It now develops that Cuba will not need the 340,000 tons which she had reserved for her home consumption. It further develops that she cannot sell the 300,000 tons which she had 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 sugar by the International Emergency Food Council, does not plan to take all the sugar which has been allocated to her.

So, Mr. President, as of today there is in Cuba a tremendous surplus of sugar going begging 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 chairman of the Finance Committee, the Senator from Colorado [Mr. MILLIKIN], desires to have the Senate proceed to consider the tax bill, and would not care to have me take further time on this matter 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. MCCARTHY]; and although sometimes we were on opposite sides in respect to the recent sugar-control legislation, nevertheless when that matter was finally disposed of, I respected 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 articles regarding the present sugar situation and the change in the sugar ration 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 what the sugar situation really was. He has written me a letter, which has been received today, and I ask unanimous consent to have his letter in response to my telephone request printed at this point in the RECORD, together with the statistics and supplemental data accompanying his letter.

There being no objection, the letter and accompanying data were ordered to be printed in the RECORD, as follows:

MAY 20, 1947.

Hon. CHARLES W. TOBEY,
United States Senate.

DEAR SENATOR: This is in reply to your recent telephone request for the latest information regarding the sugar situation.

The only change of any importance in the 1947 supply situation since the recent hearings is the increased possibility that the Cuban crop will reach a very high level. At the time of the hearings we knew that the cane plantings indicated a large crop, but we also knew that any one of a number of factors could greatly limit the size of the crop and that it was not safe at that time to plan on a too optimistic estimate. It is still too early to know the final outturn of the crop, but with good weather for the remainder of the grinding season it should reach 6,000,000 tons. We shall have a more nearly final figure early in June.

You have probably noted various recent public statements regarding current large stocks of sugar. The impression which some have that these stocks are excessive is misleading. Stocks in the hands of primary distributors on April 30, of approximately 1,492,000 tons, while larger than last year, are still below the prewar (1935–39) average for the same date which totaled 1,601,000 tons. If an adjustment were made for increased population at the present time above prewar, this stock comparison would be even less favorable. Data for the above comparisons are contained in the attached table. These relatively large stocks are due in part to the necessity of moving Cuban sugar at a very high rate in order to insure adequate storage space in Cuba for the production of a large crop. The pressure to move this sugar will be over in a short time, while the heavy summer demand for sugar will soon begin. In order to alleviate the storage situation and to insure getting the sugar into the hands of the consumers before the heavy summer demand begins, we have advanced the validation date of the next household stamp and the third quarter industrial allotments to June 1. This action is explained in the attached press release.

The sugar committee of the International Emergency Food Council is constantly reviewing the over-all sugar supply situation for the purpose of bringing into the pool any additional supplies which may become available and also to reallocate any sugar which any claimant country indicates will not be taken. We have indications at present that France may not take her entire allocation; however, reallocation of any quantity so released 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 Cuban contract, has been withheld for local consumption and free export. However, as yet none of this sugar has been offered, nor has Cuba indicated that this sugar will not be used for the purposes for which it was set aside.

At present we have nothing definite on the Javan sugar situation although, following the recent agreement between the Netherlands and the Indonesian Governments, a representative from the Department of Agriculture is on his way to Java to make every effort to get as much first-hand information as possible. We shall continue to follow developments in that area closely.

Since the allocations for all countries contain 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 early to know whether our total supply for the year will exceed the 6,800,000 tons now allocated.

Sincerely yours,

JAMES H. MARSHALL,
Director.

Stocks of sugar in the hands of primary distributors in the United States on Apr. 30, 1947, 1946, and prewar

[1,000 short tons, raw value

	1947 [1]	1946	1935-39 average
Cane:			
Raw	284	190	332
Refined	456	245	577
Total cane	740	435	909
Beet	752	646	692
Total	1,492	1,081	1,601

[1] Preliminary.

UNITED STATES DEPARTMENT OF AGRICULTURE,
SUGAR RATIONING ADMINISTRATION,
Washington, May 13, 1947.

