10789

CONGRESSIONAL RECORD—SENATE

I have the recent events pertaining to demobilization clearly indicate the potential danger that lies against that freedom as we have always known it.

I therefore want to urge 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, but as I do not threaten him with the rights of his fellow men, in his own hands during peace time.

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 reached 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 peaceful military training on a compulsory basis thinking of defense and only defense? Two years' Army service will create a freedom-loving generation to ask any 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 cadre and a reserve of officers and enlisted men taking their place in the event of a crisis, the time lag in manufacturing new war goods. For an illustration, our present equipment will be obsolete in five to ten years. It is not entirely obsolete due to the atomic bomb. Our next 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 train the people. And here is another point worth mentioning, can we take steps that will insure the assurance and fair trial by the military of new or revolutionary methods? We do not have 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.

Sincerely,

GERMAN BUSINESS STILL A MENACE—ARTICLE BY SENATOR THOMAS BUTLER

Mr. TAYLOR asked and obtained leave to have printed in the Reco a statement 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 CHAIRMAN OF THE JOINT COMMITTEES ON THE NAVAL CONSTRUCTION BILL

Mr. MAYBANK asked and obtained leave to have printed in the Reco a statement addressed by the Honorable James F. Byrnes, Secretary of State, at the mayor's dinner at the Francis Marion Hotel, Charleston, S. C., in the January 16, 1946, which appears in the Appendix.

CRITIQUE OF LABOR LAW—ADDRESS BY PROF. WILLIAM STEINBERG

Mr. BUTLER asked and obtained leave to have printed in the Reco an address entitled "Critique of Labor Law," delivered by Prof. William Steinberg, of Creighton University School of Law, to the former Institute of the Nebraska Bar Association on November 31, 1945, which appears in the Appendix.

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

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

UNIVERSAL MILITARY TRAINING

Mr. HOBY asked and obtained leave to have printed in the Reco a letter written by Edward T. Pescis of Englewood, Colo., which appears in the Appendix.

NATIONAL HEALTH PROGRAM—MESSAGE FROM THE PRESIDENT (H. DOC. NO. 389)

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

(Por President's message see p. 10817 of the House proceedings of today's Reco.)

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. Munay], I ask unanimous consent to introduce the bill which is to 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) is to provide for a national health program, introduced by Mr. Wagner (for himself and Mr. Muray), 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 and opportunities.

The need for a national health program has been proved many times. In recalling the need for health insurance, I quote from a statement, Principles of a National-Wide Health Program, issued last year by 36 leading health experts, including 18 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 fall far short of 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 consumers, advancing medical knowledge, reducing and preventing disease. Nevertheless, unmet needs for medical care are widespread and the average costs are heavy and sometimes overwhelming. There has been massive investment in medical facilities and services. The result is 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 financed with taxation in behalf of people without sufficient income, preventive services and needed extensions and improvements of all facilities. In order that comprehensive services shall be available to all, 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 contributions for medical-care insurance will now 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, and the administrative costs are regulated, instead of falling with disastrous uncertainty. Piece should be maintained for voluntary action by many agencies as well as for action by our national, State and local government.

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

1. 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 insur-
rapidity or where the development of facilities has been haphazard or the financial support completely inadequate.

III. There are extensive deficiencies in the number and type of personnel needed to provide the services. Here again, the needs vary according to categories of population and types of community.

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

VI. Expansion of scientific research is unfortunately hampered by the paucity of skilled personnel.

VII. 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 and which I am about to present, 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 have been 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 in rural areas which are not served by public-health departments; others inadequately maintain such departments.

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

Only a small portion of the population receives adequate medical care. While many millions of Americans are covered by medical service plans, this coverage is inadequate and millions of persons who choose them. Free medical services will be provided for others or for others, they choose to pay for their care privately (that is, with their own funds or with the use of the services of the system).

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

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. Mansfield in the chair.) Without objection, it is so ordered.

The matter referred to is as follows:

QUESTIONS AND ANSWERS ABOUT THE PREPAID

First, under the bill the "entire 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 in rural areas which are not served by public-health departments; others inadequately maintain such departments.

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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, if approved by the Surgeon General, of 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 would not hire doctors for the prepaid service. As to 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. This 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.

6. 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 suit them on all matters of policy. The bill is to be interpreted as a representation 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 the American Medical Association 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 interested in 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 of and 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 sum 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 represent new 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 a year for medical services excluding dentistry and home nursing.

7. Is it true that the Surgeon General will decide who will furnish medical services?

Certainly not. In each area patients will have free choice of all general practitioners of medicine or dentistry within the system (Sec. 206 (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—public, private, 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 report—would as a matter of course be included in the list of hospitals 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 (b)).

The object is to make hospital care more available to people—not less available. Such 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 (b-1)).

