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COMMUNITY HEALTH SERVICES AND FACILITIES ACT OF 1961

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HEARINGS

BEFORE THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH CONGRESS

FIRST SESSION

ON

H.R. 4998

A BILL TO ASSIST IN EXPANDING AND IMPROVING COMMUNITY FACILITIES AND SERVICES FOR THE HEALTH CARE OF AGED AND OTHER PERSONS, AND FOR OTHER PURPOSES

MAY 2, 3, 4, AND 5, 1961

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COMMUNITY HEALTH SERVICES AND FACILITIES ACT OF 1961

TUESDAY, MAY 2, 1961

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The committee met, pursuant to notice, at 10:15 a.m., in room 1334, New House Office Building, Hon. Oren Harris presiding.

Present: Representatives Harris (chairman), Mack, Moulder, Rhodes, Moss, Rogers of Florida, Hemphill, Schenck, Younger, Nelsen, Keith, Curtin, Sibal, Thomson, and Dominick of Colorado.

The CHAIRMAN. The committee will come to order.

Today the committee opens hearings on H.R. 4998, a bill to assist in expanding and improving community facilities and services for the health care of aged and other persons, and for other purposes.

(H.R. 4998 is as follows:)

[H.R. 4998, 87th Cong., 1st sess.]

A BILL To assist in expanding and improving community facilities and services for the health care of aged and other persons, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Community Health Services and Facilities Act of 1961".

GRANTS FOR PUBLIC HEALTH SERVICES

SEC. 2. (a) Section 314(c) of the Public Health Service Act is amended by striking out "there is hereby authorized to be appropriated for each fiscal year a sum not to exceed $30,000,000" and inserting in lieu thereof "there are hereby authorized to be appropriated for each fiscal year such sums as the Congress may determine".

(b) Clause (1) of the second sentence of such subsection is amended by striking out "an amount, not to exceed $3,000,000, to enable the Surgeon General" and inserting in lieu thereof "such amount as may be necessary to enable the Surgeon General".

(c) Such subsection is further amended by inserting after the first sentence the following new sentence: "When so provided in any Act appropriating funds for carrying out the purposes of this subsection for any year, such amounts as may be specified in such Act shall be available only for allotments and payments for such services and activities included under this subsection as may be provided in such Act; and in such case the requirements of subsection (h) shall be separately applied to such allotments and payments."

(d) Section 314 of such Act is further amended by adding at the end thereof the following new subsection:

"(m) The Surgeon General, at the request of the State health authority, may reduce the payments to a State under this section by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee of the Public Health Service to the State or any of its political subdivisions when such detail is made for the convenience of and at the request of the State and for purposes of carrying out its State plan approved

under this section. The amount by which such payments are so reduced shall be available for payment of such costs by the Surgeon General, but shall, for purposes of subsection (h), be deemed to have been paid to the State agency."

(e) Part B of title III of the Public Health Service Act is further amended by adding after section 315 the following new section:

"SPECIAL PROJECT GRANTS FOR IMPROVING COMMUNITY HEALTH SERVICES

"SEC. 316. (a) There are hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1962, such sums as the Congress may determine, for grants to State or other public or nonprofit private agencies or organizations for studies, experiments, and demonstrations looking toward development of new or improved methods of providing health services outside the hospital, particularly for chronically ill or aged persons. Any grant for any such project made from an appropriation under this section for any fiscal year shall include such amounts as the Surgeon General determines to be necessary for succeeding fiscal years for completion of the Federal participation in the project as approved by the Surgeon General.

"(b) Payments under this section may be made in advance or by way or reimbursement, and in such installments, as may be determined by the Surgeon General; and shall be made on such conditions as the Surgeon General finds necessary to carry out the purposes of this section.

"(c) The Surgeon General, at the request of a State or other public agency, may reduce the grant to such agency under this section by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee of the Public Health Service to such agency when such detail is made for the convenience of and at the request of such agency and for the purpose of carrying out its study, experiment, or demonstration with respect to which a grant is made under this section. The amount by which such grant is so reduced shall be available for payment of such costs by the Surgeon General, but shall, for purposes of subsection (b), be deemed to have been paid to such agency."

INCREASE IN GRANTS FOR CONSTRUCTION OF NONPROFIT NURSING HOMES

SEC. 4. (a) Paragraph (4) of section 651 of the Public Health Service Act is amended by striking out "$10,000,000" and inserting in lieu thereof "$20,000,000".

(b) Section 652 of such Act is amended by striking out "(3) or (4)" and inserting in lieu thereof "(3)" and by striking out "(1) or (2)" and inserting in lieu thereof "(1), (2), or (4)".

(c) The amendments made by subsections (a) and (b) shall be applicable in the case of fiscal years beginning after June 30, 1961.

RESEARCH, EXPERIMENTS, AND DEMONSTRATIONS IN UTILIZATION OF MEDICAL FACILITIES

SEC. 5. (a) Section 636 of the Public Health Service Act is amended by striking out "hospital services, facilities, and resources" each time it appears therein and inserting in lieu thereof "services, facilities, and resources of hospitals or other medical facilities" the first time and "services, facilities, and resources of hospitals or other medical facilities, agencies, or institutions, and including projects for the construction of experimental or demonstration hospitals or other medical facilities and projects for acquisition of experimental or demonstration equipment for use in connection with hospitals or other medical facilities" the second time.

(b) Section 636 of such Act is further amended by striking out the last sentence thereof and inserting the following in lieu of such sentence: "Any award for any such project made from an appropriation under this section for any fiscal year shall include such amounts as the Surgeon General determines to be necessary for succeeding fiscal years for completion of the Federal participation in the project as approved by the Surgeon General. Payments of any such grant may be made in advance or by way of reimbursement, and in such installments, as may be determined by the Surgeon General; and shall be made on such conditions as the Surgeon General finds necessary to carry out the purposes of this section. Except where the Surgeon General determines that

unusual circumstances make a larger percentage necessary in order to effectuate the purposes of this section, amounts paid under this section with respect to any project for construction of a facility or for acquisition of equipment may not exceed 66⅔ per centum of the cost of such project. The provisions of clause (5) of the third sentence of subsection (a) of section 625 and any other provisions of such section which the Surgeon General deems appropriate shall be applicable, along with such other conditions as the Surgeon General may determine, to grants under this section for projects for construction or for acquisition of equipment."

(c) Such section is further amended by striking out "In carrying out the purposes of section 301 with respect to hospital facilities, the Surgeon General" and inserting in lieu thereof "(a) The Surgeon General", and by adding at the end of such section the following new subsection:

"(b) If, within twenty years after completion of any construction for which funds have been paid under this section—

"(1) the applicant or other owner of the facility shall cease to be a public or other nonprofit institution or organization, or

"(2) the facility shall cease to be used for the purposes for which it was constructed or for the provision of hospital or other services for which construction projects may be approved under this title (unless the Surgeon General determines that there is good cause for releasing the applicant or other owner from the obligation to do so),

the United States shall be entitled to recover from the applicant or other owner of the facility an amount bearing the same ratio to the then value (as determined by agreement of the parties or by action brought in the United States district court for the district in which such facility is situated) of the facility, as the amount of the Federal participation bore to the cost of construction of such facility. Such right of recovery shall not constitute a lien on such facility prior to judgment."

The CHAIRMAN. Now, for fear there might be some confusion or misunderstanding, let me further state that this is not the medical care for the aged bill about which we have heard so much in the last 2 or 3 years.

This bill is an administration bill which I introduced at the request of President Kennedy. At this point in the record I would like to insert President Kennedy's letter to Speaker Rayburn requesting introduction of this legislation and Secretary Ribicoff's letter to President Kennedy outlining the provisions of the bill.

(The documents are as follows:)

FEBRUARY 24, 1961.

HON. SAM RAYBURN,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: I am transmitting herewith two drafts of legislation to carry out recommendations I made in my message to the Congress on February 9.

The first bill would, when enacted, increase opportunities for training physicians, dentists, and professional public health personnel. These are the keystones of any health program. Yet we are not presently training enough even to keep pace with our growing population. The enclosed proposal will enable us to narrow substantially our current deficit in this area.

The other bill which I am transmitting will help expand and improve community facilities and services for the health care of the aged and other persons. It will make possible a substantial addition to the number of nursing home facilities to care for long-term patients and it will help relieve the shortages of home health care programs.

The enclosed letters from the Secretary of Health, Education, and Welfare describes the two proposals in more detail. I commend this legislation to you.

Sincerely,

JOHN F. KENNEDY.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, February 23, 1961.

THE PRESIDENT,
The White House,
Washington, D.C.

DEAR MR. PRESIDENT: Enclosed is a bill to carry out those recommendations in your February 9, 1961, special health message to the Congress relating to the expansion of community facilities and services for the health care of the aged and other persons.

The bill would amend section 314(c) of the Public Health Service Act to remove the ceiling on the authorization of appropriations and to authorize earmarking of part of the appropriations for particular activities. The funds which would be available to the States under this increased authorization could thus be directed toward such activities as the establishment and maintenance of programs for improving the scope, quality, and availability of community health services such as those provided in nursing homes, home health care programs, outpatient diagnostic services, and health referral and information centers.

The bill would also authorize the Surgeon General to make grants to public or other nonprofit organizations for studies, experiments, and demonstration projects designed to develop new or improved methods of providing health services outside the hospital for the chronically ill and aged.

The annual appropriation authorization for grants for the construction of public or other nonprofit nursing homes would be raised to $20 million from its current level of $10 million. This amount together with other public and private construction funds, would make possible a net addition over the next 10 years of one-half of a bed per 1,000 population for the care of long-term patients.

The bill would also remove the current $1,200,000 annual ceiling on funds for research grants in the development and utilization of hospital services, facilities, and resources. In addition, it would authorize such research grant funds to be used for the construction and equipping of experimental or demonstration hospitals or other medical facilities.

Faithfully yours,

ABRAHAM RIBICOFF, *Secretary.*

The CHAIRMAN. I have scheduled these hearings before our full committee because this bill constitutes an important part of President Kennedy's health program.

It is my hope that as many members of our committee as possible will be able to attend these hearings so that they will be fully familiar with the provisions of this legislation when we go into executive session and later on if and when we take this legislation to the floor of the House.

I believe this bill is important not only because it forms a part of the President's health program but also because of the vital role which community health facilities and community health services play in safeguarding and promoting the health of our people.

I happen to come from a rural area and the thought therefore occurred to me that some of the health problems with which the American people will have to deal are not unlike some of the agricultural problems which we have to face in the United States.

A few decades ago farmers and Federal and State agricultural departments and agencies were greatly preoccupied with scientific research into ways in which our agricultural production could be improved. During the last decade we have been similarly preoccupied

with scientific research into methods by which diseases and disabilities can be prevented or cured. This research in agriculture and medicine have paid tremendous dividends in increasing our knowledge in these two fields.

However—and this is the main point of my remarks—the accumulation of agricultural and medical scientific knowledge is not the end but only the beginning of some of our problems.

Increased agricultural production has raised numerous social, economic, and political problems. Increased medical knowledge likewise will raise important social, economic, and political problems. What I am trying to say is that from now on the American people are going to be concerned increasingly with the question of how the benefits of medical research can be brought to our people.

For example, a few weeks ago our Subcommittee on Health and Safety held hearings on the status of the Salk and Sabin polio vaccines. While Dr. Salk and Dr. Sabin disagreed on many scientific points, they were in complete agreement that our big problem from now on is not how to produce new vaccines but how to get presently available and future vaccines to the 40 percent of our population who are not immunized against polio or any of the other diseases against which immunization is possible.

Immunizing our people against diseases is just one of the situations in which community health facilities and health services are of great importance if the American people are to get the benefit of modern medical knowledge and discoveries. I realize that the bill before us seeks to stress health services and facilities for the aged, but I would think the bill is by no means limited in such way.

I have taken perhaps more time than I should, but I wanted to stress the importance of the legislation now before us.

There are several communications I have from various groups and organizations which will go in the record later at the appropriate place.

We regret very much that the distinguished Secretary of Health, Education, and Welfare is unable to be with us. He has an ailment and has lost his voice. We do hope that the Secretary will soon have a complete recovery.

We are fortunate, and so is the Secretary fortunate, to have able assistants that he can call on at a time like this.

We are glad to welcome here Mr. Boisfeuillet Jones, Special Assistant to the Secretary on Health and Medical Affairs. We are also glad to have with Mr. Jones, Dr. Luther Terry, the Surgeon General of the Public Health Service, and Mr. Wilbur J. Cohen, the Assistant Secretary for Legislation. And, so, the Department is able represented.

Mr. Jones, we are glad to have you and your associates with us, and I believe you will present the statement of the Secretary.

STATEMENT OF BOISFEUILLET JONES, SPECIAL ASSISTANT TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE ON HEALTH AND MEDICAL AFFAIRS; ACCOMPANIED BY WILBUR J. COHEN, ASSISTANT SECRETARY FOR LEGISLATION; DR. LUTHER TERRY, SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE; DR. JACK HALDEMAN, ASSISTANT SURGEON GENERAL, CHIEF OF THE DIVISION OF HOSPITAL AND MEDICAL FACILITIES; AND SAM KIMBLE, ASSISTANT CHIEF, DIVISION OF COMMUNITY HEALTH PRACTICE

Mr. JONES. Thank you, Mr. Chairman.

May I add to what you have said so well, the very deep personal regret of the Secretary that he could not be here. He has been advised not to use his voice. He is so interested in this legislation that, were he here, he would be inclined to talk anyway. He does regret, though, that he could not be here personally.

I will present the testimony which he had planned to present.

STATEMENT OF HON. ABRAHAM RIBICOFF, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, AS PRESENTED BY BOISFEUILLET JONES, SPECIAL ASSISTANT TO THE SECRETARY ON HEALTH AND MEDICAL AFFAIRS

Mr. JONES. Mr. Chairman and members of the committee, I am pleased to appear before you today in support of H.R. 4998, introduced by Chairman Harris. This bill carries out the recommendations of President Kennedy in his special health message to the Congress for extending and improving the availability of community health services and facilities.

In that message the President stated that the ability of an individual to afford adequate health care is to no avail if the necessary community facilities and services for providing such care are not available. The facilities and services are not available in most communities of the United States to provide high quality, comprehensive health care outside the hospital.

Long-term illness is a major and growing problem in the United States. In a large measure it results from our aging population. There are now nearly 17 million persons 65 years of age and over, and this number will increase to 20 million by 1970.

Data from a recent National Health Survey indicate that 11 million of these older people who are not in institutions have some type of chronic health problem. Over 6 million of them are limited in their daily activities as a result of these problems.

But the problem of long-term illness is not confined to the elderly. It also affects the middle aged, young adults, and children as well. The problem is truly a national one, involving persons of all age groups, of all economic levels and of all States.

How best to meet this problem is a major challenge for the health professions and for the Nation. Prevention of the diseases and conditions which result in long-term illness is clearly the most effective solution. Private and governmental efforts to make available to all the preventive measures which are known must be given increased and vigorous attention.

Early and accurate diagnosis is of paramount importance when prevention is not possible. Community services are necessary to facilitate widespread early identification and diagnosis of these conditions in order that treatment can be initiated early when it has the best chance of success and when the long-term disabling effects of disease can most frequently be prevented.

Studies have shown, for example, that more than 80 percent of patients who survive a stroke can become ambulant within 2 months with proper treatment. The longer the time before proper treatment measures are started, however, the longer the patient will be disabled and the more difficult it will be to restore his functions.

Effective health care of persons with long-term illnesses also requires high quality community facilities and services. It requires hospitals for the care of such patients during the acute stages of their illnesses. It is wasteful, however, of both professional resources and funds to keep patients in hospitals beyond the time when highly specialized hospital services are necessary.

After the acute stage of illness has passed most patients can be cared for as effectively and more economically in skilled nursing homes or in their own residences. But there is a shortage of about one-half million skilled nursing home and chronic disease beds in the United States. The quality and scope of services offered by a number of nursing homes today is a national disgrace.

Organized community services to provide health care for patients in their own homes is almost nonexistent in most communities. Even limited home nursing services are available in less than 1,000 communities. Coordinated home care programs are available in only 30 communities at the present time.

Clearly, major, National, State, and local action is necessary to expand and improve the availability and quality of these types of out-of-hospital facilities and services, to find better ways of utilizing our existing hospitals, and to develop new and improved methods of providing and coordinating community services for the health care of the aged and the chronically ill.

H.R. 4998 would enable us to provide national leadership and Federal financial assistance to establish new facilities and services and also to extend and improve the scope and quality of those now in existence. These goals would be accomplished by—

(1) Making grants-in-aid to States for use in extending and improving the quality, scope, and availability of community health services for the aged and chronically ill outside the hospital.

(2) Making special project grants to public and nonprofit agencies to conduct studies, experiments, and demonstrations designed to develop new or improved methods of providing out-of-hospital community health services.

(3) Increasing the appropriation authorization for grants for the construction of nonprofit nursing homes from $10 million to $20 million annually.

(4) Making additional funds available for a broadened program of hospital research and demonstration.

I shall review and discuss briefly each of these proposals.

GRANTS TO STATES FOR COMMUNITY HEALTH SERVICES

The purpose of the amendments to the Public Health Service Act proposed in section 2 of the bill is to provide the legislative basis under which grants may be made to the States for extending and improving the quality, scope, and availability of comprehensive community health services. The amendments proposed would delete the current annual appropriation ceilings in section 314(c) of the Public Health Service Act and authorize the Congress in the annual appropriation process to earmark portions of the grant funds for use only in support of specified types of public health programs.

Under this amended authority funds would be allotted among the States for improving out-of-hospital community health activities. This legislative approach, in contrast to the enactment of an additional separate health grant category, will permit the appropriation of earmarked funds for other health purposes as necessity may arise.

Mr. Chairman, I would like permission to have inserted in the record a table of tentative State allotments for community health services under the provision as indicated here, if I may.

The CHAIRMAN. Let it be included in the record.

(The document referred to is as follows:)

Tentative State allotments of funds for community health services for aged and chronically ill (under sec. 2 of H.R. 4998)

	1962 allotment		*1962 allotment*
Alabama	$181,400	Nevada	$21,000
Alaska	19,600	New Hampshire	28,200
Arizona	62,200	New Jersey	172,000
Arkansas	117,000	New Mexico	53,500
California	451,200	New York	468,000
Colorado	76,600	North Carolina	237,300
Connecticut	66,100	North Dakota	42,800
Delaware	12,500	Ohio	305,000
District of Columbia	19,400	Oklahoma	109,100
Florida	192,100	Oregon	75,400
Georgia	197,400	Pennsylvania	377,900
Hawaii	26,100	Rhode Island	29,900
Idaho	41,200	South Carolina	140,700
Illinois	286,100	South Dakota	45,800
Indiana	164,800	Tennessee	182,600
Iowa	114,400	Texas	384,500
Kansas	95,900	Utah	49,600
Kentucky	154,900	Vermont	24,900
Louisiana	157,900	Virginia	166,100
Maine	51,900	Washington	101,800
Maryland	101,000	West Virginia	88,900
Massachusetts	159,300	Wisconsin	145,600
Michigan	249,900	Wyoming	24,800
Minnesota	137,400	Guam	5,600
Mississippi	154,800	Puerto Rico	159,300
Missouri	160,100	Virgin Islands	3,600
Montana	37,500		
Nebraska	67,400	Total	7,000,000

NURSING HOME SERVICES

Mr. JONES. One of the most crucial needs is the improvement of nursing home services. The nursing home is fast becoming an essential and integral part of the total pattern of long-term health care for older people. The scope and quality of services in most nursing

homes today, however, falls far short of meeting the needs of the individual patients and the communities which they serve.

Most nursing homes provide little more than custodial care, and this is frequently provided in unsafe and insanitary facilities. The result is that the patients not only fail to receive needed health services but their rehabilitation to maximum self-reliance is impeded. The average nursing home of today may be actually contributing to the permanent disability and dependency of elderly patients. Aggressive and immediate action is clearly necessary to correct this deplorable condition.

Funds made available under the proposed bill would assist States to develop and enforce more effective standards for nursing home operations, to provide consultation and technical assistance to nursing home operators in improving the scope and quality of health services in such institutions, and to conduct training programs to improve the competencies of nursing home personnel.

Mr. Chairman, I would like to have permission to insert in the record a compilation of existing medical facilities which may indicate more clearly the need for this particular section.

The CHAIRMAN. Without objection, it will be included in the record.

(The document referred to is as follows:)

MEDICAL FACILITIES

HOSPITALS

Number of hospitals.—In 1959, there were 5,364 non-Federal short-term general and other special hospitals and 330 long-term general and other special hospitals, according to the American Hospital Association.

Number of beds.—According to State plans submitted under the Hill-Burton program, as of January 1, 1961, the numbers of non-Federal hospital beds in the United States and its possessions were as follows:

	Existing beds or units			Additional needed
	Total	Acceptable	Not acceptable [1]	
Hospitals	1,378,035	1,194,983	183,052	843,037
General	694,696	619,666	75,030	158,415
Tuberculosis	72,893	68,768	4,125	9,298
Mental	554,775	456,940	97,835	427,781
Chronic	55,671	49,609	6,062	247,543

[1] As classified by the State agencies, on the basis of fire and health hazards.

In addition, there were 128,044 beds in Federal hospitals, of which 52,280 were in general hospitals. Most of these beds were in Veterans' Administration facilities, where about 20 percent of all patients under care were aged 65 and over.

Psychiatric hospitals.—According to the American Hospital Association listing for 1959, there were 296 State and local government psychiatric hospitals. These had a total of 671,640 beds set up (larger than shown by the State plan data which are based on designed capacity). It is estimated that about 30 percent of the patient load in these hospitals is aged 65 or over, based upon Public Health Service data for 1958.

Tuberculosis hospitals.—The American Hospital Association listing for 1959 indicates that there were 218 State and local government tuberculosis hospitals with 52,787 beds.

Cost per patient-day.—In 1959, the American Hospital Association data indicate that the average expenditures per patient-day in the non-Federal hospitals which they list were:

Short-term general and other special hospitals (5,364 hospitals listed)	$30.19
Long-term general and other special hospitals (330 hospitals listed)	12.50

As this average includes all hospital expenditures rather than those which would be reimbursed under a cost formula, the dollar amounts may not be directly applicable in determining the daily cost under a government program. Some measure of the potential overstatement may be inferred by comparing the following for 1958:

Average per diem cost of inpatient care computed under the Government reimbursement formula (JHF–1) (2,207 hospitals in American Hospital Association rate survey)	$23.70
Average expense per patient-day (5,290 non-Federal short-term general and other special hospitals listed by the American Hospital Association)	28.17

Hospitals meeting standards.—The number of hospitals which would meet the standards set forth in H.R. 4222 is, of course, unknown. In 1959, 2,866 of the 5,364 non-Federal short-term general and other special hospitals and 112 of the 330 non-Federal long term general and other special hospitals were accredited by the Joint Commission on Accreditation of Hospitals.

Hospitals with approved intern and residency programs.—H.R. 4222 provides that hospitals will be reimbursed for only those interns' and residents' services under a recognized teaching program. In student year 1959–60, 805 non-Federal hospitals (including psychiatric and tuberculosis hospitals) had approved internship programs and 1,174 had approved residency programs, as listed by the American Medical Association.

NURSING HOMES

According to State plans submitted under the Hill-Burton program, there were the following skilled nursing home facilities as of January 1, 1961:

Number of beds	325,790
Number of acceptable beds, as classified by State agencies on the basis of fire and health hazards	181,065

Cost per day.—Reported costs per patient day in skilled nursing homes range from about $3.50 to about $14.

Use by aged persons.—If it is assumed, as surveys indicate, that 90 percent of the patients in nursing homes are aged and that nursing homes have a 90-percent occupancy rate, then the aged used 91.2 million days of care in 1960, or about 5,700 days per thousand aged persons. Thus, the aged on the average spend about 2¼ days in nursing homes for every day spent in a general hospital.

Need for additional beds.—The estimated shortage of acceptable skilled nursing home beds as of January 1, 1961, was 265,883, according to State plans under the Hill-Burton program.

OUTPATIENT DIAGNOSTIC CENTERS

As of July 1, 1960, there were 3,565 diagnostic or treatment centers in the United States and its possessions providing general services of a total of 6,200 such centers. These centers were either outpatient departments of hospitals or separate clinics.

In 1958, 2,842 or 55.9 percent of the non-Federal short-term general and other special hospitals reporting to the American Hospital Association had an organized outpatient department.

HOME NURSING AGENCIES

As of January 1, 1960, home nursing care of the sick was provided by 662 visiting nurse associations and 47 combination agencies.

In addition, 250 official health agencies have reported home nursing care on a limited basis as part of their regular programs.

A 1959 study showed that 287 of the 480 U.S. cities of 25,000 or more population had this type of care available.

The CHAIRMAN. Do you have copies of these insertions?

Mr. JONES. The insertions are not available in multiple copies for distribution at this time, Mr. Chairman.

The CHAIRMAN. You do not have them?

Mr. JONES. They are not ready; no, sir.

The CHAIRMAN. I was thinking they should be made available to members of the committee in order that we may look them over.

Mr. JONES. We can have them reproduced and sent to you right away for distribution. I am sorry that we don't have them today.

The CHAIRMAN. If you can get them back by this afternoon we will be glad to receive them.

Mr. JONES. All right, sir.

HOME HEALTH SERVICES

There is also a critical need for more and better community home health care services. Not all of the aged sick or chronically ill need to be cared for in hospitals or nursing homes. Many of them, at some stages in their illness, can be cared for better in their own homes, if home nursing services, homemaker services, physical and occupational therapy services, and other types of home health care services are available to serve them. Most communities, however, lack the organized programs and professional staff necessary to provide such services to the extent that they are needed.

The grant-in-aid funds which would be available under the bill would assist States and communities to develop such home health care programs and to staff and operate them so that such services would be more widely available throughout the United States.

HEALTH INFORMATION AND REFERRAL CENTERS

Another important gap in the effective provision of out-of-hospital community health services is the shortage of community health information and referral centers. Such centers function to help find appropriate health resources and services to meet the health needs of the aged and chronically ill through health counseling, evaluation, and referral activities. Services provided in such centers represent a basic service which is of vital importance to any health program set up to provide adequate care for our aged population.

Experience has demonstrated that in addition to meeting the needs of the individual, such an activity makes it possible to constantly appraise the availability and adequacy of the community's services as a guide in the planning for improved and more economical use of health resources. Less than a dozen communities, however, have such centers today.

PROJECT GRANTS FOR IMPROVING COMMUNITY HEALTH SERVICES

Not only are there serious gaps in the scope, quality, and availability of community health services, as I have just discussed, but there is also an urgent need to develop new and better methods of providing health services outside the hospital. The bill before you, therefore, proposes the initiation of a program of special project grants to public or nonprofit agencies and organizations for studies, experiments, and demonstrations.

The purpose of the grants which would be made under this authority is to bridge the deplorable gap between knowledge gained through research on the one hand and widespread community application of such knowledge on the other. Through projects supported from these grants would be worked out the best methods and most feasible ways of providing effective, high quality services.

The project grant technique is one which has worked effectively in research and other program development areas. We feel that it is an integral and essential element in our efforts to improve community health services for the aged and chronically ill.

NURSING HOME CONSTRUCTION

Section 4 of this bill would revise section 651 of the Public Health Service Act to increase the appropriation authorization for construction of nursing homes from $10 million to $20 million annually. These additional funds are needed to overcome the serious shortage of acceptable beds for the care of long-term-care patients. This shortage will become even more acute as the size of the aged population increases and as more effective use is made of such facilities in lieu of more expensive long-term care in hospitals.

We have made substantial progress in reducing the deficit of general hospital beds, particularly in rural areas. For example, in 1948 when the Hill-Burton program began operation, only 59 percent of the general hospital beds needed were in existence. On January 1, 1960, State agencies reported that 80 percent of the general hospital beds needed were available.

The same substantial progress has not been made, however, in long-term medical care. On January 1, 1960, State agencies reported that over 500,000 additional nursing home and chronic disease beds, both of which provide care for long-term-care patients, were needed.

Increasing the supply of long-term-care beds will not only reduce the deficit in this category but, in addition, will relieve some of the community pressures for new and expanded general hospital facilities which are more expensive to construct and operate.

The additional $10 million authorization proposed for nursing home construction would produce about 3,000 beds. In addition, the existing authorization of $10 million for nursing homes and $20 million for chronic disease hospital beds would produce more than 7,000 long-term-care beds. The production of 10,000 long-term-care beds annually through the Hill-Burton program, when combined with beds produced with private funds, represents an orderly and methodical approach to reduction of the long-term-care bed deficit.

Mr. Chairman, here again I would like to ask permission to have inserted in the record a chart showing the present and proposed authorizations for long-term-care facilities. Again, we will have this reproduced and made available to the committee members.

The CHAIRMAN. Very well, it will be received for the record.

