79th Congress }
1st Session } SENATE COMMITTEE PRINT NO. 1

NATIONAL HEALTH ACT OF 1945

REPORT

TO THE

COMMITTEE ON EDUCATION AND LABOR

RELATING TO

THE BILL (S. 1606) TO PROVIDE FOR A NATIONAL HEALTH PROGRAM

NOVEMBER 26, 1945

Printed for the use of the Committee on Education and Labor

UNITED STATES
GOVERNMENT PRINTING OFFICE
79189 WASHINGTON : 1946

COMMITTEE ON EDUCATION AND LABOR

JAMES E. MURRAY, Montana, *Chairman*

DAVID I. WALSH, Massachusetts
ELBERT D. THOMAS, Utah
CLAUDE PEPPER, Florida
ALLEN J. ELLENDER, Louisiana
LISTER HILL, Alabama
DENNIS CHAVEZ, New Mexico
JAMES M. TUNNELL, Delaware
JOSEPH F. GUFFEY, Pennsylvania
OLIN D. JOHNSTON, South Carolina
J. W. FULBRIGHT, Arkansas

ROBERT M. LA FOLLETTE, JR., Wisconsin
ROBERT A. TAFT, Ohio
GEORGE D. AIKEN, Vermont
JOSEPH H. BALL, Minnesota
H. ALEXANDER SMITH, New Jersey
WAYNE MORSE, Oregon
FORREST C. DONNELL, Missouri

CHARLES A. MURRAY, *Clerk*
PAUL SAMPLE, *Assistant Clerk*
JOSEPH P. MCMURRAY, *Economic Consultant*

LETTER OF TRANSMITTAL

UNITED STATES SENATE,
COMMITTEE ON EDUCATION AND LABOR,
November 26, 1945.

To the Members of the Committee on Education and Labor:

There is herewith transmitted for the use of the members of the Committee on Education and Labor in convenient compact form relevant information concerning a national health program.

The Committee on Education and Labor is charged with the responsibility for considering proposals relating to health. In order to carry out that responsibility it is necessary that essential documents and views be brought to the committee's attention from time to time, particularly on legislation pending before the committee. In this way members of the committee can be better informed prior to and during hearings on legislation.

Sincerely,

JAMES E. MURRAY, *Chairman.*

CONTENTS

NATIONAL HEALTH ACT OF 1945

MESSAGE FROM THE PRESIDENT OF THE UNITED STATES TRANSMITTING HIS REQUEST FOR LEGISLATION FOR ADOPTION OF A NATIONAL HEALTH PROGRAM

NOVEMBER 19, 1945.—Referred to the Committee on Education and Labor

To the Congress of the United States:

In my message to the Congress of September 6, 1945, there were enumerated in a proposed economic bill of rights certain rights which ought to be assured to every American citizen.

One of them was "the right to adequate medical care and the opportunity to achieve and enjoy good health." Another was the "right to adequate protection from the economic fears * * * sickness * * *."

Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.

The people of the United States received a shock when the medical examinations conducted by the Selective Service System revealed the widespread physical and mental incapacity among the young people of our Nation. We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently in terms which all of us can understand.

As of April 1, 1945, nearly 5,000,000 male registrants between the ages of 18 and 37 had been examined and classified as unfit for military service. The number of those rejected for military service was about 30 percent of all those examined. The percentage of rejection was lower in the younger age groups and higher in the higher age groups, reaching as high as 49 percent for registrants between the ages of 34 and 37.

In addition, after actual induction, about a million and a half men had to be discharged from the Army and Navy for physical or mental disability, exclusive of wounds; and an equal number had to be treated in the armed forces for diseases or defects which existed before induction.

Among the young women who applied for admission to the Women's Army Corps there was similar disability. Over one-third of those examined were rejected for physical or mental reasons.

These men and women who were rejected for military service are not necessarily incapable of civilian work. It is plain, however, that they have illnesses and defects that handicap them, reduce their working capacity, or shorten their lives.

It is not so important to search the past in order to fix the blame for these conditions. It is more important to resolve now that no American child shall come to adult life with diseases or defects which can be prevented or corrected at an early age.

Medicine has made great strides in this generation, especially during the last 4 years. We owe much to the skill and devotion of the medical profession. In spite of great scientific progress, however, each year we lose many more persons from preventable and premature deaths than we lost in battle or from war injuries during the entire war.

We are proud of past reductions in our death rates. But these reductions have come principally from public health and other community services. We have been less effective in making available to all of our people the benefits of medical progress in the care and treatment of individuals.

In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future unless government is bold enough to do something about it.

People with low or moderate incomes do not get the same medical attention as those with high incomes. The poor have more sickness, but they get less medical care. People who live in rural areas do not get the same amount or quality of medical attention as those who live in our cities.

Our new economic bill of rights should mean health security for all, regardless of residence, station, or race—everywhere in the United States.

We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation.

There are five basic problems which we must attack vigorously if we would reach the health objectives of our economic bill of rights.

1. The first has to do with the number and distribution of doctors and hospitals. One of the most important requirements for adequate health service is professional personnel—doctors, dentists, public health and hospital administrators, nurses, and other experts.

The United States has been fortunate with respect to physicians. In proportion to population it has more than any large country in the world, and they are well trained for their calling. It is not enough, however, that we have them in sufficient numbers. They should be located where their services are needed. In this respect we are not so fortunate.

The distribution of physicians in the United States has been grossly uneven and unsatisfactory. Some communities have had enough or even too many; others have had too few. Year by year the number in our rural areas has been diminishing. Indeed in 1940 there were 31 counties in the United States, each with more than a thousand inhabitants, in which there was not a single practicing physician. The situation with respect to dentists was even worse.

One important reason for this disparity is that in some communities there are no adequate facilities for the practice of medicine. Another reason—closely allied with the first—is that the earning capacity of the people in some communities makes it difficult if not impossible for doctors who practice there to make a living.

The demobilization of 60,000 doctors and of the tens of thousands of other professional personnel in the armed forces is now proceeding on a large scale. Unfortunately, unless we act rapidly, we may expect to see them concentrate in the places with greater financial resources and avoid other places, making the inequalities even greater than before the war.

Demobilized doctors cannot be assigned. They must be attracted. In order to be attracted, they must be able to see ahead of them professional opportunities and economic assurances.

Inequalities in the distribution of medical personnel are matched by inequalities in hospitals and other health facilities. Moreover, there are just too few hospitals, clinics, and health centers to take proper care of the people of the United States.

About 1,200 counties, 40 percent of the total in the country, with some 15,000,000 people, have either no local hospital or none that meets even the minimum standards of national professional associations.

The deficiencies are especially severe in rural and semirural areas and in those cities where changes in population have placed great strains on community facilities.

I want to emphasize, however, that the basic problem in this field cannot be solved merely by building facilities. They have to be staffed; and the communities have to be able to pay for the services. Otherwise the new facilities will be little used.

2. The second basic problem is the need for development of public-health services and maternal and child care. The Congress can be justifiably proud of its share in making recent accomplishments possible. Public-health and maternal and child-health programs already have made important contributions to national health. But large needs remain. Great areas of our country are still without these services. This is especially true among our rural areas; but it is true also in far too many urban communities.

Although local public health departments are now maintained by some 18,000 counties and other local units, many of these have only skeleton organizations, and approximately 40,000,000 citizens of the United States still live in communities lacking full-time local public-health service. At the recent rate of progress in developing such service, it would take more than a hundred years to cover the whole Nation.

If we agree that the national health must be improved, our cities, towns, and farming communities must be made healthful places in which to live through provision of safe water systems, sewage-disposal plants, and sanitary facilities. Our streams and rivers must be safeguarded against pollution. In addition to building a sanitary environment for ourselves and for our children, we must provide those services which prevent disease and promote health.

Services for expectant mothers and for infants, care of crippled or otherwise physically handicapped children, and inoculation for the prevention of communicable diseases are accepted public health functions. So, too, are many kinds of personal services such as the diagnosis and treatment of widespread infections like tuberculosis and venereal disease. A large part of the population today lacks many or all of these services.

Our success in the traditional public health sphere is made plain by the conquest over many communicable diseases. Typhoid fever, smallpox, and diphtheria—diseases for which there are effective controls—have become comparatively rare. We must make the same gains in reducing our maternal and infant mortality, in controlling tuberculosis, venereal disease, malaria, and other major threats to life and health. We are only beginning to realize our potentialities in achieving physical well-being for all our people.

3. The third basic problem concerns medical research and professional education.

We have long recognized that we cannot be content with what is already known about health or disease. We must learn and understand more about health and how to prevent and cure disease.

Research—well-directed and continuously supported—can do much to develop ways to reduce those diseases of body and mind which now cause most sickness, disability, and premature death—diseases of the heart, kidneys, and arteries, rheumatism, cancer; diseases of childbirth, infancy, and childhood; respiratory diseases; and tuberculosis. And research can do much toward teaching us how to keep well and how to prolong healthy human life.

Cancer is among the leading causes of death. It is responsible for over 160,000 recorded deaths a year and should receive special attention. Though we already have the National Cancer Institute of the Public Health Service, we need still more coordinated research on the cause, prevention, and cure of this disease. We need more financial support for research and to establish special clinics and hospitals for diagnosis and treatment of the disease especially in its early stages. We need to train more physicians for the highly specialized services so essential for effective control of cancer.

