

**Federal Involvement in Healthcare:
An Historic Perspective
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With your talents and industry, with science, and that steadfast honesty which eternally pursues right, regardless of consequences-- you may promise yourself every thing but health, without which there is no happiness. An attention to health then should take [the] place of every other object. The time necessary to secure this by active exercises should be devoted to it in preference to every other pursuit.

–Thomas Jefferson (1787)

While it is highly doubtful that Thomas Jefferson, that limited government democrat, would have supported national health insurance, it is obvious from his letter to young Thomas Mann Randolph, Jr., that he felt good health was a prerequisite to pursuing happiness. Although the Constitution contemplated no specific role for the Federal government in providing health care to citizens, the need for some role became apparent at the very beginning of the Republic in 1789. For ten years Congress debated how to handle the problem of sick or injured American seamen who arrived in U.S. port cities where state and local governments refused to accept responsibility for their care.

Finally, in 1798, the Congress agreed that a Federal role in assisting sick seamen was justified on the basis of the “commerce” clause of the Constitution, and the “general welfare” clause of its Preamble. “The Act for the Relief of Sick and Disabled Seamen” was consequently signed into law. The law established the Marine Hospital Service that was made part of the Department of Treasury and funded through deductions from seamen’s pay.

Criticism of the Marine Hospital Service for poor management and inadequate care reached a peak during the Civil War and led in 1870 to enactment of legislation “to reorganize the Marine Hospital Service.” Among other things, the new act created the post of supervising surgeon general. This in turn led to enactment in 1889 of a bill “to regulate appointments in the Marine Hospital Service,” which created the elite Commissioned Corps of qualified career officers dedicated to MHS activities.

Congress was prodded into further involvement in the area of health by the deadly yellow fever epidemic in the Mississippi Valley in 1877. The following year Congress authorized Federal quarantine enforcement powers. The need for greater attention to health and environment was literally brought home to the Congress in 1894 when Congress asked the lab director of the “hygienic laboratory” of the Marine Hospital (which had been moved from Staten Island to Washington in 1891) to investigate the ventilation system in the House of Representatives. The lab director

reported back that the air was indeed quite foul and that the carpets were saturated with tobacco.

This may or may not have been the incident that convinced Congress in 1901 of the need to give official recognition to the Hygienic Laboratory's research in "infectious and contagious diseases, and matters pertaining to the public health" through a civil appropriations bill. The following year, at the request of Senator John C. Spooner (R-Wisc.), the Surgeon General submitted legislation to Congress that became the "Public Health and Marine Service Act of 1902." The legislation renamed the Marine Hospital Service (today called the Public Health Service), created a new Division of Scientific Research, and charged the Surgeon General with meeting annually with state and territorial health officers and to collect data on births, morbidity, and mortality from the states. The Service's authority was extended to "all the diseases known to man," in 1912, as well as to the pollution of U.S. waters. The new Federal thrust in healthcare was a product of the progressive era's faith in science and business organization in improving efficiency, while recognizing the need to preserve the federal-state relationship.

Another progressive era law, the Biologics Control Act of 1902, gave the Public Health Service the role of inspecting and licensing manufacturing establishments for product safety. The bill was drafted by the Medical Society of D.C. in response to incidents in St. Louis, Missouri, in 1901 in which 13 children died from contaminated diphtheria antitoxin, and in New Jersey where nine deaths were caused by smallpox vaccine. Over the next three decades, the PHS carried out numerous investigations--some with specific congressional authorization (Trachoma and pellagra, venereal disease, influenza, and narcotics control), and some without (Rocky Mountain spotted fever and hookworm disease).

In 1930, Congress enacted two bills--one that had been languishing for four years, and another that had been vetoed earlier by President Coolidge. Together, the two laws established the direction and organization of the PHS for the next four decades. One created a national institute of health to conduct basic medical research and a fellowship program; the other allowed PHS officers to assist other bureaus, state health departments, and university laboratories, and overhauled the inequities in pay and perquisites within the service. The PHS was now running four types of programs: (1) direct care to disabled mariners, lepers, narcotics addicts, and prisoners; (2) assistance to states with public health programs; (3) regulation of biologics and control of infectious diseases; and (4) research.

