It now develops that Cuba will not reach the 340,000 tons which she had
reserved for her home consumption. It further develops that she cannot sell
the 340,000 tons which she has retained as export-free sugar. Originally, Mexico
had planned to take approximately 100,000 tons of that sugar. Within the past
week Mexico has announced that she will take no part of that export-free sugar,
and that she herself has sugar for sale.

France, which had been allocated sug-
ary by the International Emergency Food
Cane: 17 average
United States Senate.

in Cuba a tremendous surplus of sugar
googling for a buyer, and there is a
tremendous surplus of sugar up and
down the eastern seaboard.

I should like to discuss this matter in
more detail; but I believe that the chair-
man of the Finance Committee, the Sen-
ator from Colorado (Mr. glend], de-
sires to have the Senate proceed to con-
sider the tax bill, and would not care to
have me take further time on this mat-
ter today. So I shall reserve any further
comments until a later time.

Mr. TOBEY. Mr. President, let me say
that I have great respect and regard for
my distinguished colleague, the Senator
from Wisconsin (Mr. McCarr;); and
although sometimes we were on opposite
sides in respect to the recent sugar-con-
tr controperation, nevertheless when that
matter was finally disposed of, I re-
spected him for his opinions, and I have
the highest regard and feeling for him.

Let me say that the question of sugar rationing is now coming up again, in
revised form, due to some changes in the existing world supply of sugar.

When I recently saw in the press ar-
ticles regarding the present sugar situa-
tion and the change in the sugar ratio-
tion over the period from June until October,
I telephoned to Mr. James Marshall, of
the Sugar Division of the Department of
Agriculture, and asked him to advise me when and how the situation really was. He
has written me a letter, which has been
received today, and I am anxious con-
sequently to have the data and the sta-
statics and supplemental data accom-
panying his letter.

I do not, however, feel that the sugar committee of the International
Emergency Food Council is constantly re-
viewing the over-all sugar supply situation for the purpose of bringing into the pool all
possible additional supplies which may become avail-
able and also to resolve any sugar which any claimant country indicates will not be
used. We have indications at present that
France may not take her entire allocation; how-
ever, realization of any quantity so re-
leased would not be sufficient to materially
change the total supply available to the
United States. There is also some possibility
that Cuba may make available some of the
sugar which, under the terms of the Cunliffe
contract, has been withheld for local con-
sumption and free export. However, at any
time of this sugar has been offered, nor has
Cuba indicated that this sugar will not be
used for the purposes for which it was
sold.

At present we have nothing definite on the Java sugar situation although, following the
recent agreement between the Netherlands
and the Indonesian Governments, a repre-
sentative from the Department of AGRi-
CULTURE is on his way to Java to make every ef-
fort to get as much first-hand information as
possible. We shall continue to follow de-
velopments in that area closely.

Since the allocations for all countries con-
tain over 700,000 tons of undesignated
sugar, it is not known at this time whether the
United States will receive more than her
200,000 tons of undesignated sugar from the
increased Cuban crop, and therefore it is too
easy to know whether or not we will allow-
to our total supply for the year will exceed the 6,500,000 tons now
allowed.

Sincerely yours,

JAMES H. MARSHALL,
Director.
Florida [Mr. Pepper], the Senator from New Mexico [Mr. Chavez], the Senator from Idaho [Mr. Talmage], and the Senator from Rhode Island [Mr. McGowan], I am introducing a bill providing for a national health-insurance system and a national public-health program. Represented by the State of Michigan, is introducing a companion bill in the House of Representatives. I send the bill to the desk, and ask that it be appropriately referred.

The President pro tempore. Is there objection?

There being no objection, the bill (S. 1320) to provide a national health-insurance and public-health program, introduced by Mr. McGraw (for himself, Mr. Wagner, Mr. Pepper, Mr. Chavez, Mr. Taylor, and Mr. McGowan), was received, read twice by its title, and referred to the Committee on Labor and Public Welfare.

Mr. Murray. Mr. President, I commend this bill to the Senate for careful and sympathetic consideration. It proposes to meet one of the Nation's most important and most urgent needs, because it would lay a broad basis for the preservation and improvement of the national health.

Mr. President, the greatness of this Nation depends not so much on its natural resources, boundless as they may be. Neither does it depend on our great industrial power or geographical position. In the final analysis, it depends on a healthy, virile citizenship. Our population is our greatest asset; our vigor and productivity, which depend on health, constitute our greatest source of strength. The health of our people, from every consideration, is of paramount importance to our future national welfare.

In this troubled world, racked by great international strains, wasted by the most devastating war in history, with tens of millions of people suffering from want and from loss of their political moorings, great burdens fall upon the people of the United States. No one at this moment can foresee our future; but every thoughtful person can foresee the wants and needs of our citizens.