NEW SUGAR RATIONING PLANS ANNOUNCED TO MINIMIZE TRANSPORTATION DIFFICULTIES

Housewives and industrial users will be permitted to buy sugar in advance of the customary rationing date to enable supplies to move while railroad transportation is available, the Sugar Rationing Administration, United States Department of Agriculture announced today. With receipts from Cuba now at their seasonal peak, and with boxcars now available which will shortly be needed to move the estimated billion-bushel winter wheat crop, the Department of Agriculture feels that speeding up sugar distribution now is imperative in order to relieve the transportation burden later in the season. This action does not increase rations, but merely advances the dates when purchases may be made.

To enable more sugar to be moved now, three changes were announced in the sugar rationing program:

1. A second 10-pound stamp for consumers (No. 12) will be validated June instead of July 1, but must still last until October 31.

2. The date of application for third quarter allotments to both percentage and provisional industrial users will be advanced from June 10 to June 1.

3. The 30-day inventory limitation will be removed for industrial users to enable them to purchase their entire allotment as soon as it is granted.

These steps will enable housewives and industrial users to obtain their requirements for canning and other needs while supplies and shipping facilities are available. The Department wishes to make certain that all users have their supply of rationed sugar on hand to can this year's fruit crops as they ripen.

This applies with equal force to home canners and industrial canners. No stamps specially designated home-canning sugar stamps will be issued this year, but the allowance of 35 pounds available for home use this year is designed to include sugar for canning.

Apparently many household and industrial users, finding supplies available at present, are postponing buying. This, together with the heavy import movement, is creating a temporary surplus in the hands of distributors. A last-minute rush to cash unused sugar-ration coupons when transportation facilities are overtaxed with the movement of other commodities could result in the development of local shortages.

Mr. MCCARTHY. Mr. President, I should like to say to the distinguished junior Senator from New Hampshire that I hope to present all the facts to him; and I feel confident that when all the facts are before both of us, we shall be on the same side.

Mr. TOBEY. Mr. President, I am sure the Senator recalls what Agrippa said to St. Paul: "Almost thou persuadest me." [Laughter.]

There being no objection, the bill (S. 1321) to decontrol sugar, introduced by Mr. MCCARTHY (for himself, Mr. BRICKER, Mr. WHERRY, Mr. KEM, Mr. MALONE, Mr. WILLIAMS, and Mr. ECTON), was received, read twice by its title, and referred to the Committee on Banking and Currency.

NATIONAL HEALTH AND DISABILITY INSURANCE PROGRAMS

Mr. MURRAY. Mr. President, on behalf of myself, the Senator from New York [Mr. WAGNER], the Senator from

Florida [Mr. PEPPER], the Senator from New Mexico [Mr. CHAVEZ], the Senator from Idaho [Mr. TAYLOR], and the Senator from Rhode Island [Mr. MCGRATH], I am introducing a bill providing a national health-insurance system and a national public-health program. Representative DINGELL, 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. MURRAY (for himself, Mr. WAGNER, Mr. PEPPER, Mr. CHAVEZ, Mr. TAYLER, and Mr. MCGRATH), 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 citizenry. Our population is indeed our greatest asset; our vigor and productiveness, 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 our need to be strong and resourceful. The years that lie ahead will make unprecedented demands upon us. We must prepare now to meet those demands. We must insure that our people have that state of health, of body and of mind, which modern science makes possible; we must see to it that completely adequate health services are available, not to some people under favorable circumstances, but to all people. That, Mr. President, is today's challenge to our statesmanship, a challenge which this bill would meet.

BACKGROUND OF THE PRESENT BILL

Before turning to the content of this bill, let me briefly review its background. The modern movement for constructive national health legislation began with the Social Security Act of 1935, a great legislative landmark in the history of our country, introduced in this body by Senator WAGNER. The Social Security Act made a small beginning through Federal grants-in-aid to the States for general public-health work and for maternal- and child-health services.

