lieve the recent events pertaining to demobilization clearly indicate the potential threat against that freedom as we have always known it.

I do not want to rear my son to be a number in the Army against his will. I feel it is his birthright to have the decision of his life, insofar as it does not transgress upon the rights of his fellow men, in his own hands during peacetime.

However we must have national defense and I sincerely believe a larger Regular Army and Navy, and expanded National Guard, ROTC, with perhaps, a new branch of training at the junior high school or high school to create an enlisted men reserve, but keep the entire program on a voluntary basis.

When our civilization reaches the point where we will not voluntarily defend ourselves, families, country, and way of life then our civilization will have reached a point where it ceases to be worth the sacrifice of armed defense. And at this point may I ask: are all the proponents of peacetime military training on a compulsory basis thinking of defense and only defense? Two years' Army service will cause a freedom-loving American to ask many questions.

I also believe the time-consuming factor in our present defense system is not the mobilization of military personnel, as illustrated by the Army 17 weeks' training program in conjunction with a Regular Army as cadre and a reserve of officers and enlisted men, but rather in the field of matériel, the time lag in manufacturing new war goods. For an illustration, our present equipment will be obsolete in a few years if it is not already obsolete due to the atomic bomb. Our best defense lies in the hands of a few scientific men and industrialists. A group of these men constantly working on new military weapons, in complete cooperation with the military, and simultaneously formulating production plans that will successfully tie in with our industrial set-up. And here is another point worth mentioning, can we take steps that will insure the acceptance and fair trial by the military of new or revolutionary matériel, methods, etc.? We do not want any Gen. Billy Mitchell type episodes in the future.

I have expressed my opinion as a citizen of the United States who is deeply concerned about the future and hope you will consider it as such.

Sincerely.

GERMAN BUSINESS STILL A MENACE—ARTICLE BY SENATOR THOMAS OF UTAH

[Mr. TAYLOR asked and obtained leave to have printed in the RECORD an article entitled "German Business—Still a Menace," written by Senator THOMAS of Utah and published in the November 1945 issue of the American magazine, which appears in the Appendix.]

WORLD COOPERATION—ADDRESS BY THE SECRETARY OF STATE

[Mr. MAYBANK asked and obtained leave to have printed in the RECORD an address delivered by the Honorable James F. Byrnes, Secretary of State, at the mayor's dinner at the Francis Marion Hotel, Charleston, S. C., in connection with the Jimmy Byrnes Homecoming Day, November 16, 1945, which appears in the Appendix.]

THE RED CROSS—ARTICLE BY AGNES E. MEYER

[Mr. GUFFEY asked and obtained leave to have printed in the RECORD an article on the Red Cross, written by Agnes E. Meyer, and published in the Washington Post of November 18, 1945, which appears in the Appendix.]

CRITIQUE OF LABOR LAW—ADDRESS BY PROF. WILLIAM STERNBERG

[Mr. BUTLER asked and obtained leave to have printed in the RECORD an address entitled "Critique of Labor Law," delivered by Prof. William Sternberg, of Creighton University School of Law, Omaha, Nebr., before the Postwar Institute of the Nebraska Bar Association on October 31, 1945, which appears in the Appendix.]

TO AN ATHLETE DYING YOUNG—SERMON BY REV. ALLEN PENDERGRAFT

[Mr. MEAD asked and obtained leave to have printed in the RECORD a sermon entitled "To an Athlete Dying Young," delivered by Rev. Allen Pendergraft on November 4, 1945, at All Saints Church, Buffalo, N. Y., which appears in the Appendix.]

UNIVERSAL MILITARY TRAINING

[Mr. HOEY asked and obtained leave to have printed in the RECORD two letters received by him on the subject of universal military training, which appear in the Appendix.]

DELAY IN DISCHARGING SERVICEMEN

[Mr. O'DANIEL asked and obtained leave to have printed in the RECORD three letters addressed to him on the subject of the discharge of servicemen, which appear in the Appendix.]

OUR CHILDREN—POEM BY EDWARD T. PACA

[Mr. JOHNSON of Colorado asked and obtained leave to have printed in the RECORD a poem entitled "Our Children," written by Edward T. Paca, of Englewood, Colo., which appears in the Appendix.]

NATIONAL HEALTH PROGRAM—MESSAGE FROM THE PRESIDENT (H. DOC. NO. 380)

The PRESIDENT pro tempore laid before the Senate a message from the President of the United States.