There is also special need for research on mental diseases and abnormalities. We have done pitifully little about mental illnesses. Accurate statistics are lacking, but there is no doubt that there are at least 2,000,000 persons in the United States who are mentally ill, and that as many as 10,000,000 will probably need hospitalization for mental illness for some period in the course of their lifetime. A great many of these persons would be helped by proper care. Mental cases occupy more than one-half of the hospital beds, at a cost of about $500,000,000 per year—practically all of it coming out of taxpayers' money. Each year there are 125,000 new mental cases admitted to institutions. We need more mental-disease hospitals, more out-patient clinics. We need more services for early diagnosis, and especially we need much more research to learn how to prevent mental break-down. Also, we must have many more trained and qualified doctors in this field.

It is clear that we have not done enough in peacetime for medical research and education in view of our enormous resources and our national interest in health progress. The money invested in research pays enormous dividends. If any one doubts this, let him think of penicillin, plasma, DDT powder, and new rehabilitation techniques.

4. The fourth problem has to do with the high cost of individual medical care. The principal reason why people do not receive the care they need is that they cannot afford to pay for it on an individual basis at the time they need it. This is true not only for needy persons. It is also true for a large proportion of normally self-supporting persons.

In the aggregate, all health services—from public health agencies, physicians, hospitals, dentists, nurses, and laboratories—absorb only about 4 percent of the national income. We can afford to spend more for health.

But 4 percent is only an average. It is cold comfort in individual cases. Individual families pay their individual costs and not average costs. They may be hit by sickness that calls for many times the average cost—in extreme cases for more than their annual income. When this happens they may come face to face with economic disaster. Many families, fearful of expense, delay calling the doctor long beyond the time when medical care would do the most good.

For some persons with very low income or no income at all we now use taxpayers' money in the form of free services, free clinics, and public hospitals. Tax-supported, free medical care for needy persons, however, is insufficient in most of our cities and in nearly all of our rural areas. This deficiency cannot be met by private charity or the kindness of individual physicians.

Each of us knows doctors who work through endless days and nights, never expecting to be paid for their services because many of their patients are unable to pay. Often the physician spends not only his time and effort but even part of the fees he has collected from patients able to pay, in order to buy medical supplies for those who cannot afford them. I am sure that there are thousands of such physicians throughout our country. They cannot, and should not, be expected to carry so heavy a load.

5. The fifth problem has to do with loss of earnings when sickness strikes. Sickness not only brings doctor bills; it also cuts off income.

On an average day, there are about 7,000,000 persons so disabled by sickness or injury that they cannot go about their usual tasks. Of these, about 3¼ millions are persons who, if they were not disabled, would be working or seeking employment. More than one-half of these disabled workers have already been disabled for 6 months; many of them will continue to be disabled for years and some for the remainder of their lives.

Every year, four or five hundred million working days are lost from productive employment because of illness and accident among those working or looking for work—about 40 times the number of days lost because of strikes, on the average, during the 10 years before the war. About nine-tenths of this enormous loss is due to illness and accident that is not directly connected with employment and is therefore not covered by workmen's compensation laws.

These then are the five important problems, which must be solved if we hope to attain our objective of adequate medical care, good health, and protection from the economic fears of sickness and disability.

To meet these problems, I recommend that the Congress adopt a comprehensive and modern health program for the Nation, consisting of five major parts, each of which contributes to all the others.

FIRST. CONSTRUCTION OF HOSPITALS AND RELATED FACILITIES

The Federal Government should provide financial and other assistance for the construction of needed hospitals, health centers, and other medical, health, and rehabilitation facilities. With the help of Federal funds, it should be possible to meet deficiencies in hospital and health facilities so that modern services—for both prevention and cure—can be accessible to all the people. Federal financial aid should be available not only to build new facilities where needed but also to enlarge or modernize those we now have.

In carrying out this program, there should be a clear division of responsibilities between the States and the Federal Government. The States, localities, and the Federal Government should share in the financial responsibilities. The Federal Government should not construct or operate these hospitals. It should, however, lay down minimum national standards for construction and operation and should make sure that Federal funds are allocated to those areas and projects where Federal aid is needed most. In approving State plans and individual projects, and in fixing the national standards, the Federal agency should have the help of a strictly advisory body that includes both public and professional members.

Adequate emphasis should be given to facilities that are particularly useful for prevention of disease—mental as well as physical—and to the coordination of various kinds of facilities. It should be possible to go a long way toward knitting together facilities for prevention with facilities for cure, the large hospitals of medical centers with the smaller institutions of surrounding areas, the facilities for the civilian population with the facilities for veterans.

The general policy of Federal-State partnership which has done so much to provide the magnificent highways of the United States can be adapted to the construction of hospitals in the communities which need them.

SECOND. EXPANSION OF PUBLIC HEALTH, MATERNAL, AND CHILD-HEALTH SERVICES

Our programs for public health and related services should be enlarged and strengthened. The present Federal-State cooperative health programs deal with general public health work, tuberculosis and venereal disease control, maternal and child-health services, and services for crippled children.

These programs were especially developed in the 10 years before the war and have been extended in some areas during the war. They have already made important contributions to national health, but they have not yet reached a large proportion of our rural areas, and, in many cities, they are only partially developed.

No area in the Nation should continue to be without the services of a full-time health officer and other essential personnel. No area should be without essential public health services or sanitation facilities. No area should be without community health services, such as maternal and child-health care.

Hospitals, clinics, and health centers must be built to meet the needs of the total population and must make adequate provision for the safe birth of every baby and for the health protection of infants and children.

Present laws relating to general public health and to maternal and child health have built a solid foundation of Federal cooperation with the States in administering community health services. The emergency maternity and infant care program for the wives and infants of servicemen—a great wartime service authorized by the Congress—has materially increased the experience of every State health agency and has provided much-needed care. So, too, have other wartime programs, such as venereal disease control, industrial hygiene, malaria control, tuberculosis control, and other services offered in war essential communities.

The Federal Government should cooperate by more generous grants to the States than are provided under present laws for public health services and for maternal and child health care. The program should continue to be partly financed by the States themselves and should be administered by the States. Federal grants should be in proportion to State and local expenditures and should also vary in accordance with the financial ability of the respective States.

The health of American children, like their education, should be recognized as a definite public responsibility.

In the conquest of many diseases prevention is even more important than cure. A well-rounded national health program should, therefore, include systematic and widespread health and physical education and examinations, beginning with the youngest children and extending into community organizations. Medical and dental examinations of school children are now inadequate. A preventive health program, to be successful, must discover defects as early as possible. We should, therefore, see to it that our health programs are pushed most vigorously with the youngest section of the population.

Of course, Federal aid for community health services—for general public health and for mothers and children—should complement and not duplicate prepaid medical services for individuals, proposed by the fourth recommendation of this message.

THIRD. MEDICAL EDUCATION AND RESEARCH

The Federal Government should undertake a broad program to strengthen professional education in medical and related fields and to encourage and support medical research.

Professional education should be strengthened where necessary through Federal grants-in-aid to public and to nonprofit private institutions. Medical research, also, should be encouraged and supported in the Federal agencies and by grants-in-aid to public and nonprofit private agencies.

In my message to the Congress of September 6, 1945, I made various recommendations for a general Federal research program. Medical research, dealing with the broad fields of physical and mental illnesses, should be made effective in part through that general program and in part through specific provisions within the scope of a national health program.

Federal aid to promote and support research in medicine, public health, and allied fields is an essential part of a general research program, to be administered by a central Federal research agency. Federal aid for medical research and education is also an essential part of any national health program, if it is to meet its responsibilities for high-grade medical services and for continuing progress. Coordination of the two programs is obviously necessary to assure efficient use of Federal funds. Legislation covering medical research in a national health program should provide for such coordination.

FOURTH. PREPAYMENT OF MEDICAL COSTS

Everyone should have ready access to all necessary medical, hospital, and related services.

I recommend solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system. This is not socialized medicine.

Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk and to benefit the insured who actually suffers the loss. If, instead of the costs of sickness being paid only by those who get sick, all the people, sick and well, were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately served without overburdening anyone. That is the principle upon which all forms of insurance are based.

During the past 15 years, hospital insurance plans have taught many Americans this magic of averages. Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people's needs. Only about 3 or 4 percent of our population now have insurance providing comprehensive medical care.

A system of required prepayment would not only spread the costs of medical care, it would also prevent much serious disease. Since medical bills would be paid by the insurance fund, doctors would more often be consulted when the first signs of disease occur instead of when the disease has become serious. Modern hospital, specialist, and laboratory services, as needed, would also become available to all and would improve the quality and adequacy of care. Prepayment of medical care would go a long way toward furnishing insurance against disease itself, as well as against medical bills.

Such a system of prepayment should cover medical, hospital, nursing, and laboratory services. It should also cover dental care—as fully and for as many of the population as the available professional personnel and the financial resources of the system permit.

The ability of our people to pay for adequate medical care will be increased if, while they are well, they pay regularly into a common health fund instead of paying sporadically and unevenly when they are sick. This health fund should be built up nationally in order to establish the broadest and most stable basis for spreading the costs of illness and to assure adequate financial support for doctors and hospitals everywhere. If we were to rely on State-by-State action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross State boundary lines.

Medical services are personal. Therefore, the Nation-wide system must be highly decentralized in administration. The local administrative unit must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions. Locally as well as nationally, policy and administration should be guided by advisory committees in which the public and the medical professions are represented.

Subject to national standards, methods and rates of paying doctors and hospitals should be adjusted locally. All such rates for doctors should be adequate and should be appropriately adjusted upward for those who are qualified specialists.

People should remain free to choose their own physicians and hospitals. The removal of financial barriers between patient and doctor would enlarge the present freedom of choice. The legal requirement on the population to contribute involves no compulsion over the doctor's freedom to decide what services his patient needs. People will remain free to obtain and pay for medical service outside of the health-insurance system if they desire, even though they are members of the system; just as they are free to send their children to private instead of to public schools, although they must pay taxes for public schools.