Although a Federal program begun in 1921 to provide grants to states from the Children's Bureau to improve the "welfare and hygiene" of mothers and infants expired in 1929 due to opposition from the AMA and PHS, a similar program for maternal and child health and crippled children was resurrected as Title V of the Social Security Amendments of 1935. Moreover, Title VI of that landmark act provided PHS matching grants to states to build state health departments and help in developing and training for new services, including hygiene.

In 1937, despite AMA opposition, both houses of Congress overwhelmingly passed legislation to create a new institute dedicated to Cancer research through additional PHS research

and extramural grants. In 1938, Congress strengthened the 1906 Food and Drugs Act in response to a public outcry over the deaths of more than 100 people from a toxic sulfa preparation. The new law banned interstate commerce in hazardous substances, required that new drugs be submitted to the FDA for approval, with proof of safety, and that they be appropriately labeled with directions for use and warnings of hazards.

Wars and Healthcare

The needs of military veterans in the wake of wars has always been a spur to new Federal healthcare initiatives, beginning with the Marine Hospitals (1799-1811), and later the Naval Home (1833) and the Soldiers' Home (1851). The Civil War gave raise to the establishment of national homes for residential care for the 1.9 million veterans of that war. Following World War I, The War Risk Insurance Bureau provided for hospitalization and medical care for any veteran with a service-connected injury or disability. It was initially run by PHS but later turned over to a new, Veterans' Bureau in 1921. World War II also spawned new health programs aimed at benefitting the military services, including a giant new medical research program and a medical assistance program for needy dependents of servicemen. A new Department of Medicine and Surgery was established after the War in 1946. It officially recognized medical specialties and arranged contracts with medical schools to provide training and research opportunities in return for medical care.

The National Mental Health Act of 1946, championed by Senators Lister Hill (D-Ala.) and Claude Pepper (D-Fla.) established the National Institute of Mental Health and provided for direct federal aid to state mental health agencies for demonstration projects, training grants, and community education. In August, 1946, Congress enacted the Hill-Burton Act (named after sponsors Senators Lister Hill and Harold Burton (D-Ohio)), providing funds for hospital construction.

A new National Heart Institute was created in 1948 and made a part of the newly named National Institutes of Health. This was followed in short order by the National Institute of Dental Health Research, the National Institute of Neurological Diseases and Blindness, and the Institute of Arthritis and Metabolic Diseases. Through the 1950s, Congress provided strong, bipartisan support for medical research, and each year Administration budgets were increased for the causes of interest to members of the relevant health committees.

Following President Kennedy assassination in 1963, the legislative log-jam on Capitol Hill was broken for a host of programs to help the disadvantaged under the umbrella of President Lyndon B. Johnson's Great Society, including demonstration community health centers as part of the War on Poverty (the Economic Opportunity Act of 1964), and of course the Medicaid bill to provide healthcare for the indigent. Other health initiatives extended health assistance through migrant workers' health centers, the mental health centers, and maternal and child health projects.

In 1965, Congress enacted the Heart Disease, Cancer, and Stroke Amendments, providing funds and support for regional cooperative programs for research and training. And, in 1966, Congress enacted the Comprehensive Health Planning Act which mandated hierarchical design for

state and local health planning agencies. In 1964, Congress extended construction grants and student loan funds to schools for nurses, and in 1965 to allied health professionals. In 1966 it provided basic and special improvement grants and scholarship funds for professional medical schools in addition to new scholarships.

