A National Health Program for the United States

By Theodore Sanders

EDITOR'S NOTE: The Federal Government has announced a comprehensive Dominion-wide program of health care which will make available adequate medical services to Canadians irrespective of their ability to pay for them. The plan is on the agenda of the Dominion-Provincial conference which is being held at the present time. The United States is pursuing similar aims. It wants to make health care an integral part of its social security program. This is the purpose of the much disputed Murray-Wagner-Dingell Bill now before Congress. Dr. Theodore Tarders, a prominent member of the Executive Committee of the Physicians' Forum, a group of progressive doctors who are backing the bill, explains the implications of the American health plan in the following article.

THE Wagner-Murray-Dingell Bill[1] results from the growing demand in the United States for better medical care through a national health program. It expresses the results of a vast movement toward improved health security which has developed and become increasingly vocal in the United States during the last two decades.

Despite its great riches, the United States is far from the best health record in the world. Physical and mental defects resulted in the rejection of 40% of the Selective Service age youth for military duty. Financial barriers to medical care are so serious that the low income groups, which are sick more and need more care, get only a fraction of the medical and dental care the upper income groups get. Provisions for medical care still rest on the archaic system of fee payment by the patient at the time of sickness to an individual private practitioner. Voluntary medical care insurance reaches only a small minority of the population and shows no signs of losing its well-known unfavorable attributes—restricted benefits, little emphasis on prevention, adverse selection of risk, high turn-over in membership, high administrative costs, and unavailability to large groups of the population, such as inhabitants of rural areas. The United States undoubtedly has the dubious distinction of being the most backward in its health planning of all the great nations of the world.

The 1945 bill is the most comprehensive piece of health and social security legislation ever introduced into the United States Congress. It is not only a social security code, but includes also the essentials of a national health program. It represents a great improvement over its predecessor, a similar bill which was before the last Congress,[2] in including provisions for public health, hospital and health centre construction, maternal and child health, training of personnel, medical research, and protection of group practice, as well as clarification and improvement of the health insurance section.

The health provisions of the bill can be considered under six headings.

1. Health insurance.
2. Medical education and research.
3. Health facilities.
4. Public health services.
5. Maternal and child health and welfare services.
6. Provisions for disabled and needy.

The provisions are offered as amendments to the Social Security and Public Health Services Acts. Items 1, 2 and 6 would be financed through an addition of 3% to the Social Security tax on wages up to $3,600 a year for the insured and his dependents. Wage-earners would pay 1½% which the employer would match; self-employed would pay the full 3% themselves. The other provisions would be financed from general tax revenues. Their total cost is not estimated.

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1. S. 1050 and H. R. 3293. 79th Congress, 1st Session. Introduced May 24, 1945.

2. S. 1161. 79th Congress.

Health Insurance

The keystone of the health arch would be the insurance of day-to-day medical and hospital services[2] called "Pre-paid Personal Health Service Insurance." Its sponsors claim that this section would reach 135,000,000 people, or all but a tiny fraction of the population of the country. It would provide the following services to wage-earners, self-employed or their dependents:

1. *General practitioner*, in office, home, and hospital, including preventive, diagnostic and therapeutic work and periodic physical examination. Free choice of participating physicians or groups is assured.

2. *Specialists*, on referral by the attending physician. Specialists would be entitled to higher rates of payment if they meet the required professional standards.

3. *Hospital care*, up to 60 days per insured individual in any year. The maximum can be increased to 120 days, providing the insurance fund can afford it.

4. *Laboratory benefits*, including X-ray, pathological, chemical, and bacteriological tests, physiotherapy, eye refractions, and appliances.

5. *Dental benefits*, limited at first to diagnosis, prophylaxis, extractions, and treatment of acute dental disease, but expanded as soon as possible.

6. *Home Nursing*, ordinarily only on the advice of the attending physician.

The United States Public Health Service, and specifically its Surgeon-General, would administer the program. He is directed to establish a National Advisory Medical Policy Council of professional and public members. The professional representatives would be appointed from panels of names submitted by professional health and medical organizations.

The bill requires that administration be decentralized. Existing state and local agencies, both governmental and non-governmental, such as health departments, hospital and medical service plans, group practice clinics, and other types of agencies would be utilized.