In 1939, the Senator from New York [Mr. Wadsworth] introduced the first comprehensive national health bill. It was considered at length by a subcommittee of the Committee on Education and Labor of which I had the privilege to be chairman. Though given a favorable interim report by the subcommittee, no final action was taken on the bill. In 1940, the Senator from New York [Mr. Wadsworth] and the Senator from Georgia [Mr. Goode] introduced a hospital-construction bill which was favorably reported by the Committee on Education and Labor, and passed by the Senate. It died in the House committee. A bill dealing with the same general problem was finally enacted by the Seventy-eighth Congress, Public Law 128, approved August 13, 1945.

In 1945, while we were still in the midst of the war, the Senator from New York and I introduced in the Seventy-eighth Congress, Senate bill 1161, which provided for a comprehensive postwar social security program. To make this program complete in its aim to protect the people against major economic hazards, we included provisions for health insurance. The bill died in committee.

In May 1945, the Senator from New York and I introduced a similar measure, Senate bill 1056. Later in the same year, in a special message, President Truman proposed a broad legislative program for national health and we presented Senate bill 1056, known as the National Health Act of 1945, which was specifically devoted to a health program. This bill had two major parts: Title I provided for the expansion of public health services, maternal and child health service, and the medical care of needy persons; and Title II provided for a system of personal health services to be developed on a social insurance basis.

This bill was, in many respects, the forerunner of the bill we present today.

In President Truman's three major messages in the early days of the present Congress, the State-of-the-Union message, the budget message of January 3, 1947, and the economic report, he again called attention to the need for health insurance. The President submitted a broad public health program and recommended that the Congress lay the legislative groundwork for a national system of compulsory health insurance.

Yesterday, in a special message on health, he again called to the attention of the Congress the large health needs of the Nation and again recommended the enactment of a broad national health program.

These recommendations are in line with the expressed will of the people, as attested by numerous polls of public opinion which indicate that our citizens want a comprehensive health program, and particularly a system for the prepayment of medical costs. The strong expressions of public opinion should be a guide for us to proceed with legislation that meets this demand.

At last we can dispense with lengthy consideration of the need for a comprehensive health program, and the need for insurance protection against sickness costs. The record is complete and readily available. Even the leading medical organizations, which for years denied the existence of need, now admit it and are themselves actively sponsoring insurance against medical costs. It is time for us to move on to constructive planning and cooperative action. The bill we present today is intended to meet the wants and needs of our citizens.

At the hearings on Senate bill 1056, held before the Committee on Education and Labor of the Seventy-eighth Congress, the provisions of that bill were subjected to close scrutiny and full debate. More than 100 witnesses, including representatives of physicians, dentists, nurses, labor unions, private health insurance plans, lawyers, church groups, government, and various civic and welfare groups contributed their oral and written testimony. The hearings, extending from April through June 1946, constitute a printed record of over 3,000 pages.

During the course of the hearings, many points of view were expressed, a great deal of factual information was presented, and many constructive suggestions were made. These have all had their influence on the rewriting of Senate bill 1056 and on the preparation of the bill introduced today. The testimony was overwhelmingly in favor of this kind of legislation. The need for a comprehensive health program, especially a plan for the prepayment of medical costs, was generally approved by most witnesses, excepting only those from certain professional associations. Many witnesses offered suggestions for changes. All of these proposed changes were given careful consideration. In drafting the present bill, every effort was made to improve on Senate bill 1056.

A careful reading of the provisions of this new measure will show that all reasonable criticisms of a health insurance program as set up in Senate bill 1056 have been overcome.

General Outline of the Present Bill

Our present bill has three titles, the content of each being shown in a table of contents which, for convenience, has been included with the preamble.

Title I—Declaration of Purpose.

Title II—Prepaid Personal Health Service Benefits.

Title III—Development and Expansion of Health Services.

BROAD MENU.

First, a comprehensive national system of prepaid personal health services, with decentralized administration to be carried out by the States and by local agencies.

Second, Authorization to use Federal grants-in-aid to the States—public assistance—toward paying for personal...
The national advisory council is to consist of the chairman of the five-man board and 16 members appointed by the Federal Security Administrator. The appointed members would have 4-year terms of office. At least eight of them shall be well-informed persons who would represent the people entitled to benefits; and at least six are to be outstanding professional persons who would represent those who provide the health services. The advisory council could appoint its own special committees and would have broad responsibility to advise the Board on policy and administration.

Similarly, each State would be required to have an advisory committee that includes public and professional representatives. Also each local administrative or advisory committee must be similarly constituted.

These advisory bodies would not be merely window dressing. The bill gives them broad and important functions. They would be a basic part of the whole system, assuring active and continued participation by the public and the professions.

This is not a tax bill, since all tax bills must originate in the House of Representatives. Therefore, it deals with only part of the financial provisions that are needed. This bill provides for annual appropriations to a Personal Health Services account of the money needed to finance the system, the total not to exceed 2½ percent of covered earnings; in the first 3 years or 4 percent in the next 3 years. Therewith, Congress would determine the limits in light of operating experience. These fiscal provisions have been written on the assumption that a separate tax bill would provide for social-insurance contributions.

