

Committee for the Nation's  
Health 1946-52

# Committee for the Nation's Health

CHAIRMAN: 1790 BROADWAY • NEW YORK 19 • NEW YORK

CHANNING FROTHINGHAM, M.D.

CIRCLE 7-0421

TREASURER:

CARL C. LANG

December 16, 1946

HONORARY VICE-CHAIRMEN:

JONATHAN DANIELS

RUSSELL DAVENPORT

JO DAVIDSON

WILLIAM GREEN

BISHOP FRANCIS J. McCONNELL

PHILIP MURRAY

BISHOP G. BROMLEY OXNAM

MRS. FRANKLIN D. ROOSEVELT

DAVID SARNOFF

GERARD SWOPE

*file*  
Mrs. Franklin D. Roosevelt  
29 Washington Square South  
New York, 11, New York

Dear Mrs. Roosevelt:

We enjoyed reading your column today in which you took the American Medical Association to task for attacking Surgeon-General Thomas Parran. The Committee, you will be pleased to know, also made a similar protest last week by means of the enclosed telegram.

I am taking the liberty of sending you a copy of "Platform" which gives a well-balanced presentation of the pros and cons of National Health Insurance, and was worked out by the Newsweek Club Service staff with the assistance of our public relations counsel. Newsweek has sent it to 7800 women's clubs and we are urging all our members to encourage officers of women's clubs to schedule club discussions of the subject.

We are happy to report that we are still continuing to get returns from your appeal letter. So far 2,255 persons have contributed a little over \$12,000.

Your continued interest in our work is greatly appreciated.

Sincerely yours,

*Joseph H. Louchheim*  
Joseph H. Louchheim  
Executive Director

JHL/je  
Enc. 2

WASHINGTON OFFICE

EXECUTIVE 2985

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Feb

This is copy of  
letter which Mrs R  
agreed to sign

# Committee for the Nation's Health

CHAIRMAN: 1790 BROADWAY • NEW YORK 19 • NEW YORK

CHANNING FROTHINGHAM, M.D.

CIRCLE 7-0421

TREASURER:

September 6, 1946

• CARL C. LANG

HONORARY VICE-CHAIRMEN:

Dear :

JONATHAN DANIELS

I want to ask your active assistance in a great movement to ensure that no American shall lack essential medical care because of financial need. We all know that medical care in our country falls far short of the standards it could attain. It has long been recognized that most families face economic catastrophe when confronted by serious accident or protracted illness.

RUSSELL DAVENPORT

JO DAVIDSON

WILLIAM GREEN

BISHOP FRANCIS J. McCONNELL

PHILIP MURRAY

BISHOP G. BROMLEY OXNAM

MRS. FRANKLIN D. ROOSEVELT

DAVID SARNOFF

GERARD SWOPE

The experience of draft board physicians, who rejected 40 per cent of our young men as defective physically, brought into sharp focus the distressing inadequacy of the health care available to most of our children. It showed us more, that the healthfulness of our rural districts is an illusion, that the toll of disease, accident and undernourishment is even greater on the farm and in the village than in our crowded cities. Fresh air and sunshine alone cannot maintain sound bodies in areas where there are far too few doctors, hospitals are lacking and sub-standard incomes are the rule. While we record with justifiable pride the brilliant medical achievements of our scientists, we must face the shameful fact that most of our people cannot benefit by them.

For decades it has been recognized that only through a system of prepayment of medical costs could most of our people meet their medical bills. Thirty-five countries have introduced national health insurance plans in the last thirty years. The United States is not among them. We, in the richest country in the world, permit millions of our children to grow up handicapped because preventable defects are not treated in time; we permit hundreds of thousands of families to be plunged into humiliation and despair because they cannot meet physicians' and hospital expenses when grave illness strikes one of their members. We have failed to provide a national insurance plan which would bring the gifts of our great medical institutions and our skilled doctors into every home.

WASHINGTON OFFICE

EXECUTIVE 2985

402 SIXTH STREET N.W. • WASHINGTON 1 • D.C.

September 6, 1946

Through the Committee for the Nation's Health, under the chairmanship of Dr. Channing Frothingham, the distinguished physician and former president of the Massachusetts Medical Society, we are seeking to raise the modest sum of \$100,000. We want to let the people know that national health insurance, through a plan which will assure every individual of adequate care from a physician of his own choosing in a hospital he selects, is within their reach. It can be legislated by Congress if we act.