(The chart referred to is as follows:)

Present and proposed authorizations for long-term-care facilities, Hill-Burton program

	Comparative State allotments for nursing home construction			Comparative State allotments for long-term care facilities		
	Present authorization	Proposed authorization	Increase	Nursing home proposed authorization	Chronic hospital present authorization	Total
Total	$10,000,000	$20,000,000	$10,000,000	$20,000,000	$20,000,000	$40,000,000
Alabama	304,081	608,162	304,081	608,162	608,162	1,216,324
Alaska	50,000	100,000	50,000	100,000	100,000	200,000
Arizona	78,394	156,788	78,394	156,788	156,788	313,576
Arkansas	182,949	365,898	182,949	365,898	365,898	731,796
California	496,049	992,098	496,049	992,098	992,098	1,984,196
Colorado	94,348	188,696	94,348	188,696	188,696	377,392
Connecticut	58,389	116,778	58,389	116,778	116,778	233,556
Delaware	50,000	100,000	50,000	100,000	100,000	200,000
District of Columbia	50,000	100,000	50,000	100,000	100,000	200,000
Florida	298,334	596,669	298,335	596,669	596,669	1,193,338
Georgia	335,618	671,236	335,618	671,236	671,236	1,342,472
Hawaii	50,000	100,000	50,000	100,000	100,000	200,000
Idaho	50,000	100,000	50,000	100,000	100,000	200,000
Illinois	314,785	629,569	314,784	629,569	629,569	1,259,138
Indiana	247,094	494,189	247,095	494,189	494,189	988,378
Iowa	166,324	332,647	166,323	332,647	332,647	665,294
Kansas	128,855	257,710	128,855	257,710	257,710	515,420
Kentucky	261,636	523,271	261,635	523,271	523,271	1,046,542
Louisiana	262,668	525,336	262,668	525,336	525,336	1,050,672
Maine	68,996	137,991	68,995	137,991	137,991	275,982
Maryland	133,355	266,710	133,355	266,710	266,710	533,420
Massachusetts	199,643	399,286	199,643	399,286	399,286	798,572
Michigan	352,302	704,604	352,302	704,604	704,604	1,409,208
Minnesota	203,724	407,448	203,724	407,448	407,448	814,896
Mississippi	245,702	491,403	245,701	491,403	491,403	982,806
Missouri	232,991	465,983	232,992	465,983	465,983	931,966
Montana	50,000	100,000	50,000	100,000	100,000	200,000
Nebraska	82,368	164,736	82,368	164,736	164,736	329,472
Nevada	50,000	100,000	50,000	100,000	100,000	200,000
New Hampshire	50,000	100,000	50,000	100,000	100,000	200,000
New Jersey	190,400	380,800	190,400	380,800	380,800	761,600
New Mexico	65,781	131,563	65,782	131,563	131,563	263,126
New York	477,232	954,464	477,232	954,464	954,464	1,908,928
North Carolina	409,308	818,616	409,308	818,616	818,616	1,637,232
North Dakota	50,890	101,779	50,889	101,779	101,779	203,558
Ohio	408,782	817,564	408,782	817,564	817,564	1,635,128
Oklahoma	165,447	330,894	165,447	330,894	330,894	661,788
Oregon	94,435	188,871	94,436	188,871	188,871	377,742
Pennsylvania	532,310	1,064,619	532,309	1,064,619	1,064,619	2,129,238
Rhode Island	50,000	100,000	50,000	100,000	100,000	200,000
South Carolina	236,721	473,443	236,722	473,443	473,443	946,886
South Dakota	54,425	108,850	54,425	108,850	108,850	217,700
Tennessee	309,272	618,544	309,272	618,544	618,544	1,237,088
Texas	605,513	1,211,025	605,512	1,211,025	1,211,025	2,422,050
Utah	59,762	119,525	59,763	119,525	119,525	239,050
Vermont	50,000	100,000	50,000	100,000	100,000	200,000
Virginia	272,622	545,244	272,622	545,244	545,244	1,090,488
Washington	131,232	262,463	131,231	262,463	262,463	524,926
West Virginia	143,065	286,131	143,066	286,131	286,131	572,262
Wisconsin	213,882	427,764	213,882	427,764	427,764	855,528
Wyoming	50,000	100,000	50,000	100,000	100,000	200,000
Guam	7,675	15,350	7,675	15,350	15,350	30,700
Puerto Rico	268,969	537,939	268,970	537,939	537,939	1,075,878
Virgin Islands	3,672	7,344	3,672	7,344	7,344	14,688

Mr. JONES. One further point regarding nursing homes is of significance. All too many of the nursing homes in this country are in a deplorable state. They frequently are poorly designed and constructed, and located in makeshift structures which may not be fire-safe, and are inadequately staffed and supervised. Nursing homes constructed under the Hill-Burton program, however, are quality care facilities.

Facilities receiving Hill-Burton aid must provide skilled nursing care, and great emphasis is given to the functional layout of the facility, and the inclusion of space and equipment which will enable patients to make such rehabilitation progress as is possible. No compromises are made to accepted principles of structural and fire safety.

HOSPITAL RESEARCH

Section 5 of the bill would remove the statutory ceiling of $1,200,000 on annual expenditures for hospital research, and would authorize special project grants for the construction of experimental and demonstration health facilities.

Comparatively little research is being carried on relating to hospital facilities, resources and services even though hospital expenditures amount to over $8 billion annually and there is genuine concern throughout the Nation over the spiraling costs of hospital care.

Greater emphasis must be placed on research, experimentation, and demonstration in all areas of health facilities and services if the physical plant, equipment, and organizational and operational aspects of health facilities are to reach peak efficiency. While such research may not be the only answer to this financial crisis, we believe it represents our best hope of developing a course of action which will help to put a damper on the spiraling costs of care in health facilities.

The grant authority for construction of experimental and demonstration health facilities is needed to test research findings, and to demonstrate new and novel ideas of health facility design and construction to communities in various parts of the country.

Community officials are inclined to stick with traditional types of design and construction, and are reluctant to use community funds for experimental and novel concepts. These circumstances led to our proposal that funds be made available to test, evaluate, and demonstrate new and novel ideas pertaining to the effective development and utilization of health facility services, facilities, and resources.

Here again, Mr. Chairman, I would like authorization to have inserted in the record a progress report on research programs in relation to hospital facilities and care, and accompanying this the publications having to do with research in this area. It may be useful to the committee and for the record.

The CHAIRMAN. Let it be received.

(The documents referred to are as follows:)

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Progress Report on Research Program

This review of major research projects being carried out under the Public Health Service grants program shows how in-hospital research contributes to raising standards of patient care

Burnet M. Davis, M.D., and Louis Block, Dr. P.H.

PUBLIC LAW 380, which authorized the surgeon general of the Public Health Service to conduct research, experiments and demonstrations relating to the effective development and utilization of hospital facilities, services and resources and to make grants-in-aid to governmental and nonprofit groups for these same purposes, was enacted in 1950 although funds were not appropriated until 1955. In the last four years a total of $4,800,000 has been made available for this purpose.

To date, 146 applications for extramural research alone have been received requesting almost $22,000,000 in funds for these studies. Of this group, 72 have been recommended and approved by the Hospital Facilities Research Study Section, the technical review body for such projects, and the Federal Hospital Council. Fifty-five of these approved applications have been activated as of April 1, 1959.

Although the program has been in operation for only a little more than three years, significant contributions have already been made as a result of the research in these areas.

Study and Development of Organizational Patterns for the Provision of Patient Care. One such new technic for improving health services that has attracted considerable attention is progressive patient care.

Many hospitals are contemplating the introduction of the progressive patient care concept into their operation. At least 22 hospitals have completed construction embodying progressive patient care features during the last year; several others are under construction at present. In answer to a questionnaire, 395 additional hospitals indicated that they were planning such a move. A continuing intramural research project[1] is studying certain aspects of this approach to health care.

Another study[2] is analyzing the organizational structure and administrative patterns necessary to provide complete coordination of hospital, health and welfare activities, facilities and services in Puerto Rico. This study is demonstrating the applicability of such an organizational pattern to an actual situation and will provide detailed information on the organizational problems to be considered in evolving such a new pattern.

Another study of organizational patterns is found in a project[3] in western Tennessee, which is evolving administrative patterns of relationships between rural hospitals and the medical school for the purpose of improving patient care. The study developed an educational program for this purpose.

It is generally recognized that each community should consider means of coordinating the facilities of the general hospital with resources of other medical and related services, such as hospitals for long-term care, nursing homes, homes for the aged, home medical care programs, family service agencies, and rehabilitation services.

A new pattern of organization has been proposed as a result of a study of this subject.[4] It suggests that the problems of the aged as a group should not be segmented when planning facilities and services. It recommends that care for the aged in good health and for the aged in ill health should be planned together in close proximity and under the same administration. Emphasis in this study is given to the role of the general hospital in providing care for the aged ill.

Hospital Utilization. Community planning for hospitals and other medical facilities involves a determination of the size of the facilities that the community will use and support. Research in this area[5] has shown that persons with comprehensive hospital and medical care insurance use hospitals less than persons whose policies cover only hospital care. These findings suggest that comprehensive coverage encourages more efficient utilization of hospital facilities. In addition, it

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[1] For this and succeeding bibliographic references, and list of projects, see page 4.

stresses the need for taking into account not only the amount but the kind of prepaid care provided in a community when determining the uses a community will make of its hospitals.

Planning for hospitals raises the question of whether or not office space should be made available for the private office practice of physicians. A study of the extent to which such facilities are provided throughout the United States[8] shows: They result in effective utilization of the time of professional men and their patients; hospital scientific facilities are used more; attending physicians more easily keep in touch with their hospitalized patients; hospital offices have not led to improper institutional control over private medical practice; development of doctors' offices at hospitals is not regarded by doctors or hospitals as a type of social reform, and the motivation has been professional, economic and administrative.

Planning facilities is complicated by the lack of understanding of terms used to describe certain facilities. A study[9] has developed terminology to be used by all groups planning for facilities and their utilization.

Personnel Needs. Training of food service supervisors to make up for the lack of graduate dietitians in small hospitals has been undertaken by the Georgia State Department of Health.[4] The desirability of having consultants on the staff of the state hospital association to upgrade dietary and personnel services, particularly in small hospitals, has been demonstrated in Connecticut.[4] An annotated bibliography of literature on the training of hospital supervisory personnel has been published.[10] This bibliography will be a part of a practical program for inservice training of supervisors.

A curriculum for doctoral training of workers in health organization research has been published[11] as part of a project to prepare a course of graduate training in research for students in hospital administration. Another study has prepared an outline for a full-scale study of medical technology.[12] A study of the rehabilitation needed in county hospitals will produce a guide for the staff of such facilities.[13]

In Minnesota the state department of health, through a study and demonstration grant,[14] is combining surveys of the number and qualifications of paramedical hospital personnel with development of inservice training programs for such personnel. Consultation is provided by the state health department to laboratory technicians, dietitians, nurse anesthetists, physical therapists, and medical records personnel in small hospitals. Analysis of the survey data on these employes will assist with recruitment efforts and indicate areas in which training is especially needed.

Architectural, Engineering and Equipment Design. A pilot study has been completed which shows the need for a practical listing of safety considerations as a guide to products purchased by hospitals.[15] Such a list is of value in teaching safety precautions to hospital workers.

Standards of hospital design may be evaluated by applying criteria developed through studies of hospital functions.[16] Based on such studies, guide material has been published for planning recovery rooms, oxygen supply to patient rooms, and patient voice communication systems.

A result of research conducted in the area of ether trail hazards[17] has permitted the committee on hospital operating rooms of the National Fire Protection Association to disprove any possible relationship between explosive concentrations of anesthetic gases and recirculatory ventilating systems. On the basis of this report, the committee has been able to state in the "Recommended Safe Practices for Hospital Operating Rooms" that "recirculation of air in anesthetizing locations does not increase the hazards of fire and explosions from flammable anesthetic gases." This conclusion reached by the committee has helped clarify an important problem in hospital design.

Quality of Care. With respect to the improvement of hospital services, certain tentative conclusions have emerged from a study by the American College of Physicians of the practice of internal medicine in hospitals.[18] The study committee has found that the quality of internal medicine can be judged best by a thorough analytical study of patient records, which should be done by selected members of each hospital staff rather than by outsiders as a routine procedure. A guide for hospital medical care appraisal committees has been published by the study committee.

Factual data gathered through an American Pharmaceutical Association audit of 3654 hospitals are being compiled and may furnish the basis for a manual that will benefit the small hospital without a full-time pharmacist as well as larger institutions.[19] The study will include data on current practices in drug control in the nursing unit, the accuracy in prescription filling, quality and potency of drugs, quality and safety of products made

How Hospitals Can Make Research Worth While

We are just entering a period when research on hospital and health services will have a profound effect on the way health services are provided. In order to make the most of this opportunity there should be intensified research efforts directed toward improving:

1. The operating efficiency of the hospital as an organization and the optimum employment of skilled personnel.
2. The functional design of the hospital structure, particularly with a view to making that design flexible and adoptable to further scientific and technological discoveries.
3. Coordination of community health facilities, with hospitals serving as the center of a complex to assure continuity of quality patient care at minimum cost to community and individual.
4. Patient care organization with a view to relating levels of nursing skill and care more realistically to the specific needs of the individual patient.

How To Apply for Research Grants

Hospitals interested in obtaining a research grant from the Public Health Service should make application on a standard form obtainable upon request from the Division of Research Grants, National Institutes of Health, Bethesda, Md. This grant program is administered under the same rules that apply for other P.H.S. research grant programs.

Applications are reviewed by a study section composed of authorities in the fields of hospital administration, medical care, socio-medical economics, biostatistics, anthropology, sociology and basic scientific research.

On the basis of the study section's recommendations as to priority of the applications, the surgeon general of the Public Health Service consults the Federal Hospital Council concerning the project applications and then awards the research funds to the selected applicants.

in the pharmacy, and the indiscriminate distribution of drugs in hospitals.

Methods Improvement and Work Simplification. Fourteen hospitals have participated in a research study conducted by the United Hospital Fund of New York to develop a manual of training methods improvement which will serve as a guide for hospitals on methods improvement activities.[30]

Pointed To Small Hospitals

Another study shows the application of methods improvement in the streamlining of business reports to the administrator. This study is particularly pointed to the small hospital without trained accountants.[31]

Coordination of Facilities and Services. Final reports are in preparation that contain information to assist hospitals and other medical facilities in providing more effective service. These projects will demonstrate methods by which health facilities and services may be coordinated so that they work together as a team in bringing the best medical care to the people within a large region or state.

A study in metropolitan Boston seeks to achieve coordination through cooperative planning by representatives from each of the communities in that region.[32] This study has pointed out possible elimination of duplicated services, need for new services, and redistribution of existing services. One result of this coordinated approach has been to enable groups to work together to establish a regional two-year school of nursing affiliated with a junior college.

A project in Kansas City is preparing a master plan for the region from which patients come to city hospitals for specialized services. The technic of determining the logical service area for metropolitan facilities is being used in planning for other sections of the state.[33] An additional element of this project is development of methodology for determining acceptability of a hospital's facilities through measurement of its component service units.

Ambulatory Patient Care. Most efficient use of medical facilities and improved medical care are achieved when the family physician, the patient, and the staff of the medical center have a common understanding about the role of the clinic in patient care, according to a study of the outpatient department at the University of North Carolina Hospital.[34] Such understanding tends to reduce the number of clinic patients that are hospitalized. The study will point out the importance of adjunct diagnostic services and their availability in relation to the extent of the referral process.

The problem of congestion and waiting in outpatient clinics is being studied.[35] Results of this project should provide tested methodology for predicting congestion and determining methods of relieving it.

Improved Operating Efficiency in Hospital Departmental Activities. Efficiency and economy in indexing medical records are expected as a result of a recent study which compared current indexing systems.[36]

Methods for improving medical records in chronic disease institutions are also being studied.[37]

The Joint Blood Council has issued a complete directory of hospital blood banks and tissue banks,[38] based on a recent study. This directory shows the location of facilities, the extent of their operations, how they are organized, what specific services they offer, and other information of importance to physicians, hospitals, and any person or organization interested in blood and its derivatives. It will be extremely useful as a reference for existing hospitals and in planning for disaster services.

Other Areas of Study. A study of operation of state programs for hospital planning and licensing has recommended that such activities be carried on as a function of the state health department.[39] The need for an adequately trained staff is clearly indicated in this study. The study also points out that the state government has at least the following responsibilities with regard to health facilities: to prevent the operation of facilities when their physicial aspects or practice of patient care constitute a public hazard, and to encourage optimal standards of physical facilities and practices of patient care.

A study of legal aspects of hospital operations[40] has been completed. A result of this study is the publication of a legal guide for administrators. The value of this research is seen in the formation of a new Health Law Center at the University of Pittsburgh, the first of its kind in the nation.

In addition to the projects already mentioned, the list beginning on page 4 includes all other active projects under the program.

The fact that the progress outlined here is already resulting from the research studies under way stresses the importance of hospital research and its application to development of more efficient patient care methods, better administrative technics, improved physical plant design, and more effective coordination of community health resources. Such improvements contribute to quality of patient care and also represent our best hope for coping with the upward spiral of hospital costs. ■

List of Research Projects and Publications

FOLLOWING is the list of research projects being carried on under federal grants-in-aid and publications.

1. Progressive Patient Care. An intramural research study conducted by the Division of Hospital and Medical Facilities, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

Hayden, A. C.: Progressive Patient Care Reflected in the Records, Mod. Hosp., 92:85 (January) 1959.

Haldeman, J. C.: Elements of Progressive Patient Care, U. S. Department of Health, Education, and Welfare, Public Health Service, February 1959.

Haldeman, J. C.: Progressive Patient Care - A Challenge to Hospitals and Health Agencies, Public Health Reports, 74:405 (May) 1959.

Abdellah, F. G., and Strachan, E. J.: Progressive Patient Care, Am. J. Nursing, 59:649 (May) 1959.

Haldeman, J. C., and Abdellah, F. G.: Concepts of Progressive Patient Care, Hospitals, Part I, 33:39 (May 16) 1959, Part II, 33:41 (June 1) 1959.

2. Regionalization of Health Care Services, Bayamon Area, Puerto Rico. Reinaldo A. Ferrer, M.D., regional coordinator and director of research, Puerto Rico Department of Health, Santurce.

Operation Regionalization in Puerto Rico, Department of Public Health, Commonwealth of Puerto Rico, San Juan, 1957.

Editorial, A Puerto Rican Experiment in Regionalization, Am. J. Pub. Health, 48:1210 (September) 1958.

3. Integrated Hospital Service in West Tennessee. O. W. Hyman, dean, College of Medicine, University of Tennessee, Memphis.

4. Coordination of Hospital and Community Resources. Franz Goldman, M.D., project director, and Robert Morris, consultant for social planning, Council of Jewish Federations and Welfare Funds, New York City.

Preliminary Findings of the Nationwide Study on Coordination of Health Services for Patients with Long-term Illness: Council of Jewish Federations and Welfare Funds, Inc., New York City, Part I, November 1957, Parts II, III & IV, February 1959, Part V, March 1959.

Part VI, July 1959, Part VII, August 1959.

5. Prepaid Medical Care and Hospital Utilization. Paul M. Densen, director division of research and statistics, Health Insurance Plan of Greater New York, New York City.

Densen, P. M., Balamuth, E., and Shapiro, S.: Prepaid Medical Care and Hospital Utilization, Hospital Monograph Series No. 3, American Hospital Association, Chicago, 1958.

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39. A Study of Hospital Operations. Thomas M. Hill, associate professor, School of Industrial Management, Massachusetts Institute of Technology, Cambridge, and Victoria M. Cass, M.D., acting director, Peter Bent Brigham Hospital, Boston.

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42. Collaborative Research in Hospital Planning. James J. Souder, American Hospital Association, Chicago.

43. A Comparative Study of Two Community Hospitals. Ivan C. Belknap, associate professor of sociology, University of Texas, Austin.

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45. Developing Scientific Personnel Systems and Methods. Sister Loretto Bernard, administrator, St. Vincent's Hospital, New York City.

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47. Relations of Anglo-Latino Groups With Hospitals. Charles P. Loomis, professor, department of sociology and anthropology, Michigan State University, East Lansing.

48. Study of Individual Patient Needs. Morris W. Stroud III, M.D., associate director of medical services, and David R. Weir, M.D., director of medical services, Highland View Hospital, Cleveland.

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50. Study of Specifications for Children's Hospital Units. Joseph Stokes, Jr., M.D., professor of pediatrics, The School of Medicine, University of Pennsylvania, Philadelphia.

51. Training of Hospital Administrators. James A. Hamilton, director and professor, course in hospital administration, School of Public Health, and Edith M. Lentz, associate professor and research director, course in hospital administration, School of Public Health, University of Minnesota, Minneapolis.

52. Administration in the Small General Hospital. Keith O. Taylor, professor of hospital administration, Betty Mathews, associate in public health, and Dr. Julian R. Friedman, assistant professor of speech, School of Public Health, University of California, Berkeley.

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60. Factors Affecting Efficiency of Rural Hospitals. Verne A. Pangborn, director, division of hospitals, Nebraska State Department of Health, Lincoln.

61. Economics of Automating Selected Hospital Activities. Mark S. Blumberg, M.D., operations analyst, Stanford Research Institute, Menlo Park, Calif.

62. Education of Dietitians and Food Service Personnel. Mary E. Bloetjes, professor and head, department of institutional management, and Regina Gottlieb, assistant professor, department of institutional management, New York State College of Home Economics at Cornell University, Ithaca, N. Y.

63. Factors Affecting Hospital Bed Occupancy Rates. Morris London, research associate, and Robert M. Sigmond, executive director, Hospital Council of Western Pennsylvania, Pittsburgh.

64. Performance Standards for Hospital Business Offices. Harold Hinderer, director, Financial Management Services, The Catholic Hospital Association of The United States and Canada, St. Louis.

The list of publications above has been up-dated since the time of original publication to include articles published through September 1, 1959.

February 1, 1961

Additional Publications In Connection With The Attached,
"Progress Report On Research Program"

Item Number	Project Number	
13.	W-97	Donahue, W. and Rae, J. W., Jr., Design for a Study of Geriatric Rehabilitation, GERIATRICS, Vol. 15, pp. 229-232, April 1960.
13.	W-97	Di Napoli, A., Kingery, R. H., and Gibbons, P., Dental Conditions of County Hospital Patients, GERIATRICS, Vol. 15, pp. 306-314, April 1960.
13.	W-97	Bloomer, H. H., Communication Problems Among Aged County Hospital Patients, GERIATRICS, Vol. 15, pp. 291-295, April 1960.
13.	W-97	Brandt, R. L., Decreased Carbohydrate Tolerance in Elderly Patients, GERIATRICS, Vol. 15, pp. 315-325, April 1960.
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31.	W-44	Wooden, H. E., The Hospital's Purpose Is The Patient, But ---, MODERN HOSPITAL, January 1959.
31.	W-44	Obstetrics Department Is Not Hospital-Centered, Medical Distaff, SCOPE WEEKLY, June 1, 1960.
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4.	W-64	Council of Jewish Federations and Welfare Funds, Inc., New York City, Preliminary Findings of the Nationwide Study on Coordination of Health Services for Patients with Long-term Illness, Part VIII, October 1959; Part IX, February 1960; Part X, March 1960; Part XI, April 1960; Part XII, June 1960, and Part XIII, August 1960.
4.	W-64	Goldmann, F. and Fraenkel, M., Patients on Home Care: Their Characteristics and Experience, JOURNAL OF CHRONIC DISEASES, St. Louis, Vol. 11, No. 1, pp. 77-87, January 1960.
4.	W-64	Goldmann, F., A Profile: Residents of Homes for the Aged, GERIATRICS, Vol. 15, pp. 329-337, May 1960.
4.	W-64	Goldmann, F., and Wilson, E. A., A Study of Chronically Disabled Clients, SOCIAL CASEWORK, July 1960.
47.	W-108	Klapp, O. E. and Padgett, L. V., Power Structure and Decision-Making in a Mexican Border City, THE AMERICAN JOURNAL OF SOCIOLOGY, Vol. LXV, No. 4, January 1960.
47.	W-108	Redekop, C., and Loomis, C. P., The Development of Status-Roles in the Systemic Linkage Process, JOURNAL OF HUMAN RELATIONS, Vol. VIII, No. 2, 1959.
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14.	W-49	Lundgaard, M. J., Knudsen, H. L., Harrison, W. C., Wolcyn, B. A., White, R. M., Survey of Nursing Anesthesia: Personnel, Policies and Procedures in Minnesota Hospitals, 1956-1957, JOURNAL OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Part I - 28:161-174, June, 1960; Part II - 28:225-234, Aug. 1960.
14.	W-49	Mimeographed quarterly reports which depict the progress of this project are available from the Minnesota Department of Health.
4.	W-64	Goldmann, Franz, What Are Social Workers in General Hospitals Doing for Long-Term Patients?, JOURNAL OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, SOCIAL WORK, October 1960.
4.	W-64	Goldmann, Franz, Personal Health Services in Homes for the Aged, AMERICAN JOURNAL OF PUBLIC HEALTH, Vol. 50, No. 9, September 1960.
31.	W-44	Wooden, H. E., Family-Centered Maternity Care, A Summary and Analysis of the Program, HOSPITAL PROGRESS, August 1960.
31.	W-44	Wooden, H. E., Patient-Centered Hospital Bends in the Patient's Direction, MODERN HOSPITAL, Sept. 1960.
31.	W-44	Family-Centered Maternity Care, A Panel Discusses The Maternity Program At St. Mary's Hospital, HOSPITAL PROGRESS, July 1960.
63.	W-141	London, Morris, Too Many General Hospital Beds?, Part I, MODERN HOSPITAL, January 1961, Vol. 96, No. 1.
60.	W-105	Kurtz, R. A. and Saathoff, Donald E., The Hospitals of Nebraska, 1960.

THE FOLLOWING ADDED APRIL, 1961

16.	W-53	Thompson, John D., Hartman, Jane, and Pelletier, Robert J., Two Types of Tray Service Studied Side by Side, Part I of Two-part article, HOSPITALS, February 1, 16, 1960.
16.	W-53	Pelletier, Robert J., and Thompson, John D., Yale Index Measures Design Efficiency, THE MODERN HOSPITAL, Nov. 1960.

16. W-53 Thompson, John D., Avant, Oscar Wade, and Spiker, Ellawyne D., How Queuing Theory Works for the Hospital, THE MODERN HOSPITAL, March 1960.

40. W-17 Maloney, Milton C., M.D., Trussell, Ray E., M.D., and Elinson, Jack, Ph.D., Physicians Choose Medical Care: A Sociometric Approach to Quality Appraisal, Vol. 50, No. 11, AMERICAN JOURNAL OF PUBLIC HEALTH, Nov. 1960, pp. 1678-1686.

40. W-17 Trussell, Ray E., M.D., and Van Dyke, Frank, Utilization of Routinely Available Information on Health Insurance Studies, AMERICAN JOURNAL OF PUBLIC HEALTH, Vol. 50, No. 10, Oct. 1960.

31. W-44 Cole, William, Having A Baby is a Family Affair, Family Circle Magazine, Feb. 1961.

18. W-79 Editorial: Standards of Practice of Internal Medicine Methods of Judging Its Quality in Hospitals, Annals of Internal Medicine, Vol. 51, No. 4, Oct. 1959.

49. W-127 Roemer, Milton I., M. D. and White, Rodney F., Community Attitudes Toward Hospitals, HOSPITAL MANAGEMENT, Vol. 89, pp. 37-39, Jan. 1960.

63. W-141 London, Morris and Sigmond, Robert M., Authors' Reply to Reader Opinion, "Are We Building Too Many Hospital Beds?, THE MODERN HOSPITAL, Vol. 96, No. 4, P. 6, April 1961.

35. I-1 Brewster, Agnes W. and Kramer, Lucy M., Health Insurance and Hospital Use Related to Marital Status, PUBLIC HEALTH REPORTS, 74:721, Aug. 1959.

1. I-17 Felton, Bernard, What Administrators Want to Know About Progressive Patient Care, THE MODERN HOSPITAL, Vol. 93, No. 2, p. 71, Aug. 1959.

1. I-17 Lockward, Howard J., M.D., Giddings, Lane, M. D., and Thoms, Edward J., Progressive Patient Care - A Preliminary Report, JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, Vol. 172, p. 132, Jan. 1960.

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1. I-17 Lentz, Edith M., Ph.D., The Impact of Social Change, HOSPITAL PROGRESS, Vol. 40, pp. 46-49, Feb. 1959.

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1. I-17 Donovan, Anne Claire and Meyer, Burton, Ph.D., Dietary Service in Progressive Patient Care, JOURNAL OF THE AMERICAN DIETETIC ASSOCIATION, Vol. 37, No. 5, pp. 448-454, Nov. 1960.

1. I-17 Donovan, Anne Claire, and Meyer, Burton, Ph.D., How To Plan Progressive Patient Food Service, THE MODERN HOSPITAL, Vol. 95, No. 6, pp. 116-120, Dec. 1960.

1. I-17 Abdellah, Faye G., Ed.D., Meyer, Burton, Ph.D., and Roberts, Helen, R.N., THE MODERN HOSPITAL, Vol. 95, No. 2, Aug. 1960.

1. I-17 Abdellah, Faye G., Ed.D., Progressive Patient Care - A Challenge for Nursing, MILITARY MEDICINE, Vol. 125, and HOSPITAL MANAGEMENT, Vol. 89, No. 6, June 1960.

February 1, 1961

Research Projects Activated Since Attached Article, "Progress Report On Research Program," Was Published

Item Number	Project Number	Title, Principal Investigator, and Sponsor
65.	W-154	STUDIES OF LIGHTING NEEDS FOR "INTENSIVE CARE" NURSING UNITS IN HOSPITALS. Ralph Chester Williams, M.D., Director, Division of Hospital Services, Georgia Department of Public Health, Atlanta, Georgia.
66.	W-159	STUDIES IN OUT-PATIENT SERVICES: ATTITUDES AND FUNCTIONS. Marvin B. Sussman, Ph.D., Associate Professor of Sociology, Western Reserve University, Cleveland, Ohio.
67.	W-164	STUDY OF THE FEASIBILITY OF AUTOMATION IN HOSPITALS. Edward H. Noroian, Director of Administrative Research and Development, University Hospital, Baltimore, Maryland.
68.	W-167	STATISTICAL PATTERNS OF DEMAND FOR HOSPITAL SERVICES. Charles D. Flagle, Ph.D., Director, Operations Research, The Johns Hopkins Hospital, Baltimore, Maryland.
69.	W-170	BASIC STUDIES FOR PLANNING OF THE OPERATING SUITE. Robert H. Jacobs, Jr., Architect, AIA, The New York Chapter of the American Institute of Architects, New York, New York.
70.	W-123	SOCIAL CAUSES OF LABOR TURNOVER IN MODERN HOSPITALS. Llewellyn Z. Gross, Ph.D., Professor and Chairman, Department of Sociology, University of Buffalo, Buffalo, New York.
71.	W-174	EVOLUTIONAL METHODOLOGY AND REGIONAL CO-ORDINATION. Robert C. Lowe, M.D., Associate Professor, Department of Medicine and Preventive Medicine, The University of Oklahoma School of Medicine, Oklahoma City.
72.	W-181	ESTABLISHMENT OF SUPPLY CONSUMPTION CRITERIA. Edward H. Noroian, Director of Administrative Research and Development, University Hospital, Baltimore, Maryland.

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73.	W-184	THE HOSPITAL AS A COMPREHENSIVE COMMUNITY HEALTH CENTER. C. Rufus Rorem, Ph.D., Executive Director, Hospital Planning Association of Allegheny County, Pittsburgh, Pennsylvania.
74.	W-151	RESEARCH DEVELOPMENT IN HOSPITAL ADMINISTRATION. Walter J. McNerney, Professor, School of Business Administration, University of Michigan, Ann Arbor, Michigan.
75.	W-186	ROLE CONFLICT RESOLUTION IN EMERGENT & STABLE HOSPITALS. Thomas H. Holmes, M.D., University of Washington, School of Medicine, Seattle, Washington.
76.	W-194	HOSPITAL UTILIZATION. Gordon R. Cumming, Chief, Bureau of Hospitals, State of California Department of Public Health, Berkeley, California.
77.	W-197	GERIATRICS RESEARCH AND CURRICULUM PLANNING. Dr. Geraldine H. Pearson, Assistant to the President, Mt. Angel College, Mt. Angel, Oregon.
78.	W-180	USE OF TEAMS IN A HOUSEKEEPING DEPARTMENT. Edith M. Lentz, Ph.D., Associate Professor, University of Minnesota, Minneapolis, Minnesota.
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79.	W-187	NON ACADEMIC EDUCATION IN HOSPITAL ADMINISTRATION. Ezra V. Saul, Ph.D., Director, Institute for Applied Experimental Psychology, Tufts University, Medford, Massachusetts.
80.	W-188	COORDINATION AND PATIENT CARE IN VOLUNTARY HOSPITALS. Floyd C. Mann, Ph.D., The Institute for Social Research, University of Michigan, Ann Arbor, Michigan.
81.	W-190	ECONOMICS AND ADMINISTRATION OF MEDICAL CARE PROGRAMS. Mary Lee Ingbar, Ph.D., Research Associate, Graduate School of Public Administration, Harvard University, Cambridge, Massachusetts.
82.	W-192	STUDY OF HOSPITAL OPERATIONS AS A COMPLEX SYSTEM. Glen D. Camp, Ph.D., Professor, Operations Research Group, Case Institute of Technology, Cleveland, Ohio.