Likewise physicians should remain free to accept or reject patients. They must be allowed to decide for themselves whether they wish to participate in the health-insurance system full time, part time, or not at all. A physician may have some patients who are in the system and some who are not. Physicians must be permitted to be represented through organizations of their own choosing, and to decide whether to carry on in individual practice or to join with other doctors in group practice in hospitals or in clinics.

Our voluntary hospitals, and our city, county, and State general hospitals, in the same way, must be free to participate in the system to whatever extent they wish. In any case they must continue to retain their administrative independence.

Voluntary organizations which provide health services that meet reasonable standards of quality should be entitled to furnish services under the insurance system and to be reimbursed for them. Voluntary cooperative organizations concerned with paying doctors, hospitals, or others for health services but not providing services directly, should be entitled to participate if they can contribute to the efficiency and economy of the system.

None of this is really new. The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have misnamed it "socialized medicine."

I repeat—what I am recommending is not socialized medicine.

Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed.

Under the plan I suggest, our people would continue to get medical and hospital services just as they do now—on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all-important difference: whether or not patients get the services they need would not depend on how much they can afford to pay at the time.

I am in favor of the broadest possible coverage for this insurance system. I believe that all persons who work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employees, Government employees, and employees of nonprofit institutions and their families.

In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies. Increased Federal funds should also be made available by the Congress under the public-assistance programs to reimburse the States for part of such premiums, as well as for direct expenditures made by the

States in paying for medical services provided by doctors, hospitals, and other agencies to needy persons.

Premiums for present social-insurance benefits are calculated on the first $3,000 of earnings in a year. It might be well to have all such premiums, including those for health, calculated on a somewhat higher amount such as $3,600.

A broad program of prepayment for medical care would need total amounts approximately equal to 4 percent of such earnings. The people of the United States have been spending, on the average, nearly this percentage of their incomes for sickness care. How much of the total fund should come from the insurance premiums and how much from general revenues is a matter for the Congress to decide.

The plan which I have suggested would be sufficient to pay most doctors more than the best they have received in peacetime years. The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists, and nurses for the services they render.

Federal aid in the construction of hospitals will be futile unless there is current purchasing power so that people can use these hospitals. Doctors cannot be drawn to sections which need them without some assurance that they can make a living. Only a Nation-wide spreading of sickness costs can supply such sections with sure and sufficient purchasing power to maintain enough physicians and hospitals.

We are a rich Nation and can afford many things. But ill health which can be prevented or cured is one thing we cannot afford.

FIFTH. PROTECTION AGAINST LOSS OF WAGES FROM SICKNESS AND DISABILITY

What I have discussed heretofore has been a program for improving and spreading the health services and facilities of the Nation and providing an efficient and less burdensome system of paying for them.

But no matter what we do, sickness will, of course, come to many. Sickness brings with it loss of wages.

Therefore, as a fifth element of a comprehensive health program, the workers of the Nation and their families should be protected against loss of earnings because of illness. A comprehensive health program must include the payment of benefits to replace at least part of the earnings that are lost during the period of sickness and long-term disability. This protection can be readily and conveniently provided through expansion of our present social-insurance system with appropriate adjustment of premiums.

Insurance against loss of wages from sickness and disability deals with cash benefits rather than with services. It has to be coordinated with the other cash benefits under existing social insurance systems. Such coordination should be effected when other social security measures are reexamined. I shall bring this subject again to the attention of the Congress in a separate message on social security.

I strongly urge that the Congress give careful consideration to this program of health legislation now.

Many millions of our veterans, accustomed in the armed forces to the best of medical and hospital care, will no longer be eligible for such care as a matter of right except for their service-connected disabilities. They deserve continued adequate and comprehensive health service. And their dependents deserve it too.

By preventing illness, by assuring access to needed community and personal health services by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic productivity. We shall increase the professional and economic opportunities of our physicians, dentists, and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people.

We need to do this expecially at this time because of the return to civilian life of many doctors, dentists, and nurses, particularly young men and women.

Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available. By meeting that demand we shall strengthen the Nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land.

HARRY S. TRUMAN.

THE WHITE HOUSE, *November 19, 1945.*

79489—46——3

JOINT STATEMENT BY SENATOR ROBERT F. WAGNER ON BEHALF OF HIMSELF, SENATOR MURRAY, AND REPRESENTATIVE DINGELL ON THE NATIONAL HEALTH ACT OF 1945

Mr. President, on behalf of myself and the distinguished chairman of the Committee on Education and Labor [Mr. Murray], I ask unanimous consent to introduce the bill (S. 1606) which I send to the desk and request that it be referred to the Committee on Education and Labor. The bill proposes to establish a national health program along the lines set forth by the President in his message on this subject just read. Representative Dingell has introduced a companion bill in the House of Representatives (H. R. 4730).

Mr. President, in 1939 I introduced a national health bill, which was considered by the Committee on Education and Labor. The bill was given a favorable report by a subcommittee, but because of the war no action was taken.

In 1940, I, with the Senator from Georgia [Mr. George], introduced a hospital construction bill. The bill was reported out favorably by the Committee on Education and Labor and passed by the Senate.

During the past 5 years I have continued to study very carefully the entire health problem. The bill introduced today is an improved bill. It is the result of the constructive suggestions of many outstanding medical authorities and of labor, farm, consumer, and health organizations interested in improving the Nation's health.

The need for a national health program has been proved many times. In restating the need I should like to quote from a statement, Principles of a Nation-Wide Health Program, issued last year by 29 leading health experts, including 13 outstanding doctors. Here is what these experts said:

> American medicine at its best is unsurpassed, but it is also beyond doubt that the medical facilities and services actually available to many of our people are far below the best or even the sufficient. There have been great achievements of the American medical profession, American hospitals, public health and welfare agencies in providing care for sickness, educating personnel, advancing medical knowledge, reducing and preventing disease. Nevertheless unmet needs for medical care are widespread and the burdens of sickness costs are heavy and sometimes overwhelming. There has been a gratifying reduction in the death rate, but the lowering of death rates is not an adequate measure of the extent to which medical care is available or needed. Moreover, the fact that death and disease rates are much greater in some States than in others, and greater among low than among high-income groups, demonstrates that there are still unmet needs and opportunities.
>
> Medical services should be made financially accessible to all through a national system of contributory health insurance, combined with taxation in behalf of people without sufficient income, preventive services and needed extensions and improvements of all facilities. In order that comprehensive service shall be available to all or most of the population and in order to minimize the administrative costs of acquiring members, it is essential that financial participation in the system be required by law. The contribution for medical-care insurance will not mean an added burden on the earnings of workers. The American people are now spending for physicians' services and hospitalization enough to provide for all with

only minor supplementation, if these payments are regularized, instead of falling with disastrous uncertainty. Place should be maintained for voluntary action by many agencies as well as for action by our National, State, and local governments.

The same basic facts and proposals were contained in the official statement of policy on Medical Care in a National Health Program adopted in October 1944 by the American Public Health Association. Here is what that association said in its official statement:

I. A large portion of the population receives insufficient and inadequate medical care, chiefly because persons are unable to pay the costs of services on an individual-payment basis when they are needed, or because the services are not available.

II. There are extensive deficiencies in the physical facilities needed to provide reasonably adequate services. Such facilities include hospitals, health centers, and laboratories. The needs are most acute in poor communities, in rural areas, and in urban areas where the population has increased rapidly or where the development of facilities has been haphazard or the financial support inadequate.

III. There are extensive deficiencies in the number and the distribution of personnel needed to provide the services. Here again, the needs vary according to categories of personnel and to characteristics of communities.

IV. There are extensive deficiencies in the number and categories of personnel qualified to administer facilities and services.

V. Many communities still are not served by public health departments; others inadequately maintain such departments. Thus, some communities have never utilized organized health work to reduce the burden of illness, and others share its benefits only in part. In these communities especially, people lack information on the benefits of modern medical care.

VI. Expansion of scientific research is urgently needed. Despite past and current scientific advances, knowledge as to the prevention, control, or cure of many diseases is lacking.

BRIEF SUMMARY OF HEALTH PROVISIONS

Mr. President, the bill which I have introduced includes five provisions which will make available basic health services to all the people wherever they may live and whatever their income may be.

First, the present Federal grants-in-aid to the States for public-health services are broadened and increased to speed up the progress of preventive and community-wide health services. It should therefore be possible, over a period of years, to assure that essential public-health services are available in all parts of the country, especially the rural areas which are so sadly in need of such services.

Second, the community-wide maternal and child-health services, aided by Federal grants to the States, are similarly broadened and strengthened.

Third, Federal grants-in-aid to the States are authorized for meeting the costs of medical care for needy persons.

At the present time there are 3,000,000 needy persons receiving cash assistance grants under Federal-State public assistance programs. However, Federal funds under existing laws cannot be used to match State or local expenditures which are made directly to doctors, dentists, nurses, hospitals, or other medical agencies.

By authorizing Federal grants to the States for meeting these direct medical expenditures, more adequate medical care will be made available to these persons; and hospitals and practitioners will receive more adequate compensation for their services.

Fourth, prepaid medical care is made available.

All four of the provisions which I have just mentioned will greatly help to round out the health services of the Nation. By preventing sickness, disability, and premature death, they will pay vast dividends in human welfare and, at the same time, reduce the costs of other public and private welfare programs. Unless we provide a method of spreading the cost of medical and hospital care, people will still not obtain the treatment they need.

Fifth, grants-in-aid are provided under the prepaid medical care plan to nonprofit institutions engaging in research or in professional education.

