The Development of the Hill-Burton Legislation: Interests, Issues and Compromises

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ABSTRACT. The Hill-Burton Hospital Survey and Construction Act has its roots in the social health and welfare programs of the New Deal. This paper traces its development and the positions of three groups—the hospital industry, the U.S. Public Health Service, and the Senate Subcommittee on Wartime Health and Education—on four issues: the nature of federal funding to states, the use of public funds by private hospitals, the oversight powers of a Federal Hospital Council, and health services for the poor. The analysis involves two lines of thought: the political strategy of incrementalism and the roles of the three interest groups in reaching compromises to quickly pass an “unsponsored” bill. Relevance to the current effort to pass a single payer national health insurance is explored.

The Hospital Survey and Construction Act of 1946 (PL 79-725), more popularly known as the Hill-Burton Act, was enacted within the remarkably short time period of 20 months. Introduced into the Senate (S. 191) on January 10, 1945, hearings were quickly held and the bill reported out on October 30th. The Senate passed it on December 11th, the House passed it in July, 1946 and it was signed into law on August 13, 1946.

The policy history of this landmark bill involves a successful attempt by health interests and their champions who took full advantage of a unique opportunity in late 1945 to gain favorable federal legislation that would influence health care policy for over a
quarter of a century, Starr (1982: 348-351) argued that although it was passed almost without dissent, Hill-Burton probably retarded administrative rationalization and growth of an integrated system of hospitals by limiting federal political discretion and intervention. He mentioned that liberals secured concessions in the legislation requiring hospitals to make available a reasonable volume of services to persons unable to pay and a weak anti-discrimination separate but equal clause.

Fox (1966: 117-131) concluded that the Hill-Burton Act expressed a consensus on the centrality of hospitals in health policy and the role of government in health care by decentralizing control over hospital policy to the state and local levels where the established health interests could exert their power. The American Hospital Association and the U.S. Public Health Service, supported by philanthropic foundations and Congressional allies, created a fragile coalition with limited goals. They assured conservatives that they were not threatening the autonomy of physicians or reorganizing the practice of medicine by socializing it. They promised the liberals that the bill would recognize wealth disparity among states, would give special consideration to rural areas and those with many low income inhabitants and they would support legislation to subsidize health services. But, according to Fox, the liberals were overwhelmed and unable to pass amendments strengthening federal authority or prohibiting discrimination.

Based mainly upon Congressional records and documents, this paper contends that the bill itself is evolutionary, and marks the climax of a decade of planning and effort by the President, Congress and health interest groups. The hospital interests were able to separate legislation for their construction and funding from broader national health programs and health insurance. Conservatives supported a federal spending bill with limited subsidies for wealthier urban areas, and liberals obtained mandatory planning and formula allocation with potential safeguards for the poor and underserved. This may, in fact, be an excellent example of incrementalism. Lindblom (1959) stated that successful policies are those that propose marginal changes in the existing structure and evolve through a long series of day-to-day compromises and trade-offs. This paper, then, will focus on the nature and timing of these compromises. It will also draw some parallels to current attempts to enact a national single payer health insurance program.

This process involved the advocacy and negotiations of champions who represent interest groups and government agencies which culminated in the institutionalization of policy through legislation (Spector and Kitsuse, 1973; Mauss, 1975). Relatively small organized interest groups mobilized their supporters and secured a special advantage for their members which was perceived as contributing to the public good (Olson, 1971; Buchanan and Tullock, 1962). The tracing of events between 1934 and 1945 focuses on three interested parties: the American Hospital Association (AHA), the United States Public Health Service and the Senate Subcommittee on Wartime Health and Education, and four policy areas: the nature of federal funding to states, the use of public funds by private hospitals, the oversight powers of a Federal Advisory Committee, and health services for the poor.