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 even less difficult—than those required by the Blue Cross plans.

Will the government be responsible for grants-in-aid for medical education meant that medical education will be controlled by the Surgeon General and that the government will dictate what medical educators do? Of course not. The provisions of the 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, 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 Surgeon General can limit the number of patients a physician will be allowed to treat. Won’t keep people from having the doctors 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 (b1)) is merely permissive. This was the only way 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 finds it wise to use it, would, to a small extent, interfere with the guaranteed freedom of insured persons to choose their own doctors.

10. 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?

Absolutely not. This is nonsense. The Surgeon General will make no attempt to control the activities of doctors. Questions like this confuse and disturb physicians and the public. They can be answered by neither a flat "yes" nor a flat "no." Under the prepaid program, specialists will be compensated at a rate higher 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 the standards must be accredited by physicians through their professional organizations.

11. Will the enactment of the bill mean 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 treat-
ment services it requires. The provisions for consultant and specialist services, for hospital services, and for X-ray and laboratory services as benefits under the bill will mean that doctors will use these services when they consider it advisable, without the patient's pocketbook.

Whenever they consider it advisable, doctors can make use of these services for hospital care, and for X-ray and laboratory services he requires. The provisions who answers a patient's call today have no answer to it yet to get a doctor if they need one at night or on holiday.

Certainly not. Any such idea is nonsense and an insult to the medical profession. There is no one statement in the bill which even implies that doctors are to work any longer for the fee. More a doctor who answers a patient's call today has no idea when or whether he will be paid for his services, but the doctors will look after their patients conscientiously any way they know they will be paid today when payment is under a certain minimum.

Is it true that, under a system of pre- paid medical care, physicians will have lower incomes than they have now? With 60,000 physicians in the armed services during the war, those left in private practice have been overworked and their incomes have been very high. They have not been getting any pay in one year. The question really means "Will physicians have less income under this bill than they usually have" the answer certainly is "No." Before the war, the highest average gross incomes were $15,000 in 1930 or 1929—again years when all incomes were unusually high. In those years physicians earned on the average about $10,000 gross, but in the years since then and before the war at such average have been from $6,000 to $8,500 gross.

It is calculated that on the average $1,000,000,000 annually could be spent for physicians' services. At this rate, if 150,000 physicians are in private practice, they would average about $10,000 income in a normal year under the bill. Like the previous figure, this includes incomes of both general practi-
tioners and specialists. The general prac-
tioners' incomes are less than the specialist and, as the bill provides, the qualified specialist with full experience would receive a higher rate than they usually have the answer certainly is "No." Before the war, the highest average gross incomes were $15,000 in 1930 or 1929—again years when all incomes were unusually high. In those years physicians earned on the average about $10,000 gross, but in the years since then and before the war at such average have been from $6,000 to $8,500 gross.

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Every 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) plans being able to handle hospital care; but even after more than 15 years of existence these plans cover only seventeen to twenty million people, most of these in large urban centers. Hos-
pitization is the largest single kind of insurance in the medical field to sell. Voluntary plans that provide medical care now cover only about 40 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 societies plan 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 to cover any group which are 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 recently 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 construct-
ing hospitals in rural areas, and other areas where they are needed, it will be possible to speed up the progress of comprehensive hos-
tial care. In turn the prepayment of medi-
cal care costs, including the costs of hos-
pitalization, will assure the maintenance of the hospitals which will be built and will encourage the construction and improve-
ment of needed hospitals. A sound hospital-
construction program requires that there is also an insurance system to cover hos-
pitalization 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 INCOME**

The Senate Committee on Military Affairs already has before it legislation providing for the promotion of medical research and professional educa-
tion. The passage of such legislation should help to advance medical discoveries, to improve the quality of med-
ical research in our universities and medical schools, and to make it possible to give opportunities for further training and educa-
tion to many more young men and women. At the present time many promising individ-
uals 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 in-
troduced contains provision for medical re-
search and education, particularly in section 314 (f) and 314 (1) of the Public Health Service Act (p. 345, 1 p. 341, 2 of the bill) and section 215 of Title II of the bill.

The amended provisions in the Public Health Service Act provide additional Fed-
eral funds available to the States through the United States Public Health Service for pub-
llic health research, training of personnel, public health education, and planning and coordination of health service and activities.

Section 215 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 educa-
tion and training of persons in furnishing health benefits or of making valuable contribu-
tions with respect to the care, preventi-
on, or methods of diagnosis or treatment of disease or disability. Provision is made for giving preference to educational projects for returning servicemen seeking postgradu-
ate training in medicine, surgery, and related fields. The initial sums available for each of these purposes for the fiscal 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 mod-
ern medical discoveries. Under present-day arrangements the results of new discoveries are not brought quickly enough to the atten-
tion of all practitioners.