The bill indicates how the insurance funds are to be allotted as between normal and emergency needs, and how they are to be allocated among the States that actually administer the system. Administrative expenses would be under direct congressional control.

In addition to the annual appropriations, the bill provides for an initial one-time appropriation to the insurance account of an amount equal to 1 percent of covered earnings, to provide an initial reserve fund. This could be an appropriation from general revenues, or a loan to be repaid to the Treasury in small installments over a period of years out of current social-insurance income, or the yield of a small social-insurance tax levy inlaid in advance of the date when benefits first become available—according as may seem best when the tax bill is considered.

A special section amends the Social Security Act so that States can use public assistance grants-in-aid, along with their own money, to pay insurance premiums for needy persons who are not insured through their own earnings. Workmen's compensation cases can be served by the system and the insurance account reimbursed for the costs involved.

There are many specific provisions to deal with particular problems that are sure to arise in the operations of a health insurance system. For example, there are provisions for:

First. Making further studies and reports to Congress;

Second. Nondisclosure and confidential protection of the records about individuals;

Third. Prohibition against discrimination on account of race, creed, or color;

Fourth. Special arrangements to meet the needs of rural areas that lack practitioners or hospitals or that need ambulance services, travel to larger communities, or special health education services;

Fifth. Appeals by insured persons or by practitioners against decisions or practitioners that do not like which;

Sixth. Judicial review of administrative decisions;

Seventh. Special provision to use a small fraction of the insurance funds to support research and practical education so that the system will constantly contribute to the progress of science, the training and advancement of practitioners, and the improvement of health services.

The purpose of title III, part A, is to provide for a reasonable, balanced, and flexible development of community-wide health services.

Under present laws Federal and State governments cooperate in general public-health work, maternal, and child-health services; crippled-children's services; campaigns against venereal diseases, tuberculosis, mental diseases, and so forth. These present laws, however, develop in a spotty and uneven way. They are not altogether coordinated, they have many inadequacies, and they leave large gaps. Title III repeals those existing laws and substitutes a simplified, comprehensive plan under which the Federal and State governments could go forward in a more systematic and more effective way to prevent disease and improve national health. The allotment of Federal grants amounts to the establishment of a uniform basis for all the health programs involved, and the Federal-State financial sharing under this bill is on an explicit statutory basis.

The purposes of title III include basic State and local public-health services for all communities in a State; maternal and child-health services and the location and care of crippled or otherwise physically handicapped children; programs to attack and control tuberculosis, venereal diseases, mental disorders, cancer, heart and degenerative diseases, dental disorders, nutritional deficiency diseases, other important diseases and conditions; health services for the aged, the chronically ill, workers in industry, and other groups whose health problems involved special public concern; training of personnel; and development of effective ways to carry out these various purposes. Such services may not duplicate those available under title II of this bill.

Title III, part A, authorizes the appropriation of funds to be used as grants to the States, beginning with $100,000,000 in fiscal 1948, increasing to $500,000,000.
000,000 in the fifth year, and to sums sufficient to carry out the stated purposes of the program in succeeding years. These funds are to be allotted to the States according to the population and the financial resources of the States.

Each State may develop its own plan to carry on any or all of the various purposes for which the funds are authorized, according to its own judgment as to the needs of the State. If the plan meets the minimum essential requirements specified by Congress to assure that the funds will be properly expended for the intended purposes, the plan must be approved by the Federal Security Administrator. The Administrator is given only limited discretion to assure that the Federal funds are not used excessively to finance some particular aspect of a plan to the neglect of other urgent needs in a State.

The minimum conditions to be met by a State plan includes provisions in its plan for:

- First, a single State health agency to administer or supervise—within transitional provisions for States using multiple agencies;
- Second, financial participation by the States;
- Third, training of personnel;
- Fourth, State-wide extension of services within 10 years;
- Fifth, State standards for services;
- Sixth, no discrimination on account of race, color, creed, citizenship, or economic status, and opportunity for a hearing regarding denial of services, or to those furnishing services or desiring to participate;
- Seventh, efficient administration, including personnel standards on a merit basis;
- Eighth, safeguards to restrict the use or disclosure of information about individual providers of services;
- Ninth, cooperation with medical, health, educational, welfare, and other organizations, and with other public agencies;
- Tenth, advisory councils and similar bodies, with members from public and private agencies, the professions and the public;
- Eleventh, reports needed by the Federal Security Administrator; and
- Twelfth, closure of any gaps in the particular purposes and program to be carried out and the financial plan for the operations.

From within its allotment of total funds, each State would be entitled to Federal grants ranging from 50 to 75 percent of the cost of the program. A Federal percentage is determined by a formula which gives more to the poorer than to the wealthier States, according to their per capita income.