The Quest for National Health Insurance

Calls for compulsory national health insurance date back to Teddy Roosevelt and his run for president on the Progressive (“Bull Moose”) Party ticket in 1912. In 1914 the American Association for Labor Legislation began a campaign for national health insurance. However, little further attention was given to the idea in Congress or the Administration through the New Deal. The most attention healthcare got was a series of studies conducted by the Committee on Costs of Medical Care between 1927 to 1932. Its final report recommended a coordinated system of group practices based on regional medical schools and teaching hospitals, as well as improved medical education and research. Due primarily to strong opposition from the American Medical Association (AMA) the group did not endorse compulsory health insurance. When President Franklin Roosevelt came to office in 1933, he was very interested in proposing a national health insurance program. However, he was persuaded by his advisers to steer clear of such a bold move lest it jeopardize chances for passing his New Deal programs for economic recovery from the depression. In 1935, the President’s Committee on Economic Security, which formed the basis for Social Security enactment, also endorsed the concept of compulsory national health insurance in principle.

Between 1939 and 1943, national health insurance bills were repeatedly introduced in Congress by Senators Robert Wagner (D-N.Y. and James Murray (D-Mont.), and in the House by Representative John D. Dingell (D-Mich.), father of the current Michigan Congressman (who has reintroduced his father’s national health insurance bill in every Congress). Without Administration support, the proposals were blocked by the anti-New Deal coalition in Congress.

In 1945, President Truman sent a message on health to Congress in which he proposed a comprehensive, prepaid medical insurance plan for persons of all ages, to be financed by increasing the Social Security tax. It was one of the hardest fought issues during the Truman administration (1945-51). In 1948, in the middle of the presidential election, President Truman pushed for but failed to get Congress to enact his national health insurance bill, again due to Republican and conservative southern Democratic opposition, and that of the AMA.

In 1957, Representative Aime J. Forand (D-R.I.), a member of the House Ways and Means Committee, resurrected the cause for national health insurance by introducing legislation to provide the elderly with minimal hospitalization coverage financed through a payroll tax. In July 1960, in the midst of the presidential campaign, Senator John F. Kennedy, who had introduced a Senate version of the Forand bill, announced that the bill’s enactment should be one of the chief legislative goals of Congress’s post-convention August session. In August 1960, Senator Clinton Anderson (D-N.M.) offered a revised version of the bill as an amendment to the omnibus Social Security bill. The amendment was opposed by the Eisenhower Administration, and was defeated on a vote of 44

to 51.

The counterpart provision to the Anderson amendment was tabled in the House Ways and Means Committee by a vote of 17 to 8. Instead, the medical care provisions that were later added to the bill in 1960, cosponsored by Senator Robert S. Kerr (D-Okla.) and Ways and Means Committee Chairman Wilbur Mills (D-Ark.), offered Federal matching funds for a state administered program to provide medical services to those not poor enough to qualify for public assistance. Only 32 states signed onto the Kerr-Mills program and only four provided full medical services. But it laid the groundwork for what was to become the Medicaid health program for the poor in 1965.

The Birth of Medicare

When Kennedy became president in 1961, he called for a more Federal approach to healthcare, similar to that recommended by Congressman Forand (but without coverage of surgical costs). The legislation was sponsored over three congresses (1961-65) by Representative Cecil B. King (D-Calif), the second ranking Ways and Means Committee Democrat, and in the Senate by Senator Clinton Anderson (D-N.M.). Known as the “King-Anderson bill,” the bill provided for compulsory health insurance for the aged by covering spells of hospital and post-hospital care, financed through an increase in the Social Security tax. The legislation specifically avoided payments for doctor and surgery bills in an effort to avoid longstanding AMA criticisms that such coverage would lead to “socialized medicine.”

Chairman Mills, however, retained control of the committee’s agenda and resisted the administration’s entreaties for action on their legislation. For one thing, Mills believed in building bipartisan consensus for legislation within his committee so that it would have broad support on the House floor. For another, he felt the existing proposal would over-tax the Social Security system, and thus was a crusade doomed to failure, according to historian Julian Zelizer’s account. Zelizer notes, however, that throughout 1963-64 Mills carried on ongoing negotiations and discussions with President Johnson’s agent, Wilbur Cohen, and with Johnson himself, to work out a viable financing system.