(For President's message see p. 10817 of the House proceedings of today's RECORD.)

The PRESIDENT pro tempore. The message will be referred to the Committee on Education and Labor.

NATIONAL HEALTH PROGRAM

Mr. WAGNER. 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 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.

The PRESIDENT pro tempore. Without objection, the bill will be received and referred to the Committee on Education and Labor, as requested by the Senator from New York.

The bill (S. 1606) to provide for a national health program, introduced by Mr. WAGNER (for himself and Mr. MURRAY), was read twice by its title and referred to the Committee on Education and Labor.

Mr. WAGNER. 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. 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 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 failing 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 non-profit 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.

Now, Mr. President, I ask unanimous consent to include in the Record as a part of my remarks the remainder of my statement, including questions and answers on the bill itself.

The PRESIDING OFFICER (Mr. HUFFMAN in the chair.) Without objection, it is so ordered.

The matter referred to is as follows:

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 number of Negro mothers who died when their babies were born was twice the number of white mothers. Twenty-five 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 over-crowded district has a death rate from this cause which is 30 times the rate in more favored districts. The highest 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 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 4 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 people 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 and 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 (section 205).

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 all 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 commonsense 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 (f) 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 seventeen to eighteen 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 for which care is not given under these plans.

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 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.

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 section 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 section 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 section 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 percent 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 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 criticized 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 under the Blue Cross 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 Sugeon 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.

Mr. HILL. Mr. President, will the Senator from New York yield?

Mr. WAGNER. I yield.

Mr. HILL. I have been very much interested in the statement of the Senator from New York about the bill which he on behalf of himself and the distinguished Senator from Montana [Mr. MURRAY] has just introduced. Does the Senator's bill take care of all the people, particularly I have in mind the large group engaged in agriculture and those living in the rural districts?

Mr. WAGNER. It does.

Mr. HILL. In other words, it is all-inclusive?

Mr. WAGNER. Yes; it is all-inclusive.

Mr. HILL. The provision for the prepayment of medical costs under the insurance plan would take in everybody.

Mr. WAGNER. Yes.

Mr. HILL. I thank the Senator.

REORGANIZATION OF GOVERNMENT AGENCIES

The Senate resumed the consideration of the bill (S. 1120) to provide for the reorganization of Government agencies, and for other purposes.

The PRESIDING OFFICER. The question is on agreeing to the amendment proposed by the Senator from New Jersey [Mr. SMITH] as a substitute for the committee amendment, as amended.

Mr. WHITE. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk called the roll, and the following Senators answered to their names:

Austin	Gurney	Murdock
Bali	Hart	Myers
Barkley	Hatch	O'Daniel
Bilbo	Hawkes	O'Mahoney
Brewster	Hayden	Radcliffe
Bridges	Hickenlooper	Reed
Buck	Hill	Revercomb
Bushfield	Hoey	Robertson
Butler	Huffman	Russell
Byrd	Johnson, Colo.	Shipstead
Capper	Johnston, S. C.	Smith
Carville	Knowland	Stewart
Chavez	La Follette	Taft
Connally	Lucas	Taylor
Cordon	McCarran	Thomas, Okla.
Donnell	McClellan	Tunnell
Downey	McFarland	Tydings
Eastland	McKellar	Vandenberg
Ellender	McMahon	Wagner
Ferguson	Maybank	Walsh
Fulbright	Mead	Wheeler
George	Millikin	White
Gerry	Mitchell	Wiley
Green	Moore	Wilson
Guffey	Morse	Young

The PRESIDING OFFICER (Mr. MCCLELLAN in the chair). Seventy-five Senators having answered to their names, a quorum is present.

TERMINATION OF RATIONING OF BUTTER, OLEOMARGARINE, FATS, OILS, AND MEATS

Mr. STEWART. Mr. President, I desire to detain the Senate for but a few moments.

On the 8th of November I submitted a resolution (S. Res. 185), which was referred to the Committee on Banking and Currency. The resolution concludes with the following:

Therefore be it:

Resolved, That it is the sense of the Senate of the United States that the Department of Agriculture should order the Office of Price Administration to cease rationing of butter, oleomargarine, fats, and oils, and meats as soon as is practicable, but in no case later than November 15, 1945.

Mr. President, the date of November 15, of course, has already passed. The