The States may also be assisted through Federal services, as may be provided by Congress through appropriations that are authorized in this title. These services may include demonstrations, studies, grants to public or other nonprofit institutions, training or detail of personnel, and so forth.

The Federal Security Administrator is to carry out the program of title II, part A, through the Public Health Service, the Children's Bureau and other constituent units of the Federal Security Agency. There is special provision that Federal regulations shall be prescribed only after prior consultation with representatives of the States participating in the program and, insofar as practicable, with their administrative agents for the national health program.

The second part of title III deals with construction of hospitals and related facilities. Last year, Congress enacted the Hospital Survey and Construction Act—Public Law 756, Seventy-ninth Congress, approved August 13, 1946—adding a new title VI to the Public Health Service Act. Under that new act, Federal funds were provided to make State-wide surveys of hospital facilities and needs, and to aid public and other nonprofit agencies and organizations in the construction of needed hospitals, health centers, laboratories, outpatient departments, nurses' homes, clinics, and so forth. There are several major deficiencies in that act, and they should be corrected, lest they hamper the balanced development of a national health program.

Part B of title III makes the following improvements:

First, since the funds authorized were too small to take care of all the urgently needed hospital construction, they are increased from $75,000,000 to $100,000,000 a year—after the fiscal year 1948;

Second, since the 5-year program is too short to meet the needs, the authorizations are extended for an additional 5 years;

Third, since the Hospital Survey and Construction Act made no financial provision for the "maintenance and operation" of hospitals, the program had to allow special exceptions or flexibility concerning assurances that needed hospitals could be financed after they are built; but since the system of prepaid personal health services proposed in title I would guarantee payment for hospital services and thus supply money for "maintenance and operations," these provisions would no longer be needed and they are deleted.

Fourth, since the 1946 act provides, through Federal aid, only 35% percent of the construction cost, it is less helpful than it can or should be to the poorest areas, and this provision endanger the whole program by giving insufficient aid to those areas that need it most; in our bill, the Federal aid is therefore made flexible, ranging from 35% percent for a construction project in the poorest States up to 75 percent for a project in the poorest States. This provision was made in the form in which it originally passed in the Senate.

PRINCIPAL CHANGES IN THE HEALTH INSURANCE PROPOSALS

I should like to summarize the most important changes made in title II of the present bill, by comparison with the provision in Senate bill 1606 of the Seventy-ninth Congress. Since the bill has been completely rewritten and rearranged, it is difficult, if not impossible, to identify all changes, but some major items can be indicated.

In the new bill, the coverage provisions are extended to include civilian Federal employees, including retired employees receiving civil-service annuities, and their dependents. As before, there is explicit provision for coverage through voluntary agreements of groups of persons not otherwise covered; that is, State and local government employees and their dependents. Also, as before, the needy persons can be covered through action by State or local public agencies in procuring voluntary coverage for them. An amendment to the Social Security Act makes clear that the public-assistance grants may be used by the States for this purpose.

The rights of organized groups, as such, to participate in furnishing services and to be paid from the insurance fund have been clarified in the new bill to make even more explicit than before that such groups have in the law of the land the kind of guarantees as apply to individuals. Thus, groups of practitioners, hospitals and their staffs, any organized group of individuals, any partnership, association, or consumer cooperative, any voluntary organizations operating health-service insurance plans or other health-service plans can participate, enter into agreements with the insurance system, serve eligible persons who choose them, and be remunerated, and no agreement can act as agent for others in negotiating or carrying out agreements.

These provisions are accompanied by necessary safeguards. Under agreements with groups of organizations, services must still be provided only by persons who are themselves qualified, have authorized the agreement on their own behalf, and who remain responsible to both the individuals and the system. Moreover, as in the case of agreements with individuals, no agreement with a governmental organization may be monopolistic in scope or, for more than 1 year, preclude any person who is otherwise qualified from making another agreement or choosing another agent.

ADMINISTRATION BY THE STATES

An important change in the bill relates to State participation in the health-insurance program. In Senate bill 1606, State participation was provided, but many critics of the bill thought this was inadequately spelled out. In this bill it is definitely stated that if States meet specified minimal conditions, their plans must be approved, and they become the administrative agents for the national system.

It was always intended that a maximum of administrative freedom be given to States and local areas, but it has now been made mandatory that a State be given the right to administer its own program when its plans conform to the basic national requirements. Although States are given explicit opportunity to be responsible for the administration of health insurance, the guaranties to the public regarding the kind, amount, and quality of service, and to the professions, hospitals, and other furnishing services, regarding their rights and prerogatives, are laid down in the bill, and these must
be observed by the States when they take over administration.

Another clarification concerns administration, which was often erroneously interpreted to be centralized under the provisions of Senate bill S. 1606. In the new bill, administrative responsibility is clearly decentralized, down to a system of local administration under State-wide plans.