We have postponed this action far too long; the cost to our nation is far too great. Will you join in pledging your support to National Health Insurance and will you give as generously as you can to our campaign? Those of us who are able to face the future unafraid, because of fortunate economic circumstances, are privileged to be able to help millions of Americans to whom sickness means mental despair and physical suffering because our nation has failed them.

Sincerely yours,

# **Why Do We Need National Health Insurance?**

**Ernst P. Boas, M.D.**

**Chairman, The Physicians Forum**

**COMMITTEE FOR THE NATION'S HEALTH**  
**1790 Broadway                  New York 19, N. Y.**

## Why Do We Need National Health Insurance?

ERNST P. BOAS, M.D.

I DEAS are but slowly translated into social action. Years, even generations may elapse before the mass mind becomes sufficiently saturated with a concept to permit the crystallization of public opinion into laws and into patterns of social organization. This process is often retarded by the educated classes who, because of their uniform training and traditions, tend to think in terms of their class instead of in terms of the people; and who resist new ideas and changes that may alter the complexion of their particular part of society. The more specialized the group, the greater its vested interests, the greater its resistance to change. We have seen these forces operate again and again in the development of this country. Governmental regulation for the benefit of all the people was fought by the railroads, the public utilities, the stock exchange and the bankers, and by employers of labor. Even today, when such control is in effect and accepted as useful by the people of this country, certain special classes or groups continue to fight to nullify such regulation, still placing class interest before public interest.

The past decades have witnessed a ferment of ideas in the field of medicine and medical care. Physicians, typifying a segregated class, are satisfied for the most part with things as they are, or at most see the need for minor changes. But the people at large have become aware of grave deficiencies in medical care and have a dawning vision that better things are possible. The most articulate expression of this viewpoint is found in Franklin D. Roosevelt's new Bill of Rights. In January 1944 he said:

"We have accepted, so to speak, a second Bill of Rights, under which a new basis of security and prosperity can be established for all—regardless of station, race or creed." Among these, he said, is:

"The right to adequate medical care and the opportunity to achieve and enjoy good health; the right to adequate protection from the economic fears of old age, sickness, accident and unemployment."

Medical care is not a luxury whose availability should depend on the patient's ability to buy it. The sick person should not have to undergo a means test to determine whether or not he is eligible for treatment. Medical care should be regarded as a right to which all citizens are entitled, as they are to education.

If we accept this point of view we are faced with a serious dilemma. Medical care is a commodity that must be bought. Its distribution and availability depend on the incomes of the people in the community. Hence doctors and hospitals are plentiful in large cities and in wealthy industrial centers, for here there is money to pay for them.

But we are confronted with the basic fact that a large proportion of our population have not the money to buy decent medical care. In poorer communities, in the South, in farming areas, and in small towns the available medical resources are scanty or lacking. The National Health Survey and subsequent studies give ample evidence, but few realize the tremendous discrepancies that have developed.

## II

EXPENDITURES for medical care are consistently correlated with income. The lowest income group spends least, and the amount spent steadily increases as income increases. Twenty-one per cent of American families had aggregate money incomes of less than \$1000 during the year 1942. These families spent on the average \$42 or 6.8 per cent of their income for medical care that year. Families in the \$1000 to \$2000 income class spent an average of \$68, those in the \$2000 to \$3000 class an average of \$96 for medical care. Families with incomes from \$3000 to \$5000 spent an average of \$143 for medical care, and this represented only 3.7 per cent of their annual income. So we find the higher income group spending over three times as much for medical care as do those with incomes of less than \$1000. Yet illness is nearly three times as frequent among those in the lowest income groups.

The same relation between medical care and income observed among families is seen in whole communities, even in States. In New York City, for instance, there is one doctor to every 700 of the population, in Mississippi the ratio is one to 2100; in New York there is one general hospital bed to every 196 of the population, in Mississippi one to 667. It is ability to pay, rather than medical need that determines the availability of medical resources.