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83.	I-31	COST FACTORS INVOLVED IN EXTERIOR WALL CONSTRUCTION. The Division of Hospital and Medical Facilities of the Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.
84.	I-32	JOINT UNIFORM REPORTING OF HOSPITAL STATISTICS. The Division of Hospital and Medical Facilities of the Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.
85.	I-33	CHARACTERISTICS OF NURSING HOMES AND RELATED FACILITIES. The Division of Hospital and Medical Facilities of the Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

Mr. JONES. In conclusion, the legislation proposed in H.R. 4998 represents a balanced and effective approach by the Federal Government to stimulate and assist States and communities to establish, expand, and improve these community services which are essential for comprehensive high quality health care for the aged and chronically ill in the United States.

The program proposed is a modest one based on approaches which have been proved effective in other health programs. We have confidence that it will have a substantial and constructive impact on community health services needed urgently today and increasingly in the future.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Clerk, get those insertions for me, as I would like to look them over.

Mr. JONES. That concludes the formal statement, Mr. Chairman.

The CHAIRMAN. At this time I would like to recognize the presence of students from the class on government from the Woodrow Wilson High School here in the District of Columbia.

I am advised that they are studying government procedures and are, thus, doing us the honor this morning of attending this hearing as an example of legislative procedure.

We are glad to welcome you.

Let me extend to the teacher of this class, on behalf of the committee, a welcome this morning. And I am very happy that you have chosen this committee in the furtherance of your studies of this important subject.

May I say that I congratulate you on a program of this kind which enables these students to get a firsthand observation as to how their Government works, how legislative policy is made, and how bills are dealt with which may have a great deal to do with your life later on.

You have already, of course, observed the nature of the legislation being considered this morning. The Department of Health, Education, and Welfare is here to supplement and substantiate their recommendations to Congress that this program be undertaken.

Stay as long as you wish. You may leave when you feel you must go.

Mr. Mack, any questions?

Mr. MACK. Yes, Mr. Chairman.

Mr. Jones, what is the total cost of the proposed legislation amount as submitted?

Mr. JONES. Mr. Mack, the total for 1962 would be $24,172,000.

Mr. MACK. Do you estimate it would be greater than that in future years?

Mr. JONES. Yes. It would go up to $35 million in 1963; to $52 million in 1964; reduced to $44 million in 1965, and remain at that level in 1966. Those are the appropriation requirements, Mr. Mack.

Mr. MACK. Now this amount of money provides regional facilities as you have stated, the care for the chronically ill?

Mr. JONES. A portion of it would relate to facilities; some would relate to grants for research and demonstration projects.

Mr. MACK. That would be minor.

Mr. JONES. Yes, sir.

Mr. MACK. It would be less than $5 million.

Mr. JONES. The research grants, sir, would be $4 million for 1962.

Mr. MACK. $4 million?

Mr. JONES. Yes, sir.

Mr. MACK. Would that expand some of the present research facilities for medical schools?

Mr. JONES. No, sir.

Mr. MACK. It would not?

Mr. JONES. No, sir. That is included in another program. This relates only to community health services and facilities as administered through the States.

Mr. MACK. No part of this goes as a grant to the individuals that are being cared for in the institutions?

Mr. JONES. No, sir; this does not involve a care program in any way. It is related only to the community facilities and services.

Mr. MACK. Well, has the Department given any thought to how these people are going to get money to pay the prices they charge today in these fancy nursing homes?

Mr. JONES. Yes, sir; it has given a great deal of thought to this, and it is the subject of legislation in another bill.

Mr. MACK. Has that bill been submitted as yet?

Mr. JONES. It has been submitted.

Mr. MACK. Now I would like to inquire about section 651 of the Public Health Service Act. That is on page 7 of your testimony. You want to increase the authorization for appropriation for construction of nursing homes from $10 million to $20 million annually.

Mr. JONES. That is correct.

Mr. MACK. Well, now that is strictly a grant to the States.

Mr. JONES. That is a grant to the States. The proposed allotment among the States is in the table which will be made available to you. The program is determined and administered as a part of the State health activity.

Mr. MACK. You state that on January 1 they estimate they will have a shortage of 500,000 beds in the country?

Mr. JONES. That is correct.

Mr. MACK. But they do have a tremendous program on today to expand the facilities of nursing homes in particular. Is that not true?

Mr. JONES. There is a very strong pressure to do this, sir, and we feel an increase in the grant in aid through the States would greatly accelerate this program.

Mr. MACK. The Public Health Service Act, of course, under those provisions, that does include private expansion as well as public expansion, does it not?

Mr. JONES. Private, nonprofit.

Mr. MACK. Nonprofit?

Mr. JONES. That is correct, yes.

Mr. MACK. In recent years we have made available loans to private organizations who are in this business.

Mr. JONES. That is correct.

Mr. MACK. They have expanded in the last few years; they have built many new nursing homes.

Mr. JONES. That is correct.

Mr. MACK. That has been taken into account in the 500,000-bed estimate?

Mr. JONES. That is correct.

The CHAIRMAN. To what extent have we increased the facilities available under that program where Government loans have been made to a profitmaking organization?

Mr. JONES. We can put this in the record, Mr. Chairman.

Under the Small Business Administration nursing home program, as of December 31, 1960, there were 399 application received with $28,674,000 of loans requested. The applications actually approved were 188.

The CHAIRMAN. How many?

Mr. JONES. There were 188 applications approved for a total of $11,157,000.

The CHAIRMAN. The rest of them were turned down?

Mr. JONES. They probably have either been turned down or processing is not complete.

The CHAIRMAN. That is under Small Business?

Mr. JONES. Yes, sir. The FHA program to guarantee loans for proprietary nursing homes, as of February 28, 1961, there were 88 firm proposals in a preapplication stage; there were 29 proposals being processed; there were 12 commitments and 5 projects actually under construction.

The applications being processed totaled 29 in number, with 2,276 beds, and amounted in loans to $12,694,160.

The CHAIRMAN. And that is for 1960?

Mr. JONES. That is as of February 28, 1961, under the FHA program to that date.

We also have here, sir, the figures for the Hill-Burton program, which would add some further information if you would like to have that.

Mr. MACK. Mr. Chairman, I think it would be good to have that in the record.

Mr. JONES. There were 277 nursing home projects with 14,422 beds at a total cost of $158,186,000, of which the Federal share was $47,403,000, less than a third of the cost.

The chronic disease hospitals under the Hill-Burton program numbered 176 with 15,816 beds, which included replacement of nonacceptable beds, at a total cost of $151,796,000, the Federal share of which was $42,183,000.

Mr. MACK. Then you have a substantial construction program underway at the present time.

Mr. JONES. It is substantial but relatively small in relation to the needs for 500,000 additional nursing home beds as of now, and we feel that to make more rapid progress in a methodical, orderly way through State programs will require an acceleration in the Federal grant program.

This is the only way we see where this program can be carried forward at a fast enough rate to make further progress. It seems absolutely necessary if we are to care for the chronically ill and the aged in facilities that are much less expensive than hospitals.

Mr. MACK. Under this grant program, do you feel that beds made available will be within reach of the people who are not extremely wealthy?

Mr. JONES. These will all go to public or nonprofit institutions.

Mr. MACK. Yes.

Mr. JONES. Therefore, the cost to the individual patient will be related to the actual cost of operating the facilities and it will be considerably less than the cost of comparable hospital care. These facilities will be a highly acceptable and preferable substitute in many cases. Therefore, the cost is likely to be within reach of many of the older population who are now unable to take advantage of such facilities because they do not exist and must go to hospitals if hospital beds are available.

Mr. MACK. Yes. But isn't it true that the nursing homes today are being utilized for the same purpose, the ones that are in existence?

Mr. JONES. That is correct; but there are just not enough of them and the quality of them leaves a great deal to be desired.

Mr. MACK. Yes; but do you feel that this price charged for the beds in the nursing homes that will be built under this proposal will be within reach, for instance, of the State-aid cases under the public assistance program in the State of Illinois?

Mr. JONES. Many of them will.

Mr. Cohen points out that the Kerr-Mills bill provides funds in addition to the State aid that will help take care of the costs of nursing home care.

Mr. MACK. Yes.

Mr. JONES. In lieu of hospital care.

Mr. MACK. Yes. Under the FHA program in Illinois anyone who was handling public aid cases, that is public assistance recipients. could not have their applications approved because they wouldn't receive enough money to make it a profitable operation. Now that seems to defeat the entire purpose of the bill as passed in Congress, and I was wondering if you were aware of this problem.

Mr. JONES. Yes; this is true, but this is a State decision. I think our Department would not encourage this kind of decision within States. But this nonetheless is a State matter for determination.

Mr. MACK. Is this an isolated problem in the State of Illinois or one that you have in every State in the Union?

Mr. JONES. Generally, the States do not have enough money to properly care for this group of sick patients.

Mr. MACK. So that under this program it did not make beds available to those who needed them the most in my State of Illinois.

Mr. JONES. Well, we need to have the facilities available, Mr. Mack. The use of these facilities, the method of paying for the care, is a subject of separate legislation.

Mr. MACK. Yes; and I am very happy that you have brought that up because I am wondering if we are not putting the cart in front of the horse with this program.

The thing that concerns me is the fact that you are going to need doctors to take care of all these people—I think you mentioned 17 million people over 65 years, and it is quite staggering. But the medical schools are very reluctant to expand the number of students that go in each year.

The medical schools want to expand their facilities, but they keep the same number of students or increase it by 1 percent each year, and they have indicated that the American Medical Association is still putting tremendous pressure on them to reduce the number of medical students entering schools each year.

Mr. JONES. Assistance to enable schools to produce a large number of physicians, dentists, and public health workers is the subject of a third bill which has been presented by the administration and will be available for consideration shortly.

There is very strong sentiment, unanimous support actually, by the Association of American Medical Colleges for legislation that will permit the development of additional facilities to enable these schools which can expand to expand, and for the building of perhaps 20 new medical and 20 new dental schools which will be needed if we are to produce just enough physicians and dentists to keep pace with the rising population in terms of a ratio of physicians and dentists to the population.

There is no arbitrary limitation on a school that we know anything about from any source on the size of enrollment. It is merely a question of the quality of the education given in the medical and dental schools in relation to the resources to provide this education.

Mr. MACK. The president of one of the great medical schools in this country, and one of the oldest, just last week discussed with me this very matter. He indicated that it is true that they are expanding their facilities but they are not able to take any additional students in, and if they do they won't have the medical school accredited. Now that is rather shocking to me, that after 12 years since we have been aware of the critical shortage of doctors we haven't proceeded to expand our medical schools to train these young people, especially those who can afford it and want to go into this profession.

I am very concerned about this problem. I followed it for a number of years, and from 1900 to 1950 we only held our own while the population doubled. In 1950 we graduated 5,000 students and this was increased to 6,000 while our population skyrocketed again, and I think that is one of the very first problems we must face in solving this very difficult overall problem.

I hope that you gentlemen have been working in that area also.

Mr. JONES. We are deeply concerned about this and strongly urge support of the bill that takes care of this particular problem when you have the opportunity to consider it.

Sir, I might say that the existing medical schools have indicated that with additional facilities, and the kind of support that is provided for in the proposed legislation, they can increase the enrollments by some 1,700 a year which is that many above the 7,200 now graduating each year from our medical schools.

Mr. MACK. Well, is it not true that the American Medical Association does approve all the medical schools?

Mr. JONES. It does from the standpoint of accreditation.

Mr. MACK. Yes.

Mr. JONES. In terms of the quality of their operation.

It is not the American Medical Association as an organization. Rather, it is the joint council, made up of representatives of both the Association of American Medical Colleges and AMA.

Mr. MACK. Well, I knew they were very influential in this area. I didn't know the exact arrangement that they had made. But isn't it really up to them and not to colleges to make final determination?

Mr. JONES. I think it is up to the individual institution.

Mr. MACK. Or the committees you just mentioned?

Mr. JONES. It is up to the institution to set its own program, its own academic goals across the board in terms of the curriculum, the job to be done, the admission of students, and the number of students that can be trained.

The only place the council would come into the picture is if the quality of the educational program degenerated because of a lack of facilities, lack of faculty, or lack of quality of program. Then there would be a question of accreditation, but I do not think this is a serious bottleneck, and I would like to ask the Surgeon General, Dr. Terry, to speak to this point.

The CHAIRMAN. I might say to the gentleman that this is the subject of another bill which was introduced at the same time as this bill, H.R. 4999, and it is the intention of the Chair to get hearings scheduled on that legislation as soon as the commitee can get to it.

I think it is important to get as much information as we can in connection with this other bill, but we hope that we can develop this bill and then have a chance to develop the other when we get to it.

Mr. JONES. Mr. Chairman, may I respond to the point that Mr. Mack raised earlier as to getting the cart before the horse.

We feel very strongly that a program designed along the lines presented here is essential to begin more effectively to develop nursing homes which are in great demand now.

There are people who need to go into nursing homes that cannot get in them at all, all across the Nation. They cannot afford them either directly or through benefits provided to them. The number of beds provided here is only beginning to meet this need, and we cannot begin too soon. This program, in conjunction with others that we have discussed briefly, are necessary and there is no question of priority. They all must go along together in our judgment.

Mr. MACK. Thank you very much.

Mr. Chairman, thank you for the extension of my questioning period. I am happy to know that we are going to bring this other bill up.

The CHAIRMAN. I think, however, in view of the discussion here and the record as it stands now—isn't there also a problem, Mr. Jones, that the capabilities of those who apply to enter medical schools have not kept up with the requirements, and isn't it a fact that there is an unusually large percentage of students who have entered medical schools that have not made it beyond the first year?

Mr. JONES. The first problem you mentioned, Mr. Chairman, is the more acute. The number and quality of applicants for admission to medical schools is not what we would like to see. We feel that the major reason for this decline is the financial barrier, the long years of considerable expense ahead for a prospective medical student, with very limited opportunity for scholarship or fellowship support.

A medical education costs a student an average of about $11,000. Many medical students cannot anticipate the time when they can be in productive practice, until they reach the age of 27 to 30 years. They finish their medical education at this stage of life with a considerable financial deficit facing them.

It is a problem of great concern and is also the subject of the other bill in terms of medical education.

The CHAIRMAN. We will go into that later.

Mr. Schenck?

Mr. SCHENCK. Thank you, Mr. Chairman.

I shall try to keep my questions brief and pertinent.

I am wondering if Mr. Jones has any figures as to the cost to individuals who seek service in nursing homes.

Mr. JONES. Yes, Mr. Schenck, we do have that available.

Mr. SCHENCK. I am referring, Mr. Jones, to these nursing homes which you say shall be constructed by nonprofit organizations.

Mr. JONES. We have here the monthly charges and source of funds for patients in proprietary nursing homes which presumably would be somewhat more than in the nonprofit homes. I do not have that at hand. I will see if we have the average monthly charge for the nonprofit homes.

I am informed the charges range from $130 a month to $187 a month in 1954, at which time this study was made.

Mr. SCHENCK. Is that the latest study you have?

Mr. JONES. It is the only one I have at hand.

I am informed by Dr. Haldeman, chief of the Hill-Burton program of the Public Health Service, that that is the only study made, but the Public Health Service did review nursing home cost studies in 1960.

We can enter in the record a summary of these cost studies which may answer your question.

(The summary referred to is as follows:)

Nursing home costs per resident day

State and city	Description of facility	Date of data	Cost per resident day
Georgia	32 nursing homes	January 1960.	[1]
	25 beds or less (8 homes)		$4.23
	26–49 beds (11 homes)		4.64
	50–99 beds (9 homes)		3.68
	100 beds and over (4 homes)		3.38
Iowa	15 nursing homes ranging in size from 10 to 108 patients.	1958	[2] 4.22
Ohio	80 nursing homes	1958	[3] 4.59
Florida	Basic services of minimum adequacy	1955	4.76
	Average patient		5.01
	Acutely ill		5.68
Alabama	30-bed nursing home in conjunction with county general hospital; R.N. available from hospital.	1958	[2] 5.00
New Jersey	52 licensed proprietary nursing homes having a total of 1,512 beds.	1954	5.31
New York (Utica)	23 nursing homes ranging in size from 5 to 44 beds.	1957	5.36
New Jersey	10 licensed proprietary nursing homes ranging in size from 20 to 60 beds.	1957	5.66
Pennsylvania	18 nonprofit nursing homes	1956	[4] 6.00
Maryland	Estimated cost of adequate care in nursing homes.	1958	[2] 6.00
Unknown	Estimated minimum operating costs:	1957–58	
	165-bed nursing home		6.25–6.90
	55-bed nursing home		6.35–7.00
New York	16-bed nursing home (suggested guide)	1954	[2] 7.00
Virginia (Richmond)	Proprietary nursing home providing "good" care.	1957–58	[5] 7.46
[6]	8 proprietary nursing homes and 1 large nonprofit home.	1958	8.09
Arkansas (Fort Smith)	50-bed geriatric unit of Sparks Memorial Hospital.	1958	[2] 8.10
New York (New York)	Nonsectarian facility providing care for chronically ill and disabled adults.	1958	9.11
New York (Saratoga Springs).	Nursing home operated as long-term care unit of Saratoga Hospital.	1957	10.74
New Jersey (Princeton)	42-bed, long-term unit of Princeton Hospital; routine nursing care, rehabilitation, and occupational therapy facilities.	1957 [2]	[2] 13.85

[1] Range $1.84 to $8.35.
[2] Estimate.
[3] Range $1.41 to $10; average cost for 22 proprietary nursing homes submitting detailed reports was $4.91.
[4] For 53 proprietary nursing homes reporting data, 32 homes averaged less than $5 per day, in 20 homes the cost ranged from $5 to $10 and 1 home reported a cost of more than $10 per day.
[5] Current cost is estimated at $8 per day.
[6] Homes were located in States east of the Mississippi and as far south as South Carolina.

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Division of Hospital and Medical Facilities. Costs of Operating Nursing Homes and Related Facilities: An Annotated Bibliography. Public Health Service Publication No. 754. Washington, U.S. Government Printing Office, May 1960, pp. 2–3, 6.

Mr. SCHENCK. Is it your impression that the per-patient cost would be considerably increased over the figures you have just mentioned?

Mr. JONES. I think this is undoubtedly true; yes.

Mr. SCHENCK. Do you have any proposal here to include a facility where an aged man and his wife may be cared for together?

Mr. JONES. Some of these nursing homes are designed to do just exactly that; yes.

Mr. SCHENCK. Is such cost prohibitive to the individual?

Mr. JONES. Well, it depends on the facilities which they share. Of course, the expenses for two are not quite double the expenses for one if they share quarters as husband and wife.

Mr. SCHENCK. Is there any requirement in this legislation for matching funds from the States?

Mr. JONES. Yes; it is a matching program comparable to the existing formula.

Mr. SCHENCK. Do you have any idea how long it is going to provide, how long it is going to take to provide these 500,000 additional beds which you say are needed?

Mr. JONES. How long it will take to provide them?

Mr. SCHENCK. Yes.

Mr. JONES. It will take some years. Just how long we do not know, but we would like to make a modest beginning at this time to spur local activity in this area.

Mr. SCHENCK. Do you have any information as to the average cost per bed?

Mr. JONES. Dr. Haldeman says that they range from $8,000 to $10,000 per bed.

Mr. SCHENCK. Well, Mr. Jones, if you are envisioning such an appropriation ranging from $24 million in 1962 up to $54 million in 1965 and thereafter, that is an increase above the present budgetary requirements of the Department of Health, Education, and Welfare, is it not?

Mr. JONES. That is correct.

Mr. SCHENCK. Would these additional budgetary requirements then be added to the cost of individual taxes?

Mr. JONES. They would come out of general revenue; yes. I do not know how they would relate to other budget needs or requirements. This would be an increase insofar as this particular activity is concerned.

Mr. SCHENCK. Well, to the extent that increased business and increased employment does not provide the additional and necessary increased Federal tax income, then it will be necessary to increase individual taxes and the national debt, or both. Is that not true?

Mr. JONES. This would be a matter for decision by the Congress, sir, in terms of this particular program. I do not know how it would relate to other claims on the general tax revenue, but the money would have to be provided if Congress decided the program should be made effective at this rate.

Mr. SCHENCK. If the Congress continues to levy additional taxes on individuals and corporations, increasing those taxes each year, then where will the State and local governments get their funds with which to match these costs? The same taxpayers pay both, do they not?

Mr. JONES. That is correct.

Mr. SCHENCK. Then where will the State and local governments get their funds to carry out their share of these matching funds if we continue to preempt the field to a greater extent by Federal Government taxes?

Mr. JONES. I would not presume, sir, to answer the question in the field of economics, of the sort that you present.

Certainly we can expect, I think, a healthy growth in our gross national product as a measurement of economic activity. Certainly we will have an increase in population which will be a productive increase, we should hope. And certainly we have a health problem in this aged group of our population.

I would say that we should be a nation wealthy enough to take care of the health problems of the kind which are so evident and with us as of now.

Mr. SCHENCK. Well, of course, you agree, Mr. Jones, that as the population increases the problem increases also, do you not agree?

Mr. JONES. Yes, sir.

Mr. SCHENCK. And to the extent that the taxes, as a result of increased gross national product, do not pay the increased cost to the Federal Government and State and local governments, taxes must be increased. Is that not true?

Mr. JONES. That would be essential, yes.

Mr. SCHENCK. Thank you.

Mr. JONES. But the question would be a matter for Congress to determine year by year as it reviewed the general economic situation.

The CHAIRMAN. Mr. Moulder?

Mr. MOULDER. Mr. Chairman, just one question.

Mr. Jones, under the provisions of this bill or any other provisions of any other law, does the Department of Health, Education, and Welfare have authority to acquire surplus properties and facilities which are declared surplus by other agencies to be made available to State nursing homes?

Mr. JONES. We do have that authority; yes.

Mr. MOULDER. Has the Department made a study of that in an attempt to make and encourage such purchases?

Mr. JONES. We have a very active program for the distribution of surplus property of the kind that is helpful to medical and health facilities of the States.

Mr. MOULDER. You do have that now?

Mr. JONES. Yes, sir.

Mr. MOULDER. Does that include the structural properties, buildings, and so forth, which have been declared surplus by some other agency or military installation which might be made available to the States for nursing homes?

Mr. JONES. Surplus property of all kinds.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. Mr. Jones, you say your survey shows there is a need of 500,000 additional nursing home beds?

Mr. JONES. That is correct; yes.

Mr. YOUNGER. When was that survey made?

Mr. JONES. As of January 1 of this year.

Mr. YOUNGER. When they made that survey why didn't they also find out what the patient cost of these beds was such as just asked for? You have no information beyond 1954 you say.

Mr. JONES. This is being done now, Mr. Younger, as a comprehensive survey. It is more difficult to get this information than it was to get the other. It takes a little more time. We are in the process of this now.

Mr. YOUNGER. Is it more difficult to get the need of the beds than it is to get the patient cost of them?

Mr. JONES. No, sir. It is more difficult to get the cost because you have to go to each of the individual homes and determine the cost on some common accounting basis to get a common result, whereas the need for additional beds is determined and has been determined through the various State agencies which have kept up with this particular problem.

Mr. YOUNGER. The health centers and referral centers that you call for is a new feature; is it not?

Mr. JONES. That is new, yes. These exist in very few communities.

Mr. YOUNGER. What do you contemplate as the activity of a referral center?

Mr. JONES. Primarily it would be a counseling service to individuals who do not know how to take advantage of the existing community health facilities. As a result, they may go to a hospital when they could go to a nursing home that is available at considerably less expense to them and the community.

It is a question of communication and information as to the available resources to take care of a particular health problem.

I would like to ask the Surgeon General to comment more specifically, if you care to.

Dr. TERRY. In general, Mr. Jones has described the basic purpose of these centers. They are a central agency which would bring together the various resources in the community or at least information concerning them to be available to anyone.

In other words, a person with heart disease having a problem, or a person having cancer or some other disease, having a need for a different type of facility, could get information from a central facility in the community. It saves the patient from not only being shifted around from one agency to another but, in addition, it also makes services more effective in terms of helping the patient get access to the facility that is most appropriate to him.

Mr. YOUNGER. You say there are less than a dozen communities that have these centers. Can you name those communities?

Mr. JONES. Providence, R.I.; Chicago; San Francisco; Cleveland; Milwaukee; Essex County, N.J.; Cambridge, Mass.; Niagara Falls, N.Y.; Los Angeles; Worcester, Mass.; and Niagara County in New York.

Mr. YOUNGER. Do they operate under the county health facilities?

Mr. JONES. They operate through a local health agency, either an extension of the State health program or a county or local operation.

Mr. YOUNGER. All they do is have a list of the nursing homes and so forth that are available for special treatment of certain diseases, and they tell the patient where those are; is that true?

Mr. JONES. Well, yes, this in general is the idea. The individuals seeking counsel for the most part are not indigent and are unknown to the social agencies. They represent a large group for which no counseling has ever been available in the past.

When the communities have a variety of health resources, these people don't know what or where the health resources are, and, therefore, as Dr. Terry has indicated, they get shifted about.

This would be a coordinated information center at which available information about the health resources of the community would be easily related to the needs of people.

Mr. YOUNGER. What do you include now as the health resources of the community?

Mr. JONES. Well, they would include such facilities as hospitals, nursing homes, clinics, voluntary agencies, community health councils, and specialized services such as home nursing, homemaker, and home care programs.

Mr. YOUNGER. And have nothing to do, however, with diagnosis of the disease.

Can a person go into these centers and say I am ill? I don't know whether I have cancer or heart disease or liver disease. Can you tell me what I have?

Mr. JONES. This center would refer this individual to a diagnostic facility of the community that would provide the kind of help that this individual needed. It would tell him where he could go to get the help he needed. They would not undertake to provide the medical service at this particular information center.

Mr. YOUNGER. Well, that is the point. Where would those facilities be? Are they public or private?

Mr. JONES. They would be public centers operated by the public health authorities.

Mr. YOUNGER. They would give the diagnosis?

Mr. JONES. No, sir. It would depend upon the circumstances of the individual. He might be referred to a private medical clinic; or he might be referred to an outpatient diagnostic service of a community hospital, either public or nonprofit or, in some instances, even private.

It would be an information center that would try to have available information which will help people determine where to go for the kind of help they need.

Mr. YOUNGER. You do not have available material from any of these centers which give in detail exactly what services they render, do you?

Mr. JONES. We could provide that for you, Mr. Younger, certainly, for the record.

Mr. YOUNGER. I would appreciate it if you would do that.

Mr. JONES. I think that would be a very valid request, sir, and we will conform.

(The information is as follows:)

CHRONIC ILLNESS INFORMATION CENTERS

Committee on Aging
COUNCIL ON MEDICAL SERVICE
AMERICAN MEDICAL ASSOCIATION

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INTRODUCTION

In most cities a wide variety of services and facilities are available for long-term patient care. These may range from a chronic disease hospital or an organized home-care program to nursing homes or visiting nurse and homemaker services. Whatever their function or sponsorship, they are too frequently either unknown to or overlooked by physicians having patients with illnesses that do not require general hospital care.

A comparatively recent approach to the better utilization of such services and facilities has been the establishment of what are being variously termed "central services for the chronically ill," "chronic illness information centers," or the like. These agencies provide information and referral services to physicians or to patients seeking the proper facility, conduct fact-finding studies on needs and resources for care, stimulate and coordinate planning, and, in general, serve as community clearing-houses on chronic illness planning and activity. The first such service was established in Chicago in 1944. Four others have been organized along similar lines at later dates in San Francisco, Milwaukee, Cleveland, and Essex County, N. J.

Although these agencies differ in the emphasis placed on various facets of their operation, all are organized to a greater or lesser degree around the following general functions: (1) to collect and maintain current information on all available community facilities and agencies offering service to the chronically ill or aged and to provide referral services to individual patients or other persons seeking the appropriate service; (2) to provide consultation and guidance to the operators of nursing homes, homes for the aged, and other long-term facilities in regard to standards of care, operating methods, and costs; (3) to conduct or participate in fact-finding research into the prevalence of long-term illness or disability in the community, the important unmet needs for care, and the additional facilities and services necessary; and (4) to initiate, stimulate, and coordinate community planning to meet these needs, through contacts and conferences with appropriate groups and individuals and through public education, both professional and lay.

The Council on Medical Service has undertaken an expanded program of research, education, and implementation in the various problem areas of aging and long-term illness. Because of the important role such information and referral centers play in coordinating care for these two groups, it was decided to gather information on their organization and operation, the types and needs of persons they serve, the special programs and projects undertaken, and the major problems encountered in serving the aged and chronically ill.

Reports on the chronic illness centers in Chicago, Milwaukee, San Francisco and Cleveland are given below. Information on the Essex County, New Jersey Chr-Ill Service was unavailable at the time of the survey. It is believed that the data obtained will be of interest to physicians, medical societies, and other groups and individuals who are either involved in the care of these types of patients or concerned with the over-all problems of aging and long-term illness.

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CENTRAL SERVICE FOR THE CHRONICALLY ILL OF THE INSTITUTE OF MEDICINE OF CHICAGO

The Central Service for the Chronically Ill of the Institute of Medicine of Chicago began operation in January, 1944, with the financial sponsorship of the Community Fund. Its inception had been preceded by more than 10 years of increasing concern and tentative planning for the growing number of chronically ill in Chicago, on the part of various committees of the Welfare Council, the Institute of Medicine, and other medical, public health and welfare agencies. In the fall of 1942, plans were crystallized when the Welfare Council Committee on Chronic and Convalescent Care recommended that a special agency be established to devote full-time attention to the needs of the chronically ill and the community services necessary to meet these needs. It was intended that the agency would serve as a central point for assembling comprehensive and current data on facilities for the chronically ill in Chicago and on the improvements and additional facilities needed, would concentrate the interest of medical and welfare groups and the general public on these unmet needs, and would formulate specific proposals for improvement of care. It would also provide information on the best services available to patients or other persons seeking care.

In the belief that the work should be under medical auspices, the welfare council had approached the Institute of Medicine during the planning stages with a suggestion that the institute sponsor the project and had added representatives of the institute to the planning committee. Funds for the work became available before final arrangements for sponsorship had been completed, and, to avoid delay, the project was established under the auspices of the welfare council, with institute representation on the governing committee. It operated in this way for the first four months of its existence. On May 1, 1944, it was formally transferred to sponsorship of the Institute of Medicine with the same governing committee, including representatives of the welfare council, and with the same staff and program. A representative of the welfare council continues to serve on the governing board of the Central Service for the Chronically Ill, and, in this and other ways, efforts are made to coordinate the work of the two organizations.