Where States accept the responsibility for administration, they may choose the form of administration for each local health area from two broad alternatives: First, an administrative committee in charge, with an executive officer under it; or, second, an administrative officer in charge, working with an advisory committee or board, including three full-time members. In the new bill, administrative responsibility is assigned to a five-man Advisory Council, retained in the new bill, operating under the supervision of the Board. The Federal Advisory Council, in charge of the program's operation through membership on these local area committees or on special professional committees, is of which entrusted with substantial and important functions.

Since the Federal Government undertakes an obligation to the persons eligible for services under the insurance system, and finances the program, it reserves the right to administer the program where benefits would not otherwise be available because a State declines or is unable to take over. If the Federal Government, through the program, is recognized in a State, it also must establish local administrative agencies and local advisory and professional committees.

**ALLOCATION OF FUNDS TO STATES**

Since the present bill provides for administration by the States, it also provides that the States may know how the Federal funds will have to carry out the responsibilities they undertake. The new bill contains an allocation guide for the distribution of funds to the States and through the States to local areas.

Although no specific mathematical formula is given, the statement of basic factors, including population, availability of medical and hospital services, and supplies, and the costs of fair compensation—to be considered in making the allocations—can be identified. In its annual reports to Congress, the Board must make a full report upon the adequacy of financing and the methods of allocation. In time, a definite statutory formula for allocations may be evolved, but this should await the development of further data through actual experience.

**FEDERAL ADMINISTRATION BY A BOARD**

Senate bill S. 1606 was criticized by some people because it lodged the Federal administrative responsibility in one officer, the Surgeon General of the Public Health Service, operating under the supervision and direction of the Federal Security Administrator. In the new bill this responsibility is assigned to a five-man board, including three full-time members to be appointed by the President and approved by the Senate, and, in addition, the Surgeon General and the Commissioner of Social Security, ex officio. The appointed members are to have fixed 6-year terms of office, and at least two-thirds must be doctors of medicine. The President is to designate one of the appointed members to serve as Chairman of the Board. The Federal Advisory Council, retained in the new bill, would have indicated proportions of public and professional representatives.

**SPECIAL PROVISIONS FOR RURAL AREAS**

It is well established and widely accepted that rural areas lag behind the rest of the country in health services, availability of doctors, dentists, nurses, hospitals, and other facilities. A special section, as well as numerous general provisions, regarding rural areas have therefore been added to this new bill. Coverage provisions are clarified to leave no doubt that they include farm operators, as well as farm employees. Rural representation on State advisory committees and on the National Advisory Medical Policy Council is specifically required.

The new bill also contains provisions designed to attract doctors to areas that lack practitioners and to make it possible for them to afford to stay there—by special methods of payment, guarantees of minimum annual income, payment of expenses for moving into such areas, loans for office equipment, and so forth. This section also contains special provisions for the training and education of practitioners needed in rural areas, for ambulance service and transportation expenses to obtain health services elsewhere, and for special rural health informational activities. Also, the Board is required, in its annual reports, to make recommendations on additional measures to assure rural people equal health opportunities under the bill.

**OTHER CHANGES**

Many other changes have been made, especially in light of the constructive criticism offered at the hearings on Senate bill S. 1606. For example, the guarantees of professional rights for practitioners and hospitals are more specifically stated. In the new bill, the provision regarding limitations on doctor-patient ratios, which was intended in Senate bill S. 1606 as a protection for doctors just as much for patients, has been clarified so that the States and the practitioners in any area have primary responsibility for establishing such standards. The 30-day-a-year limit for hospitalization, and the cash indemnity provision in lieu of hospitalization, have been dropped. The new bill clarifies the guarantee of benefits in their relation to the availability of State and local personnel and facilities, with the addition of a new provision specifically calling for improvements in the availability of benefits. If complete dental services cannot be provided to the whole eligible population because of shortage of personnel, facilities, or funds, priority shall be given to children so that they may have comprehensive services ahead of other persons.

These are some of the major changes in the health insurance part (title II) of the new bill. There are many others of a more detailed character than can be included here. The effect of these changes is, I believe, a better program. The major constructive suggestions offered by interested groups and individuals and by representatives of public organizations are reflected in the new specifications. The new specifications meet squarely all legitimate criticisms of the old bill, regardless of whether they came from persons supporting or opposing the bill.

I believe that the bill we now offer is as sound and workable as it can be without the further guidance of actual experience in administering a program of prepaid health benefits.

The sponsors of the new bill are grateful to all who have contributed useful suggestions.

**THE NEED FOR COMPREHENSIVE LEGISLATION NOW**

Mr. President, we believe that the bill I have just introduced for myself and my colleagues, the National Health Insurance Program for the United States, offers a thoroughly practical plan of providing personal health services and community-wide health services for the Nation.

The bill was written with the intention that the system of medical benefits should be financed and administered on a State-by-State basis and that the details of financing have been left to the Congress to decide in connection with related financial matters.