This is strikingly brought out by the situation in rural areas. Over 1250 of the 3070 counties in the nation are without a single satisfactory

general hospital. Over 700 of these 1250 counties have populations exceeding 10,000 people. Experience has shown that about 4.5 general hospital beds are needed for every 1000 persons. Most rural areas do not have even 2 beds per 1000. Moreover these country hospitals tend to be smaller and less well equipped with modern diagnostic and therapeutic apparatus. Similar lacks are found in the provision of hospitals for the tuberculous and the mentally ill. There are far too few doctors in rural areas, and dental care is practically unknown.\*

Among the Negro population, which is predominantly poor and rural, these difficulties are magnified. They are further exaggerated by lack of education, poor housing, and racial discrimination in the provision of governmental facilities for welfare and medical care. Death and sickness rates are very high among Negroes. The mortality rate of Negro males is 57 per cent higher than that of white males, and that of Negro females 74 per cent higher than that of white females. Syphilis, tuberculosis, pellagra, and malaria are the leading causes of illness. As would be expected from the data presented in the preceding paragraphs, the medical care of Negroes is woefully inadequate, and far inferior to that of whites in the same economic station. Whereas, in the year 1937, 95 per cent of white mothers were attended by doctors at childbirth, only 45 per cent of Negro women were delivered by physicians. It is difficult for Negroes to get medical care from white physicians, yet there are far too few Negro doctors—for the country at large only 1 to 3000 of the Negro population. Added to this, only 60 per cent of these doctors practice in the South, although 85 per cent of the Negro population live in that region. Again we see economic factors that draw Negro physicians away from rural areas to cities where their patients have more money and where better hospital and educational facilities are available to them. For in the South few Negro physicians have access to hospitals and to opportunities for graduate education.

Recently the United States Public Health Service reviewed the cases of the young men rejected by the Selective Service in Hagerstown, Maryland, and compared the physical defects found with the defects noted in these same men when they had been examined as school children 15 years earlier. In many cases the same defects that had been

\*Farm families are 23 per cent of the national population but farm income is only nine per cent of the national income. Two-thirds of farm families had gross incomes under \$1000 a year and one-third had under \$400 a year. In 1940 the States with 70 per cent or more urban population had per capita incomes of about \$800, while States with 70 per cent or more rural population had per capita incomes of about \$300.

discovered at the school examination had remained uncorrected, and were now the causes for rejection by Selective Service. In the whole country 4,500,000 men had physical and mental defects which made them unfit for military service. 600,000,000 work days were lost during the year 1943 by employed men and women because of sickness.

### III

DEVELOPMENTS within the field of medicine itself have made more difficult the adequate distribution of medical care. Medicine in the United States, at its best, is unsurpassed. The past decades have been years of tremendous medical discovery and progress, resulting in a sharp reduction in disease and in marked prolongation of the average life span. But knowledge how to prevent and cure disease has far outstripped the actual performance. The techniques of medical care have become more and more complex and specialized. Medicine as it is practiced by organized medical staffs of our university and large voluntary hospitals offers the best there is of medical care. No longer is the solitary medical practitioner able to give adequate service to his patients. The constant development of new laboratory techniques, the increasing tempo of specialization, with the complex and difficult technical procedures which this involves, have brought it about that frequently many doctors must cooperate to reach a diagnosis and carry out treatment for a single patient.

The idea of cooperative group medicine has not yet penetrated to the general practise of medicine. Indeed it is constantly being thwarted by the present economic set-up of medical practice. The patient pays a separate fee for each service rendered, and the doctor is compelled to send the patient from one specialist or one laboratory to another in order to obtain the data that he needs to reach a diagnosis or carry out treatment. The costs rapidly mount, so that often needed special examinations are postponed or omitted because the patient cannot afford to pay for them. Moreover it is to the practitioner's interest to minimize the number of these special examinations because that will make less money available for the payment of his own bill. Medical care still centers around the individual practitioner who is a private entrepreneur, and who singlehanded, to the best of his ability, provides medical care for those who seek him out, and who at the same time is compelled to make a living from these activities.