THE SENATE CHAMPIONS

The Hill Burton Act bears the names of two Senators: Sen. (Joseph) Lister Hill of Alabama, the son of a noted surgeon, was elected to the U.S. House in 1923. He became allied with a faction of the Alabama Democratic Party that included Sen. Hugo L. Black. In 1938, Black was appointed to the Supreme Court, and in November, Hill was elected to fill Black's seat. Hill also took Black's place on the Committee on Labor and Public Welfare which dealt with health and medical affairs. He would remain on the Committee for over 30 years, serving as chair from 1955 until his retirement in 1969.

Sen. Harold H. Burton of Ohio was the son of a professor and dean at MIT. At both Bowdoin College and Harvard Law School he roomed with Owen Brewster, who would become governor and then Senator from Maine. In 1934 he ran for Mayor of Cleveland as a reform candidate, and pledged to end the political patronage system at Cleveland Municipal Hospital. Burton put an end to the practice, and was reelected twice (Berry, 1978). In 1938 he hired as hospital superintendent George Bugbee, who later as AHA executive director was to become a key player in promoting the legislation (Weeks and Berman, 1985). In 1940, Burton was elected to the
U.S. Senate over the objections of the Republican state leadership. Although not a member of the Labor and Public Welfare Committee, at Bugbee’s request (Weeks and Berman, 1985), he joined with Hill in sponsoring the hospital survey and construction bill. Two months before the Senate would vote on the bill that would bear his name, Burton was appointed to the Supreme Court.

At the time he agreed to sponsor the bill, Burton indicated that Sen. Robert A. Taft (R-OH), who was on the committee, should also agree to it. Bugbee found Taft agreeable since he was planning to run for president and was looking for a health bill (Weeks and Berman, 1985). Taft asked extensive questions at the hearings and had an important hand in recrafting the original bill for the committee report (Klarman, 1977: 28). Hague argued that Taft’s name really belonged on the bill because he did the work and came up with the grant-in-aid formula (Weeks and Berman, 1985:38).

THE NEW DEAL ROOTS OF HILL-BURTON

The origins of the Hill-Burton Bill can be traced back to 1934 when President Franklin D. Roosevelt appointed the Committee on Economic Security which developed the outline of a national health program as part of its general plan for economic and social security. While maternal and child welfare along with public health works were incorporated into the 1935 Social Security Act (Titles V and VI), medical care, hospital construction, and disability-illness compensation were deferred. Subsequently, a study was undertaken by the Technical Committee on Medical Care whose members included Martha M. Elliot of the Children’s Bureau, I.S. Falk of the Social Security Board and Dr. Joseph W. Moormin of the Public Health Service. Mouton would later conduct one of the two influential background studies leading to the Hill-Burton Act.

In February 1938 the Committee’s preliminary report found that facilities for modern medical practice must be available throughout the United States to enable practitioners to give the level of care for which they were trained. It recommended a 10-year program providing for the expansion of hospital facilities and construction of health and diagnostic centers in areas accessible to hospitals. Since the new hospitals or units would require financial assistance during the first three years of operation, the Committee recommended that approximately one half of the total annual cost be met by the Federal Government (Anderson, 1985).

In 1939 President Roosevelt sent Congress an “Health Security Message” and Sen. Robert F. Wagner (D-NY) introduced S.1620 to establish a National Health Program. The bill would amend the Social Security Act in five areas: maternal, infant and child health; general public health; hospital and related facility construction; general medical care; and compensation for disability wage loss. It would be financed by Federal grants to the states.

The hospital portion of the bill would help States construct and improve needed hospitals and health centers, and defray operating costs during the first three years. Special emphasis was placed on the needs of rural and economically disatressed areas. The bill required state plans to assure continued public ownership of hospital facilities and equipment, and to provide a system for federal advisory councils for making of necessary rules and regulations with the Surgeon General.

POLICY PROBLEMS ARISE

The Wagner bill (S. 1620) raised a set of issues that would resurface in the debate over Hill-Burton some six years later. The first involved federal aid to states. The proposed grants-in-aid program with variable rather than uniform matching proportions was modeled after the Social Security program. The American Public Health Association and the Children’s Bureau viewed variable matching as being flexible and adjustable to differing state needs, funds as being flexible and adjustable to differing state needs.