Insurance against medical costs is a sound, businesslike proposition that has been widely accepted in principle by the public and the medical professions alike. It is an effective, decent, and self-respecting way to make it possible for our people to have access to modern medical care and to pay the costs without undue sacrifice. And I wish to point out here that the contribution method of financing would be the only compulsory feature in compulsory health insurance. As one witness said at the hearings on Senate bill S. 1606 last year:

> "The system of prepaid personal health services provided is in the best interest of the public and the medical professions alike. The service is to be provided exactly as at present by existing hospitals and existing physicians—the present practitioner being that payment of fees is guaranteed (hearings, pt. 4, p. 2256)."

The American people have repeatedly and in many different ways expressed their desire to have a system whereby their pay the costs of their own medical and hospital care, on a budget, contributory basis, in advance of the time such care is required. Nevertheless, Senate bill S. 88 was presented in the Senate on February 18, 1947, again offering the outmoded stopgap of medical care for the poor. That bill is another charity program—a particularly bad kind of charity program because it offers charity not only to the destitute but even to those of our citizens who are ordinarily self-supporting.

Recognizing the fact that large numbers of people, well able to meet all the
usual expenses of living that can be budgeted, are not always able to meet the impact of an unexpected medical or hospital bill. Senate bill 545 proposes that we regard such persons as the proper objects of public charity. It would subject the man who has always earned a decent living for himself and his family and has always paid his way to the process of a "means test" or an "income test" to determine his eligibility for public help in meeting the costs of, say, an unexpected surgical operation for which he cannot pay. It is a conceivable—in deed, I think it is almost inevitable—that in time we could become a nation of public-Charity patients under such a plan.

Who are the people, in terms of Senate bill 545, having insufficient income to pay the whole cost of hospital, surgical, medical, and dental services? They are not only those who are destitute and needy, and who need public aid for food, shelter, or clothing, but they are needy when confronted with the cost of expensive medical, dental, or hospital care. They are the "medically needy," and they are the backbone of the American population.

Senate bill 545 offers Federal grants-in-aid to the States to provide subsidy toward meeting, in whole or in part, the costs of medical care "for all those families and individuals in the State having insufficient income to pay the whole cost of hospital, surgical, medical, and dental services." It seems clear that one of two developments must come from such a plan.

If enough money is provided by the Federal Government and by the States to pay the services needed by all having insufficient income for medical services, there would be a great decrease in the numbers of people who need charity help in meeting the costs of medical care. They are not only those who are destitute and needy, and who need public aid for food, shelter, or clothing, but they are also the majority of the population. Who among us does not know that there are tens of millions of ordinarily self-supporting individuals who cannot afford expensive medical care? They are not needy for food, shelter, or clothing, but they are needy when confronted with the cost of expensive medical, dental, or hospital care. They are the "medically needy," and they are the backbone of the American population.

If enough money is provided by the Federal Government and by the States to provide subsidy toward meeting, in whole or in part, the costs of medical care "for all those families and individuals in the State having insufficient income to pay the whole cost of hospital, surgical, medical, and dental services," large amounts would have to be provided from general revenues and a large percentage of the American population would be getting their expensive medical care on a charity and subsidy basis. The Senator from Ohio (Mr. Taft) in a speech which he made on January 5, 1945—Appendix of the Record, page 477—when discussing housing for low-income groups, repudiated a similar proposal. The inevitable end of that road is public medical care, financed out of general revenues, for most or all the population. It must be plain to anyone who will think about it that Senate bill 545 is far more likely to lead to socialized medicine than is any system of contributory social insurance such as we propose.

If, in the alternative, the amount of money proposed for Senate bill 545 is not sufficient to pay for the services needed by all having insufficient income for health services, then the declared purposes of that bill will not be met. The program would serve only a small fraction of the people who cannot meet heavy sickness costs. It would fail to solve a great national need. And it could leave tens of millions of people with the conviction that their Federal and State governments had failed them or had played a tragic hoax on them.

In this connection, note that Senate bill 545 authorizes the appropriation of only $200,000,000 a year of Federal money for medical care and $8,000,000-$20,000 a year for dental care. Since the States are permitted to match this money by present expenditures for similar purposes, as well as by new appropriations, the additional money to be available for all those families and individuals in the State having insufficient income to pay the whole cost, is mainly the Federal money proposed under that bill. That amount would do little more than meet the medical and dental needs of the people who are already receiving public aid under our welfare programs. It would do little indeed for self-supporting families who have great difficulty in paying large medical, hospital or dental bills.

The insurance method of handling medical expenses is approved by both the medical profession and by the sponsors of that bill. To be sure, they favor voluntary insurance. So should we all if we were possible to do the job through voluntary insurance. Experience seems to show that there is no way of achieving the objectives—the methodical financing of medical expenses—on a voluntary basis.