In 1939, the Senator from New York [Mr. WAGNER] 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. WAGNER] and the Senator from Georgia [Mr. GEORGE] 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-ninth Congress, Public Law 725, approved August 13, 1946.

In 1943, 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 1050. Later in the same year, in a special health message, President Truman proposed a broad legislative program for national health and we presented Senate bill 1606, 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. That 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 buget 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 existing needs, now admit them 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 1606, held before the Committee on Education and Labor of the Seventy-ninth Congress, the provisions of that bill were subjected to close scrutiny and extended discussion. 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 1606 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 repeatedly demonstrated from many points of view. The large majority of witnesses, many from the medical and allied professions, reaffirmed the need for a national program of personal health services to be financed on an insurance basis.

The provisions for meeting this need, as contained in Senate bill 1606, were 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 1606.

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 1606 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.

Broadly considered, the present bill makes five provisions for the health of our population, wherever they may live—

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

health services furnished to needy persons;

Third. Improved Federal grants-in-aid to the States for comprehensive, community-wide, public-health and maternal-and-child-health services;

Fourth. Improved Federal grants for the construction of needed hospitals and other health facilities; and

Fifth. Grants-in-aid, under the prepaid medical-care plan, to aid nonprofit institutions which engage in research or in professional education. Each of these provisions is essential to meet urgent health needs.

A BRIEF SUMMARY OF THE HEALTH INSURANCE SYSTEM (TITLE II)

The system of prepaid personal health services, under title II, is national in scope and would cover close to 85 percent or more of the population. This includes employees, persons in business for themselves, those receiving social-security or civil-service pensions, and their dependent children, wives—or disabled husbands—and parents.

The persons who become eligible for benefits would be entitled to medical and dental services from general practitioners and specialists, home-nursing care, hospital care, and auxiliary services—laboratory, X-ray, expensive prescribed medicines, eyeglasses, special appliances, and so forth. Other persons who are not automatically insured, including the needy who are eligible for public assistance, may be covered just like all others through premiums paid on their behalf.

Free choice of doctor, dentist, and so forth, by the patient is guaranteed, as well as the right to change one's choice.

Every qualified doctor, dentist, nurse, hospital, and so forth, is also guaranteed the right to participate or not, and to accept or reject patients. These guarantees apply to organized groups of practitioners, clinics, health-service plans, consumer cooperatives, and so forth, as well as to individuals. Every hospital that participates is guaranteed against supervision or control of its management.

The insurance fund, instead of the patient, would pay the costs for the various services. The method of payment is to be decided mainly by those practitioners who furnish the services. The bill contains guarantees that the amount of payment will be fair and adequate.

The insurance system is to be administered, at the Federal level, by a five-man board, assisted by an advisory council of lay citizens and professional people, located in the Federal Security Agency. Each State is guaranteed full responsibility for administering the system to its own population through its own State agency. The requirements which a State plan would have to meet are the minimum necessary to assure that the State carried out the intent of Congress and meets the obligations of the insurance system to the insured persons and their dependents. In each local area, administration would be carried out with the help and participation of local citizens, lay and professional. The Federal board would administer the system only where a State is unwilling or unable to do so.

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 3½ percent of covered earnings in the first 3 years or 4 percent in the next 3 years. Thereafter, 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 allotted 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 initiated 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 operation 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 practices that they do not like;

Sixth. Judicial review of administrative decisions; and

Seventh. Special provision to use a small fraction of the insurance funds to support research and professional 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.

A BRIEF SUMMARY OF THE GENERAL HEALTH SERVICES (TITLE III)

PART A

The purpose of title III, part A, is to provide for an adequate, 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, developed 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 among the States is placed on a uniform basis for all the health programs involved, and the Federal-State financial sharing is placed 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 $300,-

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 out any or all of the various purposes for which the funds are authorized, according to its own judgment as to State needs. 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—with transitional provisions for States using multiple agencies:

Second, financial participation by the State;

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 to any individual denied service, 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 individuals receiving or providing 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, indication of 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 a program. The Federal percentage is determined by a formula which gives more to the poorer than to the wealthier States, according to their per capital 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 III, 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 agreement. Transitional provisions are included to assure that the States have sufficient time to adjust from present practices to those required of them under this bill.