Local committees including both representatives of the health professions and laymen would be established to aid in administration and assure local self-determination.

Practitioners and participating hospitals would be paid from a special account in the Social Security fund known as the Personal Health Service Account. Physicians and dentists would be allowed to choose whether they wished to be paid fee-for-service, capitation, or salary, from the account. Rates of pay for general hospitals would ordinarily be $3 to $7 er day of hospitalization (ward rates), and chronic hospitals $1.50 to $3.50, with flexible adjustment formulas.

Certain benefits could be limited at first, according to the availability of personnel and the necessities of protecting the program against abuse, but it must be proven that such limitations are necessary. Extra charges then might be required by practitioners for home visits and the first, or even all services, in a period of sickness or treatment. Different fees between urban and rural, and between different States and localities, could be set. Dental care and home nursing could also be limited at first, but such limitations would have to be withdrawn as rapidly as possible. The Social Security Board and Surgeon-General are directed to study the best ways of making dental, nursing, mental, and chronic disease care available.

Medical Education and Research

The social insurance fund would set aside some 2% of the medical care insurance expenditures (perhaps $65,000,000 a year) for grants to non-profit institutions and agencies engaged in medical research and education (undergraduate and post-graduate). This would include medical, dental, nursing, rehabilitation, and related fields. Preference would be given to projects for service men and women seeking post-graduate medical, dental or health administration education.

Grants and Loans for Health Facilities

A ten-year billion dollar program of federal grants and loans for construction and expansion of hospitals, public health centres, and related facilities (such as nursing homes) would be provided. General, tuberculosis, and mental hospitals would be included. Non-profit agencies as well as State and local governments would be eligible. The federal grants would vary from State to State between 25 and 50 per cent of the cost of projects according to need. Loans could not exceed 25% of the cost of a project. State plans would be drawn up and submitted by the State health agency after a State hospital survey had been conducted. They would be approved by the Surgeon-General of the United States Public Health Service in accordance with regulations laid down after consultation with a National Advisory Hospital Construction Council, which would be newly created by the bill. The Council would include both public and professional representatives.

The provisions of this section are similar to those contained in the "Hill-Burton Bill," which was reported out favorably by the Senate Education and Labor Committee on October 29, 1945, and is now on the Senate calendar awaiting consideration. Its chances for passage are considered good. The bill grew out of the recommendations of the Surgeon-General of the United States Public Health Service, Dr. Thomas Parran, and of the Senate Subcommittee on War-time Health and Education (Pepper Committee). It was drafted however, largely by the American Hospital Association, and represents a more conservative document in many ways than the corresponding title of the Wagner-Murray-Dingell Bill. For example, the Hospital Council in the Hill-Barter Bill would approve or disapprove projects and in other ways actually administer the program. Senator James Murray, Chairman of the Senate Education and Labor Committee in a vigorous exception to this in the Committee report states that the Council would almost certainly be weighted with hospital representatives and that for it actually to have administrative functions, would introduce a thoroughly undesirable principle into government.

Public Health Services

The current $20,000,000 a year authorization for grants to the States under the Public Health Service Act would be upped to whatever is necessary. State grants would vary between 25 and 75 per cent of the total costs of projects. The services would be quite inclusive, providing for training of public health personnel, sanitation, communicable disease control, health education, public health nursing, public health research, administration, protection of health in maternity, infancy, and childhood, and the like, but does not include major construction such as water supplies and sewage systems. Special subsections deal with tuberculosis and venereal disease control, $10,000,000 annually being authorized for the former and "whatever is necessary" for the latter. Demonstrations and training of personnel for State and local health work would get up to $5,000,000 a year.

Maternal and Child Health Services

Special attention is paid to the needs of mothers and children. The bill (section 5) would amend the Social Security Act to increase the authorization of funds available for State programs of maternal and child health services and facilities to "whatever is necessary." A separate part deals with authorization of funds and standards for the crippled children's and other handicapped children's health services. By expanding the program to include all handicapped children the sights have been lifted considerably. Children with chronic illnesses such as rheumatic fever, deafness and mental disease could, and undoubtedly would, be included.

The program would be administered by the Children's Bureau of the Department of Labor through State health departments as it is now.