The GI bill of rights contains educational provisions which also should be made 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 and the people must have permanent and comprehensive legis-
lation 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 secured without providing for cash benefits to individuals during periods of sick-
ness or disability. The Senate Committee on Social Security has in its report on a companion bill, the National Health Act which I have introduced, provided for cash benefits during periods of sickness or disability as a part of our other social security programs. This legis-
lation already is pending before the Senate Committee on Finance and the House Commit-
tee on Ways and Means. These pending bills also provide that there should be set aside annually an amount equal to 3 percent of the social insurance benefits paid on behalf of all such disabled individuals to be used for med-
ical, surgical, institutional, rehabilita-
tion, or other services to disabled individ-
uals entitled to receive cash disability insurance benefits, if such services are not otherwise available through existing legislation, and might aid such individuals in gain-
ful work.

I am hopeful that Committees of the Sen-
ate and House which have this matter now will hold hearings on it soon to expedite the passage of both a national health program and an expanded social security program.

**OTHER HEALTH LEGISLATION**

There also are pending before the Congress bills at the present time with respect to health, relating to health, each limited to a particu-
lar problem. While each problem—such as pensions for disabled veterans, or med-
care for dependent children or for the elderly—has its merit, piecemeal considera-
tion of each separate problem by the Cong-
ress is not the best method of developing a sound national health program. Such a piecemeal approach invariably results in gaps, overlap and inconsistencies. Such bills in competition for trained personnel to administer such programs, especially in care 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.
conditions in these institutions. State li-
censure laws are so complex, so lacking in
uniformity, and so obstructive of interstate
mobility of qualified practitioners that some
 Physicians, who make medical care necessary to bring ord
out of this chaos. There are no medical
school standards, and measures for retai-
ning 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 Serv-
ices

Title II—Personal Health Service Benefits

Title III—General Provisions

THE 1945 HEALTH ACT—CARE FOR NEED-
ED PERSONS

Title 1 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
for Needy Persons

All three parts of title I provided grants
in aid to the States for health services for
which the Federal Government already pro-
vides funds.

In general, the purpose of this title is
to amend and broaden existing legis-
lation to 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 dis-
case 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
meeting as practicable toward the
development of adequate public-health
services in all parts of the country.

The present authorization of $30,000,000 a
year for grants to States is replaced by an
authorization to appropriate a sum sufficient
to carry out the purposes. Also, the maxi-
mum annual amount authorized to be avail-
able 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 speci-
cified in the bill. An essential part of any ar-
rangement is laid down, insuring reasonable
standards and systematic financial partici-
pation by the States. This is the same gen-
eral pattern as has been followed for public
assistance programs since the original Social
Security Act of 1935.

The amounts of the grants to States are
determined by an exponential formula, de-
digned to give proportionately more aid to
the poorer States. The variable Federal
grant is based on the per capita income of
60 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 serv-
ces 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
cild 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 Chil-
dren's Bureau. The requirements are those
that are essential to insure reasonable stand-
ards, systematic financial participation, and
reasonably rapid extension of the services to all parts of the States and on an
adequate basis. Administration by the Fed-

eral 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 vari-
able 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 Govern-
ment 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 136 (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 laws).

These Federal grants, like the similar pro-
visions of the present law, are to be made out of general revenues of the States. As under existing
law, State plans must meet various require-
ments specified in the bill, including mainte-
nance of civil-service merit standards for ad-
ministrative personnel.

The limitations governing the existing Federal
law are removed so that the States may obtain Fed-
eral funds to help provide medical care to
needy persons and thereby to reduce illness
and suffering and wherever possible to help
needy persons to maintain or improve self-support.
Most States are already providing such care
under existing public-welfare laws, but, be-
cause of the restrictions in the Federal law,
this care is inadequate. By providing Fed-
eral financial aid toward meeting part of the
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 legis-
lation would make federal Federal funds
available to every State in the Union, it is
essential that the Federal programs provide
more adequate assistance and improved
and simplified administration. Since under this
portion 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 pro-
vides that as a condition for obtaining Fed-
eral funds the State public-assistance plan
must provide for the distribution of funds so as
to assure meeting in full the medical need of
individuals throughout the State as deter-
mained in accordance with standards estab-
lished by the State. This provision would not
modify the existing law in any way by which
these cases of 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 all needy
individuals in a particular county will not be
deny assistance because of the lack of ade-
quate financial participation by such county.

Section 136 of this part provides for coordi-
nation between the administration of med-
ical care under this program with the serv-
ices provided under the other programs in the
bill.

Title II—PREPARED PERSONAL HEALTH SERVICE

Benefits

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

Section 313 of the bill establishes a per-
sonal health service account, out of which all
the benefits under title II are paid.