The Social Security Board, objected to the grant-in-aid concept. The search for an acceptable formula that balanced population, financial resources, and need for hospital beds would continue to perplex lawmakers.

The second problem involved the relationship between public funds and private hospitals. The Wagner bill (S. 1620) provided for...
the assurance of continued public ownership of hospital facilities and equipment constructed or improved through Federal grants-in-aid. This would imply that funds would be given only to publicly owned hospitals and facilities. Fears were expressed that the public hospitals would be built in communities where voluntary (private, non-profit) hospitals were or could adequately serve community needs. The Report dealt with this infringement on the existing hospital industry by promising to amend the bill by requiring an unequivocally clear showing of need through impartial state and local surveys and a positive provision that qualified public and private hospitals be utilized in state plans (S.Rpt. 1139, 1939:36-37). These would be incorporated into Hill-Burton’s surveys and state plans.

The third problem involved the creation of the Federal Advisory Council for making necessary rules and regulations, with administrative authority assigned to the Surgeon General. The Council would include both public and professional representatives and would be established jointly by the three agencies charged with administration. The Hearings Report (S.Rpt. 1139, 1939:34) indicated that all comments appear to be in agreement, yet the Federal Advisory Council was to become one of the most confusing aspects of the Hill-Burton Act.

THE NATIONAL HOSPITAL BILL

Up to this point, Federal interest and support for hospital construction was part of a much broader national health program. But on February 1, 1940 President Roosevelt separated out proposals for the construction of small hospitals in needy areas of the country, and especially in rural areas (Congr. Rec. 1940: 878). In response Sen. Wagner and Sen. Walter George (D-GA) introduced the National Hospital Bill of 1940, S.3230 which proposed a limited program of hospital construction and equipment and for assistance towards the maintenance of such hospitals. Construction funds were to come entirely from the Federal government because current hospital facilities were built according to income and wealth of the community rather than to the needs of the people. These new public hospitals would be made available within reasonable limits to every person residing in the relevant area regardless of their financial ability to pay. The Surgeon General could issue rules and regulations not only covering construction and planning, but also the standards of personnel, maintenance, and operations of such hospitals. He would also have an advisory council patterned after the National Advisory Cancer Council (S.Rpt. 1558, 1940). This bill avoided the grants-in-aid problem through direct Federal funding and the management oversight problem by not funding non-public hospitals. But it raised the issues of access to care for the poor and service to the community, and both of these would be last-minute insertions into the Hill-Burton bill as required obligations for receiving federal funds.

In 1941, a public works plan, the Lanham Act (PL 77-137) provided for the construction of hospitals, including public non-profit hospitals. The Lanham Act, however, prohibited the Federal government from exercising any supervision or control over the administration, personnel or operations of non-federally owned or operated facilities. Although a victory for the hospital interests, most of the funding went to municipal and county hospitals and the start of World War II quickly foreclosed further appropriations. Nevertheless, the Lanham Act opened the door for future Federal funding of public non-profit hospitals.

THE HEALTH INTEREST GROUPS Mobilize

While World War II took center stage, three interest groups, the American Hospital Association (AHA), the U.S. Public Health Service (PHS), and the U.S. Senate, began to mobilize and undertake studies on the future of hospital and health care in the United States. In late 1943, the AHA house of delegates passed the Bishop resolution calling for voluntary health insurance, federal aid for the construction of hospitals and government aid for those who could not afford to pay as a counter to a national health program and insurance. The next year AHA created the Commission on Hospital Care, under the direction of Arthur C. Buchmeyer, then head of the University of Chicago clinics and a former President of the AHA. With funding from the Commonwealth Fund, the Kellogg Foundation and the Foundation for Infantile Paralysis, the Commission developed a set of recommendations on hospital services and facili-

Bachmeyer would point out that hospital service was inadequate in some regions of the U.S. and wholly lacking in others. “We frequently refer to our splendid system of hospitals, whereas there actually is none. There is very little coordination between our hospitals” (Hearings, S.191, 1945:241). He warned against a uniform standard for all hospitals because the wide range of differences in health status, habits, population changes and economic bases meant that proposals for extension of hospital facilities and services in one area may be wholly inadequate for meeting the needs in another area. The reliance on State surveys appears to be the direct result of the Commission’s interest in building new hospitals while protecting existing ones.