Early in the work of the central service the purposes and program were broadened to include activities directed toward prevention and control of long term illness, as well as toward the improvement of care. These revised purposes, which have directed the central service's activity to the present, are (1) the determining of the important problems of chronic illness in the community through fact-finding studies and accumulation of information from other sources on the number of chronically ill persons, the nature of their disabilities, the services required to meet their needs, the kinds of agencies and institutions best able to provide the necessary services, the part each should play in the total community program, and the ways in which the various personnel, agencies, and institutions should be integrated with each other in providing service; (2) the development of a comprehensive plan outlining the additional services and facilities required in the community and promotion of the development of these facilities through education, consultation with persons and organizations planning new facilities, and other methods; (3) the promotion of the most efficient use of existing services by providing information, counseling, and referral to patients and their families, physicians, health and social agencies, and others seeking suitable facilities for care; (4) the furthering of the effective programs for the prevention and control of long-term illness by encouraging additional effort in this field and by coordinating the facilities and services for care with those whose primary activities are related to prevention; and (5) the fostering of good standards of care and rehabilitation for the chronically ill and disabled at home and in all types of institutions by developing and making available to the personnel and institutions involved specific descriptive and standard-setting material on the quantity, quality, and reasonable costs of services and supplies necessary for adequate care, and by providing consultation in problems of management and administration to these institutions and facilities.

Although the information and counseling service has been operated continuously since the central service was established, a major part of the organization's work up until 1954 revolved around the collection of community-wide data on the needs of the chronically ill, the formulation of standards, and the development and promotion of a community plan to meet the needs. By 1954, the major community problems of chronic illness had been identified and clarified. Information had been collected on the types and extent of additional services and facilities needed, the advantages and disadvantages of various methods of organizing these services, costs, and possibilities for financing; the comprehensive community plan had been developed. This brought to a close the temporary purposes for which the center had been established.

The need continued, however, for referral and counseling services to individual patients and for guidance and consultation to facilities caring for these patients, particularly private nursing homes. In response to considerable community pressure,

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and with financial help from the Chicago Medical Society, Community Fund, Chicago Community Trust, Illinois Division of the American Cancer Society, Chicago Heart Association, and some private foundations, the central service was established on a permanent basis in the Institute of Medicine to continue these two functions. It has been operating on this basis up to the present.

Organization and Operation

The central service now occupies an office in the John Crerar Library Building adjacent to the general offices of the Institute of Medicine in downtown Chicago. Organized as a separate corporation, it operates under the jurisdiction of the Institute of Medicine's Committee on Chronic Illness, which acts as the board of directors. This committee includes eight physicians, an administrative nurse, an executive of the welfare council, two lawyers, and four other lay persons.

The agency began operation with a staff of five: a director, a consultant on standards who was a home economist familiar with the development of quality-quantity-cost standards, a nurse and a medical social worker designated as consultants on resources, and an office secretary. With the termination of the special fact-finding phase of the agency's work, the position of consultant on standards was discontinued. An additional typist has since been added, leaving a present active staff of five.

The director of the central service is a registered nurse, with a bachelor's degree. Her duties, in addition to administrative supervision of staff, include reporting to the board on all agency operations and activities and implementing all decisions of this group, formulating new policies and programs, employment of personnel, expenditures of funds, and representing the service to the community.

The two consultants on resources are responsible for the collection and maintenance of information on the available nursing homes, institutions, agencies, and other facilities in the community and for day-to-day counseling with patients and other persons seeking suitable facilities for care. Information is collected and kept up to date through visits, telephone calls, summarizing of reports from agencies, institutions, and patients, and other methods. Much of the work toward improving quality of care is carried on during visits to the homes and institutions, through the provision of consultant service to operators of the facilities, and through the distribution of printed material.

The secretary and a typist handle the major part of clerical-administrative detail inherent in the agency's operation. Their duties include maintaining administrative files of the agency, preparing financial and statistical reports and records, handling staff schedules and payrolls, purchasing of supplies as authorized by the director, and performing stenographic work for the professional staff.

Request for service forms are kept for each patient or other person contacting the central service, giving diagnosis, degree of disability, services requested and needed, action taken, and other pertinent information. The service also maintains detailed individual records on agencies, homes and institutions, sources of financial assistance, and all other resources for long-term care or service in the community, and it has abbreviated this information in a desk card file for quick reference. Finally, the service maintains over-all statistical information on the relationship of needs and resources for care in Chicago. This includes full information about resources for care of patients in their homes and a yearly register of all nursing and old-age homes, hospitals, rehabilitation centers, and other institutional facilities serving long-term patients, giving bed capacity and type of ownership or auspices.

Services to Patients

In line with the central service's policy to act purely as an information and counseling center, rather than as a case-work agency, persons requesting service are accepted without any prior investigative procedures. For this same reason, and because of the expense involved, the service does not attempt any organized follow-up of patients to see whether a satisfactory solution or placement has been completed.

The service has not attempted any community-wide publicity campaign directed toward patients or other agencies. The annual reports of the central service are reprinted in the Proceedings of the Institute of Medicine, and there has been an occasional article or editorial in this publication. Notices of the availability of the service are published from time to time in the Bulletin of the Chicago Medical Society, and descriptive listings are carried in the Welfare Council's Social Service Directory and the classified telephone directory.

There have been a number of informational mailings about the service to physicians in Chicago and Cook County, and a letter and leaflet recently were sent to all physicians in the area, all clergymen, and a selected list of lawyers, trust officiers, and personnel directors in various business and industrial establishments. Finally, there have been sporadic newspaper articles and radio announcements concerning the availability of the service. Current thinking is that more publicity specifically directed toward the service's informational and counseling functions would be helpful.

During the calendar year 1958, a total of 2,892 patients or other persons sought information or counseling at the service center. Of these requests for service, 433 were recall cases, or patients who had previously contacted the center and 314 were requests for service not related to an individual patient. Table 1 shows the number of requests

during 1956, 1957, and 1958, divided by new and recall cases, and other requests not concerned with a specific patient.

A special tally of a randomly selected 100 patients served during December, 1957, shows that 83% of these were over 60 years of age. Three-fifths, or

TABLE 1.—*Persons Served in 1956, 1957, and 1958*

Year	Patients, No.		
	New*	Recall†	Other No.‡
1956	1,509	236	227
1957	1,721	304	225
1958	2,145	433	314

* Patients known to center for first time.
† Patients who have received previous service from center.
‡ Requests for service not related to specific patient.

60% of this group, were women, a proportion which has held relatively constant over the years of operation. Of the cases on which the data were available, 27% of the patients were married and 73% were single, widowed, separated, or divorced; 26% were in hospitals at the time of contact, and an additional 14% were in nursing homes, boarding homes, and other institutions; 14% were living at home with husband or wife, 27% with other relatives or friends, and 19% alone. The proportions of ambulant, semiambulant and bedridden patients referred to the service have been relatively constant since its inception, as have been the number of patients able and unable to pay full costs of care.

Table 2 gives a breakdown of these 100 newly referred cases by age, degree of disability, financial status, source of referral to the service, and other characteristics.

Needs of Patients

During September and October, 1958, nearly 65% of patients contacting the central service for the first time requested nursing home or other institutional care. The next most frequent requests were for some type of housekeeper-attendant service and for general counseling and help in planning a patient's care. Other requests were for information on some specific facility, home nursing care, or rehabilitation services. Table 3 shows the nature of requests for service among 638 calls received by the central service during September and October, divided by new and recall cases. Also included are calls received from nursing home operators on management problems, from persons planning to establish such facilities, and from individuals and organizations seeking general information on needs and resources.

Some 60 to 65% of all patients requesting service are given help in finding homes and institutions providing long-term care. Another 10 to 12% of patients are given information or counseling on home-care services or resources for financial assistance. Five to eight per cent of patients are referred to social case work agencies. Other referrals are to rehabilitation facilities and similar community services. For a small number, further medical or psychiatric evaluation is recommended before attempting a plan for care.

Problems and Developments

The important unmet needs and problems of Chicago's chronically ill, as evidenced by requests to the central service and by its extensive fact-finding work in the community, seem to revolve around a need for substantial improvements in financing of services; a shortage of good inpatient facilities for long-term care; a need for broadening the range of services offered, especially rehabilitation services within the various long-term institutions; some deficiency in the services available to help patients and their families at home; and a need for closer coordination of the activities of the many different organizations now becoming involved in the planning and development of community services in the field of chronic illness.

At present, in Chicago, there are about 16,000 beds for long-term care—in special hospitals for treatment and rehabilitation of the chronically ill; in voluntary, public, and private nursing-care facilities; and in infirmary sections of homes for the aged. Although this represents an encouraging growth from the some 10,000 beds available at the time of the central service's inception, and is not far short of the total number needed, at least 6,000 of these presently available beds are of such poor quality and offer so little possibility of substantial improvement that they should be replaced by new facilities. Most of these 6,000 substandard beds are

TABLE 2.—*Characteristics of One Hundred Patients Newly Referred to Center, December, 1957*

	Patients, No.
Sex	
Male	40
Female	59
Not recorded	1
Age	
<20	2
21-40	2
41-60	10
>60	83
Not recorded	3
Marital status	
Married	22
Single	15
Widowed, divorced, or separated	46
Not recorded	16
Living arrangements	
Alone	17
With spouse	13
With relatives or friends	23
Boarding or nursing home	12
Hospital	24
Other institutions	1
Not recorded	9
Degree of disability	
Ambulatory (includes senile)	45
Semiambulatory	36
Bedfast	18
Not recorded	1
Method of contacting center	
Phone	93
Letter	3
In person	4
Main source of income or support of referred persons*	
Spouse	6
Other relatives and/or friends	14
Old Age Assistance	9
Old Age Assistance, relatives, Old Age & Survivors Insurance, etc.	5
Other public welfare	2
Pensions	15
OASI, savings, relatives	8
Business, employment, rentals	1
Savings only	2
Capital assets, convertible property	3
Disability and employment insurance	...
No income	1
Not recorded (unknown)	5
Private funds (exact source not specified)	18

* Figures are weighted toward self-supporting persons, as arrangements for care of financially dependent usually are made by welfare agencies.

in small proprietary nursing homes in the city, and the central service feels that this is a reflection of two primary factors. One of these is the fact that many of the operators of these facilities have not had the experience or training necessary to provide good care economically and efficiently. Until recently there have been no institutes, training centers, or other educational resources from which these operators could obtain guidance in organizing and operating a nursing home, or even any books or journals devoted to this subject. There has been a definite need, first, for a specific definition of what good care consists of, and what is required to provide it in terms of organization and ownership of nursing home facilities, relationships between these facilities and other inpatient care institutions, physical plant and equipment, numbers and training of personnel required, and costs; and, second, for educational channels through which this information can be made available to the owners and operators of the facilities.

A major part of the central service's work has been directed toward these needs. A 400-page book giving practical guidance for persons planning to establish new homes and institutions has been published by the service, and a companion volume on organization, management, and budgeting procedures is forthcoming. Hospital organizations and journals are publishing material of this type with increasing frequency. A number of short training courses covering patient care, personnel, management, budget, and other such areas have been set up for nursing home owners and operators, and efforts along this line are increasing. The second important factor in the inadequacy of many proprietary nursing homes has been the lack of sufficient funds to provide good care, particularly for public assistance recipients.

The central service continues to urge and work for more realistic standards of payment for public assistance recipients, through its contact with other agencies and individuals in the community, talks and programs before interested organizations, and cooperating with the Health Division of the Welfare Council in efforts to improve the payment standards now in use by the Illinois Public Aid Commission.

Services to the Community

From its inception in 1944 up until 1955, a major part of the central service's work was taken up with various special studies into the nature, prevalence, and problems of chronic illness in the Chicago area. In addition to the broad, day-to-day collection of information on the number, types, and needs of chronically ill, and the community services required to meet these needs, the service has completed the following specialized studies: (1) terminal care for cancer patients—a study of the facilities available and needed in Chicago for care of this group, specially financed by the American Cancer Society; (2) a specially financed study of the services available and needed for home care; (3) the need for institutional facilities for the long-term care of children; (4) the need for special institutional facilities for young adults; (5) an analysis of personnel and services required in different types of homes and institutions for long-term care; and (6) costs of care in long-term institutional facilities, compared with the costs of home services for the chronically ill.

By the end of 1954, the central service had identified and clarified the major problems and unmet needs of the chronically ill in Chicago and had assembled information on the services needed and extent of the need, types and numbers of agencies and institutions required, the pros and cons of various forms of organization of services, probable costs, and the possibilities for financing. The central service has developed and is planning to publish a model plan for a coordinated community-wide program in Chicago directed toward all aspects of the chronic illness problem—early diagnosis and prevention; care and rehabilitation of the long-term patient at home, in hospitals, nursing and old-age homes, and other institutions; coordination of community facilities and services; fund-raising and financing of care; maintenance of statistical information on needs as related to facilities available; and the basic community and professional services needed in research, professional, and public education, and licensing and standard setting for institutions and personnel.

TABLE 3.—*Nature of Requests for Service Among 638 Calls Received During September and October, 1958*

Type of Request	Percentage of Total Cases		
	New Cases	Recalls	Total
Nursing home, boarding home, institution	64.2	60.3	63.7
Nursing home and financial assistance	2.7	1.4	2.5
Housekeeper, attendant, etc.	7.6	1.3	6.9
Nursing care in patient's home	1.8	...	1.6
Information re facilities and resources			
Sheltered or home employment	0.2	1.4	0.3
Financial assistance	1.6	1.3	1.6
Rehabilitation services	1.6	...	1.4
Wheel chairs, hospital beds, etc.	0.3	...	0.3
Medical and dental care, free or cheaper medicines	0.4	...	0.3
Transportation to clinics	0.2	...	0.2
Recreation and companionship plus medical and dental care	0.2	...	0.2
Day care	...	...	...
Restaurants serving special diets	...	...	...
Miscellaneous procedures, legal advice, camp, etc.	0.3	...	0.3
Information regarding a specific facility	4.1	5.5	4.2
Help in formulating specific plan for care of patient, information about various types of facilities	6.2	5.5	*6.1
Information on costs of care	0.3	...	0.3
Consultation to nursing home managers on management problems	1.6	...	1.4
Consultation to persons planning establishment of new facilities	2.3	...	2.1
Consultation to persons and organizations seeking information about care of chronically ill (including statistical data, information on costs of care, and standards)	4.4	...	3.9
Additional information only	...	23.3	2.7
Total	100	100	100

Other material published or about to be published by the central service includes a 25-page pamphlet summarizing methods for surveying community

needs and resources for long-term care; a 55-page booklet on the role of the nurse in caring for the chronically ill; a monograph on community services for rehabilitation; a monograph on licensing and standard-setting for long-term care institutions; a casework manual for welfare agencies to assist them in arranging care for the chronically ill patient; and a monograph on home-care services.

Finally, the professional staff of the service continues on a day-to-day basis to counsel with the operators of institutions providing long-term care, particularly privately owned nursing homes, in efforts to develop and maintain good standards of care, and to maintain and make available to the community centralized information about the needs and resources for care of the chronically ill in the Chicago area.

CENTRAL AGENCY FOR THE CHRONICALLY ILL OF MILWAUKEE

The Central Agency for Chronically Ill, of Milwaukee, was established in February, 1948, as the result of a two-year study into the problems and unmet needs of chronically ill persons in Milwaukee County. This study, which was financed by the Women's Club of Wisconsin and conducted by a special study committee of physicians and other citizens appointed by the Community Welfare Council of Milwaukee County, showed a need for some type of central clearing house to collect information on the facilities providing long-term care and the additional facilities and services needed in the county. The study committee was then charged with developing, in cooperation with other agencies, a central information-gathering and educational service for the chronically ill.

The central agency was supported through its first years by a grant of $10,000 from a service club and presently by the Community Chest, of which it is a participating agency. Its objectives are (1) to gather and maintain current information on nursing homes, homes for the aged, and other facilities providing service for the long-term patient and to assist with placements in these facilities; (2) to stimulate through community education the setting aside of additional hospital beds for long-term illness, the expansion of good nursing home facilities, the extension of bedside nursing care in private homes, and the development of additional facilities for recreation and rehabilitation; and (3) to stimulate further study of degenerative diseases from all aspects.

Organization and Operation

The central agency occupies a small office in the downtown Milwaukee area. The original staff consisted of the executive director and an office secretary. A professional staff worker was added as operations progressed. The central agency functions under the supervision of a 21-man board of directors, representing the fields of medicine, industry, finance, law, the clergy, public relations, and service groups. This board, which meets once monthly, is responsible for over-all policies of the agency and for approving budget expenditures and any changes or additions in the agency's program. The agency is organized as a corporation, with an unlimited number of members who are elected for five-year terms. These members represent various fields and professions in the community, participate in special program meetings several times a year, and serve as a reservoir from which to draw new members for the board of directors.

The executive director of the agency is a registered nurse, with a masters degree in public health. Her duties, in addition to over-all administrative supervision of the agency and preparation of the budget, include formulating new programs and policies for the agency and submitting them to the board of directors and the Community Welfare Council, interpretation of agency policies and programs to the community, developing educational programs and institutes directed toward the general public and various professional groups, securing data and preparing reports on the individual and community problems of long-term illness, and continuous liaison with other community social and health agencies in order to foster a coordinated approach to problems of the chronically ill.

The professional staff worker is a registered nurse with a degree in public health nursing. Under supervision of the executive director, she is responsible for counseling and referral of patients seeking nursing homes and other facilities for care, for visiting and evaluating all nursing, old-age, and foster homes within a 50-mile radius of Milwaukee, for keeping a running file on these facilities, and for consulting with persons planning new nursing homes and other such facilities in regard to standards of care. Her duties also include meeting regularly with state and local organizations of nursing home operators and assisting these operators with problems related to management efficiency, nursing care, and costs.

The office secretary handles most clerical-administrative detail in the agency's operation, including typing, maintaining files and records, and serving as receptionist and telephone operator. Monthly narrative, statistical, and financial reports on the agency's operation, in addition to an annual report, are prepared jointly by the director and the staff worker and distributed to the board and all corporation members. Other records and files maintained in the office include request-for-service forms for all patients or other persons seeking information—these include diagnoses and the name of the

physician in charge for all patients—a complete nursing home evaluation report on all facilities visited by the staff worker and a summary of these evaluation reports in a desk card file. The agency also maintains a reference library of books and other educational material.

Services to Patients

About one-fourth of the time of the professional staff is taken up with counseling and referral of patients to nursing homes or other institutions and services for the chronically ill. The central agency has not attempted any intensive publicity toward this facet of its operation. Articles noting the availability of the counseling service have been published from time to time in the local newspapers, and the agency has published brochures or pamphlets directed toward persons seeking information on the services available in Milwaukee.

TABLE 1.—*Characteristics of Patients Newly Referred to Center in 1957*

	Patients, No.
Sex	
Male	199
Female	314
Age	
<39	2
21-40	17
41-60	47
>60	447
Marital status	
Married	72
Single	91
Widowed	305
Divorced or separated	2
Not recorded	43
Living arrangements	
Alone	126
With spouse	64
With relatives or friends	115
Boarding or nursing home	20
Hospital	126
Other institution	48
Not recorded	14

	Patients, No.
Degree of disability	
Ambulatory	146
Semiambulatory	241
Bedfast	126
Method of contacting center*	
Phone	437
Letter	57
In person	99
Main source of income or support of persons referred	
Spouse	74
OAA plus relatives, OASI, etc.	62
Pensions (retirement, veterans, etc.)	47
OASI plus savings, relatives, etc.	30
Income from business, employment, or rentals	338
Savings only	
Capital assets, convertible property	
Not recorded (source unknown)	2

* Includes more than one type of contact by some patients.

Patients seeking information or placement counseling are accepted for service without any prior investigative or casework procedures. The agency has at times had sample clearances with the Social Service Exchange in Milwaukee but decided against making it a routine practice. The agency does not attempt any organized follow-up of patients to see whether the referral or placement made in individual cases has been completely satisfactory.

The number of patients and other persons seeking help at the agency has increased slowly but steadily since its inception in 1948. In the fiscal year 1954-1955, 619 new patients or other persons contacted the agency for service; in 1955-1956, 688, and in 1956-1957, 693 new patients were served by the agency. At present patients are referred to the agency by their families, themselves, the Visiting Nurse Association, hospitals in Milwaukee, physicians, lawyers and courts, and friends, in about that order of frequency.

Of the 513 individual patients referred to the agency during the calendar year 1957, over 85% were 60 years of age or older. This age percentage has held relatively constant over the years of operation, with an average patient age near 75. Over three-fifths of patients referred to the center were women, a proportion which has also held constant. About 77% of the patients were widowed or single, 25% lived alone, and 22% lived with relatives. An increasing percentage of bedfast or incapacitated patients have sought help at the agency in recent years. The percentage of senile or mentally disoriented patients referred to the agency has also risen. Table 1 shows the characteristics of individual patients referred to the agency during the calendar year 1957 by age, degree of disability, living arrangements, financial status, and other factors.

Needs of Patients

In the period from October, 1957, through September, 1958, requests for 24-hour nursing, boarding, or other institutional care accounted for a little over 36% of all needs for service among newly referred patients or other persons. The next most frequent requests were for counseling or educational material. Other frequent requests among new contacts were for information on establishing a new facility for care and for information on sheltered or home employment and custodial day care. Table 2 shows the nature of requests for service received during this period, divided according to new and recall patients. Not included in this tabulation are some 259 calls received from nursing home operators during this period, reporting vacancies or the filling of vacancies in their facilities.

The community facilities or services to which patients are most frequently referred have been nursing and old-age homes, the Welfare Department, Visiting Nurse Association, the Family Service Agency, and the local Old-Age and Survivors Insurance (OASI) Bureau.

Problems and Developments

As a result of its referral and fact-finding work with patients and other individuals and agencies in the community, the central agency has been able to pinpoint some of the more pressing problems in meeting the needs of Milwaukee County's chronically ill. There is an urgent need at present for some type of visiting homemaker or housekeeper service which could be made available to the considerable number of chronically ill or infirm patients living at home. Such a service has been approved by the Visiting Nurse Association, but its inception has been delayed by a difficulty in recruiting housekeepers. The central agency is also planning to inaugurate, on a demonstration basis, an organized home-care program similar to those operating in other communities. This project is presently awaiting the approval of the Milwaukee Medical Society.

Another major problem is the lack of suitable facilities for care of the "in-between" type of senile patient, who is too much of a supervisory problem for the average nursing home operator but does not need or belong in a mental institution. Progress on this problem has been nil to date. There is also a lack of suitable nursing care facilities for persons in the middle and higher income group who desire and are able to pay for a private room and bath. The central agency, in its consultation work with nursing home operators, has stimulated those persons planning new or improved facilities to include more such private and semiprivate accommodations in their planning.

Finally, the agency feels that there is a definite need for additional organized inpatient rehabilitation services. Milwaukee has adequate rehabilitation services at the outpatient level, but more inpatient facilities than those presently provided by the general hospitals of the city are needed.

Services to the Community

More than 40% of the working time of the director and staff worker is taken up with activities of a community-wide nature—classes, talks and other educational projects, visits to nursing homes and counseling with their operators, and assistance to nursing home organizations, both state and regional. The central agency has sponsored, organized or participated in a number of annual workshops for nursing home operators. These workshops have utilized the educational resources of a number of state and local agencies and organizations and have covered such areas as nursing service, nutrition, rehabilitation, administration, budgetary and management problems, enlistment and training of nursing home personnel, and broad trends in the nursing home field. The first such workshop was given by the agency in Milwaukee in 1951, with the help of the newly formed Milwaukee County Nursing Home Association. Two similar programs were given in the years following, and in 1954 a statewide workshop was held in Milwaukee in cooperation with the Marquette College of Nursing and the State Nursing Home Association. Another statewide program was held in 1955, conducted jointly by the central agency, the University of Wisconsin Extension Department, the State Health Department, and the State Nursing Home Association; similar workshops have been given up to the present.

The central agency has compiled and published a small fact booklet on the patients in Milwaukee's proprietary nursing homes. The booklet gives statistical information on age, sex, diagnoses, types of care required, referral sources, patient income, and costs of care. These data were obtained with a special questionnaire used by the staff worker in the course of her routine nursing home visits.

Other informational and educational material published and distributed by the agency includes a brochure on the important problems of chronic illness written for the general public, a 12-page booklet giving some of the general points to be considered by patients and their families in selecting a nursing home, and a similar booklet highlighting some of the essential problems in the operation of a nursing home, directed toward administrators of these facilities.

A recent project has been the mailing of a quarterly "Food Notes" bulletin to nursing home operators and cooks. This 2-to-4-page bulletin, which is prepared with the help of the Milwaukee Health Department nutritionist, notes some of the plentiful and easily obtained foods in a particular season, gives suggestions for their use in menus, and contains recipes in serving quantities for from 10 to 50 persons. Suggestions are also given on attractive and efficient serving methods, special dishes, and the like.

TABLE 2.—*Nature of Requests from Oct. 1, 1957, to Sept. 30, 1958*

	New Cases	Recalls*	Total
Nursing Home, boarding home, institution	517	154	671
Housekeeper, attendant, etc.	34		34
Information re facilities and resources			
Sheltered or home employment	47		47
Financial assistance	15		15
Wheel chairs, hospital beds, etc.	9		9
Rehabilitation services	5		5
Free or cheaper medicine	2		2
Housing	6		6
Transportation to clinics	2		2
Day care (custodial)	45		45
Restaurant serving special diets	3		3
Establishing new facility	79		79
Consultation, educational material	246		246
Counseling	277		277
Additional information only	141		141
Total	1,428	154	1,582

* Persons previously receiving service from agency

The director of the central agency is co-author of a book on the care and rehabilitation of the chronically ill; she continues to write articles and develop exhibits, literature for distribution, and other educational material on the general and specific problems of the chronically ill and their care.

The central agency is currently investigating the possibilities for future study and action in such areas as encouraging the development of new skilled nursing care facilities by church and other nonprofit groups, who have not been too active in this field in the past, possible contributions by the general hospital in improving long-term care, improved methods of caring for the homebound chronically ill, and a study of the incidence of chronic disease in certain special groups, such as the Negro population and industry. The agency continues to work toward fostering an enlightened public attitude toward the problems of the aged and chronically ill and to stimulate the coordination of community facilities and services in meeting these problems.

CHRONIC ILLNESS SERVICE CENTER OF SAN FRANCISCO

The Chronic Illness Service Center of San Francisco was established in October, 1950, as the result of two years of study and planning by a special subcommittee of the Social Planning Committee of the Community Chest. This subcommittee, after reviewing the problems of the chronically ill both nationally and in the San Francisco area, recommended a two-year demonstration program to test the feasibility and value of a central information-gathering, coordinating, and referral agency for the city's chronically ill. Originally supported by foundation funds and later by the United Community Fund in 1955 the Chronic Illness Service Center of San Francisco began operations directed toward the following objectives: (1) to promote the development of a coordinated community-wide program for adequate care of the chronically ill; (2) to assemble and make available information regarding the unmet needs and problems of chronic illness; (3) to assemble, study, and make available information on existing community facilities and resources for the chronically ill; (4) to stimulate public interest and understanding of the problems of chronic illness and its prevention and control; and (5) to assist organizations in planning facilities and programs for the chronically ill.

Organization and Operation

The original staff of the service center, which was housed rent-free in the Community Chest Building, consisted of a director and an office secretary. A medical social worker was added to the staff in August, 1952. The center functions under the guidance of a 21-man board of directors, who are familiar with the community and its resources and specifically concerned with the problems of chronic illness. Additional consultation and guidance is provided by a technical advisory committee, representing various professional groups with a knowledge of the key fields related to chronic illness.

The director's duties, in addition to over-all supervision of the administrative and program activities of the center, include liaison with the board of directors and the technical advisory committee, interpreting agency policies to the community and professional groups, consultation with individuals and groups planning resources for the chronically ill, preparing reports on the individual and community problems of long-term illness, and the planning of meetings and educational activities for specific groups.

The medical social worker is responsible for the day-to-day operation of the information, counseling, and referral service. Consultation with and referral of patients or other persons seeking suitable facilities for care is her continuing responsibility. She secures and maintains current information on the various facilities and resources for long-term care in the community and makes this information available to persons and organizations who need assistance in planning care for chronically ill or disabled patients. She also acts as a consultant to the operators of nursing homes and other long-term care facilities on administrative policies, needs of the long-term patient, and ways of improving care.

The office secretary, under direction, is responsible for the management of the office and the clerical-administrative details inherent in the center's operation, maintaining files, records and correspondence, and preparing monthly statistical reports. She also acts as receptionist and telephone operator.

The center occupies about 450 sq. ft. in the Community Chest Building and is divided into three offices. Inasmuch as the majority of referrals and information can be given by telephone and all office interviews are by appointment, the lack of space has not presented a serious problem as yet. Files maintained in the office include detailed data on proprietary nursing and boarding homes and other facilities and services currently operating in the community (this information is usually obtained by a questionnaire followed by a visit to the facility) and complete individual case records for all persons requesting services, which are divided according to new requests, recall cases, and persons seeking information not related to a specific patient.

Services to Patients

From the beginning, it was felt that emphasis should be placed on counseling, guidance, and referral services to individual patients and others seeking information and that in this way insight would be gained into the over-all planning, coordinating, and educational services needed in the community as a whole. In accordance with this policy, services were made easily available and individuals requesting help were accepted without being

obliged to undergo detailed investigative procedures. However, there was no emphasis on case-finding activities nor on publicity concerning the center's existence. An announcement letter was mailed to other agencies notifying them of the center's availability, and two articles describing the center were published in the San Francisco Medical Society Bulletin. No organized follow-up is made

TABLE 1.—*Persons Served in 1954, 1955, and 1956*

Year	Patients, No.		
	New*	Recall†	Other, No.‡
1954	788	340	185
1955	1,087	641	276
1956	1,329	902	268

* Patients known to center for first time.
† Patients who have received previous service from center.
‡ Requests for service not related to specific patient.

of patients to see whether the solution or the placement suggested has been completely satisfactory in each case.

From its inception in October, 1950, to the end of 1956, the center provided services to 7,037 individual patients or other persons. During the calendar year 1955, 1,728 patients sought help at the center, an increase of 51% over 1954 (641 of these patients had received service previously from the

TABLE 2.—*Source of Requests for Patient Services*

Source	New Patients, No.		Recalls, No.
Patients, relatives, and friends		721	700
Hospitals and welfare agencies			
Hospitals	327		
Other health agencies	47		
Family agencies	43		
Information services	17		
Relief agencies	5		
Miscellaneous	22		
Total		461	129
Other			
Physicians	54		
Nursing and boarding home operators	33		
Unions	12		
Press	9		
Nurses	7		
Employers	6		
Attorneys	5		
Trustees, guardians	4		
Clergy	4		
Insurance companies	3		
Landlords	3		
Fraternal & veterans organizations	3		
Professional associations	2		
Foundations	2		
Total		147	64
Grand total		1,329	902

center; the remainder were new referrals). Table 1 shows the number of services requested during the years 1954, 1955, and 1956, divided according to new and recall cases and requests not related to an individual patient. Table 2 shows the referral sources for both new and recall patients during the year 1956.