Good medical care today is better than it has ever been, but it is also more expensive, so costly, in fact, that the majority of patients

cannot afford to benefit from the present available medical knowledge. Furthermore it is an old story that exceptionally heavy medical expenses affect only a relatively small number of families every year, families in which there is some major or catastrophic illness. The Committee on the Costs of Medical Care found that in families with incomes under \$1,200, one family in a hundred had to meet medical charges of \$500 or more in a given year. A recent survey by the National Opinion Research Center of the University of Denver revealed that 31 per cent of the people questioned had put off seeing a doctor because of the cost, and 23 per cent had had to borrow money to pay doctor or hospital bills.

This generation is also witnessing a radical change in the nature of disease, and this in turn leads to new problems in medical care. The infectious diseases such as measles, diphtheria, summer diarrhea, typhoid fever, tuberculosis, and even pneumonia are pretty well under control. Indeed the death rate from these diseases has fallen so greatly that the average span of life has been greatly increased, from 50 years in 1900 to 64 years today. More and more people are living to more advanced ages at which they acquire one of the so-called degenerative diseases, such as a heart disease, high blood pressure, diabetes, cancer or chronic rheumatism. It is these diseases that today are the great hazard to health and life. Their diagnosis and treatment, and still more so their prevention, is more difficult and complex and as a rule more expensive than that of the infectious diseases. Well established methods of sanitation or of mass vaccination are of no value in preventing their onset. Their control and prevention depend on making available to all complete medical care, not alone when the disease has run its course and is in its last stages, but at the time of its earliest manifestations, when it still may be checked and arrested. Preventive medicine has largely become a personal type of medicine which concerns itself with maintaining the health of the individual. The distinction between preventive medicine and the practice of medicine is being broken down, and one of the important fields for the public health official concerns itself with the creation of opportunity for early and adequate diagnosis and treatment of disease.

In spite of minor changes that have been grafted on medical practice here and there, medicine is still practiced in the way it was practiced a generation ago, and the philosophy that justifies these methods, the philosophy proclaimed by organized medicine, is based on social and economic conditions, and a scientific and technological status of previous generations. Yet medicine is a public service or a public util-

ity and should adapt itself to the framework of the society within which it functions. New methods must be found to assure the best medical care to everyone.

Physicians have traditionally espoused the view that medicine is an esoteric science and art, and that only they, the initiates in the cult, have the knowledge to determine what is good for the public and for their patients. Accordingly, physicians as individuals, as well as through their organizations, have insisted that they alone can plan for the medical care of the country, that medical care is a matter that does not concern the public or the government. And since any and every group dislikes and resists changes that may impair their traditions and their vested interests, doctors have balked at any plans that would alter the status quo. They have not been disinterested pleaders.

Yet it is clear that the patient, that is, the recipient of medical care, working through governmental agencies or through consumer organizations, has both the right and duty to be heard. He pays the bills and is entitled to determine the kind of medical care that he wants. Of course in the strictly professional and technical aspects of the problem, he must yield to the knowledge of the physician as expert advisor, but the layman is quite competent to decide whether or not he wishes to correct the gross inequalities in the distribution of medical care that exist today. That is why it is so important for laymen and doctors to work together to this end.

#### IV

WE HAVE learned that very many people cannot buy good medical care because their incomes are too small. If we agree that medical care is a right to which all are entitled, it is clear that a large part of the money to pay for it must come from other sources. There is ample precedent to look to government to fill this gap, whether it be local, State or Federal government. For years government has provided medical care for the indigent, and it has borne almost the total cost of the medical care of the mentally ill and of the tuberculous, because families are unable to bear the drain of such long drawn out chronic illnesses. Expenditures by government for public health activities, for child and maternal health, and for veterans run into sizable figures. In the year 1941 public agencies in the United States spent between 600 and 700 million dollars of tax revenues for the support of medical facilities for the civilian population.

No one challenges the principle of the use of public funds for the *prevention* of disease. But the prevention of disease today involves much

more than the old line activities of the public health officer—sanitation and vaccination. Today the chronic, so-called degenerative diseases are the great hazard to life and health. Their control and prevention involves the creation of complete facilities for early diagnosis and treatment, and for making them freely available to all. People must be encouraged to consult a physician at the first intimation of a bodily disorder, and not wait until the disease has progressed to an advanced stage at which damage may be irreparable. The financial barrier that keeps patients from seeking medical advice must be eliminated.