The second interest group was the U.S. Public Health Service. Surgeon General Thomas Parran was able to assign a PHS physician to the staff of the Commission who served as more than a liaison. Basically, the Commission collected necessary hospital data and the PHS tabulated and handled it (Weeks and Berman, 1985:34-35). The research was conducted by Joseph W. Mountain, director of the PHS States Relations Division which was involved with the construction of health care projects under the Lanham Act. In 1944 Mountain reported to the American Public Health Association on the haphazard attempts to construct hospitals in the past and the need for conscious planning on a regional basis, preferably through local health departments. And in 1945, Mountain, Pennell and Hoge established a method to assess utilization and need for hospital care according to trade area patterns (Pearson, 1975). The inclusion of hospital service areas in Hill-Burton and its authorization for some 2,700 local health centers bears his mark.

The third interest group was the Senate Subcommittee on War-time Health and Education. In 1943, Sen. Claude Pepper (D-FL), concerned about the large number of young men who were unfit for military service, held hearings on health manpower including public health and the distribution of doctors. An interim report was issued on January 4, 1945 just six days before Senator Hill and Burton introduced S.191, the Hospital Construction Act. According to Sen. Hill, the Pepper Committee documented the shortage and need for hospital facilities and expressed the firm conviction that “adequate hospital and public health facilities, properly distributed, were the first step in finding a solution to our national health problems” (Hearings, S.191, 1945:7).

**POLICY AGENDAS**

In addition to linking the Pepper Report to his bill, Sen. Hill’s introductory remarks included a set of five principles: (a) that facilities constructed be part of a long-range program and not part of a public works plan; (b) that a survey of health facilities was necessary before granting construction funds; (c) that funding be controlled by the states; (d) that voluntary non-profit hospitals as well as non-Federal hospitals be eligible for assistance; and (e) that States’ rights and local initiative be encouraged and preserved (Hearings S.191, 1945:8). The Hill-Burton Act would not resemble the 1940 National Hospital Bill or the Lanham Act in promoting public works and direct Federal funding and supervision, although, like the Lanham Act, it would provide assistance to private non-profit facilities. Sen. Hill was proposing a compromise between the direct Federal intervention strategy favored by Sen. James E. Murray (D-MT) and Wagner and the state or local initiative favored by the hospital and public health interests.

Several things strongly suggest that the Hill-Burton Act was not sponsored by the President, the Senate leadership or the Committee Chair. Ordinarily, the first witness would be the Surgeon General or the Federal Security Administrator (the equivalent of the Secretary of Health and Human Services at the time). But this was not an administration bill as Surgeon General Thomas Parran made quite clear the following day: “I am not advised as to the relation of S.191 to the program of the President (Roosevelt). Therefore, I shall speak only as a student of the hospital problem in this country, and what I say will represent a professional opinion, not a statement of official policy” (Hearings, S.191; 1945:53).

In the opening statement at the February, 1945 hearings, Donald C. Smelzer, MD, President of the American Hospital Association, explained the bill’s provisions in clear and concise language and gave it his full support. When Dr. Smelzer replied to the very first
question that determination of financial need of the states would be made by the Public Health Service. Sen. Hill recognized Dr. Parran in the audience. An exchange ensued between the Surgeon General and the Committee about when he would testify (Hearings, S.191, 1945:20-21). The next morning, Parran outlined an integrated hospital system with four types of institutions: medical school affiliated medical centers, district hospitals, rural hospitals and health centers for small relatively isolated communities. The bill would assist district type hospitals and build health centers, thereby filling out the missing pieces in a completely integrated hospital system (Hearings, S.191, 1945: 59-60).

