n. 1), p. 20.
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