These 5 provisions are essential to the development of a broad national health program. They must, however, be supplemented by other provisions in order to assure a truly comprehensive national health program.

HOSPITAL CONSTRUCTION BILL

The Senate Committee on Education and Labor has already favorably reported out S. 191, the hospital survey and construction bill which will enable hospitals, clinics, and public health centers to be built in communities where they are needed. While the bill has several defects and inadequacies it is an important beginning. By constructing hospitals in rural areas, and other areas where they are needed, it will be possible to speed up the progress of comprehensive hospital care. In turn, the prepayment of medical care costs, including the costs of hospitalization, will assure the maintenance of the hospitals which will be built and will encourage the construction and improvement of needed hospitals. A sound hospital-construction program requires that there is also an insurance system to cover hospitalization costs in order to make sure that hospitals will be used by sick persons and that satisfactory wages, hours, and working conditions of hospital employees will insure high standards of hospital maintenance.

MEDICAL RESEARCH AND EDUCATION

The Senate Committee on Military Affairs already has before it legislation providing for the promotion of medical research and professional education. The passage of such legislation should help to advance medical discoveries, to improve the quality of medical research in our universities and medical schools, and to make it possible to give opportunities for further training and education to many more young men and women. At the present time many promising individuals are denied this opportunity because of lack of financial means and because of the restrictions which the medical schools apply particularly to persons of minority groups.

The National Health Act which I have introduced contains provision for medical research and education, particularly in section 314 (f) (1) and 314 (l) of the Public Health Service Act (pt. A of title I of the bill) and sections 121 and 123 of title I, and section 213 of title II of the bill.

The amended provisions in the Public Health Service Act will make additional Federal funds available to the States through the United States Public Health Service for public health research, training of personnel, public health education, and planning and coordination of health services and activities. Sections 121 and 123 will similarly provide for the training of personnel for maternal and child health and for crippled children's services.

Section 213 of the bill provides that, as a part of the prepaid medical care program, the Surgeon General is directed, with the advice of the National Advisory Medical Policy Council, to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education. Such grants would be made for projects showing promise of making valuable contributions to the education and training of persons in furnishing health benefits or of making valuable contributions with respect to the cause, prevention, or methods of diagnosis or treatment of disease or disability. Provision is made for giving preference to educational projects for returning servicemen seeking postgraduate education or training in medical, dental, and related fields. The initial sums available for such grants-in-aid would be $10,000,000 for 1946 and $15,000,000 for 1947. The sum available each subsequent year for such grants-in-aid would be 2 percent of the amount expended for health benefits. These grants-in-aid are a necessary part of any prepaid medical-care program. They will enable medical schools to develop more adequate programs for general practitioners, specialists, and other medical personnel to take refresher and postgraduate courses so that such persons can keep abreast of modern medical discoveries. Under present-day arrangements the results of new discoveries are not brought quickly enough to the attention of all practitioners.

The GI bill of rights contains educational provisions and loans which also should help during the next few years to break down the barriers to further professional education and research which have existed. But the GI bill will only apply for a limited period of time to only part of the population. We must have permanent and comprehensive legislation covering all medical research and education and allied fields. Such legislation under a national health program should, of course, provide for coordination with general research and education programs.

CASH BENEFITS DURING DISABILITY

A comprehensive national health program cannot be achieved without providing cash benefits to individuals during periods of sickness or disability. I have already introduced legislation with Senator Murray (S. 1050) and Representative Dingell has introduced a companion bill in the House of Representatives (H. R. 3293) which provides for such payments during both temporary or extended sickness or disability as a part of our other cash social-insurance payments. This legislation already is pending before the Senate Committee on Finance and the House Committee on Ways and Means. These pending bills also provide that there should be set aside annually an amount equal to 2 percent of the social insurance benefits paid on behalf of all such disabled individuals to be used for medical, surgical, institutional, rehabilitation, or other services to disabled individuals entitled to receive cash disability insurance benefits, if such services are not otherwise available through existing legislation, and might aid such individuals to return to gainful work.

I am hopeful that committees of the Senate and House which have this matter now before them will hold hearings on it soon to expedite this legislation as part of both a national health program and an expanded social-security program.

OTHER HEALTH LEGISLATION

There also are pending before the Congress at the present time several other special bills relating to health, each limited to a particular problem. While each problem—and each bill—has certain merit, piecemeal consideration of each separate problem by the Congress is not the most satisfactory way of developing a sound national health program. Such a piecemeal approach inevitably results in gaps, overlaps, and inconsistences; it may result in competition for trained personnel to administer such programs, especially in cases where a sufficient number of trained persons is not yet available. I hope, therefore, that each such pending bill will be considered in relation to a comprehensive national health program.

The appropriate committees of Congress also should go into all aspects of health which impede providing adequate medical care. The present deplorable situation with respect to institutional care in many communities indicates the need for Federal grants-in-aid to the States for the improvement of standards, services, and working and living conditions in these institutions. State licensure laws are so complex, so lacking in uniformity, and so obstructive of interstate mobility of qualified practitioners that some Federal legislation is necessary to bring order out of this chaos. There are no medical schools in some States, and measures to remedy this defect should be considered. Finally, the discrimination which most medical schools practice against student applicants from minority groups requires congressional consideration and appropriate action.

SUMMARY OF MAJOR PROVISIONS OF THE NATIONAL HEALTH ACT OF 1945

The National Health Act of 1945 contains three titles, as follows:

Title I—Grants to States for Health Services.

Title II—Personal Health Service Benefits.

Title III—General Provisions.

TITLE I—GRANTS TO STATES FOR HEALTH SERVICES

Title I contains three parts, as follows:

Part A—Grants to States for Public Health Services.

Part B—Grants to States for Maternal and Child Health Services.

Part C—Grants to States for Medical Care of Needy Persons.

All three parts of title I provided grants-in-aid to the States for health services for which the Federal Government already provides funds. In general, the purpose of this title is to amend and broaden existing legislation by eliminating existing restrictions so that present State and local programs can operate more effectively.

Part A—Grants to States for public-health service

This part amends section 314 of the Public Health Service Act. The provisions concerned with grants for the venereal disease and for the tuberculosis programs are unchanged. The subsections dealing with general public-health work are revised so as to strengthen the program and pledge complete Federal cooperation to the States in moving as rapidly as practicable toward the development of adequate public-health services in all parts of the country. The present authorization of $20,000,000 a year for grants to States is replaced by an authorization to appropriate a sum sufficient to carry out the purposes. Also, the maximum annual amount authorized to be available to the Surgeon General of the Public Health Service for demonstrations, training of personnel, and administrative expenses is increased from $3,000,000 to $5,000,000 a year.

In order to receive the Federal grants the States are required to develop their own plans in accordance with their own needs, and to submit these plans for approval. They must be approved by the Surgeon General if they meet the requirements that are specified in the bill. An orderly system of arrangements is laid down, insuring reasonable standards and systematic financial participation by the States. This is the same general pattern as has been followed for public assistance since the original Social Security Act of 1935. The amounts of the grants to States are determined by an explicit formula, designed to give proportionately more aid to the poorer States. The variable Federal grants would range from 50 to 75 percent of the total public funds expended under the approved State programs.

Section 314 (k) of the Public Health Service Act provides for coordination between the administration of the public-health services under this program with the services provided under the other programs in the bill.

Part B—Grants to States for maternal- and child-health services

This part relates to Federal cooperation with the States to provide health services for mothers and children. A common plan is followed in each of the two aspects of this part, dealing respectively with maternal and child health and with crippled children. In order to receive Federal grants, the States are to develop their own plans, in accordance with their own needs. If these plans meet the requirements specified in the bill, they must be approved by the Chief of the Children's Bureau. The requirements are those that are essential to insure reasonable standards, systematic financing and administration, and reasonably rapid extension of the services to all parts of the States and on an adequate basis. Administration by the Federal authorities is required to be in close consultation with the State authorities.

As in the case of grants for public-health work and medical care for needy persons, the Federal grants in part B would be on a variable basis, so as to give special aid to the poorer States. The variable Federal grants would range from 50 to 75 percent of the total public funds expended under the approved State programs, the amount in each case being determined by a specific formula written into the bill. The Federal Government would be entering into full partnership with the States in providing services for mothers and children, leaving wide latitude to the States as to the scope and content of the programs.

Section 128 (c) of this part provides for coordination between the administration of the provisions under this program with the services provided under the other programs in the bill.

Part C—Grants to States for medical care of needy persons

This part provides Federal grants to States for medical care to persons determined by the States to be needy under a cooperative Federal-State plan of public assistance. It provides variable Federal grants to the States, ranging from 50 to 75 percent of the total expended, depending upon the State's per capita income. The higher rates apply to the States with the lower per capita incomes. The program authorizes Federal matching, on this variable-grant basis, of medical care expenditures for any needy individual (without the rigid maxima contained in existing law).

These Federal grants, like the similar provisions of the present law, are to be made out of general revenues. As under existing law, State plans must meet various requirements specified in the bill, including maintenance of civil-service merit standards for administrative personnel.

The limitations in the existing Federal law are removed so that States may obtain Federal funds to help provide medical care to needy persons and thereby to reduce illness and suffering and wherever possible to help needy persons to be restored to self-support. Most States are already providing such care under existing public-welfare laws, but, because of the restrictions in the Federal law, this care is not adequate. By providing Federal financial participation toward meeting part of such costs, States will be encouraged to broaden the scope and improve the quality of such medical care.