Policy Issue: Federal Aid to States

The testimony at the hearings centered on four issues: the type and amount of Federal aid to states, public funds for voluntary hospitals, powers of the Federal Advisory Council, and provision of health services for the poor. In his opening testimony Dr. Smelzer of the AHA argued that the proposed bill presented a very sensible division of authority between Federal and State Governments, included standardized methods and supervision to insure proper utilization of funds and allocated funds for construction to the states based on population, financial need, and inadequacy of current hospital facilities (Hearings, S.191, 1945:11, 13).

The New Deal perspective on Federal aid was clearly presented by Sen. Murray in his statement of reservations. He was upset because practically all of the administrative authority was given to the States. He felt this was "a dangerous and unwise proposal, considering how inadequate—and in many cases, non-existent—State control of hospitals has been in the past" (S. Rpt. 674, 1945:19). He also wanted the Surgeon General to be able to issue standards covering the maintenance and operation of hospitals, as was proposed in the 1940 construction bill, in addition to the Hill-Burton provisions for standards covering construction and equipment.

From the other side of the political spectrum Sen. Robert Taft (R-OH) wanted to know the underlying theory of Federal aid and the justification for Federal interest in hospitals. He pointed out to Dr. Parran that the City of Cincinnati was perfectly able to provide its own hospitals and there was no reason at all why the Federal Government should come in and help. He argued that it was the Federal Government’s interest in medical care to fill up the gap and denied the idea that the medical system was inadequate as a whole (Hearings, S.191, 1945:76-77).

Policy Issue: Public Funds for Voluntary Hospitals

Some of the gap could be bridged through public funding of existing private non-profit hospitals which were operated by religious and non-denominational groups. In his opening statement, Dr. Smelzer noted that since private non-profit hospitals rendered a major portion of the general hospital care in the country, the bill would maintain the best in our present system of hospital service by making grants to both voluntary and government hospitals (Hearings, S.191, 1945:14). In apparent support of funding for non-governmental facilities, Surgeon General Parran noted that little difference existed between church operated and other voluntary hospitals. Although private in organization, these hospitals were tax exempt and quasi-public in function because they performed a service which otherwise would have to be provided by the government (Hearings, S.191, 1945:57).

But a fly was in the ointment. Both Parran and Reginald M. Arway, Secretary of the American Public Health Association, pointed out that some State constitutions forbid spending of tax revenues on making contributions to voluntary, private and religious groups (see Hearings, S.191, 1945:70 and 107-118). The solution was to permit some direct Federal payments to private or religious voluntary organizations. Sen. Murray’s reservation was that it was of “the utmost importance to assure that the specifications of the bill adequately protect public funds that may be granted to other than public bodies” (S. Rpt. 674, 1945:20).

On the conservative side, Sen. Taft could not remember, with the possible exception of the Lanham Act during the war, any Federal funds being presented permanently and finally to private institutions. He favored helping the private hospital system to expand, but believed long-term loans to private hospitals were more reasonable than an outright public gift (Hearings, S.191, 1945:22-23).
Policy Issue: Powers of the Federal Advisory Council

In contrast to the Lantham Act which prohibited federal supervision or control over private institutions, Hill-Burton proposed that the Federal Advisory Council and Surgeon General determine the obligations voluntary hospitals would have to the Federal government in exchange for the funds. The obligations might include standards of care, staffing and provision of service to the public. In his opening remarks, Dr. Smedley noted that the bill very sensibly insured protection against arbitrary judgment and for input from those experienced in administering health programs by creating a strong eight-member Federal Advisory Council which would approve standards and plans with the Surgeon General (Hearings, S.191, 1945:17).

In his reservations, Sen. Murray argued that the powers and status of the Council should be revised. The Council would be entirely independent of both the Surgeon General and the Federal Security Administrator regarding certain administrative duties and quasi-judicial functions with no appeal from its actions. He claimed that the proposed Council is probably unprecedented and would make for muddled, inefficient and even bad administration (S.Rpt. 674, 1945:18).