Today we can no longer say, "This is preventive medicine, a proper function of government; and this, on the other hand, is curative medicine, the function of the practitioner of medicine whose services must be bought in the open market." These two aspects of sickness control have become merged; preventive medicine begins with measures of personal hygiene and health examinations instituted by the medical practitioner. So it is a logical and natural step to turn to government for funds to extend adequate medical care to all citizens of this country.

Because of the uneven distribution of wealth in the United States the Federal Government must assume responsibility. A state such as New York could finance its own system of medical care, but there are many states that are unable to do so. North Carolina, for instance, has an average net per capita income of \$317 compared to \$573 for the country as a whole; it has only two-thirds as many doctors and two-thirds as many hospital beds per unit of population as the country at large. Similar parallels between income and medical resources can be traced throughout the country. The increasing mobility of our population also makes it necessary that health plans be national in scope, so that the worker will not lose his benefits when he moves from one state to another.

To spread good medical care to all, the Federal government will have to spend a very large sum of money. Will this lead to "socialized medicine," the great bugaboo that we have been taught to fear? What is "socialized medicine"? The term as used today has an emotional, not a factual connotation; it is a catchword employed to arouse emotional resistance to plans to improve or change the methods of distributing medical care. The term socialized medicine, correctly used, means state medicine, an arrangement under which all medical facilities are owned by the state, all doctors are salaried civil servants, and all citizens have the right to complete medical care without charge. Only the Soviet Union has true socialized medicine, and there have been no proposals to introduce such a system in the United States. Yet we have a good deal of state medicine in this country—hospitals erected by cities, counties,

fect, particularly those set up by labor or fraternal organizations. The reason lies in the simple fact that the clients have incomes too low to allow payment for complete satisfactory medical services.

For all these reasons, protection offered by voluntary sickness insurance in this country is minute in comparison to the need. A mere handful have complete medical coverage. According to a report of the Senate Sub-Committee on Health and Education (Pepper Committee) dated July, 1946, 12 per cent of the population have hospital insurance only; 10.5 per cent are insured for partial medical care; and only 2.5 per cent are entitled to comprehensive medical care. In this the experience of the United States reflects the experience of other countries more advanced in the organization for the distribution of medical care; voluntary plans fall far short of meeting the needs of the country.

## VI

NATIONAL compulsory health insurance is the only practical method of spreading the benefits of good medical care to the whole population. People can budget and make regular payments when they are well that will pay for medical services when they are ill. Such insurance would be financed by payments from all workers, with equal payments from their employers, supplemented by funds from general taxation. Contributions would be collected by payroll deductions, like other social security payments. Only by supplementing the workers' contributions by contributions from their employers and from taxation can sufficient funds be raised to finance a satisfactory medical care program. Since payroll deductions are calculated at a certain per cent of the worker's wages, those with small incomes would pay less than those with larger incomes. It is estimated that a deduction of 3 per cent of wages up to the first \$3600 of income would provide sufficient funds. One-half of this would be paid by the worker, one-half by the employer. Thus a man earning \$500 in a year would pay \$7.50 for one year's coverage for himself and family, whereas one earning \$3600 would pay \$54; their employers would pay equal amounts. Yet both families would receive the same complete medical care.

There are definite advantages in financing a national health program by contributory insurance payments through payroll deductions under the social security laws. It is just and psychologically sound for the worker to contribute to the costs of his own medical care. Knowing that he has paid for medical service, he will regard this service as a right, he will demand that it be adequate; and every stigma of charity

that in the past has been associated with medical services provided by government, will be eliminated.

Tax funds will have to be provided in addition to the social security payments. Medical care of the indigent, who are not covered by virtue of employment, should also be included in a national health program. Additional funds are needed for the construction of hospitals and health centers, especially in rural areas, for the extension of full-time public health departments, for research, and for medical and other professional education. Without the leaven of teaching and scientific investigation no national health plan will develop the highest type of medical care.