In 1962, Senator Anderson offered the King-Anderson bill as an amendment to a public assistance bill on the Senate floor, and it was tabled on a 52 to 48 vote. In 1964, Senator Albert Gore, Sr. (D-Tenn.) offered a version of King-Anderson as an amendment to a Social Security amendments bill, and it was adopted, 49 to 44, but the provision died in conference committee with the House.

Finally, in 1965, the third time was a charm for King-Anderson, introduced in the House and Senate as H.R. 1, and S. 1 to denote its importance. Several factors contributed to its success this time around, not the least of which was the changing political complexion of Congress and the conversion of Wilbur Mills from onetime opponent to supporter, and the application of his considerable expertise and legislative skills to develop an ingenious compromise.

In the 1964 elections, not only did “Landslide Lyndon” Johnson live up to his once sarcastic nickname by overwhelmingly trouncing Republican presidential nominee Senator Barry M. Goldwater, but Democrats made big gains in Congress as well, picking up 38 new seats in the House. The new party makeup was 295 Democrats to 140 Republicans in the House, and 68 Democrats to 32 Republicans in the Senate.

Most importantly, the new party ratios meant an adjustment in committee compositions as well, and this was especially important at Ways and Means where opposition to Medicare had shrunk from three votes in 1961 to just one vote in 1963, with 12 favoring and 13 opposing (D: 12-3; R: 0-10). Now, with the large influx of new Democratic members to the House, the Ways and Means party ratio was changed from 15 Democrats and 10 Republicans, to 17 Democrats and 8 Republicans. The new Democrats on the committee tipped the balance in favor of Medicare legislation which had been one of the central issues of the 1960 elections. Seeing the writing on the wall, Mills told reporters the morning after the election that he “would be receptive to a Medicare proposal” in the upcoming session.

The AMA also sensed that the political winds were changing, and also switched tacks. Perceiving that the public believed that the Administration’s bill covered doctors’ costs, the AMA went public to criticize the bill for not doing so, and proposed its own “eldercare” alternative that expanded on the “Kerr-Mills” Act. It would be a voluntary plan, administered by the states, could cover doctors’ and hospital bills as well as prescription drugs, would draw on Federal and state general revenues, with benefits based on a patient’s ability to pay. The AMA proposal was introduced in the House on January 27 by Ways and Means Committee members Thomas B. Curtis (R-Mo.) and A. Sydney Herlong, Jr. (D-Fla) (H.R. 3727; H.R. 3728). However, it was not embraced by the Republican leadership.

Instead, a variation on it (H.R. 4351) was introduced on February 4 by Ways and Means Committee ranking minority member, John W. Byrnes (R-Wisc.), with the full backing of the GOP leadership. The Byrnes bill was a hybrid of public assistance and social insurance that would allow retirees to choose to participate in the program which would cover doctors and hospital bills as well as other patient services. It would be administered by the Federal government with two-thirds of the financing coming from general revenues, while participants could match that contribution with a graduated premium, thereby distinguishing it from a welfare program.

Thus, there were three options before the committee: the King-Anderson social insurance approach that offered hospital coverage financing through a higher Social Security tax; the AMA “Eldercare” public assistance approach that expanded coverage to the “medically indigent” using general revenues; and the Byrnes “Bettercare” approach that offered voluntary hospital and doctor coverage drawing both on general revenues and premium contributions by participants.

After extensive hearings, deliberations, and actuarial computations, Chairman Mills surprised everyone. As historian Zelizer describes the scene, at 3 p.m. at the March 2 executive session, Mills “leaned back in his chair, turning to Wilbur Cohen, and said, ‘Well, now let’s see. Maybe it would

be a good idea if we put all three of these bills together. You go back and work this out over night.’ Byrnes just sat there with his mouth wide open.”