Sen. Taft, however, concluded that the Surgeon General would have a blank check and become the czar of the hospital field (Hearings, S.191, 1945:84), and told him “it authorizes you to use any money in any amount and authorizes you to do practically anything you want to do with the hospital system . . . (and) . . . When I say ‘you’ I mean you and your Advisory Council” (Hearings, S.191, 1945:21). He did not see how a part-time Council would be a real limitation on the power of the Surgeon General. But then Sen. Taft noted that the Surgeon General did not write the bill and the Senator did not necessarily blame him for it (Hearing, S.191, 1945:88).

For his part, Surgeon General Parran occupied the middle ground between two points of view: (1) that the Council would have too much authority and be dominated by vested interests, specifically hospital administrators, and (2) that any Federal Advisory Council would become a rubber stamp for the administration (Hearings, S.191, 1945:71). He envisioned a small technical committee of experts who would give good advice but not interfere with the administration of the bill.

Policy Issue: Health Services for the Poor

With the separation of hospital construction from a national health program and insurance, a guarantee of health services for the poor and medically indigent was not included in the original draft of the Hill-Burton bill. The case for the poor was couched in terms of a community’s ability to raise matching funds and continue to support the hospital financially after construction. The hospital position was quite clear. When asked if the commission had tried to determine the best method by which the indigent can be taken care of, Bachmeyer replied, “No. . . We have addressed ourselves to the one problem of facilities, because we believe that it makes no difference how medical care is to be paid for” (Hearings, S.191, 1945:245).

Drawing from the 1940 Hospital Construction Bill, liberals pointed out the incoherence of providing funds to construct hospitals in communities which did not have adequate funds to operate and maintain them. They claimed that such hospitals would be forced to charge high fees for service and thereby deny access to individuals unable to pay but in need of hospitalization. By the fall of 1945, the Truman administration was calling for the public financing of health insurance and services, including the construction of hospitals and related facilities (Hearings, S.191, 1945:53; S.Rpt. 674, 1945:20).

In written statements (Hearings, S.191, 1945:177-178; S.Rpt. 674, 1945:20), Sen. Murray expressed his reservations about the inability of the poorest and neediest communities to raise sufficient matching funds to qualify for the program and to give adequate assurance of post-construction financial support. A poor area with inadequate hospital facilities in a wealthy state might have to raise 67% to qualify for “matching” funds and would be no better off since they would get little or no help under the Hill-Burton Act. Murray advocated amending the Social Security Act to provide for the payment of hospital care of needy persons and thereby enable poor communities to financially maintain their hospital.

Sen. Taft agreed with Sen. Murray that “the very places where
hospitals are most needed are the places where they cannot operate without getting assistance for operation and maintenance” (Hearings, S.191, 1945:79). But Taft wanted to adopt standards so that a hospital district could reach a ratio of four or five beds per thousand people, but limit further growth. Otherwise, “every hospital in Cincinnati would be here with a tremendous crowd of influential people wanting to double the size of their hospitals. They would look forward to putting on a drive to raise a million dollars to match a million dollars from the Federal Government” (Hearings, S.191, 1945:67).

SUMMARY AND DISCUSSION

The rapid success of an apparently “unsponsored” bill in the Senate depended on a series of fortuitous events. The administration was initially unprepared and failed to intervene between the end of the hearings in March and the Committee’s report at the end of October because of President Roosevelt’s death in April and the end of World War II in August. President Harry S. Truman did not get around to health legislation until late November when he submitted a health message calling for a comprehensive prepaid medical insurance plan (Starr, 1982:281; Fox, 1986:123). The Committee chair, Sen. Murray, who did not attend most of the hearings or the committee mark-up sessions (Weeks and Berman, 1985:39), was working on the Wagner-Murray bill (S.1606) which proposed to make basic health services available to all the people wherever they may live and whatever their income may be (Committee on Labor and Public Welfare, 1970:69).

This left the field open to the hospital interest groups and their champions who took an incrementalist approach. Hospital construction was originally a very small part of the health section of a comprehensive plan for economic security. Social Security was the first piece, and a National Health Program featuring universal and comprehensive health insurance should have been next (APHA, 1944; Starr, 1982:280; Fox, 1986:117-118). But construction was separated out in the 1940 National Hospital Bill and after the Lanham Act opened the door for federal funding to the private sector, the hospital interests could always show how reasonable and incre-

mental their bill was compared with a National Health Program and Insurance.