Of the 1,329 new patients referred to the center in 1956, almost 60% were between the ages of 65 and 85. The average patient age has been steadily rising since the center's inception and was 71.6 years in 1956. Almost twice as many women as men are referred to the center. About 63% of the patients were widowed or single, 36% lived alone, and 26% lived with relatives. An increasing percentage of ambulatory patients are being referred to the center. During the early experience one-half of the patients referred were bedfast, while in 1956 this percentage has shrunk to ⅓ of total referrals.

Factors which might explain this trend have been an increased bed capacity in the voluntary chronic disease hospitals, the setting aside of 20 new long-term beds in two general hospitals in the city, and, on a broader scale, a growing recognition on the

TABLE 3.—*Characteristics of New Patients Referred to Center in 1956*

Sex	Patients, No.	Degree of disability	Patients, No.
Male	471	Bed	435
Female	858	Ambulatory	682
		Semiambulatory	184
Age		Unknown	28
<55	10		
55-64	69	Main source of income or support	
65-74	233	Spouse	85
>84	976	Other relatives and/or friends	156
Not recorded	39	Old Age Assistance only	46
Average age	71.6	Old Age Assistance supplemented by relatives, OASI, etc.	208
Marital status		Other public welfare	27
Married	317	Pensions (retirement, veterans, etc.)	176
Single	180	OASI, OASI & savings, relatives, friends	171
Widowed	646	Business, employment, rentals	145
Divorced or separated	79	Savings only	128
Unknown	97	Capital assets, convertible property	48
Living arrangements		Disability and unemployment insurance	15
Alone	487	No income	14
With spouse	294	Source unknown	130
With relatives	357		
With friends	82		
Boarding or nursing home	57		
Hospital	29		
Other institutions	30		
Unknown	48		

part of agencies and individuals that bed care is not always the best answer to needs of the long-term patient. Table 3 shows the characteristics of patients newly referred to the center during 1956 by age, degree of disability, living arrangements, financial status, and other factors.

Needs of Patients

During 1956, requests for 24-hour nursing or supervisory care accounted for a little over 60% of all needs for service among newly referred patients. The next most frequent requests were for counseling and for some type of housekeeper-attendant service. Other requests were for general information on facilities and resources for long-term care, information on a specific facility or resource, or for consultation. Table 4 shows the nature of requests for service received by the center during 1956, divided by new and recall patients.

Problems and Developments

In answering these requests and in attempting to find and effectively utilize existing services and facilities, the center has brought into clearer focus some of the more pressing problems in meeting chronic illness needs in San Francisco.

One of the major problems encountered by the center has been the inability of many patients to pay for the type of care they need. The trouble lies not so much in a shortage of good nursing homes, boarding homes, and other long-term facilities as in the fact that the rates at these better facilities are too often beyond the patient's ability to pay. This has been true both for patients seeking 24-hour nursing care and for those seeking domiciliary or boarding home facilities.

The center has also found that there is not enough provision for rehabilitation in the various

TABLE 4.—*Nature of Patient Requests, 1956*

	New Cases	Recalls	Total
Nursing home, boarding home, institution	819	228	1,047
Housekeeper, attendant, etc.	142	51	193
Information re facilities and resources			
Sheltered or home employment	13		
Financial assistance	11		
Wheel chairs, hospital beds, etc.	11		
Rehabilitation services	7		
Medical and dental care	10		
Free or cheaper medicine	11		
Housing	12		
Transportation to clinic	10		
Recreation & companionship	8		
Day care (custodial)	3		
Restaurants serving special diets	2		
Misc. procedures, legal advice, camp, etc.	12		
Total	110	42	152
Information on specific facility	56	51	107
Consultation	52	54	106
Counseling	150	107	257
Additional information only*	---	969	969
Total	1,329	902	2,231

* Applies to recalls only.

long-term facilities. In the proprietary nursing and boarding homes the emphasis given to rehabilitation varies widely and reflects the philosophy of the operator, his idea of the rehabilitative potential of the elderly chronically ill person, and the economic effect such services will have on his own business. Consistent physical and occupational therapy and diversional programs are for the most part lacking in proprietary facilities for long-term care, where the lack of adequate staff and the cost of such services prohibit organized efforts.

Considerable overlapping and duplication of function exists among the various chronic disease facilities and services. No facilities especially adapted to the needs of the younger chronically ill adult presently exist. There are limited subsidized convalescent resources for women and none for men in the city.

Another problem has been obtaining efficient, reliable homemaker-attendant services. Previous attempts at homemaker service for the city's chronically ill have been sporadic and temporary in nature, and there is no permanent, established program of this type at the present. (A limited demonstration Homemaker Service primarily for chronically ill and aged persons was established on May 1, 1957.) As a result, the cost of obtaining reliable full-time attendant service has been prohibitive for many families, and the type of consistent, dependable part-time help which would make secure family planning possible has been equally hard to find.

Another need that has become increasingly clear as operations progressed is for more counseling specifically geared to the chronically ill, embracing the many problems that accompany long-term sickness or disability, such as dwindling finances, family attitudes, living arrangements, and the psychological impact of long-term dependency. The center reports that there has not been too much change in the types of patients or problems since its inception, but there has been encouraging progress in the community's thinking about chronic illness. Some change is evident in the "hopeless" pattern of patient management and more emphasis is being placed on rehabilitation.

Services to the Community

As the result of its contacts with patients and its work and findings in the community, the center has been able to implement and participate in broader community planning for service to the chronically ill. In addition to maintaining complete information on the services, rates, and facilities in commercial nursing and boarding homes in the San Francisco area, the center has sponsored two institutes for nursing and boarding home operators. The second in a series of five meetings, held in the fall of 1955 by popular request of the operators, featured demonstrations and discussion of new techniques in patient management. The center also continues to provide consultation on standards of care and operating practice to operators on a day-to-day basis, and to sponsor a closer working relationship between nursing and boarding homes and hospitals, physicians, and other related organizations.

Partly as a result of the center's recommendations, and with its informal participation, a home-care plan for the chronically ill of San Francisco is in operation at the Mount Zion Hospital, and the Center has continued to stimulate the formation of other such programs, particularly under public auspices. Finally, the center continues to bring together representatives of the voluntary health organizations concerned with long-term illness and has provided these organizations with a basis for joint planning and action.

CHRONIC ILLNESS INFORMATION CENTER OF CLEVELAND

The Chronic Illness Information Center of Cleveland was established in March, 1955, as a department of the Welfare Federation in that city. Prior to this, requests for referral services and information on chronic illness facilities and services had been handled by a number of different agencies in Cleveland, among them the Benjamin Rose Institute (a philanthropic health and welfare agency for older persons), the Catholic Charities Bureau, County Welfare Department, Jewish Family Service Bureau, the Welfare Federation Community Information Service, and the Highland View Hospital for Chronic Diseases. Duplication and overlapping of functions often resulted in confusion and inadequate services. In recognition of the need for coordination of services and pooling of information, the chairman of the Welfare Federation's Committee on the Chronically Ill appointed a subcommittee of persons from the various organizations furnishing service to the chronically ill to consider the need for a central information-gathering, counseling, and referral agency. The subcommittee, after its study, unanimously recommended establishing a central information service in Cleveland.

A subsequent committee of lay and professional persons was appointed to draft the organizational details of the center and to develop its specific functions and purposes, which were established (1) to give patients and other persons direction and advice regarding facilities for long-term care, to guide the individual patient to the proper facility as his needs change, and to serve as a focal point for closer cooperation between agencies in service to the individual patient; (2) to centralize the consultation and referral services being given in part by several different agencies, thereby eliminating duplication and promoting the most efficient use of facilities available; (3) to continuously evaluate community resources and unmet needs through systematic inquiries, follow-up of patients referred, and contacts with other agencies serving the chronically ill and to refer to the Welfare Federation Committee on the Chronically Ill any gaps in service which require community action; (4) to serve in a consultant capacity to the operators of nursing and boarding homes and to persons planning to establish such facilities in regard to improved standards of care; and (5) to cooperate with other community agencies in promoting the development and expansion of needed facilities and services and in fostering an enlightened public attitude toward the problems of long-term illness.

The information center is still operating as a department of the Cleveland Welfare Federation and receives financial support from the federation, the Benjamin Rose Institute, and a private source. In addition, the Cleveland City Division of health has assigned a public health nurse to the staff. The Academy of Medicine of Cleveland contributed to the support of the center during its first three years of operation.

Organization and Operation

The information center occupies office space in the Community Service Building, which houses most of the Welfare Federation departments. Office staff consists of a director, a public health nurse, and a secretary. The center operates under the supervision and guidance of an advisory board composed of professional and lay persons representing the Cleveland Academy of Medicine; the Visiting Nurse Association; Catholic Charities; Jewish Community Federation; various city, county, and state health and welfare agencies; special health organizations; private casework agencies; general and chronic disease hospitals; and hospital social service departments. This advisory board, under chairmanship of a physician, acts as a liaison group between the center and the Welfare Federation's Committee on the Chronically Ill. Although each has its own staff, the work of the Committee on the Chronically Ill and that of the information center is well integrated.

The Committee on the Chronically Ill is directed by the same executive secretary as the Committee on Older Persons because of the many overlapping needs of the chronically ill and the aging. Its functions are the planning and coordination of community services relating to chronic illness in the light of data gathered by the information center in its work with individual patients and facilities.

The director of the center is a medical social worker, employed on a part-time basis. Her duties, in addition to over-all administration and supervision of staff, include providing information, counseling, and referral services to patients or other persons in regard to facilities for care; contact with agencies providing direct services in regard to their policies and procedures; maintenance of statistics on services provided; and intepretation of the pro-

gram to those providing the services and to other appropriate groups in the community. The director also visits and consults with nursing home operators and those planning such facilities in regard to standards of care and cooperates with the state licensing division in improving standards of care.

The public health nurse was assigned from the Cleveland Division of Health to work with the information center. She spends half of her time in the information center office where her work includes counseling and referral of persons seeking facilities for care and liaison with the division of health and other city and state agencies concerned with licensing and inspection of nursing homes. She also acts as a consultant in standards of care to nursing home operators and persons planning new facilities. Her duties as a consultant to operators of nursing homes and homes for the aged are performed directly as a program of the division of health, but as such are also in line with the purposes of the information center.

The secretary handles most of the clerical-administrative detail in the office. She serves as receptionist and telephone operator, receives all requests for information—the majority of which come by telephone—and obtains identifying information before routing the request to the professional staff. She also makes many of the follow-up calls on inquiries.

TABLE 1.—*Persons Served in 1955, 1956, and 1957*

Year	Patients, No.		
	New*	Recall†	Other, No.‡
1955	744	7	479
1956	884	65	467
1957	824	63	582

* Patients known to center for first time.
† Patients who have received previous service from center.
‡ Requests for service not related to specific patient.

Files and records maintained in the center include a detailed individual request form on each patient for whom service is sought, giving diagnosis and health status, referral source, socioeconomic information, and other data; a monthly numerical check sheet summarizing data on all requests for service during that period; closed case records filed by type of disposition or placement; and yearly reports.

The center also maintains detailed records on chronic illness facilities and services in the community. These include an individual record sheet for each nursing home, boarding home, or home for the aged in Cleveland and card files on persons or groups wishing to establish these facilities, persons providing care for one or two patients only, hospitals, special health organizations, and other health and welfare agencies. Records are also kept of various institutes, conferences, and meetings on chronic illness, along with a general source file of information on the subject.

Services to Patients

Patients requesting help from the center are accepted for service without any detailed investigative procedures, except that any other agency which has had prior contact with a patient is contacted for clearance and pertinent data. The center has not carried on any intensive publicity campaign directed toward either patients or community agencies, although health and welfare agencies were informed of its functions. This policy was established at the beginning, when the advisory board felt that widespread publicity should wait until the center was well established and community facilities were more readily available in order to avoid disappointment when no ready solution could be suggested for a number of persons seeking service. However there was some newspaper publicity at the time of the center's opening. A brochure describing the center was published by the City Division of Health and the center, for general distribution, and articles have appeared in local medical and other professional journals from time to time. Other channels of information have been talks by center personnel to various lay and professional groups, participation in state and local conferences and institutes, one television program devoted to the chronically ill, and mention of the center's services in radio programs on health.

The center routinely follows up every request for services. Anywhere from 60 to 90 days after the original contact, the family or other person who referred the patient to the center is called to see what arrangements were worked out. To date, a solution which is satisfactory in varying degrees has been reported in about 60% of the cases.

The average inquiry to the center usually involves about eight calls—the original contact, calls from other members of the family, calls to physicians and social agencies, and the follow-up. In some cases, the number of calls has been as high as 20 to 30, and the center feels that this, among other factors, reflects a lack of coordination among the different agencies serving a particular person. Patients are referred to the center by their families, relatives, friends, hospitals, private physicians, public and private welfare agencies, attorneys and guardians, the clergy, and industry.

The number of patients and other persons seeking help at the center during a year's time has stabilized at around 1,200 to 1,400 during the first three years of its operation. During the calendar year 1957, a total of 1,469 patients or other persons contacted the center for service, an increase of only 3.7% over 1956. Sixty-three of these requests were recall cases or patients who had previously contacted the center for service, and 582 were requests for service not related to an individual patient. Table 1 shows the number of requests for service

for the latest three years data was available, divided according to new and recall patients, and other requests not concerned with a specific patient. The large number of contacts in this last category is partly due to requests for information by the personnel of health and welfare agencies who were contacted by the center when it was compiling a directory of services for the chronically ill.

Of the 824 new patients referred to the center in 1957, more than 80% were 60 years of age or older, and the average patient age has been close to 75. About twice as many women as men have been referred to the center, a rate which has been relatively constant over the years of operation until the later part of 1957, when there was an increase in male patients. About 63% of the patients were widowed or single, 27% lived alone, and 38% lived with friends or relatives. Over the years of operation an increasing proportion of semiambulatory patients have been referred to the center, with a corresponding decrease in fully ambulatory and bedfast patients. There has also been some change upward in patients' ability to pay for frequently requested services. There was an increase of two-thirds in those able to pay $300 or more per month and a one-third increase in those able to pay from $200 to $300. There was no significant change in

TABLE 2.—*Characteristics of New Patients Referred to Center in 1957*

	Patients, No.		Patients, No.
Sex		Method of contacting center*	
Male	337	Phone	770
Female	479	Letter	161
Not recorded	6	In person	45
Age		Main source of income or support of persons referred†	
<20	3	Spouse	69
21-40	29	Other relatives and/or friends	161
41-60	91	OAA	29
>60	679	OAA plus relatives, OASI, etc.	27
Not recorded	22	Other public welfare	23
Marital status		Pensions (retirement, veterans, etc.)	99
Married	207	OASI plus savings, relatives, etc.	186
Single	134	Income from business, employment, or rentals	41
Widowed	395	Savings only	22
Divorced or separated	37	Capital assets, convertible property	68
Not recorded	61	Disability and employment insurance	23
Living arrangements		No income	1
Alone	223	Not recorded (source unknown)	43
With spouse	174		
With relatives or friends	310		
Boarding or nursing home	57		
Hospital	21		
Other institution	1		
Not recorded	39		
Degree of Disability			
Ambulatory	275		
Semiambulatory	339		
Bedfast	152		
Not recorded	58		

* Includes more than one contact by some patients.
† Most of the requests are for financially independent persons; plans for financially dependent are made by public assistance agencies.

the number able to pay $176 to $200 a month and a decrease in those who could pay $100 to $175 per month.

Table 2 shows the characteristics of patients newly referred to the center during 1957, by age, degree of disability, living arrangements, financial status, and other factors.

Needs of Patients

During the calendar year 1957, requests for nursing home, boarding home, or other institutional care accounted for 76% of all needs for service among newly referred patients. The next most frequent requests were for consultation with other

TABLE 3.—*Nature of Requests in 1957*

	New Cases	Recalls*	Total
Nursing home, boarding home, institution	627	38	665
Housekeeper, attendant, etc.	27	14	41
Information re facilities and Resources			
Sheltered or home employment	5	1	6
Financial assistance	64	8	72
(Referred to agencies: 21 new, 2 recalls)	34		
Wheel chairs, hospital beds, etc.	5	0	5
Rehabilitation services	18	1	19
Medical & Dental care	145	8	153
Free or cheaper medicine	8		8
Housing	49	0	49
Transportation to clinics	2		2
Recreation and companionship	52	15	67
Day care (custodial)	5	1	6
Restaurants serving special diets	0	0	0
Miscellaneous procedures, legal advice, camp, etc.	114	4	118
Information re a specific facility	111	23	134
Consultation with:			
Agencies' staffs, clergy, lawyers, personnel directors in industry, etc. (where these persons take responsibility for advising regarding care)	212	0	212
Prospective operators of nursing and boarding homes	93	0	93
Counseling, where center assumes responsibility for providing information, advice, and referral services for care of individual patients (Frequently involves consultation with physicians, agencies, and others concerned)	675	0	675
Total†	824	63	887

* Persons previously receiving service from agency.
† All cases reported are kept open for a minimum of 60 days when a follow-up call is made. If additional service is needed the case is continued as long as necessary. No case is closed until a decision has been made regarding the care of the patient. Cases listed as recalls are those which were closed after a solution had been reached and a change of situation brought further request for service. During the time cases are kept open there may be frequent requests for additional information. While these are indicated on the case history, no separate count is kept of them.

agencies and individuals regarding care, for information on a specific facility, and for consultation on standards of care from persons planning new nursing or boarding homes. Table 3 shows the nature of requests for service received by the center during 1957, divided according to new and recall contacts.

Requests for service to patients come to the center from the patients themselves and their families, hospitals, friends, private physicians, private and public welfare agencies, clergy, attorneys, guardians, and industry, in roughly that order of frequency.

The community facilities and services to which patients are most frequently referred have been nursing and boarding homes. Other referrals have been to homes for the aged, physicians, private casework organizations, public assistance agencies, the Visiting Nurse Association, special health organizations, public and private employment agencies

handling nursing and/or attendant services, agencies providing homemaker service, chronic hospitals (through physicians), the Legal Aid Society, probate court, and agencies providing counseling on rehabilitation services, housing, or recreational programs.

Problems and Developments

In some three and one-half years of counseling, referral, and follow-up with patients, and contacts with other community agencies, the center has brought out into clearer focus a number of problems and future areas for action in meeting the needs of aged and chronically ill persons in Cleveland. The major problems yet to be resolved are summarized by the center as follows: (1) greater coordination and integration of service among all agencies serving the chronically ill and more flexibility in policies and services, particularly between general and chronic disease hospitals regarding their discharge policies; (2) additional nursing home facilities for male patients and for other specific groups such as Negroes of both sexes, persons with arrested cases of tuberculosis, younger persons from 18 to 30 and 30 to 50, physically disabled persons who are also alcoholic, mentally ill convalescent patients, mentally retarded children under 6 years of age, persons able to pay from $350 to $500 a month for care, ambulatory patients who require mostly sheltered living, and "in between" senile patients who are severely confused but do not require care in a mental hospital; a need for improvement of services in nursing homes generally, including better integration with hospitals and the entire community program for the chronically ill; related problems such as adequacy of public assistance payments for nursing home care and stronger action by state and local agencies regarding unlicensed facilities; (3) additional social casework and counseling services geared to the many problems accompanying long-term illness, such as dwindling finances, family attitudes, living arrangements, and the psychological impact of long-term dependency; (4) financial assistance for marginal income persons who are ineligible for public assistance but are unable to meet the full costs of care themselves; (5) additional services for chronically ill patients at home, including housekeeping, "meals on wheels," friendly visiting, rehabilitation services, and recreational activities, ideally provided through an organized home care program; (6) expansion of recreational services for chronically ill or aging persons, including some day care centers, and a visiting recreational or diversional service for persons at home or in nursing homes; (7) a method for insuring continuity of medical and rehabilitation services, from the hospital through the nursing home to the patient's own home, with additional special facilities or services provided as needed; (8) housing facilities tailored to the income of disabled older persons who can still carry on independent living; (9) more public education regarding the facilities available and the additional services needed for the chronically ill; and (10) increased participation by private and public agencies, particularly the latter, in financing care for this group.

The progress which has been made in each of these specific areas is summarized by the center as follows:

1. A study of public health methods in Cleveland was made by the Cleveland Metropolitan Services Commission in 1957. Recommendations growing out of this survey include the merging of the Cleveland and other municipal and county health departments into a single agency and, pending such a merger, the appointment of a county coordinator for chronic illness and aging who would act as a deputy commissioner for all health departments (this position to be retained after the merger); strengthening the contacts between public agencies such as health departments and hospitals and private nursing homes to improve the scope and quality of services in the latter; and, finally, developing an over-all plan for the selective placement of persons needing long-term institutional care.

The Cleveland City Hospital has already been merged administratively with the Highland View Chronic Disease Hospital, and a similar step is being considered for the two county nursing homes. Great progress has been made in integrating the services of the general and chronic disease hospitals for patients with long-term illnesses. There are now sufficient hospital beds for such patients.

2. A number of nonprofit nursing homes and homes for the aged in Cleveland have or are planning to expand their facilities and scope of services. Specific projects include a new 150-bed nursing facility providing multitype services for both bed and ambulatory older persons under auspices of the Benjamin Rose Institute and integrated with its hospital and home-care services; the addition of 36 nursing-home beds and a rehabilitation unit to a Catholic home for the aged; a 39-bed wing for nursing care at the Lutheran Home for the Aged; the opening of a 26-bed facility for indigent terminal cancer patients and plans for expansion to a 100-bed facility; addition of 40 beds to the Jewish Convalescent Hospital; the addition of nursing home sections or wings to a number of homes for the aged; and tentative plans for a multiservice type nursing facility for Negro patients. There is proposed a 94-bed addition to one of the two county nursing homes. Since the information center began operation, licensed proprietary nursing home beds have increased from 910 to 1,210 in number. Some of these are homes with excellent standards; others do not have the quality of care desirable. The need for homes in the $300 to $500 bracket is rapidly being met. The Cleveland Center on Alcoholism is planning to develop a program for services to alcoholic patients in nursing homes.

Regarding the improvement of services in nursing homes, the information center, in addition to providing the consultation services of a public health nurse and a medical social worker to individual nursing homes, has cooperated with the state nurs-

ing home and county home associations in sponsoring two state-wide workshops at one of the state universities and two institutes at Western Reserve University, devoted to the care of older and chronically ill persons in institutions. The center also cooperates with the City Division of Health and the State Licensing Division in holding educational meetings for nursing home operators and on a committee for coordination of state and local licensing requirements, has arranged with individual operators for the consultant services of the welfare federation's nutritionist, and has developed record forms for exchange of medical information between nursing homes and hospitals' out-patient departments, in cooperation with the social service departments of the local hospitals. The information center is working with the Volunteer Bureau of the Welfare Federation to develop group activity programs and friendly visiting services for nursing home patients.

The center, the state licensing division, and local zoning and safety authorities are systematically obtaining information on any unlicensed nursing homes in operation and making efforts to either close or license these facilities.

3. A committee has been appointed by the Committee on the Chronically Ill to study the need and possible methods for providing additional casework services for chronically ill persons.

4. The information center and other departments of the Welfare Federation have been working with public assistance officials to promote financial aid to the marginal income group. The maximums paid by both Aid for the Aged and the County Welfare Department are presently inadequate for nursing home care, and there are continuing efforts to have these amounts raised.

5. In regard to organized home services for chronically ill and older persons, two agencies in Cleveland, the Visiting Nurse Association and the Mount Sinai Hospital, are planning to establish home care programs. The Benjamin Rose Institute is continuing its home care program, which is limited to older persons served by the institute. The Jewish Family Service Association has developed a program of homemaker-personal care services provided under the supervision of the patient's private physician and the Visiting Nurse Association and has expanded its friendly visitor service for older persons to include those in nursing homes.

6. Different groups and agencies in the community continue to develop and expand recreational programs for the aged and chronically ill. The two Jewish homes for the aged have these services in their day care programs, and the Golden Age Center, established in 1955, provides services of this type for many older persons who have some chronic disability. A group recreational worker has been employed jointly by the welfare federation and the Benjamin Rose Institute to set up programs in four homes for the aged, and the Catholic Charities Bureau has also provided such services in three of its homes.

7. The Visiting Nurse Association has added a physical therapist to its staff, to instruct nursing personnel in rehabilitation procedures which can be given in the patient's own home. The welfare federation and the health council have a joint committee on rehabilitation which considers the individual patients needs, the services available, and their use. The committee sponsored a research study in this area which is being conducted by the county chronic disease hospital.

8. A special Committee on Housing for Older Persons has been appointed by the welfare federation, and a one-day conference on this subject has been held. This committee has drawn up plans for establishing a 164-suite apartment-hotel unit for middle-income older persons who need semiprotective living arrangements with some supportive services and supervision. Western Reserve University will conduct a research study of this project, under a grant from the Ford Foundation.

9. Although there has been no formal program of public education regarding chronic illness, a number of individual activities and projects have contributed to this end since the center's inception.

In addition to the various activities mentioned previously, the information center has compiled and distributed a 108-page Directory of Services for the Chronically Ill of Greater Cleveland. The directory, published jointly by the Welfare Federation's Committee of Special Health Organizations and the Cleveland Academy of Medicine, lists over 200 Cleveland health and welfare agencies providing services to the chronically ill and gives information on eligibility requirements, fees, hours, areas served, and referral procedures for each. The Committee on Older Persons and the Occupational Planning Committee of the Welfare Federation has also published a directory giving the services available in the community for older persons. The Committee on Older Persons cosponsors an annual conference on aging with the Junior League, and programs on chronic illness have also been conducted at three of the recent annual health and welfare institutes.

Finally, the staff of the information center and that of the Welfare Federation Committee on Chronically Ill continue to give talks, prepare exhibits, and plan programs on the chronically ill and their care, directed toward lay and professional groups in the community.

Because of the division of the functions of planning and coordinating community care for the chronically ill (which are the responsibility of the Committee on the Chronically Ill) and those of direct information, consultation and referral services to individuals (which are the responsibility of the Chronic Illness Information Center), the center does not direct, conduct, or sponsor by itself a great many of the community programs or activities previously mentioned but cooperates with the Committee on the Chronically Ill and other organizations and agencies in the community in providing them.

Mr. YOUNGER. Thank you very much.

The CHAIRMAN. Mr. Rhodes?

Mr. RHODES. Mr. Chairman, I am strongly in favor of this bill because it promises to improve the health care of the aged, the chronically ill, and others while, at the same time, reducing the heart-sickening drain on private earnings and savings as well as on public funds for higher cost hospitalization.

I note that the bill would permit expansion of demonstrations and training of public health personnel by the States themselves and by the Surgeon General in cooperation with the States.

I will submit a statement later in these hearings concerning support of practical training in the university schools of public health to prepare physicians, nurses, and others to organize and administer such a program as is envisioned in H.R. 4998, the bill now before us.

You, Mr. Chairman and members of this committee, took the lead in enacting Public Law 85–544 which authorizes grants for comprehensive professional training in accredited schools of public health.

At this time I should simply like to ask the departmental witness, Mr. Jones, how the program of grants under Public Law 85–544 is progressing and to what extent you see need for a comprehensive, highly trained person in connection with the proposed Community Health Services and Facilities Act.

Mr. JONES. I would like to have Mr. Kimble comment on that.

Mr. KIMBLE. This legislation that Congressman Rhodes mentioned is now in its third year of operation. Under this legislation $1 million is authorized to be appropriated each year for grants to the schools of public health in the United States, of which there are now 12 accredited schools.

Funds that are appropriated are allotted among the schools primarily on the basis of the number of federally sponsored students that are attending such schools.

Our estimation of the progress of this legislation is that it is serving a useful need, that through these funds these schools have been enabled to increase their faculties to better provide training of a graduate nature for people going into employment in public health agencies both in the United States and foreign countries, that through these grants it has been possible for them to expand the type of curriculum hat they have been able to offer and to adjust this curriculum to the emerging and newer needs of public health such as we have been talking about here this morning.

In short, we feel it has been working out quite satisfactorily.

Mr. RHODES. Thank you, sir.

Mr. Chairman, I would like to ask Mr. Jones another question as to the cost of these programs. Whether we can afford it is a very important question. To answer it fully, we should consider whether we have the know-how and material resources in this country to do the job that we believe is necessary to be done.

Do you believe, Mr. Jones, that we can afford to ignore the human and national need for these essential services?

Mr. JONES. This is a concern of the American people. There is an increasing demand for attention to the problem of care of our older population. More and more, older people are becoming chronically ill who require nursing home care or some kind of health care

that is not now available in the individual home to a satisfactory degree.

I think the American people are waking up to this fact in a very serious way, to the point that they will require some kind of action. It is toward this developing and increasingly acute problem that this particular legislative proposal has been advanced by the administration.

Mr. RHODES. It seems to me that when we talk about cost we often ignore the waste of the real wealth of this Nation which is our human and natural resources. In the name of economy we often waste the real wealth without which all our dollars would be meaningless.

I think this is a job that needs to be done. We have what it takes in this country to do it. We should move ahead as rapidly as we can with the program which this bill has proposed.

Mr. JONES. We fully subscribe to that statement, which is a fine and eloquent presentation of the objective, Mr. Rhodes.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

Mr. Jones, on the tables that you inserted in the record it is my understanding that the ceiling is removed, the $30 million ceiling is removed, but the tables that are inserted are based on the $24 million that you have suggested as an overall cost.

On page 4 you inserted a table showing the allocation to States.

Mr. JONES. Yes, sir.

Mr. NELSEN. And is it my understanding that this is based on the $24 million figure first year?

Mr. JONES. There is a table there, sir, for a cost of $7 million.

Mr. NELSEN. I see. This is, however, a part of the total.

Mr. JONES. And that involves an increase of $5 million over the present $2 million.

Mr. NELSEN. Thank you.

Now section 5, page 8 of the bill. There is a reference here to construction of experimental demonstration health facilities.

In Minnesota the medical center at Rochester has done an extensive amount of research work on hospital construction with the idea of keeping to a minimum personal requirements and at the same time affording maximum care to the patients. Under the Hill-Burton Act it is my understanding that there is some limitation as to allocation of funds where the total hospital beds and population formula is used.

In this particular case we have patients from all over the world and all over the United States, and if that formula were to apply perhaps there would be no available funds in this particular case.

Does this take into account that fact?

Mr. JONES. This is precisely an illustration of what is intended by this particular provision of the bill, Mr. Nelsen. It is the feeling of the Department that when a new technique, a new idea for the delivery of services in hospitals and nursing homes is presented, which has merit in the judgment of the Surgeon General and his advisers and is of a kind which a community should not be expected to provide as an established traditional program, it should be thoroughly researched and then demonstrated. It is important for all the communities of the country, that these new ideas be developed in the hope that better methods and less expensive procedures can be devised for

the sake of all. Therefore, when a project of this sort is presented, this particular provision will make it possible for a grant to be made to cover this kind of cost rather than as a part of an on-going community program.