In view of the fact that the proposed legislation would make additional Federal funds available to every State in the Union, it is essential that the State programs provide more adequate assistance and improved and simplified administration. Since under this part the largest part of the total cost will come from Federal funds, it is reasonable that all persons in the United States who are actually determined to be needy by State agencies be given medical care. The bill provides that as a condition for obtaining Federal funds the State public-assistance plan must provide for distribution of funds so as to assure meeting in full the medical need of individuals throughout the State as determined in accordance with standards established by the State. This provision would not modify the existing law which places upon the State the responsibility for determining who is a needy individual and the amount of assistance to be granted such individual. It is designed, however, to assure that needy individuals in a particular county will not be denied assistance because of the lack of adequate local financial participation by such county.

Section 136 of this part provides for coordination between the administration of medical care under this program with the services provided under the other programs in the bill.

TITLE II—PREPAID PERSONAL HEALTH SERVICE BENEFITS

Title II of the bill provides for a system of prepaid personal health service benefits.

Section 212 of the bill establishes a personal health services account, out of which all the benefits under this title are to be paid.

The financial barrier to adequate hospital and medical care is the basic reason for the unequal distribution of doctors and hospitals as between urban and rural area and as between prosperous and underprivileged communities. It is the basic reason for the failure of low-income families to receive as much medical care as the well-to-do, although they have more sickness. It is an important cause of the shockingly high rate of rejections under selective service.

A system of prepaid medical care will go a long way toward breaking down this financial barrier. Such a system will enable the people to obtain all needed medical care and will give them security against catastrophic costs for which they cannot budget individually. It will encourage doctors to settle in rural areas and communities to construct needed hospitals and health centers by assuring adequate incomes, equipment, and facilities for modern medical practice. It will benefit patients, doctors, and hospitals.

Title II of the bill provides for a comprehensive system of prepaid medical care. The provisions of the bill are based upon long and careful study of existing prepayment medical care plans in this country and abroad. The provisions of the bill are consistent with the policies and program set forth (1) in the Report of the Health Program Conference on Principles of a Nation-wide Health Program, issued in 1944 by 29 leading health experts, including 13 medical doctors; (2) in the report on medical care in a national health program, adopted in 1944 by the American Public Health Association; (3) in the policies set forth in the recent statement on the people's health, issued by the Physician's Forum; and (4) in statement No. 16, issued October 3, 1945, by the Committee of Physicians for the Improvement of Medical Care. Representatives of the American Federation of Labor and the Congress of Industrial Organizations joined in the adoption of the first-named report. The provisions of the bill are consistent with the policies and programs set down by both the American Federation of Labor and the Congress of Industrial Organizations in their annual conventions.

A Nation-wide comprehensive prepayment medical-care plan can be financed in any one of several different ways. Premiums can, for such a purpose, be raised through income or general taxes or through pay roll contributions, or both. In either case minimum and maximum provision can be provided. The extent of a general governmental contribution out of general revenues to such a plan depends upon the comprehensiveness of the groups covered and the services provided. All in all, these problems are best decided after a decision has been reached on all the details of the medical-care plan itself. Moreover, the financial details relating to the raising of the revenue for the plan raises many special problems which have a bearing on existing income taxes and pay roll contributions and should be considered in relation to these laws.

The bill does not, therefore, specify any particular method by which the sums authorized to be appropriated under section 212 of title II would be raised. Since under the Constitution legislation relating to the raising of revenue must originate in the House of Representatives, this matter has been left to separate legislation. There is already pending before the Congress legislation (H. R. 3293 and the companion bill S. 1050) which provides for the raising of revenue for personal health service benefits. This separation of legislation between the revenue and benefit aspects of the program is in keeping with previous practice. In both 1935 and 1937 legislation relating to railroad retirement was considered and enacted in this way.

It is both necessary and desirable that first and foremost consideration should be given to the benefits. If the Congress thinks that it is sound to provide prepaid medical care to the American people, the method of financing such a plan can be worked out jointly by the appropriate committees of the Congress which have jurisdiction over these matters.

Prepaid medical care is not socialized medicine

Propagandists for some organized medical groups have cricitized a national prepaid medical-care on the ground that it involves "regimentation of doctors and patients," "lowered standards," "political medicine," and "socialized medicine," and so on. But prepaid medical care is not socialized medicine; it is not State medicine. These "devil words" are all designed to confuse the issue.

A system of prepaid medical care is simply a method of assuring a person ready access to the medical care that he or she needs by eliminating the financial barrier between the patient and doctor or hospital. Since patients are guaranteed free choice of doctors, doctors are guaranteed the right to accept or reject patients, and hospitals are guaranteed freedom to manage their affairs, it should be obvious that the system does not involve regimentation of doctors, hospitals, or patients. Neither do I believe the propaganda that the doctors of this country will lower the standards of medical care simply because they are guaranteed payment for their services.

There are many individuals, honest and sincere in their desire for improved conditions, who nevertheless fear any change, and distrust all new social legislation. Those of us who have sponsored social legislation have faced similar opposition against many proposals for social betterment, but we have persevered and succeeded, and we have seen these new programs accepted as part of our basic system of American freedom and democracy. Over 30 years ago in the New York Legislature I fought for workmen's accident compensation and most of the arguments which are being made against prepaid medical care now were made against workmen's compensation then. Now all of the States but one have workmen's compensation laws—all include medical benefits, which is health insurance for industrial accidents and disease. The time has come for us to extend the principle of health insurance to cover nonindustrial accidents and diseases as well.

The fears and doubts expressed about workmen's compensation, unemployment insurance, and other measures for social security have proved to be without foundation. In the future, when we have succeeded in our struggle for a comprehensive health program for the entire country, we will be able to say about health insurance, too, that present-day apprehensions and misgivings were groundless.

Freedom of choice safeguarded

Freedom of medical practice is carefully safeguarded. Each person is entitled to choose his own family doctor from among all physicians or groups of physicians in the community who have voluntarily agreed to go into the system. Each doctor or group of doctors is free to go in or stay out of the system. These doctors who participate are free to accept or reject patients who may wish to select them as their family doctor, and the participating doctors are specifically given the right to choose the method through which they are to be paid for the services they furnish. Patients and doctors may change the arrangements after they have been made if they become dissatisfied. Doctors practicing as specialists, individually or in groups, would be entitled to special rates of payment if they meet professional standards for specialists. Existing arrangements for hospital care would not be disturbed.

Every effort also has been made to protect the professional position of dentists, nurses, and nursing organizations. Hospitals are guaranteed protection against interference in the management of their own affairs. The basic policy has been to provide medical and related services through arrangements that are worked out so that they will be satisfactory to the public and to those who furnish the services. Mutual agreements, reached through negotiations and contracts, are specified in the bill as the method to be used, and that is the democratic way of doing things.

The Surgeon General is authorized to negotiate cooperative working arrangements with Federal, State, or local governmental agencies, and with private groups or individuals, to provide the benefits by utilizing their services and facilities on payment of fair and reasonable compensation. The health benefits may be furnished to noncovered persons such as needy persons receiving public assistance, if appropriate arrangements are made to pay on their behalf the cost of services furnished to them.

Voluntary plans aided

There has been much misunderstanding about the part that voluntary hospitals, group-service organizations, existing voluntary insurance or prepayment plans and similar agencies may play in a prepaid medical-care system. Let me emphasize that our bill makes a place for them, so that they can continue their good work. All qualified hospitals, all qualified medical groups or organizations will be able to participate in the program as organizations that will furnish services to the insured persons who choose them; they will receive fair payments for the services they furnish under the bill; and they will have enlarged opportunities to be service agencies for particular groups or for their communities. This applies to service organizations created by trade unions, consumer groups, employers, nonprofit community groups, churches, fraternal associations, groups of doctors or individual doctors, medical societies, or many other kinds of sponsors, or groups of sponsors. The bill not only provides for utilizing existing service organizations but it also encourages the creation of new ones.

The groups operating as Blue Cross or similar hospital-insurance plans will be able to continue to act as representative of the participating hospitals and the community groups that own or manage the hospitals, and they will have large opportunities to be important public organizations that facilitate the administration of vital parts of the insurance system. The same will be true for many other community and public organizations.

Medical service groups—private clinics, salaried staffs of hospitals, group-service plans such as the Kaiser or the Ross-Loos plan—furnishing service under the system would be as free as they are today to select their own staffs and their own method of paying physicians and others on their staffs, irrespective of the method of payment which prevailed among the individually practicing physicians or dentists of the local area.

Hospital care

Hospital care is limited to 60 days per year, with a possible maximum of 120 days if experience proves that such benefits can be afforded. All qualified hospitals are eligible to participate. The Surgeon General is forbidden from exercising supervision or control over the management of hospitals that participate in the system.

Decentralized administration

Every effort has been made to keep a fair balance in the bill between the principles of administrative responsibility and democratic administration. The administrative officers are given duties to perform and the necessary authority so that they can carry out their duties efficiently and promptly. But their authority is carefully limited through checks and balances. Limitations are carefully specified in the bill; for example, the rights of insured persons and of physicians and hospitals are set down.

Moreover, the Surgeon General is directed to decentralize the administration of the program to the maximum extent possible, and administration through the States and localities is given preference and priority wherever the State and local authorities wish to take over the responsibility. Where no such arrangements have been made, the Surgeon General is directed to establish committees in each locality to aid in the administration of the program and to assure that the program will be adapted to local needs. Such committees shall include representatives of the insured population, doctors, hospitals, other agencies furnishing service under the program, and other persons informed on the need for, or provision of, health benefits. These provisions assure that there will not be any dictatorship or regimentation under the bill, as some propagandists have implied.