This section is similar except in the method of financing services to the provi-

sions of the proposed Maternal and Child Health and Welfare Act of 1945 (S. 1318) which has recently been introduced into both the Senate and House. This bill, sponsored by ten Senators and three representatives, would provide complete health services within ten years for all children and mothers, regardless of income, residence, or any other restrictive requirements. It represents a desire to enact a program for children immediately, without having to wait for the enactment of a complete health service for all sections of the population. It is the first Federal legislation for medical care which would outlaw the "means test" in considering eligibility for its benefits. Hearings may be held on this bill soon.

Provisions for Disabled

Both medical and financial provisions are made for the disabled. Insured workers disabled through sickness or injury for over 7 days would be entitled to cash benefits up to a maximum of 26 weeks in any year. In addition to this maximum, married women workers are entitled to weekly cash benefits for 12 weeks during maternity leave. The amount paid would vary from $5 to $30 weekly, depending on the wage and number of dependents. Cash benefits varying from $20 to $120 a month are provided for workers disabled for 6 months or more.

Rehabilitation of the disabled is provided for through a special 2% of the social insurance funds set aside from the general social insurance trust. Medical, surgical and hospital services, appliances and the like would be provided. The office of Vocational Rehabilitation, as well as the United States Public Health Service would be involved in administering this section.

Public Assistance

Federal grants to the States ranging between 50% and 75% of project costs are authorized for use in providing medical services to needy individuals. These funds would come out of general revenues. Citizenship and residence requirements would be prohibited if federal funds are desired. It is expected that public assistance agencies would pay for the health services of needy individuals by contracting with the health services fund and thus provide a single system of medical care for practically the whole population.

Effect of Other Provisions on Health

No aspect of the bill would be without its effect on health. The unemployment compensation benefits would mean better nutrition for workers and their families during periods of joblessness. The old age and survivor's insurance provisions would mean the ability of old people to have income adequate to maintain a decent standard of living. Better housing and clothing, less mental tension and social strain would result from the security this and other aspects of the bill would provide. These in turn will conserve health and help prevent disease.

Pro and Con

The support and opposition is essentially the same as it was for the 1943 version, except that the lines have sharpened. Solidly for the bill are the C.I.O., A.F. of L., Farmers' Union, Physicians' Forum, Committee of Physicians for the Improvement of Medical Care, Lawyers' Guild, Y.W.C.A., Social Action Committee of the Congregational Church, and others. Definitely, and rather violently, opposed are the American Medical Association and its outright political arm, the National Physicians' Committee. Also opposed are the Farm Bureau Federation, American Bar Association, National Association of Manufacturers, National Grange, and American Hospital Association. The Chamber of Commerce is unsympathetic.

The bill has aroused intense public interest and debate. Radio forums and other forms of public discussion are filled with opinions about the bill itself or the issue of compulsory health insurance. At least twenty million copies of the National Physicians' Committee pamphlet *Political Medicine* opposing the bill in rather violent language have been circulated. This Committee, headed

by a former advertising publicity man, and supported heavily by the big drug firms, also sends out "canned" editorials against the bill frequently to newspapers and periodicals. The supporters of the bill are nowhere near so affluent, but a recent pamphlet entitled. *For the Peoples Health*, issued by the Physicians' Forum a group of progressive physicians, is receiving wide circulation. Labor is supporting the bill strongly to the limit of its ability.

What Does the Public Think?

The best indication of what public opinion really is, are the results of a National Opinion Research Centre poll. This poll, a non-profit scientific institute located in the University of Colorado in Denver, asked a representative sample their opinion of various central features of the bill, without specifically naming it. When asked whether they favored including doctor and hospital care under Social Security, even if it meant an increase of 1½% in the wage deduction, 59% answered in the affirmative. Various other questions tended to confirm these results.

Will the Majority Rule?

Neither the 1943 nor the 1945 versions of the bill have yet had even the minimum Congressional consideration — namely hearings. The bill was referred to the Finance Committee in the Senate and the Ways and Means Committee in the House. Hearings have been promised, but there is little evidence they will be held this year. When they are held, the committees are not likely to be too receptive, the chairmen and the majority of members being conservative.