Mr. NELSEN. Another question.

In the event that there will be an allocation of funds for this particular type of research, would that detract from the total dollars allocated to the State of Minnesota?

Mr. JONES. That would have no effect on the on-going programs.

Mr. NELSEN. I see.

I recall attending the dedication of a hospital in a little community in Minnesota a number of years ago, and it seems that they had attempted to get some Hill-Burton funds but were unable to do so. They then went out with local subscription and raised the money and built a beautiful hospital and were remarking that the total cost was considerably lower; they did it on their own, and the standards they would have had to follow under Hill-Burton were so extremely stringent that actually they were doing the job almost as well with less dollars involved.

Now is it possible that some of the rules and regulations are too difficult for many communities, thereby exhausting the dollars available for the whole job?

Mr. JONES. We think not, Mr. Nelsen.

The rules and regulations have been designed to assure a standard of quality which would be required to deliver the kind of service that one would expect.

There may be local conditions that make possible an advantage in constructing other than under the standards, but insofar as the Hill-Burton program is concerned, these projects are approved at the State level. The standards were developed by the Public Health Service with the advice and guidance of persons skilled in architectural design and knowledgable in the field of hospital operation. But the standards are not extreme in any sense of the word, and are designed purely and simply to insure the quality of the finished product.

The actual responsibility for the design is a local responsibility; the standards are merely intended to assure a quality job.

Mr. NELSEN. Now, in another field under the provisions of the bill, would the Appropriations Committee be authorized, if it so desired, to appropriate and earmark funds especially for the purchase and administration by the States of vaccines to protect segments of the population which are not now immunized?

Mr. JONES. The answer is "Yes."

Dr. TERRY. Yes; such authorization would be included.

At the present time these grants to States are used for many different purposes relating to the particular health needs in that State at that time. And some are used for disease control and immunization programs even at this time, sir, and this would continue.

Mr. NELSEN. Now, is this true, both for the formula grants under section 314 and also for the project grants under section 316, or would we have to write into the bill specific language which would authorize the earmarking of appropriations, making special grants for the purchase and administration of immunization agents?

Dr. TERRY. My previous answer was with specific reference to the formula grants.

Since the language of the special project grant authorization refers generally to out-of-hospital community health services, I believe that it would permit grants to be made for projects relating to immunization programs. However, the proposed language is less flexible in scope than is the language amending subsection 314(c). In addition, the project grant proposal does not include a provision authorizing Congress to earmark portions of the funds for specific programs. In brief, I believe the answer to your qeustion is, generally, yes—but the answer is not as clear in the case of the project grant authority as it is for the formula grants to the States.

Mr. NELSEN. Thank you; no more questions.

The CHAIRMAN. Mr. Rogers?

Mr. ROGERS of Florida. As I understand it, all the features of the bill provide for a contributing State fund to the Federal grant. It is a matching fund system in all of the provisions of this bill.

Mr. JONES. Except for the special projects which are of a demonstration or general research character, Mr. Rogers. But the construction of facilities is exclusively a matching program.

Mr. ROGERS of Florida. Yes.

Now, standards for the construction of nursing homes and any other particular buildings you might build are coordinated, you say, between the State and yourself. The State would actually set the standards, but are coordinated with the Federal people as to what they feel would be minimum standards.

Mr. JONES. The Public Health Service actually issued a set of standards, and these were developed in cooperation with the State departments of health and with individuals who are expert in the field.

Mr. ROGERS of Florida. Is there a coordination between the Small Business Administration and FHA in the construction of these nursing homes with your standards?

Mr. JONES. I am sure there is.

Dr. HALDEMAN. Our standards of construction are minimum, and the vast majority of Hill-Burton projects that are built go way beyond these standards.

We work with FHA in development of their standards and development of their proposals. They have a little different problem, however, and under their program these standards tend to become the maximum. FHA projects usually are built precisely to the FHA standards—so we weren't able to gear in completely. However, the Small Business Administration and the FHA get a certification from the State Hill-Burton agency that there is a need for the facility, and I don't believe that they will make a loan in any case unless the State Hill-Burton agency has indicated that there is a need for the nursing home.

Mr. ROGERS of Florida. Is there any question but what standards will be met, minimum standards in the building of these nursing homes through SBA and FHA?

Dr. HALDEMAN. No; I have no concern on that point whatsoever.

Mr. ROGERS of Florida. There is no problem there at all?

Dr. HALDEMAN. No, sir.

Mr. ROGERS of Florida. One last question.

In the research program, in trying to find better ways for carrying out hospitalization and utilization of hospital facilities, I believe you

asked for removal of the statutory ceiling of $1,200,000 for these projects.

Mr. JONES. That is right.

Mr. ROGERS of Florida. How many projects do you have going on now in active research, and what is the money involved?

Dr. HALDEMAN. We have had a total of 74 research projects. Currently there are 35 active projects. The remainder have been completed.

Mr. ROGERS of Florida. And how much money is involved in that?

Mr. HALDEMAN. The ongoing projects amount to $5,196,000; 35 projects amounting to $2,511,000 are now terminated.

Mr. ROGERS of Florida. So there is still active over $5 million in research projects?

Dr. HALDEMAN. That is correct, sir.

As you know, a number of these will go on for 2, 3, 4, or even 5 years possibly.

Mr. ROGERS of Florida. Mr. Chairman, if you do not object, I think it might be helpful for the committee to have a breakdown of these research projects and who is doing them for the record.

Mr. JONES. That is one of the tables we referred to earlier.

Mr. ROGERS of Florida. Fine.

Now, what do you project that would be necessary to have an increase in this $1,200,000 annual expenditure? How much over the expenditure do you project as necessary?

Mr. JONES. We contemplate $4 million, Mr. Rogers, in 1962, and $4,100,000 in 1963, and then it goes up to $6,800,000 in 1964, and this is an increase over the present program.

Mr. ROGERS of Florida. And have you listed or have you compiled a result that you think is beneficial for the projects that have been concluded?

Dr. HALDEMAN. We have listed a bibliography of the research projects and have included a report of some of those which are specific that would indicate results.

I think there has been some very excellent research done with the limited amount of money available. For instance, through research on more effective organizational patterns, the progressive patient care concept was developed. This is a new method of organizing hospital services according to the medical needs of patients which is really sweeping the country. I think it is responsible for the development of more effective utilization of existing personnel and for raising the quality of care.

We have had a number of research projects that are aimed at developing better coordination of health services in communities. One of our greatest difficulties in this country is in the organization of health services where there is a lack of coordination between long-term and short-term care facilities and the like.

We have had a number of projects designed to improve the operating efficiency of hospitals. Some of them have been going into automation and a variety of things of that nature.

The last big group of projects are aimed at improving the design of the hospital plant. We have developed design material relating to the various elements of progressive patient care, recovery rooms, nursing units, and other such services.

Mr. JONES. Mr. Chairman, before Mr. Rogers asks his other questions, we would like permission, if satisfactory, to insert a statement in the record about hospital research and demonstration beyond that which we have already asked for permission to insert, which will answer many of the questions Mr. Rogers is raising.

The CHAIRMAN. Very well, it will be received.

(The document referred to is as follows:)

HOSPITAL RESEARCH AND DEMONSTRATIONS

THE HISTORY AND DEVELOPMENT OF THE CURRENT RESEARCH PROGRAM

The physician and the hospital are partners in providing health care to people. In one very important aspect the development of hospitals has lagged behind the progress made in medical practice. Hospital research today is in the same position as medical research at the turn of the century. It is still trying to classify, to delineate, and to define its boundaries. Though primarily in the observational state, hospital research is beginning to make progress assisted by developments in the fundamental sciences. This progress, however, would be accelerated if it were possible to delineate the hospital's goals in more specific terms.

It is the purpose of this paper to describe—

(1) The nature of these goals, the scale of operation, and dilemmas of the contemporary hospital;

(2) The nature and definition of hospital research; and

(3) The different areas of hospital research which should be emphasized.

The contemporary hospital

The contemporary hospital is a complex institution containing many skills and resources for assisting the physician in his care of the sick. Like other contemporary institutions, the hospital has been affected by scientific, technological, economic, and social developments.

As medicine increases in complexity, medical practice becomes more closely organized around the hospital as a service agency. Hospitals must recognize this trend and strengthen their relationship with physicians. They must provide physicians the opportunity to participate more effectively in hospital planning. This can be done without disrupting the traditional pattern of hospital organization and without interfering with the physician's traditional role of being the final authority on the care of the individual patient. The art of medicine must not be lost in the process of developing the optimum environment for the practice of the science of medicine. The hospital has become essential for the proper care of major illness, for treating patients with safety and convenience, for clinical research, and for the practical education of future physicians. Thus in the public mind today hospitals and the physicians' services are interwoven.

Goals of the contemporary hospital

The goals of a hospital as commonly defined are—

(1) To assist the physician in the care of persons in the community suffering from illness or disability;

(2) To carry on educational activities and scientific research related to the care of the sick and the injured; and

(3) To promote the general health of the community.

To these should be added the goal of creating a physical and administrative structure which facilitates the provision of the optimum in medical care and the prevention of disease.

Such aims do not provide sufficiently concrete yardsticks to measure either the extent or means by which these objectives are realized. "* * * care of persons in the community suffering from illness or disability" does not imply that facilities are sufficient to eliminate disease or illness—an obviously impossible task. The amount of services provided depends on what the community is willing and able to spend. Good health within limits is purchasable. The degree to which the attainment of this goal is desired is the question facing every community. Scarcity of available resources must be considered along with the question of whether optimum use is being made of the resources available.

Decisions are made in terms of alternative application of given resources. The task still remains to compare the results attained by different courses of action.

Scale of operation

Hospitals today are a big and complex business. The nearly 7,000 hospitals, containing more than 1.5 million beds, occupied by 24 million patients annually, employ nearly 1.5 million workers. Hospital service constitutes one of the 10 major service industries in the United States involving a payroll of $4.7 billion and a plant valued at $12.7 billion with each bed representing a capital investment of $8,100.

More than one-half of the Nation's hospitals are voluntary nonprofit institutions. These have about 30 percent of the beds. One-third of the hospitals and two-thirds of the beds are owned by governmental agencies. Most of these, however, are State institutions providing care for mental patients. There are many small proprietary hospitals operated for profit (about 15 percent). These have less than 3 percent of all beds. About 60 percent of the hospitals in the country have less than 100 beds. For every hospital having 300 or more beds there are 4 having less than 100 beds. These facts merely emphasize the diversity of ownership, size, and types of institutions which constitute "the hospital."

The dilemmas of the contemporary hospital

Hospitals function within the interplay of many varied social and economic forces. These result in an unending cycle of change and adjustment and pose constant dilemmas of planning and management. Some of the more important examples are:

(1) The complex interrelationships between physician, patient, and hospital organization.

(2) The conflict between institutional efficiency and the individual needs of the patient.

(3) The increasing gap between the pressure to apply the advances in technology and medicine and the ability to finance their implementation.

(4) The growing tendency for unnecessary duplication of facilities and services, particularly in urban areas.

(5) The difficulties of obtaining maximum utilization from relatively inflexible physical and administrative structures.

(6) The need to find new patterns of care and more flexible ways of assuring continuity of care.

(7) The spread between increasing hospital personnel costs and inability to make up the difference in gains in productivity per hospital worker.

(8) The problem of developing teamwork among the professions involved in patient care within hospitals.

(9) The problem of maintaining an atmosphere conducive to the practice of the "art" of medicine in the presence of the very complex hospital administration which is devoted to assisting the physician in practicing the "science" of medicine.

Hospital research—the nature of its setting

The scientist in hospital research is interested in creating the most efficient setting for assisting the physican in restoring the sick to health. He is interested in medical research from the standpoint of the changes it promises for the hospital in physical structure, equipment, and staff relationships. Yet he may regard medical research as a significant but perhaps an unstable part of a total picture which encompasses the hospital in its entire cultural, economic, and social setting. He is not only interested in optimum means of delivering care to patients, but also in studies of administrative behavior.

Over the years, contributions to improved hospital operation have come from disciplines in which the hospital is not a direct concern. Studies in the social breakdown of cooperation apply to the problem of the community acceptance of a hospital. Psychological studies on levels of aspiration suggest means of dealing with the problem of hospital personnel shortage. The cross-cultural study methods used in anthropology may aid the student working on the vexations problems of society's attitudes and behavior toward hospitals. Ultimately, basic studies in physics, engineering, biology and sociology, as well as those in demography, the behavioral sciences and economics, will be of importance to hospital planning. The relation of the findings in these disciplines to hospital research may be remote, may be direct, or may merely consist of analogy to similar hospital situations.

Moreover, the simple question of obtaining useful numbers cannot be overlooked. Demographic, economic, morbidity, mortality, population, and social statistics provide in addition to hospital statistics the data most frequently useful in hospital research. The demand of hospital administrators for such facts illustrates their importance. Facts by themselves, however, tell us little. Only as we arrange them can we arrive at generalizations from which to plan.

In perspective, it becomes apparent that there is probably no "hospital science" as such just as there is probably no "medical science." The electric body of knowledge which is emerging under the name of "hospital research" or "medical science" is based on discoveries in the more fundamental sciences and the application of their methods to the problems of the hospital.

Current hospital research

Current hospital research is concentrated in four major problem areas:

(1) The development of new patterns of organizing patient services;

(2) The development of more efficient hospital practice, such as improved methods of operation, personnel procedure, and functional efficiency of the hospital including structure, layout, equipment, and administrative organization;

(3) The development of better means of evaluating the quality of patient care;

(4) The study of factors which affect health of people, hospital use, the nature of the patient load, the services needed, and the cost and means of financing patient care.

The studies cited below illustrate current research in the four major problem areas.

Studies devoted to new patterns of organizing patient services cover such areas as: (*a*) Progressive patient care with its philosophy of tailoring hospital services to the medical and nursing needs of patients; (*b*) patterns of coordinating hospital services with other community services, with small rural hospitals, with larger hospitals and medical schools, and within the community between the general hospital and other types of institutions, both hospital and nonhospital, which provide long-term care; (*c*) the organization of physician's services within and outside of the hospital and its effect on efficient use of professional and patient time.

The problems of obtaining the best use of expensive equipment and facilities in densely populated areas are being studied with the view of eliminating unnecessary duplication. This has taken the direction of seeking means of organizing planned cooperation among communities within a region and better mechanisms for achieving sharing of services, and for providing for continuity of patient care between institutions.

The relationship between voluntary and publicly owned hospitals and the problem of arriving at principles which will enable each to provide the community with improved services is another aspect of organizing new patterns of patient service.

Research into the development of more efficient hospital practice has covered a rather wide area. Some studies seem primarily to be concerned with improvement of methods and work simplification. These have included studies of (1) business records; (2) the problem of congestion in waiting rooms and in outpatient clinics; (3) the indexing of medical records; (4) systematic organization of information on blood and tissue banks; (5) the legal aspects of hospital operation; and (6) improved techniques of inservice training. Related to these are a series of studies concerned with personnel need involving (1) training of personnel; (2) upgrading through training of paramedical hospital personnel; (3) better means of recruiting; and (4) training personnel in short supply.

Other studies are concerned with hospital design, hospital engineering, and hospital equipment in terms of (1) safety; (2) functional layout; and (3) more efficient operation. Special hospital functions studied have been (1) recovery rooms; (2) the oxygen supply to patients' rooms; (3) hospital communication systems; and (4) the control of fire and explosion hazards.

Interpersonal relationships between staff members in a hospital and their influence on patient care have not been overlooked. Some studies have been concerned with stressful situations and their consequences on patients' responses to hospital care.

Improving the selection of students entering graduate training in hospital administration has been explored through studies which attempt to correlate characteristics of success in hospital administration. Attention has also been given

to studying the complex authority structure of hospitals and the kind of organization best suited for attaining the goal of optimum patient care.

Evaluating the quality of patient care has been a sticky problem. One study proposes to establish minimum standards of quality and efficiency for evaluating the practice of internal medicine in hospitals. This is being carried out through a survey of a number of hospitals to determine existing practices. From an evaluation of these findings, it may be possible to establish desired performance standards. Other studies have aimed at developing instruments capable of measuring the quality of patient care. This involves creating measurable criteria for evaluating such care. There have also been attempts to determine how patients can benefit from particular kinds of services and to what degree, especially in rehabilitation, long-term and outpatient care. The inadequacy of criteria by which to judge quality of care has led to an attempt to find characteristic levels of frequency for various clinical procedures as a basis for identifying quality of care.

Factors which affect the health of people and consequently hospital use influence both the patient load and services needed. Studies in this area are probably the most numerous. Concern with the number and distribution of hospital beds has led to studies in depth on factors which influence use, the nature of hospital programs and services needed, and their consequent effect on health levels. Among some of the factors studied have been morbidity rates, demographic and population characteristics, methods of financing hospital and medical care, the effect of changes in incidence of diseases on patterns of hospital use, and the social, economic, pyschological, and cultural characteristics of hospital users. More old people in our population, and the consequent need for providing health and hospital care for the ill aged, have led to studies of the needs of such patients, and how they may be met through inpatient and outpatient facilities, home care, convalescent care, nursing homes, and chronic disease facilities. Concern with the rise in the cost of hospital care has led to studies exploring such influences on hospital use and hospital costs as the physician, method of coverage, patient demand, and social and economic factors.

A definition of hospital research

Despite the fact that the operation of a hospital is a complex function, there are several unique characteristics which may be considered common denominators. Some examples are:

(1) The division of authority between (*a*) the physician who makes the final determination concerning the care of the individual patient, and (*b*) the hospital management responsible for planning and organizing hospital operation.

(2) The general and ambiguous nature of hospital goals which has resulted in differences in interpretation and methods for their attainment.

(3) The tendency for the hospital's role to be influenced by numerous external forces (i.e., social, economic, and cultural).

(4) The necessity of foregoing a specific goal if, in its execution, there is a conflict with still another objective. (For example, one goal may be the efficient economic operation of a hospital which is often in conflict with the goal of providing the highest quality of patient care.)

Because hospitals have their wide variations, it is important to recognize that generalizations resulting from research only hold true for certain types of institutions. Nevertheless, it is important to emphasize that certain influences, such as those noted above, can be described and are predictable.

Hospital research can be defined, then, as research on the conditions under which hospital goals are formulated and changed, promoted, or hindered.

Hospital research, as we see it, is the application of scientific method to resolving administrative and operational problems besetting hospitals and to developing specific techniques and methods for improving the capacity of hospitals to meet their responsibilities to their patients and to the community.

The elimination of bottlenecks which stand in the way of optimum patient care, the development of more efficient methods of patient care, the improved design of physical plants, the more effective coordination of community health resources—all these are aspects of hospital research. Since such research seeks greater efficiency, it has an obvious bearing on hospital costs.

Hospital research is clearly distinguishable from medical research, but, at the same time, intimately related to it. New knowledge of human diseases, new therapies, new cures can be employed with optimum effectiveness only if the environment in which they are applied is itself efficient. The hospital is the

environment in which new therapies and new cures are most frequently employed.

Basic hospital research

A systematic approach to the solution of hospital problems depends upon the development of more precise research tools, including classification, research techniques, design of experiments, procedures and methods of research. These in turn depend on research developments in other sciences basic to medical and hospital research. Developments in biology, the social and behavioral sciences along with medical advances influence the hospital. For example, the stability and even the existence of a hospital or health facility as an institution may depend upon the exceptations of members of community groups, as well as others far removed from the immediate institution who may influence it. Insofar as behavior can be accurately predicted, it forms a part of the influence on the hospital as an institution, especially when translated into goals, structure, equipment, facilities, program, services, and administrative organization. Hospital research will in the long run benefit from progress in other sciences. We may find that more certain progress can in the long run be achieved through comparatively greater financial support to promising theoretical and fundamental studies than will be achieved by an equal financial support of applied research.

Applied hospital research

Applied research is directed toward practical application of scientific method to specific problems of a particular field, area or institution. It seems, chiefly, to furnish reliable data on which to base decisions concerning practices, actions and programs. A perceptive investigator adapting the research tools of the social sciences, numerical analysis, statistical methods or operations research may demonstrate the value of systematically approaching the testing of existing practices through well-defined experiments which are verifiable through independent repetition. A. J. Simon, for example, has tested the relative effectiveness of two clinic systems using a measure of patient improvement as his criterion. A group of patients cared for in a comprehensive medical clinic represented the treatment of choice for the type of patient described, when compared with a matched control group which remained in the prevailing clinic system.

Development research in hospitals

Developmental research in hospitals involves the development and testing of materials, hospital techniques, systems, procedures and methods specifically applicable to hospital practices. Mark S. Blumberg, for example, is evaluating the potential of automating a wide variety of hospital activities by introducing various automatic devices into hospital activities and selecting the three or four most promising activities for study in detail to determine their economic and technological feasibility. The study is designed to develop information on types of currently available equipment worth adapting to hospital use, technically possible equipment worth developing for special use in hospitals, and the types of data needed to ascertain the likelihood of successfully developing automatic procedures in other hospital activities.

Demonstration projects in hospitals

It is not the purpose of hospital research to provide service but rather to produce a body of verifiable knowledge which can be generalized. Demonstrations, on the other hand, are deliberately service-oriented. They are directed toward more localized and specific purposes, usually to demonstrate on the basis of verified knowledge, how a particularly practice or service can be carried out. There can be demonstrations whose values are so apparent that the need for proving the worth of the procedure is not necessary. The purpose of the demonstration is primarily one of introducing into the setting the necessary procedures under controlled conditions so that the staff may learn to carry them out correctly and the procedures and new types of personnel needed may be incorporated into an organization which has had no previous experience with them. There is always in the background the implication that the project is of limited duration. It is usually expected that once the procedure is established it will be absorbed within the organization's regular budget. A demonstration also serves the purpose of a model. Others become aware of it, visit the institution, and tend to introduce the procedure or program and to adapt it to their own setting.

Another type of demonstration involves techniques and procedures which have been developed and tested in limited situations or only in "pilot" form. The purpose of the demonstration may be to test the procedure under a variety of working conditions in which controls are introduced, to test the effect of variations in administration, organization, structural design, economic feasibility or similar variations on the utility of procedure. Such demonstrations imply strict experimental control.

Development of training in hospital research

Fundamental to long-range progress is the need for investigators who are well trained in conducting research in the problems of the hospital. Other research specialists can contribute much to the development of hospital and health facility research. They must, however, be given more opportunity to become familiar with hospital operations if the more critical problems are to be studied. Hospital administrators with inquiring minds and a dissatisfacton with the status quo must be provided with a knowledge of research methodology and experience with research problems. Present training reseorces for producing such investigators are scarce. Training now offered in most schools of hospital administration neither attracts nor trains research-minded people. Many universities have resources which can be organized into multidisciplinary programs, including hospital research. Thus, students can be provided with research training.

The development of Federal support for extramural hospital research

Historically, hospital research has primarily dealt with improving hospital practices. Since hospital practices were largely dependent upon prior discoveries in other fields, improved practices in hospitals tended to await these discoveries. Modern hospitals are responsible to Morton for anesthesia; to Florence Nightingale for modern nursing; and to Pasteur and Lister for antisepsis, asepsis and modern sanitation. Nevertheless, earlier investigators were concerned to with the conditions which promote or hinder hospital service. During the regime of Louis XVI, Tenon's study of the hospitals of Paris which pointed to the desirability of single beds for patients, is in the tradition of modern hospital research. It was Florence Nightingale, however, some 60 years later, who truly set the pattern for modern day hospital research, as a result of her criticisms of existing hospital systems and her suggestions for improving nursing, hospital management, and construction. Except for the discoveries in bacteriology, which paved the way to combat hospital sepsis, the basic lines laid down by Florence Nightingale have continued.

Prior to 1920 the major concern of persons active in the hospital field appeared to have been the extension of hospital services to patients and the development of minimum standards of services. Changes from these standards came into being as a result of the Flexner report on medical education.

After 1920, concern arose about the number and distribution of hospital beds needed in relation to services. In 1921, the Public Health Committee of the New York Academy of Medicine published results of a year's study of 180 nonprofit general hospitals in the greater New York area. This study was one of the earliest formal attempts to determine need for general hospital beds. It also recognized the need for a central agency to coordinate the use of hospital beds within a specific population area.

Closely related to the question of bed needs, was the problem of where to put them. There were some who felt that "one large hospital in a community can do the job better and more efficiently than several small ones." This led to studies on the methods of measuring bed needs and the development of bed-population ratios. Concern with measuring bed needs lead to attempts to relate levels of hospital utilization and the distribution of beds to bed needs. The factors considered were broad and explored the conditions which affect the evelopment of a hospital. Some 30 groups of factors can be listed from the literature. These range from the availability of physicians and professional personnel to the characteristics of the population served. Despite the voluminous literature, the index reference to "research as a hospital function" in "Hospital Care in the United States," the important postwar study conducted by the Commission on Hospital Care, refers only to clinical research.

It was not until 2 years later that legislation was introduced "authorizing the Surgeon General to conduct and make grants for the conduct of research, experiments, and demonstrations relating to the effective development and utilization of hospital services, facilities, and resources and to promote the coordination of such experiments and demonstrations and the useful application of their

results." Curiously, testimony at the time emphasized the coordinated hospital system as the chief means of improving the quality of hospital and medical care. Smaller institutions were to be affiliated with, and obtain services from, the larger hospitals. This legislation, passed in 1949 became Public Law 380, 81st Congress, which authorized a grant ceiling of $1,200,000 annually for hospital research.

To date 201 applications for extramural research have been received requesting approximately $25 million in funds. The total grant appropriation available to date for research, experiments, and demonstrations in the hospital area has amounted to only $7.2 million. As of this date, 74 projects in the amount of $7,690,056 have been activated under this program. Thirty-five of these projects, amounting to $2,511,136 have been completed. The 39 "on going" projects amount to $5,178,920. Although the program has been in operation for a little more than 5 years, some significant contributions have resulted already.

Studies on progressive patient care have explored means of fitting hospital services to the needs of a paticular patient's illness. An analysis of the organizational structure necessary to provide effective coordination of hospital, health, and welfare activities in Puerto Rico has provided useful information on the organizational problems which occur when a new organizational structure for providing health services is evolved. A hospital-use study has shown that the persons with comprehensive coverage use hospitals less than persons having hospital coverage only. Comprehensive coverage apparently encourages more efficient use of hospital facilities. A study of the legal aspects of hospital operation has resulted in the publication of a legal guide for administrators and the formation of a new health law center, the first of its kind in the Nation. A study of the improvement of hospital services by the American College of Physicians limited to the practice of internal medicine in hospitals has resulted in a guide for hospital medical care appraisal committees.

A national survey and analysis conducted by the Joint Blood Council resulted in the development and publication of standards for collecting, storing, processing, and distributing whole blood and its derivatives. Further, this study has provided, for the first time, complete nationwide information on blood, tissue, and mothers' milk banks for use under both normal and disaster conditions.

A methods improvement study conducted in various hospitals resulted in both dollar and man-hour savings. Guidelines for the initiation and conduct of similar programs using work simplification and other techniques are to be made available to other hospitals.

Outpatient studies have led to the development of guidelines clarifying conditions under which optimum use can be made of emergency room facilities. Additionally it was demonstrated that hospital staff attitudes directly affect patterns of patient usage of outpatient facilities.

A curriculum study has demonstrated the practicability of interdisciplinary postgraduate training in health facilities research. The first doctoral graduates of this 31-year program are to be graduated in June 1961. These students are prepared to design and conduct independently advanced studies, research and experiments in the field of hospital and medical facilities utilization.

A study of personnel systems and methods as they apply to the hospital situation has shown that use of suggested procedures can substantially reduce turnover which is one of the more costly problems faced by hospital administrators. One study has assessed the potentials of automation in increasing the efficiency of hospital services. This assessment has been prepared for publication together with data on types of equipment available. A study is currently projected toward development of model specifications and guidelines for the construction of children's medical centers and facilities in general hospitals.

Future goals for Federal extramural hospital research

In analyzing existing hospital research, irrespective of the source of support, one is impressed by the scope and range of projects underway. Nevertheless, it is clear that a tradition and literature of hospital research must be created if we are to bring to bear on the problems of the hospital the methods and skills inherent in the scientific approach. Much hospital research consists of fact-finding primarily concerned with relating measures of level of health of given populations, to need, use, and availability of health facilities. The work is of a survey nature designed to extract from a mass of facts the forces which influence hospital use and patient care.

Some well-designed studies are concerned with interpersonal relationship and with the social, psychological, and economic factors which affect hospital prac-

tices and patient care. There is concern with better means of financing hospital and health care. Some excellent, critical reviews of the literature of financing health care have led to some economic and social analysis.

Nevertheless, hospital research is still characterized by a lack of well-designed studies which promise results upon which to develop broadly accepted generalizations. This stems from the fact that hospital research needs to develop trained research people who will create new research tools which can be applied to hospital problems. We need also a more systematic approach to hospital research which will emphasize guidelines and priorities for the kinds of hospital research needed. These are vital if we are to make best use of the sums presently available and lift the quality of hospital research.

The dissemination of research results

Fundamental to the dissemination of research results is systematic knowledge of the kinds of hospital research which are being carried out and knowledge of where it is published so that those interested may gain access to it. There has been to date no systematic abstracting of hospital research. The Health Information Foundation has published for the past seven years "An Inventory of Social and Economic Research in Health." The American Hospital Association has just begun to publish "The Hospital Planning Abstract Service," a service aimed at providing "concise summaries of what is appearing in journals, in reports or in any published form * * * pertinent developments in planning, financing, design and construction of hospitals." The abstracts are apparently not to be limited to research reports but are to include surveys, inventories of facilities, evaluations of Government programs, trends in design and construction and trends in medical education and medical practice which affect future hospital planning. Although there may eventually be a need for an abstract service solely confined to hospital research, the most immediate need is for more explicit interpretation of results of hospital researchers so that findings could be more readily adapted by the practitioner.

The national outlay for hospital research

The annual outlay for hospital research from all sources needs to be increased. Neither the total volume, full range of subjects, nor complete monetary value of all ongoing hospital research is known. Some joint approach should be established for determining the magnitude of the annual expenditure on hospital research, irrespective of the source.

It has been estimated that not much more than $3 million is spent annually on hospital research. This is to be compared with a research expenditure in industry totaling some $6.5 billion annually. The aircraft industry alone spends $2.1 billion, the electric industry $1.2 billion. The total medical research expenditure is about $700 million annually. In an area in which there is an annual expenditure of $8 billion on patient services, and which has a capital investment of at least $8,000 per bed, an annual expenditure of one-half of 1 percent for research does not appear excessive. The pharmaceutical industry spends from 3 to 5 percent of its total sales for research. An expenditure of one-half of 1 percent of the annual expenditure for hospital services would amount to about $40 million.

Mr. ROGERS of Florida. Could aid to migrants be given under this bill in particular communities where the impact is felt by that community because of migrant workers?

Mr. JONES. We have a separate bill, Mr. Rogers, on health services for migrants.