The Surgeon General is directed to establish a National Advisory Policy Council with which he is required to consult on all important questions of policy and administration. Members of this Advisory Council would be appointed from panels of names submitted by professional and other organizations concerned with medical services, education, hospitals, etc. The Advisory Council must also include representatives of the public. The Surgeon General is required to make a full report to the Congress each year on the administration of the program. Such report must include a record of the consultations with the Advisory Council, recommendations of the council, and any comments thereon. Such a report assures that all relevant facts, opinions, recommendations, and actions of the Surgeon General and the Advisory Council will be public information and that the Congress has full information upon which to revise or amend the law. To assure that the Advisory Council will and can meet on its own motion, the bill provides that the council shall meet not less frequently than twice a year and whenever at least four members request a meeting. The bill also provides that the council itself and each of its members shall be provided by the Surgeon General with secretarial, clerical, or other assistants. Finally, the council itself may establish special advisory, technical, regional, or local committees or commissions, whose membership may include members of the Advisory Council or other persons or both, to advise upon general or special questions, professional and technical subjects, questions concerning administration, problems affecting regions or localities, and related matters.

The bill specifically provides that all such councils—national and local—are to be only advisory to the appropriate administrative officers. Some medical groups have strongly advocated that the advice of such councils should be binding upon the administrator; that the national council should have power to veto the action of the administrator; and that the council should approve all regulations before they are issued. Such provisions have not been included in the bill because they are contrary to sound principles of public administration. Such a provision would result in the delegation of public authority to private persons. It would bestow upon private interests the control of the entire program. Only in recent years has it become apparent that adequate medical care is as much a concern to the consumer of medical care—the public—as to the producers and distributors of medical care. The technical and professional aspects of medical or hospital care should be under the constant control and supervision of qualified professional personnel. But sound public policy demands that on other aspects of medical care—such as financial matters and the administration of medical care—the public must have a voice and the controlling interest.

Throughout the bill, there are specific provisions requiring the Surgeon General to consult with the National Advisory Council on particular matters. Thus, section 205 (c) requires that in determining what are specialist or consultant services (for the purpose of higher rates of remuneration to persons rendering such services), the Surgeon General must establish general standards only after consultation with the advisory council. Similarly, in connection with including any hospital on the list of participating hospitals, section 206 (b) requires that the Surgeon General make his finding of facts and decisions on the status of any hospital in accordance with general standards established only after consultation with the advisory council. In placing any limitations on benefits under section 210 the Surgeon General must also first consult the advisory council.

Moreover, section 204 (b) of the bill specifically states that the Advisory Council shall advise the Surgeon General on—but it is not limited to—the following seven matters:

1. Professional standards of quality to apply to personal health service benefits;
2. Designation of specialists and consultants;
3. Methods and arrangements to stimulate and encourage the attainment of high standards through coordination of the services of general or family practitioners, specialists, and consultants, laboratories, and other auxiliary services, and through the coordination of the services of physicians and dentists with those of educational and research institutions, hospitals and public-health centers, and through other useful means;
4. Standards to apply to participating hospitals, to the relations or coordination among hospitals, and to the establishment and maintenance of the list of participating hospitals;
5. Adequate and suitable methods and arrangements of paying for personal health service benefits;
6. Studies and surveys of personal health services and of the quality and adequacy of such services; and

7. Grants-in-aid for professional education and research projects.

The bill places responsibility for the sound administration of the prepaid medical-care program in the hands of the Surgeon General of the United States Public Health Service. The office of the Surgeon General is and has been nonpolitical and has developed close and satisfactory relations with State and local health officers and with officials and members of the American Medical Association. By placing responsibility in the hands of a single administrator long versed in medical administration, prompt, efficient, and economical administration of the prepaid medical-care system can be assured.

Some organized medical groups have criticized this provision on the grounds that it centralizes too much authority in one man and that it tends toward medical dictatorship. As I have indicated, I do not think there is any merit to this charge. But if the Congress should come to the conclusion that there is any merit to this criticism, it could place the responsibility for the over-all administration of the program in the hands of a board of say three or five persons, with the possibility of utilizing the Surgeon General as the administrative officer of such a board. If such an arrangement is adopted it should be clear, however, that all or the majority of the members of the board should be full-time public members with no financial or other interest which would be inconsistent with their responsibility for nonpartisan, competent administration in the public interest. Any other arrangements would be contrary to the best interests of the consumers of medical care.

Specific provision is included in the bill for hearings and appeals on any disputed issues between practitioners, hospitals, and covered persons. Specific provision is made for the judicial review of any disputed issues arising under the plan. Here again, the bill establishes adequate protection against any regimentation or dictatorship.

High medical standards encouraged

High standards of medical care are protected and encouraged through incentives for the professional advancement of doctors, postgraduate study, professional education, research, and the availability—regardless of the patient's ability to pay—of consultant and specialist services (including the services of surgeons, internists, psychiatrists, obstetricians, pediatricians, dermatologists, and others), hospital and similar facilities, laboratory services, optometry services, and X-ray services. Provision is made for the addition of dental and home-nursing services as rapidly as practical. The bill is clear in requiring that the arrangements to provide the medical and related services shall be worked out so that they are mutually agreeable to the administrative officers and to those who agree to furnish the services.

The bill contains various provisions to assure that medical benefits will be of the highest quality that can be made available, will promote personal relations between doctor and patient, will emphasize prevention of disease, and will be adapted to the needs and practices of the community, in both rural and urban areas.

The Surgeon General of the United States Public Health Service—a doctor—would administer the technical and professional aspects of the program. The Surgeon General would also be directed to work out the closest possible coordination between the prepaid medical and hospital services and the public health services of the Federal, State, and local governments.

The Surgeon General and the Social Security Board are directed to make studies and to report to Congress on dental, nursing, or other services not provided under the system, and on services and facilities needed for the care of the chronic sick and for persons afflicted with mental diseases.

The Surgeon General is directed, with the advice of the National Advisory Medical Policy Council, to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education.

TITLE III—GENERAL PROVISIONS

Section 301 provides for the usual separability clause.

QUESTIONS AND ANSWERS ABOUT THE PREPAID MEDICAL CARE PROVISIONS OF THE NATIONAL HEALTH ACT OF 1945

1. Does the prepaid medical care title of the bill provide for "socialized medicine"?

No; if by the term "socialized medicine" is meant medical care furnished by Government doctors free of charge. The term "socialized medicine" has been loosely used for a number of years to describe any changes in the provision of medical services to which the American Medical Association leadership is opposed. The only definition of "socialize" in Webster's Dictionary which describes the effect of the bill on medical practice is "to adapt to social needs or uses." This, title II of the bill will accomplish by making medical services more generally available than they are today, while retaining free choice of doctor for the patient and freedom on the doctor's part to work under the system or to remain out of it as he prefers. If it is charged that the bill proposes to make medical services more generally available than they are today, that charge is valid and is a compliment to the bill.

2. If, as Dr. Fishbein declares in his editorials in the Journal of the American Medical Association, health conditions and the standards of medical service are higher in the United States than anywhere else in the world, why is a change necessary?

The United States is not the healthiest country in the world. Dr. Fishbein presents a very favorable over-all picture but he neglects to state that conditions are not nearly so satisfactory in poor agricultural States, in rural regions of wealthy States, in low-income sections of our large cities, and among low-income groups in our population. Take, for example, the infant and maternal mortality rates. In 1942, while 40 babies in the entire United States died at birth for every 1,000 born alive, in 1 State the rate was 98, and 80 in another.

We find similar wide variation in maternal mortality rates. The rate for mothers who died in childbirth was 60 percent higher in the Southern States than in New England. The ratio of Negro mothers who died when their babies were born was twice the ratio for white mothers. Per 1,000 maternity cases, 25 percent more mothers died in towns and villages with less than 10,000 population than in the cities with population of 100,000 or more.

We are proud of our steady reduction in deaths from tuberculosis Here again, however, the over-all favorable picture conceals many inequalities. In New York City one overcrowded district has a death rate from this cause which is 30 times the rate in more favored districts. The high tuberculosis mortality rates for several States are four to five times the average in the States with the best records.

Probably few people would have believed, 6 years ago, that more than half of our young men would be found physically or mentally unfit for general military duty. Yet that is exactly what was revealed by Selective Service examination records of the first 3,000,000 registrants. Soon after the early days of the war, certain of the physical standards were relaxed. Nevertheless, recent figures from Selective Service still show the appalling fact that 50 percent of the young men examined were either completely unable to perform general military service or were made fit only after correction of defects. Out of 14,000,000 men (most of them under 30) examined by June 1, 1944, 4,500,000 were classified as IV-F, unfit for military service despite the lowered physical and mental requirements for military service; more than 1,000,000 after being inducted were later discharged for defects which became apparent after induction; and 1,500,000 were inducted but made fit for service only after certain defects had been corrected—giving a total of over 7,000,000 that were initially unfit. Another fact stands out from the Selective Service figures: 1,500,000 of the 7,000,000 unfit were rehabilitated for military service readily and the numbers of such rehabilitated cases could have been easily doubled, indicating that with adequate medical care the proportion of unfit would have been much less.

Length of life is often considered a measure of the health of the people. Yet statistics of life expectancy for males in prewar years showed a number of countries in which the average future length of life was greater than in the United States. For example: At birth, life expectancy in at least four countries was better than that for white males in the United States; at age 20, life expectancy in 8 countries exceeded that in the United States; at age 60, the United States was exceeded by at least 12 countries.

Most of these are health insurance countries. In the United States, inability to pay the costs of medical care prevents many persons from receiving the care they need and limits doctors in the kind and amount of care they can provide. People who don't see a doctor don't get any kind of care—good or bad. Many doctors are unable or unequipped, because of the cost to the patient, to make use of the marvels of medical science which are described so glowingly by some medical spokesmen. Patients of these doctors get a type of medical care not much better than that their fathers or grandfathers received.