The major compromises were worked out in executive mark-up sessions at which representatives of the hospitals (George Bugbee, AHA executive director), public health service (Vane Hoge, Inter first Hill-Burton administrator), and social security (I. S. Falk) were present (Weeks and Berman, 1985:390). The role of Sen. Taft was crucial (Fox, 1986:126ff; Weeks and Berman, 1985). During the hearings, Taft was concerned about the inevitable sequence of health legislation that would follow hospital construction (Hearings, S.191, 1945:80-81) and asked “whether we should just consider the construction of hospitals alone without considering the general health plan” (Hearings, S.191, 1945:26). Taft supported the incremental step represented by Hill-Burton while branding the National Health Program as socialism (Starr, 1982:283). His philosophy was that anything the states did wrong would be less disastrous than if these happened in a national level program (Weeks and Berman, 1985:38). He was primarily concerned about the ability of wealthy communities to get more funds than they needed and worried about the arbitrariness of the regulatory powers of the Surgeon General and Federal Advisory Council.

Taft personally rewrote much of the legislation in committee, including preserving the independence of the states to carry out their plans within a specific set of general requirements clearly written into the law, with limited regulatory powers granted to the Surgeon General and the Federal Hospital Council (Weeks and Berman, 1985:285; S.Rpt. 674, 1945:8). In the final bill, the Federal Advisory Council became the Federal Hospital Council, “inasmuch as its functions are not merely advisory.” Its eight members included five experts, three in hospital operations, and two in other health fields, plus three consumers familiar with the needs of urban and rural areas (S.Rpt. 674, 1945:14). But Taft’s most acknowledged contribution was to push for the grant-in-aid formula that allocated funds to states based on population with a limiting factor for existing hospitals and community wealth (Fox, 1986:128; Klarman, 1977:28; Weeks and Berman, 1985:41).

But if Taft exercised a penny pinching hand in the mark-up sessions, and Bugbee reported that “Hill tended to give Taft anything he
wasted, within reason" (Weeks and Berman, 1985:39), then what
did the liberals like Sen. Murray get in return? Boggs stated that the
bill contained "other broad philosophical concepts... which are not
there by chance" (Weeks and Berman, 1985:285). Among these
were two key obligations, which echo some liberal provisions of the
1940 National Hospital Bill. The first, a community service obliga-
tion, stated that regulations would require hospitals constructed
with Hill-Burton funds to be open to all persons in the community without
discrimination on account of race, creed or color. The second, an
uncompensated care obligation, required that a Hill-Burton hospital
give assurances that it would furnish a reasonable volume of services
to persons unable to pay (S.Rpt. 674, 1945:8-9).

Stronger formal amendments by Murray were defeated at the
time of Senate passage (Fox, 1986:129). The liberals were unable to
further amend the bill (Rozenblat, 1978) and failed to pass subse-
quent health legislation. Developing the specific federal regulations
called for in these obligations then became the responsibility of the
Surgeon General and the Federal Hospital Council. But the strong
presence of hospital interests on the Council meant inaction, and it
would be over 25 years before the obligations would begin to be
enforced (Shaheen and Perlstadt, 1982).

A comment at the 1945 hearings by Graham L. Davis, Hospital
Director of the W. K. Kellogg Foundation which sponsored the
Rachmeyer Report and a future President of the American Hospital
Association, still is highly relevant: "A national hospital program is
what this Nation needs. At the end of the war large sums will be
spent on the improvement of hospital facilities and under present
conditions much of it will not be spent to the best advantage."
(Hearings, S.191, 1945:336). The problems of support for rural and
inner-city hospitals are still present and complicated by escalating
hospital costs spurred on by unplanned acquisition of expensive
technologies and duplication of services.