The total sum of money that would be collected for medical care under such an insurance program under the social security system would amount to between four and five billion dollars a year. This is a huge sum, but we must recognize that this will not all be new money that has to be raised over and above present expenditures. Before the war, total expenditures for medical services in the United States were about four billion dollars, which represents about 4 per cent of total consumer income. The sum collected by the national insurance fund would take the place of the four billion dollars now spent largely by private individuals, in widely varying amounts.

## VII

DURING the last session of Congress the Senate Education and Labor Committee held extensive hearings on a measure, the Wagner-Murray-Dingell Bill (S. 1606), that establishes National Health Insurance.

It is a revision of a similar bill introduced into the last Congress; and in this revision the proponents of the measure have sought the best available advice, and have accepted suggestions for changes from physicians and other professional groups as well as from many lay organizations.

The Bill will remove the economic barrier that prevents so many of our people from receiving adequate medical care. Opponents of national health insurance claim that it will lower the quality of medical care, that it will lead to regimentation and political control of medicine; that Washington bureaucrats will dictate every detail of medical practice, will select physicians for patients, and completely destroy the doctor-patient relationship. These arguments have no foundation in

fact and have a very familiar ring. One hundred years ago they were hurled at advocates of public education; more recently they were used to prevent the enactment of child labor legislation, of the income tax and of workmen's compensation insurance.

The function of the Federal administrator of national health insurance is primarily to collect the funds to operate the program. This activity must be centralized, as it is today for old age retirement insurance. The Federal authority will also set minimum standards of performance for hospitals and for doctors participating in the insurance program. The Wagner-Murray-Dingell Bill provides specifically for decentralization of administration by directing the Surgeon General, as administrator, to give priority and preference to existing State and local agencies, and to establish committees in each locality to assure that the program will be adapted to local needs. Such committees shall include representatives of the insured population, doctors, hospitals, other agencies furnishing service under the program, and other persons informed on the need for, or provision of health benefits. The patient is free to choose his own physician, and the physician is permitted to reject a patient as he can today. Encouragement is given to the development of group medical practice. There will be no interference with the internal organization of existing institutions, nor with the methods of practice of individual doctors.

Since practically every person in the United States will be covered by this insurance, and since funds are appropriated to construct hospitals and health centers in areas where they are lacking or insufficient, the financial and professional inequalities that have led to the unequal distribution of physicians will largely disappear. There will result a more equitable distribution of doctors to rural and impoverished areas.

### VIII

**P**ATIENTS, that is, the public, have everything to gain from this measure. It is not so generally recognized that the average doctor, too, will profit by its passage. The physician today is a split personality. He is a combination of a professional man and a small business man. These dual activities often conflict with one another, to the doctor's distress and the patient's disadvantage. All too often the physician is prevented from giving his patient the benefit of the full resources of medicine because the patient cannot afford the expense of the procedures involved. The doctor is unable to practice medicine in the way he wishes to and in the way it should be practiced. At present, all doctors are very busy and very prosperous. They forget that only a few years ago 60,000 doc-

tors who are now in the armed services were competing with them for patients, and that a large number of these patients had no money. In 1936 the median net income of physicians was \$3,234, in 1938, \$3,027, and in 1940, \$3,245. Compulsory health insurance will stabilize the income of doctors over the years, and in fact will increase the incomes of the majority. They will be paid for taking care of the many persons whom they have been taking care of free. It has been reliably estimated that the average income both of practitioner and specialist will increase rather than suffer under the provisions of the bill. Of course the high priced specialist and surgeon may suffer some curtailment of income, but for the patient this is not an unmitigated hardship. Today the doctor wastes many of his early years building up a practice, meanwhile living at a starvation level, and after he has reached age sixty he finds his practice and his income rapidly shrinking. By providing a stabilizing economic base, compulsory health insurance will do much to eliminate this waste of skilled manpower. And it will give security to the doctor in youth and in old age just as it will to his patients.

Our parents thought of a doctor as someone to be called in times of serious illness, after the usual home remedies had failed to cure. We are learning to think in terms of positive health. We want our doctors to keep us well, to guard us against the ravages of diseases such as cancer or diabetes, and we know that to enable them to do so we must be able to consult them freely, before the disease process has become irreparable. We must give them the opportunity to employ in our behalf the complete resources of scientific medicine. As a nation we have learned the importance of good health of all our citizens, and are realizing that we cannot afford to leave the health of our people to the chance that they may have sufficient income to command modern medical care; or to expose them to the disadvantages that their race, their color, their occupation or their residence in a less favored economic community may bring about.