Mr. ROGERS of Florida. I realize that, but I wondered if they could perhaps be included.

Dr. TERRY. Mr. Rogers, I think the point is that this bill is basically speaking for facilities. Obviously, you can't render care without proper facilities whether it is for public assistance programs or for whatever type of clientele it may be, migrant workers or whatever.

Certainly this bill would help to establish the basic service facilities from which to render medical care in whatever respect it was needed.

Mr. ROGERS of Florida. Thank you.

The CHAIRMAN. Mr. Keith?

Mr. KEITH. No questions.

The CHAIRMAN. Mr. Curtin?

Mr. CURTIN. No questions.

The CHAIRMAN. Mr. Dominick?

Mr. DOMINICK. I have a number of questions.

I just wonder whether you are going to ask this witness to come back tomorrow or try and make these as brief as I can and let me proceed now.

The CHAIRMAN. If we could conclude today, it would certainly be helpful to the committee.

Mr. DOMINICK. I would like to start by saying in this initial presentation there is an implication that there is something wrong with having too many older people, and it seems to me, rather than saying that there is anything wrong with this, we should be quite proud of it as it means our health situation has rather vastly improved recently. The mortality rate is down and our length of life is longer, which is good rather than bad.

It does bring problems with it, as you have said.

Now in the process of this statement you have also said that there are 11 million people who have some type of chronic health problem; 6 million of them are limited in their daily activities.

Do you have the date of that national health survey? Do you also have any breakdown of where those people are located which you can give me?

Mr. JONES. I think we do have it here. If not, we can provide it for you, Mr. Dominick.

While we are searching for it I would like to endorse your comment.

The CHAIRMAN. Talk a little louder, please.

Mr. JONES. I would like to endorse very much the comment that Mr. Dominick has made.

We are quite proud of the progress made in our medical care program which has greatly extended life expectancy.

We hope now that, through medical research and these other programs that you are familiar with and are authorizing from time to time, to do a great deal more in the years ahead.

Mr. DOMINICK. Mr. Jones, I happened to serve for——

Mr. JONES. We will provide the information for you, Mr. Dominick. It is in the national health survey.

(Note.—The date of the survey was July 1957–June 1959. The survey data are not broken down by State.)

Mr. DOMINICK. Thank you.

I happened to have served for 4 years on the community mental health clinic in my own State, on the board, and was instrumental in getting it started.

Would this also include that type of clinic, that type of facility? This program?

Mr. JONES. It could, yes.

Mr. DOMINICK. Is it designed to do that?

Mr. JONES. It is designed to include nursing home facilities of all kinds and to improve the care in hospitals and nursing homes of all kinds.

It is not specifically designed for mental health, but certain mental health cases can be appropriately taken care of in a nursing home

type facility. That would be quite within the purview of this program.

The CHAIRMAN. Will the gentleman yield?

Mr. DOMINICK. Yes.

The CHAIRMAN. It is not a part of the mental health program, though, as authorized by the Congress a few years ago.

Mr. JONES. No, sir.

The CHAIRMAN. So, then, it would only be applicable to mental health cases insofar as they could obtain approval for entering nursing homes where that condition might exist?

Mr. JONES. That is correct.

The CHAIRMAN. And it is not primarily a mental health program and it does not in any way amend the mental health section of the Public Health Service Act?

Dr. HALDEMAN. Many patients, as you know, in mental hospitals could perhaps be more humanely cared for in nursing homes. A number of the States have developed nursing homes that care for this type of patient who might otherwise be in a mental hospital. I don't think, however, that you can actually plan for separate mental health beds in long-term care facilities of the nature we are talking about here. In some States you have a lot of your mental patients who are confused in nursing homes, and in other States these patients are kept in mental hospitals. In general, we feel that the large State institutions should not be used for the senile, older patient who is confused. We should be caring for more of them in nursing homes or organized home care programs.

The CHAIRMAN. I understood Mr. Dominick had in mind mental health patients and not senile patients.

Is that true, Mr. Dominick?

Mr. DOMINICK. It is true.

Mr. JONES. These facilities are not designed for the mental health cases as such.

Mr. DOMINICK. Just a couple of more questions, Mr. Chairman.

On pages 4 and 8 rather sharp criticism is leveled at capability and efficiency of the nursing homes. Do you have any idea how many beds are now made available by proprietary nursing homes?

Dr. HALDEMAN. The last national inventory—and we are making another inventory at the present time—showed that there were 25,000 homes with approximately 450,000 beds. This includes all types of homes ranging from those providing shelter only up to those providing skilled nursing care.

The number at that time providing skilled nursing care was only about 7,000 although at the present time this number has increased substantially.

Mr. DOMINICK. What was the date of that?

Dr. HALDEMAN. 1954.

Mr. DOMINICK. It is true, is it not, that this has been substantially increased in the last 5 years?

Dr. HALDEMAN. Yes, that is correct. At the present time, according to the Hill-Burton State plans, we have 181,000 acceptable skilled nursing home beds. That is an increase from 113,000 in 1958.

Mr. DOMINICK. It would occur to me that as a part of this program, one of its side effects might be to put out of operation these proprietary nursing homes because it seems perfectly apparent that if a person can get cheaper service at one of these community, nonprofit organizations, they are not going to go to the other.

Have you made any estimate of the possible effect this might have on the overall beds that might be made available?

Dr. HALDEMAN. The total overall need for nursing beds is so great that there is going to be a continuing need for proprietary as well as public and nonprofit.

In other words, the need is so great that a large group of our aging population will continue to be served by proprietary nursing homes. Presently the total number of beds in the country that are proprietary is over 70 percent. So they are providing the major portion of nursing home care at the present time, and I would anticipate that it would continue.

Mr. DOMINICK. In other words, you don't think this would have an impact on their ability to keep in operation?

Dr. HALDEMAN. In general I would say no, although, as you very well know, many of our proprietary homes are in substandard facilities; not that the owners of these homes are not trying to do the best possible job they can, but the payments that are available through public assistance and for other reasons, they are not able to provide the kind of care they would wish.

I would not want to say it will not have any impact. I think that we will see more and more hospitals becoming sponsors of nursing homes and I think this is a desirable trend because you get much better coordination of your hospital and nursing home services where they are operated by the same sponsor.

Mr. DOMINICK. Do any of the tables which you have supplied or you are about to supply give a breakdown of where you think the need is most acute by States or by localities?

Dr. HALDEMAN. Yes, sir, we can supply a table showing the number of beds in existence and the needed beds by States.

(The information referred to follows:)

Long-term care beds in the United States, as of Jan. 1, 1961,[1] according to approved State plans under title VI of the Public Health Service Act

	Existing beds		Additional beds needed	Total beds needed
	Total	Acceptable		
Total	381,461	230,674	513,426	744,100
Alabama	1,085	942	10,495	11,437
Alaska	366	351	264	615
Arizona	782	782	2,854	3,636
Arkansas	3,376	2,265	6,400	8,665
California	31,473	31,473	14,282	45,755
Colorado	4,842	1,933	6,452	8,385
Connecticut	8,985	7,463	3,709	11,172
Delaware	936	936	402	1,338
District of Columbia	1,432	1,412	2,683	4,095
Florida	7,914	6,621	16,191	22,812
Georgia	3,119	1,805	16,140	17,945
Hawaii	1,306	424	1,373	1,797
Idaho	1,611	556	2,199	2,755
Illinois	28,386	8,088	40,390	48,478
Indiana	9,613	1,739	12,706	14,445
Iowa	9,794	3,196	9,837	13,033
Kansas	961	576	7,840	8,416
Kentucky	2,198	1,616	9,054	10,670
Louisiana	4,731	4,731	10,984	15,715
Maine	2,682	91	4,584	4,675
Maryland	7,265	4,400	3,099	7,499
Massachusetts	25,047	3,956	20,564	24,520
Michigan	10,971	6,359	25,557	31,916
Minnesota	11,571	9,371	7,599	16,970
Mississippi	2,095	1,740	6,912	8,652
Missouri	16,583	10,065	10,060	20,125
Montana	1,248	936	2,153	3,089
Nebraska	2,255	1,428	3,674	5,102
Nevada	475	321	1,039	1,360
New Hampshire	2,242	479	2,240	2,719
New Jersey	10,555	7,118	21,500	28,618
New Mexico	1,121	1,035	3,137	4,172
New York	46,817	24,871	47,407	72,278
North Carolina	1,721	1,562	20,698	22,260
North Dakota	936	731	1,488	2,219
Ohio	17,290	10,236	25,722	35,958
Oklahoma	9,203	8,503	2,702	11,205
Oregon	6,870	3,748	5,052	8,800
Pennsylvania	22,583	10,829	23,080	33,909
Rhode Island	2,786	2,786	1,419	4,205
South Carolina	1,778	1,049	9,784	10,833
South Dakota	1,088	742	1,670	2,412
Tennessee	4,812	3,935	9,997	13,932
Texas	11,572	8,996	37,739	46,735
Utah	2,482	2,482	1,517	3,999
Vermont	1,065	232	1,618	1,850
Virginia	5,341	5,341	8,897	14,238
Washington	14,445	10,451	2,694	13,145
West Virginia	2,641	2,641	4,121	6,762
Wisconsin	9,740	6,448	13,572	20,020
Wyoming	435	144	1,401	1,545
Guam			116	116
Puerto Rico	836	739	6,275	7,014
Virgin Islands			84	84

[1] Includes chronic disease and nursing home beds.

Dr. HALDEMAN. I might say there is great disparity in the number of beds in the States that have the highest number of nursing beds and those who have the lowest. For instance, in the 5 States that have the highest number of beds they average over 40 beds per thousand for individuals 65 years and over. In the five States with the lowest number, the corresponding figure is six beds per thousand. In other words, the ratio is about 7 to 1; the States by and large that have the most nursing home beds are the States that by and large have the highest public assistance payments.

Mr. DOMINICK. Mr. Jones, one more question.

On this community referral deal that you talked about, how much of the cost of this program is involved in that?

Mr. JONES. We provided no breakdown on that, Mr. Dominick. It is included in the single item of grants to States for community health services.

Mr. DOMINICK. You didn't mean to imply in talking about this that if a person were sick and went to a hospital that he would not be either diagnosed correctly or referred to a proper place to take care of him, did you?

Mr. JONES. Not in the least, Mr. Dominick. We are just trying to save some of the extra effort when people do not know where to turn for the kind of medical care they may need. This is a service which a community health facility or health department might properly render, as some are now doing.

We think it is a very valuable service and one that will be conducive to more efficiency in the use of general health resources of the community.

Mr. DOMINICK. Well, I will be frank to say that it seems to me that most people who are sick go to a hospital or go to a doctor, and in most cases I would think that the doctor or the hospital would tell them what is the matter with them or where to go without having a special facility for this. But I could be wrong.

Mr. JONES. A doctor may say to a patient "You need to go to a nursing home" and he may not know himself of a nursing home that is prepared to take this particular patient under the circumstances that may pertain to this patient. Referral to a center of this sort would be helpful both to the doctor and to the patient.

It is a very genuine service and has been extremely useful in the whole medical program in these communities.

Mr. DOMINICK. Thank you, Mr. Chairman. That is all I have.

The CHAIRMAN. Mr. Jones, would you give us a breakdown by categories of the total budget that would be requested beginning with 1962 and which you said that $24 million would be needed for?

Mr. JONES. We can provide this table for you and put it in the record.

The CHAIRMAN. Yes. In other words, it would be broken down into categories as presented in the various sections of the bill.

Mr. JONES. Yes, sir.

71495 O—61——6

(The table referred to follows:)

Program—Community Health Services and Facilities Act of 1961, estimate of additional cost, 1962–66

Item	1962	1963	1964	1965	1966
Appropriation requirements:					
Grants to States for community health services	$5,000,000	$15,000,000	$25,000,000	$25,000,000	$25,000,000
Project grants for community health services	5,000,000	6,000,000	10,000,000	10,000,000	10,000,000
Nursing home construction grants	10,000,000	10,000,000	10,000,000	0	0
Research grants	4,000,000	4,100,000	6,800,000	9,000,000	8,800,000
Subtotal	24,000,000	35,100,000	51,800,000	44,000,000	43,800,000
Administration costs	172,000	239,000	239,000	239,000	239,000
Total requirements	24,172,000	35,339,000	52,039,000	44,239,000	44,039,000
Expenditures:					
Grants to States for community health services	4,500,000	14,500,000	24,000,000	24,500,000	24,800,000
Project grants for community health services	2,500,000	5,000,000	7,500,000	9,000,000	10,000,000
Nursing home construction grants	1,000,000	4,500,000	9,000,000	10,000,000	5,500,000
Research grants	1,300,000	3,700,000	5,000,000	7,000,000	8,000,000
Subtotal	9,300,000	27,700,000	45,500,000	50,500,000	48,300,000
Administration costs	148,000	202,000	202,000	202,000	202,000
Total expenditures	9,448,000	27,902,000	45,702,000	50,702,000	48,502,000
Man-years of employment	20	24	24	24	24

The CHAIRMAN. Of course, you show in your statement that there is included in the bill an increase in the authorization from $10 million to $20 million for nursing home construction.

Mr. JONES. Yes, sir.

The CHAIRMAN. I assume that your budget would request the entire amount.

Mr. JONES. That is correct.

The CHAIRMAN. With all 4 years that you have in mind.

Mr. JONES. Well, it would request year by year only after the authorization was provided.

The CHAIRMAN. You said a moment ago that it was up to 1966.

Mr. JONES. Yes, sir. We suggested what a normal development in the program would be over a continuing period of years. I did not think we would ask for an appropriation at this time for the full 4 years.

The CHAIRMAN. No, but you would ask for it year by year, of course.

Mr. JONES. Yes. We are trying to project what the program would mean in the years ahead.

The CHAIRMAN. Now, are each one of these categories that you offer here programs which call for cooperation with the States?

Mr. JONES. Yes, sir.

The CHAIRMAN. In other words, section 2 provides an amendment to section 314(c) by striking out the limitations?

Mr. JONES. That is correct.

The CHAIRMAN. Now that program under section 314(c) of the Public Health Service Act is a program which is developed and carried out in cooperation with the States?

Mr. JONES. That is correct.

The CHAIRMAN. What type of service is being provided under this provision?

Mr. JONES. They include a number of services, Mr. Chairman, such as communicable disease control, sanitation services, accident prevention, air pollution programs, and a whole range of comparable services of a public health nature.

The CHAIRMAN. We have a bill which is being considered by one of the subcommittees on air pollution. Is this in any way in conflict with that?

Mr. JONES. No conflict at all, sir.

The CHAIRMAN. It supplements it?

Mr. JONES. Yes, sir. This proposed amendment would permit a sharper focusing of these funds through earmarking a portion of the grants for specific programs in the annual appropriation process.

The CHAIRMAN. Now at page 3, special project grants for improving community health services. Is that a new section of 316?

Mr. JONES. That is a new section; yes.

The CHAIRMAN. What particular type of service will be provided by this section?

Dr. TERRY. This section 316, sir, refers to the type of service organization which we have discussed already a great deal in terms of development of the new program such as homemaker programs, home nursing programs, and other related activities trying to develop a comprehensive medical care program in the community.

The CHAIRMAN. In other words, this is solely for study, example, and demonstration?

Mr. JONES. The following are some examples of projects which might be undertaken:

1. A survey to determine the feasibility and desirability of a rural health department furnishing nursing care in the home for the chronically ill and aged.

2. A project to assist a geriatric center in providing the types of programs necessary for the chronically ill and aged, through establishment of a central information and referral center.

3. A project to broaden the scope of a central evaluating team (physician-public health nurse-medical social worker), to provide in addition to initial screening, subsequent evaluation and planning for long-term patient care in the home or institution.

4. A study to determine the feasibility of adding a homemaker program to an existing chronic illness center.

5. A study within a medium-sized metropolitan area to determine local resources available to support a proposed home care project.

6. A number of demonstrations to determine how hospitals and nursing homes can cooperate with each other. The hospital provides technical assistance and both categories sponsor joint training courses.

7. Projects to set up training centers for persons interested or involved in home care programs, to provide training and field experience in the institutions themselves or in surrounding areas.

8. A study to assist a metropolitan hospital in defining the comprehensive services necessary to serve the aging population in a geographic area (the hospital district).

9. A study requested by a large metropolitan area health and welfare council, to aid their central information and referral center by

investigating the factors involved in the successful placement of people in nursing homes.

10. A study to determine the epidemiology of cerebral accidents within a county, in order to estimate the true impact of the disease within the county, to enable adequate community planning and programing, and to enable realistic program evaluation.

11. A study to determine the need for provision of dental care to homebound and chronically ill persons, as part of a home care program. Participants to be a State department of health, a school of dentistry, a hospital, and a visiting nurse association.

12. A study to determine the patterns of care of illness in the older people of three communities, limited to illnesses for which the individual goes to bed.

These, Mr. Chairman, are just examples of potential special projects that would be supported under the project grant authority.

The CHAIRMAN. It does not then increase the authorization which this committee developed and reported in the last Congress for the chronically ill care which, I believe, was $10 million, or was it $20 million?

Mr. BORCHARDT. You are thinking of facilities, and they are thinking of studies.

The CHAIRMAN. I know, but you do not increase the authorization for facilities in this program.

Mr. JONES. Not in terms of these special grants.

Now on nursing homes we do increase the authorization.

The CHAIRMAN. But at the same time we authorized nursing homes I think we had four categories at that time. One was nursing homes, one for the chronically ill——

Mr. JONES. This does not touch the chronically ill.

The CHAIRMAN. And a couple of others.

Dr. TERRY. Rehabilitation was one.

Mr. JONES. Ambulatory diagnostic and treatment centers.

These do not touch these categories, no sir.

The CHAIRMAN. Now in section 4 what experience have you had with full cooperation by the various States in the construction of nursing home facilities?

Dr. HALDEMAN. We have had complete cooperation. The principal problem that they report to us is that there has been insufficient funds to do the kind of job that they feel should be done.

The CHAIRMAN. Well, I have received complaints from my own State, that under the $10 million authorization the allocation is so small that the Department of Health of our State finds it impracticable to develop any needed facility within a given community.

I wonder if you have any information as to the applications that have been made to the appropriate agencies within the State as compared to the amount of funds available to the States for such purposes.

Dr. HALDEMAN. Each year, in January, at the request of Senator Hill, we do ask the States to give us the names of projects that have developed plans and specifications and are well underway to becoming actuality if sufficient Federal funds were available.

Now for the complete Hill-Burton program, those applications add up to about $470 million of Federal funds for fiscal year 1962. In regard to nursing homes, the States this last year indicated that they

could use a total of $61 million as the Federal share of the project for nursing homes that are ready to go.

The CHAIRMAN. $61 million?

Dr. HALDEMAN. That is correct. There is an additional sizable amount for chronic disease hospitals. So the total long-term facility picture is substantial.

The CHAIRMAN. In other words, the increase to $20 million then would not, in effect, meet the needs of the various States.

Dr. HALDEMAN. I think you have to take into account and consideration what our present authorization is. The present administration has requested in their appropriation request pending before Congress now the total authorization of $20 million for chronic disease, $10 million for nursing home, or a total of $30 million.

The additional authorization of $10 million proposed in this bill, when combined with the present authorization, would provide about 10,000 nursing home and chronic disease beds, and that is more than double that which would be provided by the appropriation for the current fiscal year.

The CHAIRMAN. You still haven't answered my question. You do not contemplate meeting the requests for funds from the States?

Dr. HALDEMAN. No, it will not be able to cover the requests from the States.

Mr. JONES. As indicated earlier, Mr. Chairman, this is a modest program.

The CHAIRMAN. I realize that.

Mr. JONES. In terms of need.

The CHAIRMAN. But I was trying to develop fully the modesty of the program as proposed here in the light of the need of the States.

Mr. JONES. The record would then show that $61 million of requests would have to be met with $20 million if what was asked for here were approved.

The CHAIRMAN. Well, I am a little confused. I thought you added it up to $40 million if this $10 million increase was permitted.

Dr. HALDEMAN. I think the confusion arises because I think in terms of long-term beds which includes the chronic disease as well as the nursing home beds, and it is true that if this legislation were enacted we would have a total authorization of $40 million for chronic disease and nursing home beds.

The CHAIRMAN. Now you say x number of dollars are appropriated for construction of facilities for the chronically ill and x number of dollars for the construction of nursing homes. Now if a State has a nursing home program but does not have a chronically ill program, my question is: Can that State utilize the chronically ill funds in the construction of nursing homes?

Dr. HALDEMAN. Yes, they can.

The CHAIRMAN. I thought that I read that that authorization was provided heretofore.

Now on page 5, section 5, research, experimentation in the utilization of medical facilities. Does that mean hospitals such as the Hill-Burton?

Mr. JONES. Yes, they would be included.

The CHAIRMAN. There were some gentlemen in to see me a few days ago, some doctors from one of the outstanding institutions in the country, interested in the development of a new-type hospital, and they

were interested in a research program for this purpose. I believe Dr. Joy from the Mayo Clinic was one of them.

Did you have an opportunity to discuss with them their ideas with reference to their needs?

Dr. HALDEMAN. Yes, sir. As a matter of fact, I visited Rochester. I am sure they told you they have an experimental nursing unit that they have been studying for the past 2 or 3 years, and they are anxious to extend the studies to compare that type of nursing unit with additional types of nursing units. This is exactly the sort of thing that we have in mind under this section—providing authority for grants for experimental or demonstration projects.

The CHAIRMAN. That is the information I wanted to get.

Dr. TERRY. Mr. Chairman, if I may, all of us in the Department and in the Public Health Service are well aware of this particular work.

The representatives have met with the Secretary and with other members of my staff, as well as the ones specifically involved in the Hill-Burton program, so that we are well aware of it, are very interested in it, watching this and many other such research activities, and we certainly want to render all the assistance we can, sir.

Mr. NELSEN. Mr. Weld is here in the room and plans to appear later, and the questions that I asked were directed toward that same project, and the points were cleared up that were in my mind relative to the conflict as to the formula.

I think it is a very worthwhile project, and I am very happy that the Department is aware of it and lends its support to this type of research. They have done quite an extensive job up to now.

The CHAIRMAN. Yes.

Well, let me on behalf of the committee, Mr. Jones, thank you and Dr. Terry and Mr. Cohen and your associates for your fine presentation. We hope when you get back you find the Secretary greatly improved.

Mr. JONES. Thank you, Mr. Chairman.

(The following letter was later received from Dr. Terry:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
Washington, D.C., May 4, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: At the hearings on H.R. 4998 before your committee on May 3, 1961, I understand the question was raised as to whether either the current provisions of section 314(c) of the Public Health Service Act or the amendments to that act proposed by H.R. 4998 would preclude the use of optometrist services.

I should like to assure the committee that the use of optometrist services is not precluded by either the existing or proposed legislation. Whether or not a State or local health program supported by grant-in-aid funds authorized by the legislation includes community health services related to the conservation or improvement of vision and, if so, whether optometrists are used to provide such services is a matter for State and local decision.

I would appreciate your including this letter at the appropriate place in the record of the committee hearings.

Sincerely yours,

LUTHER L. TERRY, *Surgeon General.*

The CHAIRMAN. This will conclude the hearing today, and the committee will adjourn until tomorrow morning at 10 o'clock.

(Whereupon, at 12:30 p.m., the committee adjourned, to reconvene at 10 a.m., Wednesday, May 3, 1961.)

COMMUNITY HEALTH SERVICES AND FACILITIES ACT OF 1961

WEDNESDAY, MAY 3, 1961

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The committee met, pursuant to recess, at 10:15 a.m., in room 1334, New House Office Building, Hon. Oren Harris presiding.

Present: Representatives Harris (chairman), Mack, Moulder, Friedel, Rhodes, Moss, Rogers of Florida, Hemphill, Younger, Glenn, Devine, Nelsen, Keith, Curtin, Thomson, and Dominick.

The CHAIRMAN. The committee will come to order.

We are resuming hearings this morning on H.R. 4998 the Community Health Services and Facilities Act of 1961.

The first witness this morning is our colleague on the committee, the Honorable George M. Rhodes. Mr. Rhodes, the committee knows of your long interest and activity in the field of health and we will be glad to hear you at this time.

STATEMENT OF HON. GEORGE M. RHODES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. RHODES. Mr. Chairman, H.R. 4998 is soundly conceived and constructive legislation which would help to meet a pressing need throughout our country for improved and expanded health-care services and facilities for the aged, the chronically ill, and others who do not actually require high-cost hospitalization but do need some professional attention out-of-hospital. It seems clear that the cost of sharing with the States in developing such out-of-hospital services and facilities would result in savings of private and public funds which otherwise would be spent for far more expensive hospital care. Furthermore, for those not now receiving proper health care for lack of adequate services and facilities in their communities, the proposed act would work to conserve human resources, which after all is the real wealth of the country. We cannot afford to ignore the health needs of that important segment of our population consisting of the senior citizens and the chronically ill in all age brackets.

The out-of-hospital services and facilities proposed in H.R. 4998 will of course require personnel to operate them. I note that the bill provides for amending section 314(c) of the Public Health Service Act to remove the overall $30 million ceiling on funds authorized there for demonstrations and training of public health personnel in the States. The bill also would remove the ceiling on the $3 million now

earmarked within the $30 million to enable the Surgeon General to provide demonstrations and training in the States.

Mr. Chairman, there is another earmarked amount within the $30 million in section 314(c) and this is not mentioned in H.R. 4998 as now written. I refer to the $1 million which was earmarked from the $30 million by Public Law 85–544 for provision of comprehensive professional training in schools of public health. I point out that this is specialized graduate training in all aspects of public health—to prepare physicians, nurses, and others to organize and administer public health services and facilities of the very kind proposed in H.R. 4998.

Now it seems to me that, along with helping to provide for community services and facilities and for demonstrations and the training of the rank and file of personnel to work in such programs, we should also take into the account the need for highly trained executive leadership—public health physicians, nurses, and others who can assess and evaluate the health care resources in the community, plan for necessary additional resources such as this bill envisions, and then organize and administer whatever programs are established or expanded.

To do this requires public health graduate training, which is provided only in the 12 university schools of public health in 10 States. Their graduates serve at all levels of government throughout the country.

Mr. Chairman, I had the honor of first introducing the bill to establish grants for comprehensive professional training schools of public health, but it was through your leadership and that of our colleagues, Mr. Williams, Mr. Roberts, Mr. Macdonald, and the support of the whole committee, that that bill was voted unanimously by the House. In the other branch, Senator Hill was joined by Senator John F. Kennedy and by Senators Cooper, Ives, and McNamara in sponsoring a companion bill which also was passed unanimously by the Senate and was signed by President Eisenhower. Last year it was evident that the new program of grants had proven itself, and the 2-year-time limit was removed through passage of Public Law 86–720. Among the seven sponsors in the House were Congressman Macdonald and myself.

On the first day of this hearing we heard the witness of the Department of Health, Education, and Welfare testify that the so-called Hill-Rhodes program, now in its third year, is serving satisfactorily to strengthen and improve the teaching of federally sponsored students in the schools of public health, thus confirming the vision and judgment of this committee in first recommending it.

Mr. Chairman, you will recall that congressional intent in establishing grants for comprehensive professional training in schools of public health was to offset the deficits which these schools incur in training federally sponsored students, such as the Public Health Service trainees sent to the schools. The present maximum of $1 million for these grants actually reimburse the schools for only one-third of the difference between the cost to the schools of public health for training federally sponsored students and the tuition received from the Federal Government. The figures for 1959–60 showed that, after applying tuition and the $1 million in grants, the schools still bore a cost in

excess of $2,400,000 for training students sent to them by the Federal Government.

Not only to correct this situation, wherein private and State schools are subsidizing training for the Federal Government, but also to further the purposes of H.R. 4998 by taking into account the need for graduate-trained personnel to implement the proposed Community Health Services and Facilities Act, I think that this bill should provide for removal of the present ceiling on grants for such training.

In Secretary Ribicoff's statement on H.R. 4998, which was read into the record on Monday, he says, in part: "The amendments proposed would delete the current annual appropriation ceilings in section 314(c) of the Public Health Service Act." Yet the bill itself mentions deletion of only two of the three annual appropriation ceilings in section 314(c). Perhaps this was an oversight in the drafting, since the Secretary's statement implies that all of the ceilings in the section would be deleted. In any event, Mr. Chairman, I propose for the reasons which I have stated that this committee once again take the initiative and provide for deletions of all three appropriations ceilings in the bill as reported by the committee.

The CHAIRMAN. We appreciate your appearance and testimony, Mr. Rhodes.

Mr. RHODES. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness is another of our colleagues, the Honorable Torbert H. Macdonald of Massachusetts. Mr. Macdonald, we will be glad to hear your testimony.

STATEMENT OF HON. TORBERT H. MACDONALD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. MACDONALD. Mr. Chairman, I appreciate this opportunity to commend to our fellow members of the committee this splendid measure H.R. 4998, which our new administration has put forth and which you, Mr. Chairman, have introduced. It represents, I believe, a humanitarian, yet practical, step toward solution of the distressing problem faced all over the Nation by the chronically ill, including a host of senior citizens, and by their families and others who have their interests at heart. It is the problem of providing adequate medical care, occupational therapy, rehabilitation, and other needed services outside the hospital, and by so doing to avoid the burdensome, often catastrophic costs involved in hospitalization.

Let us not bemoan as an irony of our age the fact that medical advances, by prolonging life, have greatly increased the proportion of our population who are old and chronically ill. Rather, let us rejoice that we can retain the productivity and spiritual worth which is theirs to offer. Let us, by offering assistance to the States and local communities as proposed in H.R. 4998, help the elderly and the chronically ill of all ages to help themselves to the fullest possible existence.

I would be untrue to my consistent and long-standing concern for the training of adequate numbers of public health personnel for the Nation's needs, if I did not endorse wholeheartedly the proposals made to this committee that H.R. 4998 should provide for an acceleration of the Hill-Rhodes grants program. I endorsed Mr. Rhodes original bill before this committee 3 years ago; indeed, I yielded to his proposal even though I had introduced a somewhat similar meas-

ure of my own to strengthen public health training. Last year my bill H.R. 7064 called for removal of the 2-year time limit on Public Law 85–544 and for removal of the $1 million ceiling. The time limit was removed; the ceiling was not.

Now as we hear from the schools of public health, from State health officers and health agencies, and from the Department of Health, Education, and Welfare that the Hill-Rhodes program is effective, we can take satisfaction in the impetus which this committee gave to it 3 years ago. You, Mr. Chairman, believed in it. Our colleagues, Mr. Williams, Mr. Roberts, and Mr. Rhodes believed in it, and the full committee sustained us.

Senator Hill believe in it; our President, then Senator Kennedy believed in it. They cosponsored it in the other branch and were sustained. President Eisenhower believed in it and signed it into law. Events have proved that we were right, and the bill at hand offers an appropriate opportunity to take the next logical step; removal of the token ceiling which was establish at the time the program was regarded as experimental.