3. Is it true that if the prepayment provisions of the bill are enacted into law "they will destroy the private practice of medicine in the United States"?

This statement is not true. If the bill is enacted into law, physicians will continue to practice medicine much as they do now. They will have the choice of practicing full time under the system, of combining care of patients paid for by the system with care of uninsured patients and of those who prefer to pay for their care privately (that is, without making use of their prepaid protection), or of continuing to practice full time outside the system. Whether caring for prepaid patients or for others, they will be free, as they are now, to practice alone or as members of a group.

Patients will be free to choose their general practitioners and to change them if their first choice proves unsatisfactory. Doctors will be equally free to accept or reject patients who choose them. Free choice is explicitly guaranteed in the bill (sec. 205).

4. Is it true that under the bill the "entire medical profession in the United States would be placed under the direction of one man, the Surgeon General of the United States Public Health Service"?

No. This is not true. Section 203 in the bill, which relates to administration, is concerned not with the administration of medical practice but with the administration of a system of paying for medical care.

The provisions in the bill do not interfere with the professional aspects of medical practice. The Surgeon General is "authorized to negotiate and periodically to renegotiate agreements or cooperative working arrangements" with the medical profession and with hospitals to "utilize their services and facilities and to pay fair, reasonable, and equitable compensation for such service and facilities."

The usual method of making payments to general practitioners is to be that which is chosen by the majority of physicians in any given local areas. However, provision is also made that, if approved by the Surgeon General, other methods of payment may be made to physicians who do not choose the method of the majority. It should be noted that the Surgeon General wouldn't hire doctors for the prepaid services or direct the medical profession. He is authorized to work out mutually satisfactory agreements or cooperative working arrangements with the doctors as to methods by which they would be paid for their services to insured persons. The same holds true for methods of payment to dentists.

In adopting the basic policies that would guide these arrangements, the Surgeon General is required to consult with the National Advisory Medical Policy Council, on which the medical and dental profession will be adequately represented through members they nominate.

5. It is said that the National Advisory Medical Policy Council will have no authority—will be merely a puppet council. Is this true?

No. This is not true. The council has been given no final administrative authority, because an advisory council is not and should not be an administrative body. An explicit statement in the bill which bound the Surgeon General to follow the advice of the advisory council in every instance would hamper his freedom of action to an unreasonable extent and would deprive him of the necessary authority to carry out his duties and responsibilities. He is, however, bound to consult them on all matters of policy. The bill is explicit and detailed in its description of the administrative policies on which the Surgeon General is authorized to act only after consultation with the council (secs. 203–206).

In appointing the members of the advisory council, the Surgeon General is required to select them from panels of names submitted by professional and other agencies and organizations concerned with medical, dental, and nursing services and education, with the operation of hospitals and laboratories, and from other persons, agencies, or organizations informed on the need for or provision of medical, hospital, or related services and benefits. It will, therefore, be a council composed of experts in the various fields and of representatives of the public. No responsible administrator would dare to act contrary to the advice of an advisory council of this character on any matter of importance unless he had adequate grounds on which he could defend his position publicly. Moreover, the Surgeon General is required to include in his annual report to Congress an account of his consultations with the advisory council, and also their recommendations and his comments thereon.

6. Isn't $3,000,000,000 a year an enormous amount of money to spend on medical care and hospitalization?

Absolutely not. We spend more than this now for medical care. The sums of money to be allocated to the personal health services account will not for the most part represent new expenditures. To the extent that they do—through budgeted expenditures—the people will receive much more service than they do today.

Medical care ordinarily costs the people of this country in direct payments and through taxation about four to five billion dollars a year. Direct expenditures by the people themselves amount to about three to four billion dollars. About two to two and one-half billion dollars is spent in an ordinary nonwar year for medical services, excluding dentistry and home nursing.

7. Is it true that the Surgeon General will assign all patients to all doctors?

Certainly not. In each area patients will have free choice of all general practitioners of medicine or dentistry within the system (sec. 205 (b)).

8. Will the hospitalization provisions in the bill destroy the voluntary hospital system?

No; this is nonsense. Nothing in the bill provides for or would even permit any interference in the internal management of any hospitals—private, public, or sectarian. This is explicitly forbidden in the bill (sec. 206 (c)). All hospitals which meet acceptable standards—such standards as those utilized by the American Medical Association or the American College of Surgeons in determining whether or not hospitals shall be included in its annual register—would as a matter of course be included in the list of hospitals eligible to receive insured patients. In communities where hospital facilities are sparse there will undoubtedly be common-sense modification of these standards. There is explicit provision in the bill for this (sec. 214 (k)). The object is to make hospital care more available to people—not less available.

Each qualified hospital is also guaranteed the right to choose how it will be paid. The hospital can be paid direct under a mutually satisfactory agreement. Or it can be paid by the patient, who receives his benefit in cash at so many dollars per day of hospital care (sec. 214 (h)).

The assurance of adequate income should enable hospitals to improve their facilities. The type of records which will be required will be no more difficult for hospitals to keep—perhaps less difficult—than those required by the Blue Cross plans.

9. Will the provisions for grants-in-aid for medical education mean that medical education will be controlled by the Surgeon General and that he will dictate which men and women may become medical students?

Of course not. The provisions of section 213 of the bill give the Surgeon General no such authority. The purpose of this provision is to provide needed funds for the stimulation and support of research and medical education. Projects must be initiated by the medical schools and research foundations themselves. Such requests must, of course, be approved by the Surgeon General after consultation with the advisory council, to make sure that public funds are wisely spent.

This provision was put in the bill as a result of suggestions made by the medical profession in regard to the earlier Wagner health bill of 1939. It seems only proper that the people who profit so much by the advancements of medical science and improvements in medical education should contribute in this way to these desirable ends.

10. Is it true that the bill would be used to "take over" medical schools and hospitals?

Of course not. There is absolutely nothing in the bill which would authorize or even permit this. Nothing in the bill permits interference in the internal management of either medical schools or hospitals. The payment of hospital benefits to hospitals and of grants-in-aid to medical schools will provide a financial security that many institutions have never before possessed. This assurance of necessary funds should strengthen and stimulate them to do more effective work than they have ever done before, without in any way giving up independence and freedom of action.

11. Is it true that the enactment of the bill will plunge the physicians into political slavery?

Absolutely no. This statement has been made by opponents of a national prepayment plan to confuse and disturb physicians and others. There is nothing "political" about the office of the Surgeon General of the Public Health Service. The Surgeon General holds a term appointment. The United States Public Health Service has a long and honorable record of almost 150 years. Many of the advances in public health which the editorials in certain medical journals credit to the private practitioners of medicine have been stimulated by the activities of the Public Health Service and by similar public agencies.

12. Is it true that under the hospitalization provisions of the bill people will not be able to choose their hospitals?

People do not usually have free choice of hospitals today. Ordinarily, they go to the hospital in which the physician treating them has a staff appointment. Sometimes they have a choice of two or more hospitals in the community. They will have the same freedom under the provisions of the bill. They will have as much free choice of hospitals as they have today under the Blue Cross plans. All hospitals in good standing will undoubtedly elect to receive insured patients in order to obtain the assurance of guaranteed income which will thus be available to them.

13. Will people be obliged to take any doctor the Surgeon General tells them to, if this bill becomes law?

Certainly not. The bill expressly provides free choice of general practitioners (sec. 205 (b)). Ordinarily, a patient will go to a specialist only on the recommendation of his physician. This is for the protection of the patient. Most people should see a general practitioner first before they go to a specialist. The patient who goes to a specialist on the advice of a physician is likely to be taken care of more satisfactorily than if he follows the suggestion of a neighbor or picks out a name in the telephone book. The same statements apply to dentists.

14. The bill says the Surgeon General can limit the number of patients a physician will be allowed to treat. Won't that keep people from having the doctor of their choice?

Not any more than at present when a patient chooses a doctor who already has all the patients he can take care of. This provision in the bill (sec. 205 (j)) is merely permissive. It states that the "Surgeon General may prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish general medical benefits * * *." It does not require the Surgeon General to do so. Protection of patients and doctors was the only purpose in giving the Surgeon General permission to set a maximum. Such a maximum would undoubtedly be the largest number of persons whom one doctor could take care of satisfactorily. It would therefore be a larger number than doctors ordinarily take care of. As a result, this provision, if the Surgeon General found it wise to use it, would rarely, if ever, interfere with the guaranteed freedom of insured persons to choose their own doctors.

15. Does the bill place in the hands of one man—the Surgeon General of the Public Health Service—the power and authority * * * to designate which doctors can be specialists?

Questions like this one confuse and disturb physicians and the public because they can be answered by neither a flat "Yes" nor a flat "No." Under the prepaid program, specialists would be compensated at a higher rate than general practitioners. This is only fair and proper. To provide a measure for determining what types of services and which practitioners should be compensated at this higher rate, the Surgeon General is authorized in the bill to set up general standards for this purpose. In establishing these standards, he must, however, consult the advisory council and utilize standards and certifications already developed by physicians through their professional organizations.

16. Will the enactment of the bill result in the deterioration of medical practice?

On the contrary, it should improve the standards of medical practice. Many doctors are hampered today in their treatment of patients by the inability of the patient to pay for the special diagnostic and treatment services he requires. The provisions for consultant and specialist services, for hospital care, and for X-ray and laboratory services as benefits under the bill will mean that doctors can make use of these services whenever they consider it advisable, without considering the patient's pocketbook.