One committee member recalled, “It was fantastic. It was Wilbur Mills at his best. His maneuvering was beautiful...” And another participant said right then, everyone in the room “knew that it was all over. The rest would be details. In thirty seconds, a \$2 billion bill was launched, and the greatest departure in the social security laws in thirty years was brought about.” The move solved many of Mills’ previous concerns about financing and political feasibility. By combining the three approaches, Mills had neutralized the opposition. As Cohen put it, “It was the most brilliant legislative move I’d seen in thirty years.”

Following additional hearings and calculations on the new plan in March, the committee went through the 253 page bill line by line, covering 40 pages a day to make sure everything fit and was financially sound. Amendments were offered, adjustments were made, and on March 23 the bill was ordered reported on a straight party-line vote of 17 to 8. Mills introduced it as a clean bill (H.R. 6675). President Johnson praised Mills for “his statesmanlike leadership in working out, on a sound and practical basis, a solution to one of the most important problems which has been pending before Congress for nearly 15 years.”

The bill was brought to the House floor under a closed rule, barring all amendments. After two days of debate, the bill passed the House on April 8, 313 to 115, but only after Byrnes narrowly lost, 191 to 236, a motion to recommit the bill with instructions to substitute a bill similar to his original bill, plus some other provisions from the committee bill (including the expanded Kerr-Mills medical program for the poor, i.e., Medicaid, and Social Security benefits increases).

The final bill had three sections: Part A (hospital insurance) that provided for 60 days of hospitalization and related nursing care to all people after age 65; Part B (supplementary Medical Insurance) that provided optional coverage of doctors fees; Part C (Medicaid) that extended coverage for the poor to dependent children and the blind and permanently disabled, required all participating states to provide hospital and physicians services, and liberalized the means test to include more elderly citizens.

On July 9 the Senate passed its version by a vote of 68 to 21, after turning back a substitute to delete the compulsory hospital portion, 26 to 64. The final version reported by the House-Senate conference committee on July 26 was 95 percent of what the House passed, according to Mills. It did increase from 60 to 90 days the hospital coverage. The first year cost of the total package was estimated to be \$6.5 billion, to be financed by \$1.4 billion in general revenues, \$4.5 billion in additional payroll taxes (to finance the compulsory basic health insurance program and 7 percent increase in Social Security benefits).

The House adopted the conference report on July 27, 307 to 116, and the Senate adopted it the next day, 70 to 24. Senate Majority Leader Mike Mansfield (D-Mont.) Called the measure “a new milestone in the history of American social legislation.” When President Johnson signed the

bill into law on July 30, he proclaimed that, “No longer will older Americans be denied the healing miracle of modern medicine.”

Conclusion

The foundations laid in the 1960s remain the bases of today’s debates over how to improve and extend health care coverage and protections to more Americans, how to hold down health care costs, and how to keep the Medicare financing system solvent. The legislative debates in Congress in recent years, whether over providing for catastrophic health insurance coverage (1987, 1989), “patients’ bill of rights” for managed care plans (2001-2003), prescription drug coverage for Medicare recipients (2001-2003), or how to adequately protect the public from the consequences of terrorists’ use chemical or biological weapons, are all variations on the multiplicity of tools and systems the Federal government has erected over the years to ensure a healthy citizenry.

The plight of some 40 million uninsured Americans continues to challenge politicians and policymakers alike, especially in even-numbered years when economic concerns take on added meaning. Balancing the healthcare needs of Americans with the need to restore fiscal soundness in the face of war and mounting budget deficits, will undoubtedly be a major issue not only in the 2004 presidential and congressional election campaigns, but in the real world of governing that will face the president and new Congress in 2005 and beyond. To paraphrase Jefferson’s advice to the son of a friend, “attention to health should be the first object, for without it there is no happiness.” That adage would seem to apply with equal force to both citizens and their elected representatives.

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