There are scattered groups of people, totaling to a very small percentage of our population, who have joined together to give themselves some sort of minimum protection against medical costs through their pooled contributions. In a interim report submitted in July 1946 by a subcommittee of the Senate Committee on Education and Labor it is stated:

"In 1945 approximately 75 percent of the population had no medical care insurance whatsoever, while 2 percent had insurance against one or more items of medical care costs. Only about 8.5 percent of the population, however, are known to have had what might be called "comprehensive" coverage, i.e., at least doctor's care in hospital, home, and office, and hospital service for illnesses other than those usually excluded by insurance policies, such as mental disease and tuberculosis. (Subcommittee Report No. 6, p. 6.)"

There is now a voluminous record of the countless inadequacies of such voluntary plans, and the futility of trying to improve them by having more such separate plans. A similar situation once existed with regard to old-age pensions and retirement funds. Private arrangements for retirement, prior to our national social insurance system of old-age benefits, had their merits, but they, too, covered only a small part of the population, and were not adequate to meet a national need. There was considerable opposition in 1938 to Government establishment of old-age benefits which in 1939 became effective old-age and survivors insurance, but that social insurance system is now accepted almost as a matter of course.

The answer to our national need for a program of financing medical care does not lie in taking care of the needy or of those having insufficient income to pay the whole cost themselves, or in stimulating along with little voluntary plans for a small fraction of the population. As one prominent witness said last year before the Committee on Education and Labor, at the hearings on Senate bill 1646:

"Such programs may be helpful in spreading costs for families of reasonably high income, but they cannot by any possibility reach down to those families which must need assistance. Nor will it suffice to increase appropriate funds for the care of the indigent or to rely on the generosity of individual philanthropists. The vast mass of our unemployed population will continue to refuse pauperization either by the philanthropist or the State; and will continue to go without medical care if it cannot obtain it as a right, for which funds have been duly set aside. ( Hearings, pt. 4, p. 2526.)"

Mr. President, long experience shows that what this Nation needs is a comprehensive and adequate health program, resting on two broad and coordinated bases—compulsory health insurance and community-wide services. That is the program we offer for the overwhelming majority of people in the bill introduced today.

Mr. President, my colleagues and I have prepared a detailed summary of our bill which we believe will be helpful to all who will have occasion to study it. I ask unanimous consent that it be printed in the Record immediately after these remarks.

There being no objection, the summary was ordered to be printed in the Record, as follows:

THE NATIONAL HEALTH INSURANCE ACT, 1947
SUMMARY OF PROVISIONS

The national health insurance and public health bill (S. 1529) provides like its predecessor (S. 1606 of 1945) for a comprehensive and adequate national health program through a Nation-wide system of prepaid personal-health-service benefits and through Federal grants to States for expanded health services. All the essential principles of national health insurance are maintained in the new bill.

MAIN CHANGES PROPOSED IN 1945-46 BILL

NAME OF BILL

The 1947 bill is entitled "The National Health Insurance and Public Health Act of 1947."

Decentralization of administration

The 1947 bill establishes a system of local administration under State-wide plans. It retains a provision for national funds (insurance and general revenue) and national standards. For details see below.

Each State, upon observing to observe minimum national standards, is guaranteed the right to administer the system. The total amount of money, would be allocated a definite amount of money each year from the national-health-insurance fund. The State in turn would allocate the money each local area. The principles for the allocations are stated in the law. Thus each State and locality would be assured a certain sum, and the general size of the amount (except for supplementary amounts needed in emergencies) would not be dependent upon the discretion of Federal officers.

Administration by a board instead of by a single Federal officer

The administration would be under a board of 20 persons, established as part of the Federal Security Agency. All members would be on full-time salary. The members of the Board would be appointed by the President with the approval of the Senate (at least one of these must be a physician);
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This principle was recognized in the 1945-46 bill. In the 1947 bill the policy is stated fully and definitely.

Persons covered

The new bill covers some groups not provided for in 1945-46, e. g., civilian Federal employees and their dependents. State and local governments may by voluntary election cover their employees and their dependents. Needy persons can be provided for, as in the 1945-46 bill, through any State and local governments paying premiums for these persons into the health insurance fund.

Other changes

The new bill covers some provisions for rural areas; expands and makes more explicit the guarantees of professional rights to doctors, dentists, and hospitals; requires the ceiling on the per diem payments to hospitals, and makes numerous additional changes based on criticisms and suggestions expressed at the hearings on the 1945-46 bill.

HEALTH-INSURANCE PROVISIONS

What services will be available?

All needed preventive, diagnostic, and curative services by a basically physician of the patient's choice, unless and until such time as professional judgment and consultation have determined that such services are unnecessary; hospital services, pharmacy and drug services, laboratory services, medical, dental, and hospital services.

Who are eligible for services?

All employed and self-employed persons. This includes all employees in industry, commerce, agriculture, and domestic service; employees of non-profit institutions; farmers, including those in business for themselves. All needed preventive, diagnostic, and curative services, and hospital services.