It is for such a national health program that all of us, doctors and laymen, must work together. Our efforts are needed to give actuality to the plans that have been developed by competent experts. The time has come to marshal the complete resources of modern medicine, and place them at the service of all our people.

# HUMAN LIFE IS THE ISSUE!

The COMMITTEE FOR THE NATION'S HEALTH is determined to wipe out the shameful record of neglect of our national health and to insure that medical care of the high quality that our scientists have made possible is available to all the American people. In his message of November 19, 1945, the President called for a comprehensive National Health Plan assuring adequate health care for every man, woman and child in the nation.

We can achieve the goal he outlined; we can break down the economic barrier that exists between physician and patient in all but the highest income groups, and we can eliminate the inadequate and unequal distribution of health facilities that make great areas of our country-side the breeding grounds of disease and physical handicap. For many years, farsighted leaders in community life have urged federal legislation providing for national health insurance. Four bills have been introduced in Congress; none reached the floor of either House. They were defeated by a combination of forces: the highly vocal opposition of certain representatives of organized medicine associated with narrow vested interests, and the public's apathy and its deep-rooted misconceptions about the workings of national health insurance.

The COMMITTEE FOR THE NATION'S HEALTH is seeking the support of all progressive Americans in its campaign to secure the health and welfare of our people above the short-sighted claims of individual interests. Will you associate yourself with this effort? Your support and your dollars are needed to bring health to millions of physically underprivileged children and security to countless homes where illness threatens economic catastrophe.

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DR. CHANNING FROTHINGHAM, *Chairman*  
Committee for the Nation's Health  
1790 Broadway, New York 19, N. Y.

- I support your Committee because I believe that no American should lack essential medical care because of inability to pay.
- I enclose \$..... as my contribution to the campaign for National Health Insurance.

Name.....

Address.....



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*Chairman*

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# Committee For The Nation's Health

1790 Broadway

New York 19, N. Y.

September 21, 1946

Dear ~~Mrs.~~ **Mrs. Roosevelt:**

I ask your help in a great movement to ensure that no American shall lack essential medical care because of financial need. It is shameful but true that unnecessary deaths and crippling illnesses occur every day among our people because of inability to secure adequate medical care, and that most families face economic catastrophe when confronted by serious accident or protracted illness.

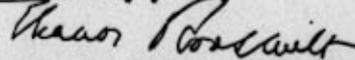
The experience of draft board physicians who rejected forty per cent of our young men as defective physically, brought into sharp focus the distressing inadequacy of the medical attention they received as children. It showed us also that the healthfulness of our rural districts is an illusion, that the toll of disease and undernourishment is even greater there than in our crowded cities. Fresh air and sunshine alone cannot maintain sound bodies in areas where there are far too few doctors and hospitals, and far too many sub-standard incomes. While we record with justifiable pride the brilliant achievements of our medical scientists, we must face the shameful fact that most of our people cannot afford to benefit by them.

Thirty-five countries have adopted national health insurance plans. The United States is not among them. We, in the richest country in the world, allow millions of our children to grow up handicapped because curable defects are not treated in time; we allow hundreds of thousands of families to be plunged into humiliation and despair because they cannot meet medical expenses. We have failed to provide a national health insurance plan which could bring the gifts of our great medical institutions and our skilled doctors into every home.

This committee was formed to let our people know that it is possible for them to have National Health Insurance that will assure to every individual medical care by a physician of his own choosing at home or in a hospital he selects. It can be legislated by the next Congress if we act now.

Will you join us in pledging your support to National Health Insurance? Will you give as generously as you can to the fund of \$100,000 which we need to carry to the American people and the Congress our conviction that every man, woman and child in this land has a right to the best possible medical care? Those of us who are able to face the future unafraid, because of fortunate economic circumstances, are privileged to be able to help in this way millions of Americans to whom sickness brings not only physical suffering, but despair, because our nation has failed them.

Sincerely yours

  
Mrs. Franklin D. Roosevelt