PART B

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 725, 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 33⅓ percent of the construction cost, it is less helpful than it can or should be to the poorest areas, and this provision endangers 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 33⅓ percent for a construction project in the wealthiest States up to 75 percent for a project in the poorest States. This provision was in the act 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 provisions 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.

COVERAGE

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 Federal public-assistance grants may be used by the States for this purpose.

VOLUNTARY AGENCIES

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 the same kinds of guaranties as apply to individuals. Thus, groups of practitioners, hospitals and their staffs, any organized group of individuals, any partnership, association, or consumer cooperative, 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. Also, any such organization can also act as agent for others in negotiating or carrying out agreements.

These provisions are accompanied by necessary safeguards. Under agreements with groups or organizations, services must still be provided only by persons who are themselves qualified, have authorized the agreement on their behalf, and who remain responsible to both the individuals they serve and the insurance system. Moreover, as in the case of agreements with individuals, no agreement with a group or 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 the new 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 always was 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 others 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 1606. In the new bill, administrative responsibility is clearly decentralized, down to a system of local administration under Statewide 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. In either case, they shall establish local professional committees to advise and assist the administrative agency. Thus, the people living within each local health-service area are given a direct responsibility in the program's operation through membership on these local area committees or on special professional committees, all of which are 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 administers the program 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 much money they 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, there is a statement of basic factors, including population, available personnel, facilities, and supplies, and the costs of fair compensation—to be considered in making the allocations. 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 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 one of them must be a doctor 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 in 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 special section on rural areas includes 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, guaranties 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 services 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 1606 as a protection for doctors just as much as for patients, has been clarified so that the States and the practitioners in any area have primary responsibility for establishing such standards. The 120-day-a-year limit for hospitalization, and the cash indemnity provision in lieu of hospitalization, have been dropped. The new bill clarifies the guaranty 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. Every effort has been made to 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 and Public Health Act of 1947, 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 social-insurance basis, but the details of financing have been left to the Congress to decide in connection with related financial decisions.

Insurance against medical costs is a sound, businesslike procedure. It has been widely accepted in principle by the public and the medical professions alike. It is the 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 heavy sacrifices. And I wish to point out here that the contributory method of financing would be the only compulsory feature in compulsory health insurance. As one witness said at the hearings on Senate bill 1606 last year:

> The system of prepaid personal health service provided in S. 1606 is not state medicine. It is an orderly procedure for collecting the funds to pay for medical care when the emergency of sickness may arise. It is a method of payment, not a method of service. The service is to be provided exactly as at present by existing hospitals and existing physicians—the chief practical difference being that payment of bills is guaranteed (hearing, pt. 4, p. 2256).

The American people have repeatedly and in many different ways expressed their desire to have a system whereby they may pay the costs of their own medical and hospital care, on a budgeted, contributary basis, in advance of the time such care is required. Nevertheless, Senate bill 545 was presented in the Senate on February 10, 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 cost of, say, an unexpected surgical operation for which he cannot pay. It is a conceivable—indeed, 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; 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.

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 for the services needed by all having insufficient income for health 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 services on a charity and subsidy basis. The Senator from Ohio [Mr. TAFT] in a speech which he made on January 7, 1946—Appendix of the RECORD, page A77—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 in a 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 our people with the conviction that their Federal and State governments had failed them or had played a tragic hoax on them.

In this connection, not that Senate bill 545 authorizes the appropriation of only $200,000,000 a year of Federal money for medical care and $8,000,000-$20,000,000 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 it were possible to do the job through voluntary insurance. Experience seems to show that there is no way of achieving the objective—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 an 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 2.5 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 Rept. No. 5, p. 5.)