17. Doesn't the phrase giving the Surgeon General the authority to "prescribe and publish such rules and regulations," used in section 203 (g) of the bill, mean that the Surgeon General will have too much power?

This phrase has been frequently quoted to convey just this impression. But no administrator can administer a national prepayment plan without setting up certain rules and regulations. It is a phrase commonly used in bills. It has no sinister significance. It merely gives the administrator the power to establish necessary administrative measures. He is specifically forbidden from using the "rules and regulations" to act contrary to the other provisions of the bill.

18. It has been said that if the bill becomes law people must depend upon "a doctor who is paid by the Government and is presumably working 8 hours a day instead of 24." Won't this make it very hard for people to get a doctor if they need one at night or on holidays?

Certainly not. Any such idea is nonsense and an insult to the medical profession. There is not one statement in the bill which even implies that doctors are to work any specified number of hours. Many a doctor who answers a patient's call today has no idea when or whether he will be paid for his services. Why should we assume that doctors will look after their patients less conscientiously when they know they will be paid than they do today when payment is often uncertain?

19. Is it true that, under a system of prepaid medical care, physicians will have lower incomes than they have now?

With 60,000 physicians in the armed services during the war, of course those left in private practice have been overworked and their incomes have been very high. They would not be so high in an ordinary year. If the question really means "will physicians have lower incomes under the bill than they usually have" the answer certainly is "No." Before the war, the highest average gross income physicians ever made was in 1928 or 1929—again years when all incomes were unusually high. In those years physicians earned on the average about $9,000 gross, but in the years since then and before the war their average incomes have been from $5,600 to $8,500 gross.

It is estimated that on the average $1,500,000,000 annually could be spent for physicians' services. At this rate, if 150,000 physicians were in full-time practice, they would average about $10,000 income in a normal year under the bill. Like the previous figures, this includes incomes of both general practitioners and specialists. The general practitioner earns less than the specialist and, as the bill provides, the qualified specialist will continue to receive a higher rate of pay than the general practitioner. Thus, specialists as a whole would receive more than the $10,000 average, and general practitioners as a whole somewhat less than the average.

20. It is claimed by opponents of a national plan that voluntary prepayment plans could do the job as well, if not better. Is this true?

Experience here and abroad has shown us that voluntary plans could not handle the job. You can't persuade enough people, much less the bulk of the people, to join voluntary plans. Moreover, the voluntary plans which have been operating so far are too restrictive and too costly in the care they provide. There has been a lot of talk about Blue Cross (hospitalization) plans being able to handle hospital care; but even after more than 15 years of existence these plans cover only 17 to 19 million people—most of these in large urban centers. Hospitalization is the easiest kind of insurance in the medical field to sell. Voluntary plans that provide medical care now cover only about 4 percent of the population in spite of recent and very vigorous efforts of the American Medical Association and State medical societies to promote this type of plan. The medical society plans now cover only a few million persons. For the most part they give care only when the patient is in the hospital.

Without exception, voluntary plans are too expensive for the lower-income groups (the people who are most in need of medical care) and there are too many illnesses and too many kinds of services for which care is not included under these plans.

21. Will health insurance help in providing more and better medical care?

Yes. The financial barrier to adequate hospital and medical care is the basic reason for the unequal distribution of doctors and hospitals as between urban and rural areas and as between prosperous and underprivileged communities. It is the basic reason for the failure of low-income families to receive as much medical care as the well-to-do, although they have more sickness. It is an important cause of the shockingly high rate of rejections under selective service.

A health-insurance system will go a long way toward breaking down this financial barrier. Such a system will enable the people to obtain all needed medical care through small, regular prepayments based on their earnings, and will give them security against catastrophic costs for which they cannot budget individually. It will encourage doctors to settle in rural areas and it will help communities to construct needed hospitals and health centers, by assuring adequate incomes, equipment, and facilities for modern medical practice. It will benefit patients, doctors, and hospitals.

22. Will the adoption of health insurance destroy existing voluntary group-service or group-payment plans?

No. There has been much misunderstanding about the part that voluntary hospitals, group-service organizations, existing voluntary insurance or prepayment plans, and similar agencies may play in the social-insurance system. The bill makes a place for them, so that they can continue their good work. All qualified hospitals, all qualified medical groups or organizations will be able to participate in the program as organizations that will furnish services to the insured persons who choose them; they will receive fair payments for the services they furnish as insurance benefits; and they will have enlarged opportunities to be service agencies for particular groups or for their communities. This applies to service organizations created by trade-unions, consumer groups, employers, nonprofit community groups, churches, fraternal associations, groups of doctors or individual doctors, medical societies, or many other kinds of sponsors, or groups of sponsors. The bill not only provides for utilizing existing service organizations, but it also encourages the creation of new ones.

The groups operating under the Blue Cross hospital insurance plans will be able to continue to act as representatives of the participating hospitals and the community groups that own or manage the hospitals, and they will have large opportunities to be important public organizations that facilitate the administration of vital parts of the insurance system. The same will be true for many other community and public organizations.

Medical service groups—private clinics, salaried staffs of hospitals, group-service plans such as the Kaiser or the Ross-Loos plan—furnishing service under the social-insurance system would be as free as they are today to select their own staffs and their own method of paying physicians and others on their staffs, irrespective of the method of payment which prevailed among the individually practicing physicians or dentists of the local area.

23. Do the health insurance provisions of the bill provide for decentralized administration?

Yes. The bill specifically provides for State and local administration (sec. 203 (c)-(i)). Every effort has been made to keep a fair balance in the bill between the principles of administrative responsibility and democratic administration. The administrative officers are given duties to perform and the necessary authority so that they can carry out their duties efficiently and promptly. But their authority is carefully limited through checks and balances. Limitations are carefully specified in the bill; for example, the rights of insured persons and of physicians and hospitals are set down. Also, the administrative officers are required to consult with a national advisory council on all important questions of policy and administration, and this council must contain representatives of both the public and those who furnish health services. Provision also is made for advisory bodies at the local level as well.

Moreover, the administration is to be decentralized to the maximum extent possible, and administration through the States and localities is given preference and priority wherever the State and local authorities wish to take over the responsibility.

24. Does the bill rely solely on health insurance as a means of providing more and better medical care?

No. The bill includes five provisions which will make available basic health services to all the people wherever they live and whatever their income.

First. The present Federal grants-in-aid to the States for public health services are broadened and increased to speed up the progress of preventive and community-wide health services.

Second. The community-wide maternal and child health and welfare services, aided by Federal grants to the States, are similarly broadened and strenthened.

Third. Federal grants-in-aid to the States are authorized for meeting the costs of medical care to needy persons.

Fourth. Health insurance is made available.

All four of the provisions just mentioned will greatly help to round out the health services of the Nation. By preventing sickness, disability, and premature death, they will pay vast dividends in human welfare and, at the same time, reduce the costs of other parts of the social security program. However, unless we provide a method of spreading the cost of medical and hospital care through social insurance, people will still not obtain the treatment they need.

Five. Grants-in-aid are provided under the prepaid medical care plan to nonprofit institutions engaging in medical research or in professional education.

25. How would the cost of health insurance be financed?

There is already pending before the Congress legislation to finance the cost of health insurance. The Wagner-Murray-Dingell social security bill introduced on May 24, 1945 (S. 1050 and H. R. 3293), provides for social insurance contributions for all social insurance programs. The Wagner-Murray-Dingell social security bill was drafted on the assumption that 3 percent of pay rolls (up to $3,600 per year) would be allocated for health insurance of which one half would be paid by employers and the other half by employees. In other words, 1½ percent of pay rolls would be contributed by employers and 1½ percent by employees. The bill also provides that the additional cost above 3 percent due to the gradual introduction of dental and home nursing services would be financed out of general revenues. In addition, the Federal Government will pay out of general revenues part of the cost of providing medical care to needy persons.

26. Why are the premiums for health insurance provided for in a separate bill?

Under the Constitution all revenue bills must originate in the House of Representatives. This means that the House must consider and pass the legislation before the Senate. In order that the health insurance legislation can be considered and passed by the Senate without waiting first for House action, it was necessary to consider the benefit and revenue provisions separately.

This separation of legislation between the revenue and benefit aspects is in keeping with previous practice. In both 1935 and 1937 legislation relating to railroad retirement was considered and enacted in this way.

Another reason for separating the benefit and revenue provisions is that under present arrangements in Congress different committees are concerned with these two matters. In the Senate, for instance, the Committee on Education and Labor handles all health legislation such as the hospital survey and construction bill, the Public Health Service Act, etc. The technical problems involved in revenue legislation are handled by the Senate Committee on Finance. Similarly, in the House of Representatives, health matters are handled by the House Committee on Interstate and Foreign Commerce but revenue matters are handled by the House Committee on Ways and Means.

In terms of priority, it is essential that the benefits should be given consideration first. If the Congress thinks that prepaid medical care should be provided, then the method of financing can be worked out in terms of the scope and character of the medical care provided.

27. Are there any medical groups in favor of the health insurance provisions of the bill?

Yes. Both the Physicians Forum and the Committee of Physicians for the Improvement of Medical Care are strongly in favor of the health provisions of the bill. These medical groups all represent doctors who are members of the American Medical Association. Many other doctors are also in favor. Similarly, many dentists and nurses are in favor of health insurance.

28. Are there any other groups or individuals in favor of health insurance?

Yes. Both the American Federation of Labor and Congress of Industrial Organizations are in favor of health insurance. Governor Earl Warren, a leading Republican, is in favor of health insurance, Many businessmen, lawyers, bankers, publishers, editors, educators, public health and civic leaders, and other outstanding citizens, are in favor of health insurance.

O