The logic of the present committee referral is that the bill contains new tax provisions. Senator Wagner in introducing the bill last May, however, entered a plea for considering the bill on its merits as social security and health legislation, instead of as a tax measure. His statement implied that it would be much more logical for the bill to be referred to the Committee on Education and Labor in the Senate and the Committee on Labor in the House where it would be certain to meet more favorable hearings. Since last May the feeling has grown that re-referral will be necessary if the bill is to have any chance of passage. Accordingly, it is expected Senator James Murray, Chairman of the Senate Committee on Education and Labor, will take the lead in proposing a new health bill without tax provisions in an effort to get it referred to his committee, where public hearings and sympathetic consideration would follow quickly. Such a step might be taken just after the President's health message, which is expected soon.

Whatever the exact legislative situation, it will be hard sledding. The oppos - tion is strong, fearful of any change in the *status quo*, and highly articulate Labor, which is spearheading the drive for the bill, is united in its support of it but distracted by wage questions and the fight for survival. However, labor is gaining potent allies—such as church, progressive farmer and physicians' groups among others. Another ally undoubtedly *is* history.

Within a short time, the basic provisions of the Wagner-Murray-Dingell bill are going to be the law of the land in the United States. How soon this will be true depends on how hard and how well its supporters fight for it.

Editor's Postscript

While this article was in press, President Truman sent his health message to Congress calling for enactment of legislation including compulsory health insurance. Immediately following its reading a new Wagner-Murray-Dingell bill "To provide for a national health program" was introduced (S. 1606 *and HR* 4730) *and referred to the Committee on Education and Labor in the Senate and the Committee on Interstate Commerce in the House. The bill proposes essentially the same health services as are described in the*

article, but with certain changes. The hospital and health centre construction section is omitted, presumably because the Committee on Education and Labor has just reported out favorably a separate measure to provide such grants, namely S. 191, *the Hill-Burton bill. The new bill has a separate part dealing in full with grants to the States for medical care of needy persons, authorizing* $10,000,000 *for the first year of operation of the program and whatever is necessary thereafter. The prepaid personal health services provisions remain essentially the same, except that no mechanism is actually included for raising the necessary funds through an increase in the Social Security tax; it was by omitting this taxation feature that it was possible to have the bill referred to the Senate Education and Labor Committee, of which Senator Murray, a sponsor of the bill, is chairman. In addition, the cash disability indemnity section has also been omitted. It is understood that it will be included in the legislation which is expected to follow President Truman's coming social security message.*

U. S. Commercial Policy

By Ernest Dale

Editors Note:—

At present trade negotiations between Canada and the United States are going on aiming to facilitate exchange of goods between the two countries. The difficulties are many and the outcome is still uncertain. The author of the following article, a young American economist, formerly with the Economics Department of Yale University, now with the American Management Association, presents the views of the internationally minded section of American public opinion, pleading for a reduction of existing tariffs.

THE Canadian public has not yet taken cognizance of two recent events which may mark a turning point in United States international trade policies: the recent renewal of the Trade Agreements Act and the new power of the United States Administration to reduce tariffs to 25 per cent instead of 50 per cent of the 1934 level. Both measures provide an unique opportunity to add to the well-being of the United States as well as to that of the rest of the world by starting an all-round reduction of tariffs and thereby removing the world's chronic dollar shortage and increasing the volume of international trade. Next to the maintenance of peace and employment the liberalization of trade regulations is the most important post-war objective. If we are not to fail again, we must act on the truth that the prosperity and happiness of one country promotes that of others.

One of the greatest obstacles to a flourishing international trade used to be the lack of dollars of much of the rest of the world. From 1922-1938 the average annual dollar shortage of countries other than the United States amounted to $500 million. With the onset of the Great Depression American loans suddenly stopped and the world's dollar deficit was no longer covered. America worsened the situation by the imposition of the Hawley-Smoot tariff increases in 1930. In an effort to meet their growing dollar deficits, the other countries raised their tariffs and imposed exchange and import restrictions. The resulting reduction in world trade and employment was a major cause of World War II. Hence the nature of America's commercial policy and the reasons for liberalizing it are vital in any discussion of the means of promoting world prosperity.

The Tariff

America's commercial policy has four main features of which the first and most