The financial barrier to adequate hospital
and medical care has been one of the major
problems of modern medicine. It will en-
courage doctors to settle in rural areas and communities to construct needed hospitals and health centers by as-
uring adequate incomes, equipment, and fa-
cilities for modern medical practice. It will
benefit patients, doctors, and hospitals.

The bill provides for a comprehensive
system of prepaid medical care. The pro-
visions of the bill are based upon long and
thorough study of existing prepaid medical
health plans in this country and abroad. The
provisions of the bill are consistent with the
policies and program set forth (1) in the Re-
port of the Health Program Conference on
Principles of a National Health Program, issued in 1944 by 20 leading health experts,
(2) in the statement on cooperation of the
American Medical Association, the American
Medical Association, and the American Fed-
eration of Labor and the Congress of Indus-
trial Organizations in their annual con-
ventions, and (3) in the report. The provisions of the
bill are consistent with the programs set
forth by both the American Federation of Labor and the Congress of Indus-
trial Organizations in their annual con-
ventions.

A Nation-wide comprehensive prepaid medical-care plan can be financed in any one
of several different ways. Provision, for such a system, might be secured through income
taxes or through pay-roll contributions, or both. In either case the maximum provision can be provided. The
extent of a general governmental contribu-
tion out of general revenues to such a plan
depends upon the comprehensiveness of the
programs 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. More-
evertheless, the financial details relating to the raising of the revenue for the plan raise many special problems which have a bearing on existing income taxes and pay-roll contribu-
tions, and should be considered in rela-
tion to these laws.
The bill does not, therefore, specify any particular method by which the sums authorized under title 212 of title II would be raised. Since under the present legislative situation, 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 (HR 212, S 100) which provides for the raising of revenue for the national 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 an arrangement consideration 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 plan 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 easy access to the medical care that he or she needs by establishing prepaid medical care similar because they are guaranteed payment for their services.

There are many individuals, honest and sincere in their desire for improved conditions, who nevertheless for any change, and distrust all new social legislation. Those of us who have sponsored social legislation have faced similar opposition as against many propo- sals for social betterment, yet we have proceeded, for as we have seen these new programs accepted as part of our basic system of American freedom and dem- ocracy. The facts are: Our precedent 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 at that time. Now all of the States but one have workmen's compensation laws—spurred on by what the people want, 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 voluntarily agreed to go into the system. Each doctor or group of doctors is free to accept or reject patients who wish to utilize his services, 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 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 has also 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 uncovered persons, patients, and other persons informed of the need for, or provision of, health benefits. These provisions assure that there will be no discrimination or regulation against the bill, as some propagandists have implied.

The Surgeon General is directed to establish a National Advisory Policy Council with which he will be able to consult and receive advice and suggestions. The Surgeon General is also required to report annually on the operation of the program to the Congress and the program must be submitted for approval to Congress each year.

This complete freedom of choice is among the most important provisions of the bill. The nonindustrial groups, churches, fraternal associations, consumer groups, employers, nonprofit community groups, churches, fraternal associations, or any others may form their own program as organizations that will furnish services to them. The bill not only provides for all existing service organizations but it also ensures 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 this program. The Surgeon General is required to report annually on the operation of the program to the Congress and the program must be submitted for approval to Congress each year.

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, to assist in the administration, problems affecting regions of localities, and related matters.

The bill specifically provides that all such councils—national and local—are to be only advisory to the appropriate administrative officials and may specifically argue the advice of such councils.
Some organized medical groups have criticized this provision on the grounds that it centralizes too much decision-making authority 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.

The Surgeon General and the Social Security Board are directed to make studies and to report to Congress on dental, nursing, or other 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 for the undergraduate or postgraduate professional education.

Title III-General Provisions

Section 302 provides for the usual separation 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 Virginia (Mr. Monravy) has just introduced. Does the Senator's bill take care of all the people, particularly those I have in mind as 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. 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. Smir] 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:

Austen Buck
Ball Hart
Barkley Hatch O'Daniel
Bills Hawkes O'Mahony
Brewer Hayden Race
Bridges Hickenlooper Reed
Butler Hill Revercomb
Buschfeld Hoy Robertson
Byrd Huffman Russell
Capper Johnson, S. C. Smith
Chase Kefauver Stewart
Chavez La Follette Taft
Connally Lucas Taylor
Cordon McCarran Thomas, Otb.
Dennett McNamara Tunney
Dewey McFadden Tymbough
Ellender McVicker Vandenberg
Eilender McMillan Wagner
Parker other Marbuk
Fullbright Mead Wheeler
George Millikin White
Gerry Mitchell Willey
Green Morse Young
Oufey Morse Young

The PRESIDING OFFICER (Mr. McMullen 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 restricting the sale of butter, oleomargarine, fats, and oils 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