RELEVANCE FOR NATIONAL HEALTH INSURANCE

The passage of the Hill-Burton Act foreshadowed detrimental
outcomes for a rational, organized health care system and a national
health insurance program. The separation of hospital construction
from a more comprehensive health care insurance and delivery
policy meant health insurance for the medically indigent and poor
(Medicare and Medicaid) was delayed for another twenty years, and
nearly fifty years later, the United States is the last major industrial
democracy not to have some form of universal health insurance.

The current push for a single payer national health insurance
program can be compared with the development of the Hill-Burton
legislation. The apparent deadline for national health insurance by
the year 2000 resembles the dedication to improve the health care
system towards the end of World War II. Now as then, almost
everyone seems to agree that health care reform is needed. Over the
past few years, several prominent liberal Democratic Senators have
introduced a variety of health insurance bills, but with no support
from the Republican Presidents. In the early 1940s health and hos-
pital construction legislation received at best lukewarm support
from Presidents Roosevelt and Truman.

In the case of Hill-Burton, pivotal roles were played by the hospi-
tal interests and a conservative Republican Senate. Motivated by
potential federal funding, the American Hospital Association was
able to take the lead, forge a united front of public and private
hospitals, and work with both the Public Health Service and the
Senate committee. In contrast, the health insurance industry is large
and diverse, encompassing national and local for-profit companies,
statewide non-profits, a variety of health maintenance and preferred
provider organizations, and even self-insured corporations. Identify-
ing one or two companies to serve as fiscal intermediaries for federal
or state health insurance programs or to have the federal govern-
ment act at the single payer will not gain industry-wide support. Therefore
a group like the Health Insurance Association of America is not
motivated to act in the same way the AHA did on Hill-Burton. The
history of national health insurance systems in other democratic
states suggests that the government coopted the myriad of small
insurance companies by giving them dispersal functions in the
national plan (Anderson, 1989; Fredri and Bjorkman, 1989).

The contribution of Taft, a conservative Republican, was to make
federalism work in the case of Hill-Burton. He carried the day by
creating a balance between Congressional guidelines, federal review
and regulations, and state administration with a role for hospitals in
the decision-making and implementation process. The interest in such a balance can be seen in the introduction of bills in many states for their own health insurance programs. Taft’s concern about the manageability of state versus federal-level programs is still relevant when one considers that the Canadian health insurance system is nationally guided, provincially administered and serves a population less than the state of California. The search for a “new federalism” in health care has not been concluded.

Hill-Burton presented a unique combination of interests and champions who, striking compromises, made a significant but incremental change in the health care system. In order for the United States to implement a universal health insurance system, the liberals will have to abandon a federally-led and administered program in favor of a strong role for states in administering a national system. The liberal belief that a single system can comprehensively cover the medical needs of all classes must yield to the reality that most of the middle class can afford and are covered by insurance (no matter how expensive or inappropriate) and therefore have little interest in subsidizing something that is of little direct benefit to themselves. For their part, the conservatives will have to agree to a compulsory withholding in lieu of voluntary premiums and fringe benefits which encourage misuse and waste of health care resources. The conservative belief in a free market system must confront the reality that health care is an imperfect market. Every other capitalist democratic state has come to grips with this and enacted a nationally coordinated health insurance plan with a mixture of public and private premium sources.

But if the Hill-Burton analogy is to work for enacting a universal health insurance program, the insurance industry needs to take a more pro-active role. It does not need a detailed master plan, but should support two principles. First, the lesson of the Hill-Burton policy analysis is to work, revise, and build consensus over a small portion of the problem. A mandatory universal health insurance might begin by covering basic family and child care coverage combined with those services currently covered by Medicare and Medicaid. Second, a role must be found for the existing private and non-profit insurers. For example, all residents could receive federal or state insurance coverage for basic services while permitting individuals to purchase additional coverage, with limited tax deductions and restrictive out-of-pocket deductibles through existing non-governmental plans. Australia has a mixed government-private sector plan along these lines (Anderson, 1989). Comprehensive health insurance coverage covering all health contingencies cannot be achieved in a single stride.

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