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 1935 to Government establishment of old-age benefits which in 1939 became 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 stumbling 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 1606:

> 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 most need assistance. Nor will it suffice to increase appropriations for the care of the indigent or to rely on the generosity of individual physicians. The great mass of our employed population will continue to refuse pauperization either by the physician 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. 2256.)

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 American 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. 1320) provides like its predecessor (S. 1606 of 1945–46), for a comprehensive 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 FROM THE 1945–46 BILL

Name of bill

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

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 agreeing to observe minimum national standards, is guaranteed the right to administer the system for its own population, would be allocated a definite amount of money each year from the national-health-insurance fund. The State in turn would allocate the money to 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 five persons, established as part of the Federal Security Agency. All members would be on full-time salary. Three of the Board would be appointed by the President with the approval of the Senate (at least one of these must be a physician); the other

two would be ex officio, i. e., the Surgeon General of the Public Health Service and the Commissioner for Social Security.

Explicit recognition of voluntary plans that provide services

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 action cover their employees and their dependents. Needy persons can be provided for, as in the 1945–46 bill, through action by State and local governments paying premiums for these persons into the health insurance fund.

Other changes

The new bill makes special provisions for rural areas; expands and makes more explicit the guarantees of professional rights to doctors, dentists, and hospitals; removes the ceilings 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 family physician of the patient's choice; services of specialists when required; hospital care; laboratory and X-ray services; unusually expensive medicines; special appliances and eyeglasses. Dental; home nursing and auxiliary services may be limited in extent, if personnel, facilities or funds are inadequate; but if dental services have to be limited, priority must be given to services for children.

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, business and professional men and women, and other persons in business for themselves. Recipients of old-age or survivors benefits, or civil-service pensions will be covered. The wives, children under 18 (or over 18 if disabled), disabled husbands, and dependent parents of all these insured persons are covered. Needy persons who are not insured through their own earnings will qualify if contributions are paid on their behalf by a public agency. The eligibility requirements are set very low, so that most people can qualify (for example, earnings of $150 in a year.)

Rights of the people and the professions

Everyone has free choice of his doctor, hospital, group clinic, dentist, or nurse from among all the practitioners and organizations in the community, that wish to participate. All physicians, dentists, nurses, and all hospitals and clinics meeting minimum standards are guaranteed the right to participate but none is required to do so.

Quality of service

Through the use of consultants, laboratory and other dagnostic services, professional advisory bodies and otherwise, provision is made for assuring high quality of services; 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 $3,600 a year. Additional sums 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 3½ 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 organized 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 in amount.

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 body which might 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.

AID TO STATES FOR PUBLIC HEALTH PURPOSES

The bill provides:

1. Federal grants-in-aid to States for expanded public health services.

2. Similar grants for expanded maternal and child health services, and services for crippled or otherwise handicapped children.

The Federal Government would pay between 50 and 75 percent of what a State spends for those two programs, with the largest percentage of Federal aid going to the poorest States.

3. For medical 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.

4. For increase in the amount of money, extension from 5 to 10 years and improvement of the grant-in-aid formula under the Hospital Survey and Construction Act for the construction of needed hospitals, health centers, and other facilities.

Mr. WAGNER. Mr. President, I shall take only a few minutes. I could not let this occasion pass without saying a word of congratulation to my friend, the Senator from Montana [Mr. MURRAY], on his splendid speech, and also paying a tribute to the public spirit of our colleagues who have joined with us in sponsoring a national health insurance and public-health bill which can be of inestimable importance for the future of our country.

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 1935, 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 those 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.

One program is still needed to complete the arch; a national health-insurance system is the capstone which will hold together all that has been done thus far, and will actually make the benefits of our medical facilities and our medical knowledge available to the families of this country.

When I first became concerned with health problems, many years ago, 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 costs 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, which had been reported from the Committee on Finance, with amendments.

RECESS

Mr. MILLIKIN obtained the floor.

Mr. WHITE. Mr. President——

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. GEORGE], 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. I therefore 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.