How financed?

3 percent of earnings (presumably to come from social insurance premiums to be levied one-half on employed persons, one-half on their employers). The 3 percent is calculated on earnings up to $3,000 a year. Additional amounts are to be appropriated from general revenues to cover specified items of service (dental and home nursing) and any additional costs. The total may not exceed 3 percent of earnings in the first 3 years or 4 percent in the next 3 years. Congress would then review and, if necessary, revise the program and the financial provisions in light of experience. Present law, providing Federal grants to States for public assistance cases, is amended so that the States may use some of that money—along with their own funds—to pay insurance premiums for needy persons.

How would physicians and hospitals be paid?

Physicians (general practitioners) will be paid according to methods (fee-for-service, salary, per capita basis, or combinations) chosen by a majority of the physicians in an area. Individual physicians or groups of physicians may be paid by methods other than that chosen by the majority of those in that area. The same applies to dentists. Specialists will be paid by the method they and the insurance officers agree upon. Hospitals would be paid full cost of service. The bill provides that all payments must be adequate to care for the sick.

How administered?

There would be a Federal administrative board as stated above, but the administration of services and funds would fall mainly upon the States and localities. Through State surveys, local administrative areas would be defined for medical, dental, and hospital services. In each area there would be a local administrative board which would be either (a) a local administrative committee which would be appointed by the State and which would in turn appoint its own executive officer, or (b) an administrative officer appointed by the State, with a local advisory committee. The local committees of either type must include both lay and professional representatives. National and State advisory councils are provided for, with similar representation, but all strictly professional matters come under wholly professional advisory bodies. Personal medical records must be kept confidential.

AIM TO SUCCEED IN PUBLIC HEALTH EFFORTS

The bill provides:

1. Federal grants-in-aid to States for expanded public health services.
2. Similar grants for expanded medical and public health services, and for crippled or otherwise handicapped children.
3. Federal Government would pay between 60 and 75 percent of what a State spends for those two programs, with the largest percentage of Federal aid going to the poorest States.
4. Federal care of needy persons, through the insurance system, the States would be authorized to use Federal grants, as well as their own funds, to pay insurance premiums for those who are eligible for public assistance.
5. In the case of the poor, the 80 percent of the cost of care for the poor would be paid by the Federal Government.

Quality of service

Through the use of consultants, laboratories and other diagnostic services, professional advisory bodies and otherwise, provisions made for assuring high quality of service; aid would be made available for medical research and for the training of physicians, dentists and others.

How financed?

Like the 1945-46 bill, provision is made for the annual appropriation to the national health insurance fund of an amount equal to 3 percent of earnings (presumably to come from social insurance premiums to be levied one-half on employed persons, one-half on their employers). The 3 percent is calculated on earnings up to $3,000 a year. Additional

Mr. President, as you and as all other Senators know, I have worked for many years to strengthen the health programs of this country. Much has been accomplished since 1925, when Federal grants-in-aid to the States were made available under the Social Security Act, for public health and for maternal and child health services. The amounts of these grants have been greatly increased. More funds have been made available for medical research. Legislation for a hospital construction program was finally enacted last year.

When I first became concerned with health problems, which has been reported, I thought in terms of limited special problems or areas of special need. I am convinced now, and I believe the American people are convinced, that only a broad program through which every self-supporting family can meet the cost of medical care, will assure adequate health services to all our people.

The bill we are introducing today represents the culmination of years of study, of popular discussion, and of detailed consideration by representatives of the professions, of labor, of consumers, and of many civic and welfare groups.

I believe the program we present is sound and important. I trust that it will receive not only the consideration but also the support of all forward-looking Members of the Congress.

REDUCTION OF INDIVIDUAL INCOME-TAX PAYMENTS

Mr. MILLIKIN. Mr. President, I move that the Senate proceed to the immediate consideration of House bill 1, a bill to reduce individual income-tax payments.

The motion was agreed to; and the Senate proceeded to consider the bill (H. R. 1) to reduce individual income-tax payments.

The President pro tempore. Does the Senator from Colorado yield to the Senator from Maine?

Mr. MILLIKIN. I yield.

Mr. WHITE. Mr. President—

THE PRESIDENT pro tempore. The President pro tempore. Does the Senator from Colorado yield to the Senator from Maine?

Mr. MILLIKIN. I yield.

Mr. WHITE. I understand it is agreeable to the Senator from Colorado, who is in charge of the unfinished business, and also that it accords with the desires of the senior Senator from Georgia (Mr. Goode), that a detailed discussion of the bill should not start this late in the afternoon, and that it is their desire that the Senate now take a recess until tomorrow. Therefore, I move that the Senate stand in recess until 12 o'clock noon tomorrow.

The motion was agreed to; and (at 4 o'clock p. m.) the Senate took a recess until tomorrow, Wednesday, May 21, 1947, at 12 o'clock meridian.