The fact that the university schools of public health, including the fine school at my own Harvard University, are still paying more than two-thirds of the cost of training Federally sponsored students is being thoroughly documented by others at this hearing. Beyond that, we know that comprehensively trained professional personnel, which only the 12 graduate schools of public health can produce, will be needed to lead in the improvement and expansion of the health services and facilities as proposed in H.R. 4998. On all counts, then, it behooves this committee, while removing the overall ceiling and one of the two other ceilings in section 314(c) of the Public Health Service Act, as already provided in the bill, to remove also the third ceiling: that is the $1 million limit on grants for comprehensive professional training in accredited schools of public health.

Mr. Chairman, I urge that this be done as we recommend adoption of this bill.

The CHAIRMAN. Thank you for your statement, Mr. Macdonald.

Mr. MACDONALD. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness is our colleague from Rhode Island, the Honorable John E. Fogarty. Mr. Fogarty, we know how interested you have been in this field and we are glad to have you testify.

STATEMENT OF HON. JOHN E. FOGARTY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF RHODE ISLAND

Mr. FOGARTY. H.R. 4998 is a bill we should have passed at least 30 years ago. I think it is no exaggeration to say that if we had done so, we could have saved the Nation tens of millions of dollars and hundreds of thousands of cases of chronic invalidism.

Our delay, in fact, reminds me of those legendary villagers at the foot of the Alps who decided to build a hospital to take care of the travelers who got injured on the dangerous mountain curves leading into the village. All the civic-spirited, right-minded citizens pitched in and the drive for funds was going fine until a crotchey old crackpot upset everything by proposing that the funds be used to make the road safe, thus eliminating the need for the hospital.

In supporting H.R. 4998, I don't want to imply that the millions of dollars we've been appropriating for hospitals have been unnecessary—if anything, we should be appropriating more, not less, for them.

Hospitals are fine for those who need them, but a lot of patients occupying hospital beds today don't need them, don't want them, and could be cared for much better and more economically in other ways.

This bill would help communities to provide those other ways. It would build decent nursing homes, for one thing. The hardships and the makeshift arrangements families have to endure to take care of aged relatives is a national disgrace. Often it's a choice between some member of the family having to be tied down to a 24-hour nursing job or putting the relative into a rambling old firetrap of a home with no assurance even of humane, let alone therapeutic, care. Not that there are no good nursing homes, there are some excellent ones, but there aren't enough even for those who have plenty of money to pay for the best. We need about a half million more nursing home and chronic disease beds than we have and we are whittling away at this backlog at the rate of about 3,000 beds a year. Under H.R. 4998, we could double this number—even that is no record to be proud of, but at least it is twice as good as we're doing now.

Another way this bill would help is by getting home nursing, homemaker and other home-care programs under way. There is no reason why an old or handicapped person can't be cared for at home without making a virtual prisoner of the able-bodied member of the family who cares for him. Yet that is what is happening today in tens of thousands of homes. It is hard enough to hire babysitters these days; it's even harder to hire patient-sitters, and it should be. The aged and ill don't need sitters—they need trained people who can give them the exercises, diets, and treatments that will enable them to look after themselves. One of the greatest tragedies of our time is the way we've allowed people to get bedridden and helpless. With the techniques that have now been developed, almost everybody—no matter how old or how crippled—can be trained to take care of most of his own needs. But about the only place those techniques are used is in the hospital, because communities simply aren't set up to offer home services.

Every year for the past several years, this Congress has supported an aggressive program of medical research. I am proud of our record in this field. I believe every American has a right to be proud of that record. Over the years, we have developed the greatest medical research center in the world.

To get the most from this investment, however, research dollars must be matched with practice dollars. In surgery, in chemotherapy, in fact, in most of the areas where the physician himself can apply the new research finding to the problems of his individual patients, this is being done. We are getting our money's worth from such research. Pick up your paper almost any day and you can read about someone's life being saved by a new operation or drug or treatment.

But where our research investment is going to waste is in those areas where the knowledge cannot be applied simply by the patient paying his physician to apply it.

For example, we aren't making much use of some of the new ways of preventing, curing, or retarding disease, ways that work only if applied long before the patient even thinks about consulting his phy-

sician. We aren't taking advantage of the day-by-day treatments that prevent mental and physical deterioration, treatments that must be medically supervised but can be done by a nurse, a member of the family or even by the patient himself. This kind of new knowledge is going to waste because the doctor can't apply it to his patient without drawing upon some type of community service or facility that does not exist.

This knowledge will continue to be wasted until communities set up the services and facilities that will make it possible to use the wonderful fruits of research, the amazing ways of helping our chronically ill and aged, that are already here. It isn't much comfort to a man who has had a stroke to know that some day science may find a way to revitalize his paralyzed muscles. But a simple little exercise booklet put out by the Public Health Service has been a lot of comfort to over 90,000 stroke patients whose doctors have used it to show them how to make better use of their remaining muscles. This booklet is one of the products of the small investment we have made in out-of-hospital programs for the chronically ill. It cost a few hundred dollars and has changed the whole outlook on life for thousands.

The thing that impresses me most about the chronic disease problem is how much could be done if there were enough people with enough time to do it.

Take deafness. It often takes months of consultation, adjustment, and training before a hard-of-hearing person can get the most out of his hearing aid. For lack of such service, thousands of people don't even use their hearing aids after they have bought them.

Take diabetes. Every patient needs at least 8 hours of instruction. Few get it. There are over 2 million diabetics in this country and 25,000 to 30,000 diabetes deaths occur every year.

Take arthritis, fractures, or almost any type of crippling condition. Exercise every day, dozens of times a day, with someone checking periodically to see that the exercises are done exactly right, can make all the difference between helplessness and self-sufficiency.

I could go down the whole list of chronic ailments—ailments that afflict 17 million Americans, including 3 out of every 4 who are over 65—and point out other examples.

Physicians haven't the time to do this type of work with patients and it would be a waste of manpower to have them do so. Nurses and various types of technicians, working under the doctor's orders and supervision, can do these things just as well.

But it takes organization, and it takes money. If you are going to teach diet or exercise to homebound patients, you have to have nutritionists, therapists, and nurses who can go out to those homes. If you are going to turn nursing homes into anything more cheerful than a place to wait for death, you have to help the nursing home operators find ways to offer special services without going bankrupt.

H.R. 4998 would help communities set up the organizations and secure the personnel to cash in on research and to cut down costly hospital care. More important, it would bring some immediate help to millions of chronically ill. These people are probably not going to live long enough for science to find a complete cure for their conditions, but they can be much less handicapped than they are if existing knowledge is used on their behalf.

This bill is not a substitute for local programs developed by local leaders. All it does is set up, in terms of out-of-hospital facilities and services, the kind of Federal-State partnership that has achieved so much, under the Hill-Burton program, to improve hospital facilities and services.

Some of you will recall that, when the Hill-Burton program was launched, the hospital shortage was a problem of national significance. Communities recognized their need; they wanted to get started; but it took Federal action to get the movement underway. The Federal share has never been a big part of the hospital construction program—States and communities have played the big role—but Federal aid provided the all essential stimulus.

We are now in almost exactly the same position in relation to out-of-hospital services. The time is ripe; the need is recognized; with a little Federal aid, we can expect a vast amount of State and local action.

No matter what the ultimate decision may be on ways to finance health care for the aged, it is certain that there must be people and places to furnish the care. Today, even the wealthiest cannot get some of the services and facilities they need because they haven't been established. This bill would help to fill that gap.

It is with the sincere conviction that this is the best, the most practical, the most economical and the most immediate way to help our chronically ill and aged that I urge passage of this bill.

The CHAIRMAN. We appreciate your appearance and testimony, Mr. Fogarty.

Mr. FOGARTY. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness we will have is Dr. Huntington Williams, president of the U.S. Conference of City Health Officers, Baltimore City Health Department.

Doctor, we are very glad to hear from you this morning.

STATEMENT OF DR. HUNTINGTON WILLIAMS, PRESIDENT, U.S. CONFERENCE OF CITY HEALTH OFFICERS, BALTIMORE CITY HEALTH DEPARTMENT

Dr. WILLIAMS. Mr. Chairman and members of the committee, I would like to qualify myself. I am the commissioner of health of Baltimore City. Next October 1, it will be 30 years that I have been in charge of that department. For 10 years before, I was in the State Health Department of New York, in Albany, as the district health officer and secretary of the State department of health the last year.

I come before you as the president of the newly organized group of city health officers in this country under the wing of the U.S. Conference of Mayors, a group that has as its chief interest, providing for the mayors of the larger cities and other cities and city-county units, health information of an up-to-date nature and support of public health development in urban areas.

It is a satisfaction for this Conference of City Health Officers to have an opportunity to urge the passage and favorable action of this committee on House bill 4998 which we have studied carefully.

I would like to file with you the bona fides of this new organization as represented by this newssheet, City Health Officers News.

The CHAIRMAN. It may be received for the committee's files.

Dr. WILLIAMS. Dr. Leona Baumgartner of the city of New York, vice president of this organization, is in Europe at the World Health Conference, but her deputy will be here a little later.

There are a number of health officers here today who will speak on this matter, but the city health officer is most closely involved in the problems before this committee in considering this bill.

The elderly in this country are congregating in the cities. You have had many statistics before you. I will just try and give you a few facts from Baltimore, and very briefly.

In 1950 our total population was 950,000 and in 1960 it had decreased to 939,000, but during this same period the number of persons over 65 had increased from 69,000 to 83,000, a percentage increase of those over 65 in the total population 10 years ago from 7.4 to 8.9 percent.

So in 1960 in Baltimore we had 8.9 percent of our total population in the 65-year-old-or-older group. I would add by way of introduction that I have read the bill and the description of its main aims and objectives and have for your consideration in the record a statement in regard to the bill which I will file with you and merely brief it in order to get into some more intensely personal and direct relations that the city health officer has with problems of this type.

(The full prepared statement of Dr. Huntington Williams is as follows:)

STATEMENT OF DR. HUNTINGTON WILLIAMS, COMMISSIONER OF HEALTH OF BALTIMORE CITY, AND PRESIDENT, U.S. CONFERENCE OF CITY HEALTH OFFICERS

Mr. Chairman and members of the Committee on Interstate and Foreign Commerce, I am happy to be here today to testify on behalf of the newly organized U.S. Conference of City Health Officers in support of H.R. 4998, to expand and improve community services and facilities for the health care of the aged and other portions of the population with long-term illness.

The cities of the United States have critical problems in meeting the health needs of their residents and of the people living in nearby areas who depend for their health care on the facilities and services located in the cities. This committee, I am sure, is fully aware of the major shifts in population from rural to urban areas over the last decade. Sixty-three percent of the population now lives in the 212 metropolitan areas as classified by the Bureau of the Census. This trend is continuing.

No element of community service is more seriously influenced by this tremendous pressure of population growth than is the capacity of the city to cope with the health needs of the people. And foremost among these health needs are those related to long-term illness. Leaving aside the question of an individual's ability to afford necessary health care—because I understand this bill is not concerned with that question—we lack the facilities and the community services to make available comprehensive, high quality health care to our aged and chronically ill.

Hospitals are overcrowded, and one of the reasons they are overcrowded is that many patients go to a hospital when they would not need to and many more stay longer than necessary. This situation exists in large measure because there are not adequate facilities and services to provide high quality health services for them anywhere else in the community.

Despite the fact that there are some very excellent skilled nursing homes in the United States, their number is small. On the whole nursing homes in the United States are deplorably inadequate in the health care they provide. Not only are they primarily custodial in character but they contribute little to the patient's restoration of normal function and independent living. It is essential that major National, State, and local attention be given to upgrading the quality and scope of health services provided in nursing homes in order to make of them a useful part of the pattern of modern community health practice.

Improving the role of nursing homes calls for action not only with respect to existing institutions but also a major increase in the construction of new nursing homes. I am told that there is a national shortage of 500,000 nursing homes and other long-term-care beds. I should expect that this estimate is a modest one if full potential utilization were made of such skilled facilities in relieving the burden of long-term patient care now provided in our general hospitals.

In addition to high quality institutional care in hospitals and nursing homes, most patients with a long-term illness can be cared for more effectively in their own homes at some stages of their illness. But necessary home health care cannot be undertaken properly unless there are community services upon which the patient and his physician can call for assistance. Such services are frankly not available or are inadequate in scope and coverage in most areas of the United States. Bedside nursing care in the home, for example, on an organized community basis is available in less than 1,000 communities. And where it is available—as in the larger cities—the services are nowhere nearly sufficient to meet the needs of home nursing services. Homemaker services which can provide necessary housekeeping services for the ill at home are even less available. For lack of such services, thousands of patients must stay in institutions beyond the period of health necessity.

Beyond these specific types of home health services lies the problem of effective community organization and integration of such services. It is a rare city in which one can find a balanced, coordinated program of home health care. The population and long-term illness pressures in cities, however, are fast approaching the situation in which such coordination is essential.

H.R. 4998, in my judgment, would make a substantial impact on the solution of these problems I have mentioned. The bill provides increased research attention to the operation and community relationships of our hospitals. It provides increased funds to assist in the construction of additional high quality, skilled nursing homes. It provides project grants to conduct studies, demonstrations, and experiments for the development of new and improved methods of providing out-of-hospital health services for long-term illness. And finally, it provides grants to assist States and communities to establish new and extend and improve existing community health services and facilities.

With the background of previous national health legislation as a guide, I am confident that the programs and funds proposed in this legislation will stimulate increasingly greater State, local, and voluntary action and funds. The benefits to the aged and other persons with long-term illness will extend beyond the beneficial programs initiated with these Federal funds.

We stand at a point where the availability of community services and facilities for the health care of the aged and chronically ill is a major bottleneck which must be broken if the advantages of modern preventive, curative, and rehabilitative medicine are to be put in practice. I urge this committee, on behalf of the U.S. Conference of City Health Officers, to take prompt and favorable action on H.R. 4998 and assist us in achieving this goal for the people of the United States.

Dr. WILLIAMS. In my prepared statement, just submitted, I have indicated that the U.S. Conference of City Health Officers hopes sincerely that this committee will report favorably and promptly on the bill.

The cities of the United States have critical problems in meeting the health needs of the elderly because of some facts I have just presented. Sixty-three percent of the population now lives in 212 metropolitan areas, as classified by the Bureau of the Census, and this increase in the elderly in the cities is continuing and will continue.

There is no element in the community service more seriously influenced by this tremendous pressure of population growth in the cities than the elderly. Hospitals are overcrowded; excellent, skilled nursing homes are small in number and inadequate.

To improve the role of nursing homes is vital and will be made possible with the passage of this bill. Also, the opportunity of caring for the elderly population in their homes, where it is most desirable for them, will be greatly strengthened and improved.

There are many other research and institutional clinical opportunities that this bill will provide, as I will describe somewhat later from the examples I want to present for your consideration.

With this formal statement, I urge you—representing the city health officers of the country—to act favorably and promptly on this bill.

The youngsters in this country are moving to the suburbs. This is recognized by anyone who is watching the population trend in the big and middle sized cities. The cities are especially interested in the fate of this bill for they are responsible to secure the best health possible for all of their citizens and the cities are becoming more and more the focal point for the elderly to congregate and to receive their medical care.

The elderly tend to congregate where the hospitals are and where the medical services are and this, of course, is in the cities.

Let me give you an example that I know of personally. An elderly lady who lived on the Eastern Shore of Maryland, east of the Chesapeake Bay, was severely crippled with arthritis. She came to the conclusion that she would move to Baltimore where she could get hospitalization and outpatient care, clinical service that she needed and that she couldn't obtain where she was. This is a simple but a concrete fact of experience that could be reduplicated any number of times.

Housing for the aged is being provided primarily in the cities so it will be close to shopping, but mainly so it will be close to the medical facilities that are needed.

Let me now give you another and slightly different point. The elderly should be permitted to continue living in their homes and not in institutions. The recent trend has been for families to shut off the elderly into institutions or homes for the aged or other places, and there are three reasons why this trend needs to be reversed and this bill will greatly help in this regard.

First, it is not necessary for the elderly to be institutionalized. It is distasteful to them and it is needlessly expensive. House bill 4998, if passed, will help in these respects.

To dramatize this a bit, I want to bring to your attention the fact from the editorial page of the Baltimore Sun, just of yesterday, a letter to the editor where this matter of assisting, as this bill will assist, in keeping the older people in their homes, or at least in their apartments and out of institutions was stressed.

Just yesterday morning, in the Baltimore Sun, this letter was sent to the editor, and I will read it. The title is "Senile Oldsters."

SIR: Since this is National Mental Health Week, it is timely to point out one of the sadder aspects of the mental health picture which I happen to know something about from a personal experience.

Many of the mentally ill do not need to be in mental hospitals. This applies particularly and emphatically to oldsters who are suffering from cerebral arteriosclerosis or senile brain disease. These diseases bring about personality changes, memory lapses, repetitive remarks and also make the senile easy prey to the unscrupulous. Their families simply do not want to be bothered with them and the mental hospital becomes a dumping ground for the unwanted. These oldsters are sick, their families are sicker from the sickness of selfishness.

The senile oldster can be managed at home where he longs to be if he has one, or in nursing homes and foster homes. Tranquilizers and drugs to improve circulation to the brain work miracles. And, of course, there is no medicine like compassion both for him who gives it and for him who receives it.

In the next session of the general assembly, I hope the committee on aging will come up with a program to regenerate the old-fashioned virtue of familial responsibility; for no less an historian than Arthur Toynbee writes that the moral tone and lifespan of a civilization can be measured by the respect and care given to its elderly citizens.

That letter is signed by Mrs. Kathryn Tydings Eager.

I am sure this is the philosophy behind this bill. I am sure the passage of the bill will make it possible to keep old people in their homes in a way that has not been possible before, and this is something that the city health officers of the country are vitally interested in.

Now I would like to be just a little bit more specific. I would like to point out in a different direction the need for more adequate facilities to provide health and medical care to elderly persons in vital items that are often overlooked in current programs.

I will mention three—eyesight, hearing, and the care of the feet in elderly people.

The CHAIRMAN. May I interrupt?

Dr. WILLIAMS. Yes, sir.

The CHAIRMAN. I have had a good many communications and some oral expressions of interest from people in the profession of optometry. There seems to be a feeling that the profession is not included in this legislation.

Do you know of any prohibition in this community health services bill or in the Public Health Service Act which would in any way prevent the profession from participating in these programs?

Dr. WILLIAMS. Well, I can speak from a long experience with the optometrist group in my city, who have sought to participate in the school health program that we are responsible for; that is in connection with eyesight testing and care.

The CHAIRMAN. Well now, that is a local problem, isn't it?

Dr. WILLIAMS. But it is a national problem, sir.

The CHAIRMAN. What I meant was that from the standpoint of responsibility, these programs are designed and operated by the local people and they determine what should be done about the students.

Dr. WILLIAMS. Yes, sir.

The CHAIRMAN. Isn't that true?

Dr. WILLIAMS. That is correct.

The CHAIRMAN. Well, that is the way it is under the Public Health Service Act. That is what we are talking about here.

Dr. WILLIAMS. I would think there are others who can answer that better than I but I would assume that optometrists are excluded by the bill, and I would like to give you the reason why I feel that is correct.

An optometrist can test the eyes, can prescribe glasses, but he is not medically trained and when he does this, he does not have the ability to discover disease in the eye that may have far-reaching effects on the health of the pupil and it has been our requirement consistently to have this work done by a medical ophthalmologist and not by an optometrist because of the potential risk to the child if a disease is not discovered by an examiner who is not qualified medically to discover it.

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The CHAIRMAN. Well, that would come under the research program.

Dr. WILLIAMS. I think it might well come under the research program.

The CHAIRMAN. What about section 314? Isn't that all inclusive so that it would include optometry as well as any other health service?

Dr. WILLIAMS. I rather imagine not, but I would rather you get the answer to that from a representative of the U.S. Public Health Service.

The CHAIRMAN. All right. You may proceed with your statement, sir.

Dr. WILLIAMS. I am anxious to put before you another specific instance because if there is anything that I may be able to do to help the committee it would be because I am on the local firing line with these problems and am not looking at it from a State level or from a national level, but from long personal experience.

Now, the case I want to mention is an elderly person, if you will permit my saying this, at an age well over 65. He has been known to me personally for a long time. It happens that he could afford to pay for the best eye specialist care, but this is not true of the many poor people in our communities. The health officer serves as the family doctor for the poor who cannot afford this and other types of health service.

In a periodic check of his own eyesight by his eye specialist, it was detected that this elderly person was beset with early glaucoma. Now glaucoma is a serious disease which, if unrecognized and untreated, can easily go on and cause blindness. Over a period of 3 weeks or more, the study of this case went on by a qualified ophthalmologist and drops were given and the disease was brought under complete control and it is this type of service that this bill will make possible for health departments to provide for those who cannot afford it and who really run risks of blindness or partial blindness for the lack of it.

Now this patient sat in a clinic being tested under drops for a period, sometimes as long as a half an hour with other patients and he heard them discussing the matter amongst themselves and one patient said to another, "You know, I am not sure and my doctor can't tell me whether I am going blind or not."

This was a glaucoma clinic in a hospital. This was a very dramatic situation and that is why I bring it to you and if you will ask me who the patient was I have been telling you about, I would tell you that the patient was myself.

Now, it is not only eyesight as I said before, but hearing loss and foot care that present problems of this kind and many other medical problems affecting the aged and your bill, if passed, would provide outpatient clinics that do not now exist in many cities and other areas for the provision of early diagnosis of just such a case as this glaucoma I have mentioned.

The lack of these services is acute in the cities of this country now. Your bill, if enacted, will remedy much of this, quite aside from the other things that it does in regard to nursing homes and nursing facilities.

After eyesight, I mentioned hearing loss. Hearing loss is something that tends to isolate the elderly person and not only isolate him physi-

cally, but isolates him mentally and emotionally in a distressing way. There is surgery now that can do much about the prevention of the loss of hearing and this is something that passage of this bill will help correct in many parts of this country.

The British are way ahead of us in many of these services and they have been paying a lot of attention lately to the care of the feet in elderly people.

These three things that I have mentioned—eyesight, hearing, and the care of the feet—are only samples to try to dramatize for you some of the intense personal problems of the elderly among the less privileged economically in our communities in this country, and these are directly from the records. These are known to me and could be reduplicated over and over again.

I will only spend a moment on one or two other items that appeared to me to be vital. The homemaker service is something that grew up in England during the first war and has only been tried in New Jersey and a few places in this country as an active health department program. Your bill will make this possible. A homemaker service makes it possible for the elderly and the infirm to stay in their homes and not go to an institution. Where a homemaker can come and clean the house and provide a daily hot meal for the elderly and perhaps do some shopping once a week, it is not necessary for them to leave their homes.

I will give you now a third instance, a specific instance to go with those that I have mentioned so that you will get this from the ground up, from the grassroots on up. This is an example of a lady 85 years old. She became very unsteady in her gait and she so feared a fall that might break her hip, as she had known these things to happen in others, that she left her own apartment and went into an old ladies' home where she really wasn't happy; where she lost the contact with the neighborhood children and where really she was miserable. If she had a homemaker service which your bill will make possible, this wouldn't have happened to her and it is this kind of thing that the health departments and city health officers throughout the country are anxious to see pushed forward.

The Visiting Nurse Association in cities is another. The visiting nurses' work is done by public health nurses in rural areas and home nursing service for the elderly will be pushed forward by the passage of this bill.

So you see, it is cases such as these that the city health officers hope your committee will keep in mind when you are acting, and I hope favorably, on House bill 4998.

It is a pleasure to see Mr. Friedel who is an old friend of mine from our city here. He knows about our medical care program in the city which is a statewide program under health department auspices. He knows about the Visiting Nurse Association and I am sure all of you are aware of the fact that there is a wide gap between existing knowledge and what is actually being put to work. This bill will greatly help in narrowing the gap by establishing community referral and information services and by meeting other items such as I have put before you.

I am sorry that I have taken quite so long. I would add in closing that the mayor of Baltimore has filed a telegram with you under date of May 1 which reads as follows:

Mr. HARRIS, *Chairman:*

As mayor of Baltimore City, I urge your committee to take prompt and favorable action on H.R. 4998 because our studies show great need for expanding and improving community facilities for medical care for the aged, especially in their homes.

That is signed "J. Harold Grady, Mayor of Baltimore."

If there are questions, I will try to answer them for you. If not, I thank you for this opportunity on behalf of the city health officers of the country.

The CHAIRMAN. Dr. Williams, we are glad to have your testimony on this legislation.

Mr. Friedel?

Mr. FRIEDEL. Mr. Chairman, I am very happy to be here and hear Dr. Huntington Williams testify on behalf of your bill, H.R. 4998.

Dr. Williams has been the health officer for Baltimore City for a great number of years. I sat in the city council in 1939 and he was head of the health department at that time and is still head of the health department. He is a dedicated man and does a wonderful job. I think if we approve this program, he will utilize every penny and make good use of it.

The CHAIRMAN. Any further questions?

Mr. YOUNGER. Has the State of Maryland taken steps to qualify under the Kerr-Mills bill?

Dr. WILLIAMS. Yes, sir; this program should be in actual operation by June 1. We have had to hire some extra space to house the staff, but the machinery is all in order, statewide, including Baltimore.

Mr. YOUNGER. Thank you.

The CHAIRMAN. Mr. Dominick?

Mr. DOMINICK. Dr. Williams, during the course of your testimony you indicated that this bill would be most helpful to those who were less privileged and unable to pay for the cost of medical services. In what particular do you find that this bill is limited to those people? Is it not available to everyone?

Dr. WILLIAMS. I don't find it limited at all. But speaking as a city health officer and for the city health officers of the country, they are not fundamentally disturbed about these services being available for those who can afford to pay for it. Now, just where you draw the line, coming down from the well-to-do is a moot point, but the health officers are responsible for seeing that the city provides this for those who can't pay for it and that is why he is particularly interested in it. But there is nothing in the bill that limits it those who can't pay.

Mr. DOMINICK. Would you think that it would be more effective if it were so limited?

Dr. WILLIAMS. No, I think not. I think the communities need the funds, have their own machinery in States and cities for adjusting its use so that it is not abused in any way, and I believe it might eventually delay and hamper the benefits that are really needed and will come by a prompt passage of this bill.

Mr. DOMINICK. Doctor, you also endorsed the referral service in here which I have had some difficulty in understanding.

Is it your position that the hospitals and medical associations now are not aware of available treatment centers for particular types of diseases in the urban areas?

Dr. WILLIAMS. No, I don't think it is the hospitals and the medical agencies that are not aware. I think it is more the people who are in need of the services who don't know which way to turn.

Now we have 200 public health nurses in our health department and they are out on the streets and in the homes referring people to agencies that can help meet the special needs of this family and that family, but it is not near enough of a referral service to get a needy person to the service waiting and anxious to give it to him.

The volume of referral needed is so great that existing services, information services are not adequate. The most dramatic in this field at the moment is alcoholism. Cities are just beginning to establish information centers and referral centers for alcoholics. That is a real toughy to handle and it is not done under Government money, State, Federal, or local money. It is done under private money at the moment.

Mental trouble is another field. I know of another personal example of a leading physician who is beset with an 11-year old grandchild who is a mental defective, a boy growing up with two sisters in the home, just on the verge of puberty in a manner that distresses his family because they don't know which way to turn. They can't afford the most expensive care for the boy. They don't want to put him in a State institution, but they don't know where to turn because they are sensitive about bringing the matter to the surface and they try to feel around among their friends to get guidance. Now in this case, referral information services would help.

Mr. DOMINICK. Doctor, on that point I happen to have been a member of the board of the Mental Health Clinic in my own State for some 4 years. I participated in starting it on a joint community effort, and I am well aware of this, but yesterday when I asked the question if this would have anything to do with the mental problems, I was informed it would not so it would seem there is some difference of opinion as to how this bill would affect that.

Dr. WILLIAMS. Yes, it is very difficult for any of us to get the clearest picture, but there is a provision for outpatient department services.

It is difficult for me now to locate it in the bill, but I believe it would be of help. I think the information referral centers are specifically mentioned in the bill. Somewhere in here there is a reference to the provision of outpatient clinics for diagnosis and treatment and prevention and here again, this is information that the Public Health Service can give you better than I can.

Mr. DOMINICK. That is all, Mr. Chairman.

The CHAIRMAN. Any further questions?

Mr. RHODES. Mr. Chairman, I want to commend Dr. Williams for what I think is a very informative and excellent statement. I feel that the people of Baltimore and Maryland are very fortunate to have such a dedicated man as their health officer.

Dr. WILLIAMS. Thank you, sir.

The CHAIRMAN. Dr. Williams, thank you very much for your testimony as president of the U.S. Conference of City Health Officers.

Our next witness is Mr. E. H. Weld, of the Mayo Clinic, who is accompanied by Dr. O. H. Beahrs and Mr. H. C. Mickey.

STATEMENT OF E. H. WELD, ADMINISTRATOR, MAYO CLINIC, ROCHESTER, MINN., ACCOMPANIED BY DR. O. H. BEAHRS AND H. C. MICKEY, OF THE MAYO CLINIC STAFF

Mr. WELD. Mr. Chairman, Dr. Beahrs is a member of the staff of Mayo Clinic and I am a member of the board of the hospital as well as a member of the administration of the clinic and if it will please you, Dr. Beahrs will make the opening statement which is more or less a summary of the information we filed with you, sir.

The CHAIRMAN. Very well, Dr. Beahrs, we will be glad to have your statement.

The letter that you have reference to, dated April 26, 1961, will be included in the record at this point.

(Said letter of the Rochester Methodist Hospital, dated April 26, 1961, is as follows:)

ROCHESTER METHODIST HOSPITAL,
Rochester, Minn., April 26, 1961.

Hon. OREN HARRIS,
House of Representatives, Committe on Interstate and Foreign Commerce, House Office Building, Washington, D.C.

DEAR SIR: The following statement is prepared for presentation at the public hearing on H.R. 4998 (Harris, Arkansas) Community Health Services and Facilities Act of 1961.

Since 1955, personnel of the Rochester Methodist Hospital, members of its board of directors and members of the staff of Mayo Clinic have studied intensively several aspects of hospital function and design, in preparation for new hospital facilities. These studies have as their objective new approaches to hospital construction and operation to more efficiently utilize personnel, to improve care of the patient and to reduce his hospitalization costs. The studies to date include construction of and controlled experiments with a circular 12-bed nursing unit for the care of the critically ill.

Further studies are needed to reach the goals of improved care and reduced costs. The Rochester Methodist Hospital is seeking financial assistance for construction of an experimental and demonstrative hospital for research in patient care, hospital function and design.

Surprisingly little controlled research is recorded in the literature on the effect of physical facilities on care of the patient or on how design can reduce hospitalization costs. The lack of research in this field contrasts sharply with the tremendous amounts of money and energy expended for research in medicine and industry.

This dearth of critical studies is particularly surprising when one realizes that the operation of hospitals is said to be the third largest industry in the United States. Billions of dollars have been spent for hospital construction in this country alone in recent years. With very few exceptions this construction has followed patterns of hospital design which have existed for many years.

A further indication of the need for careful reappraisal of hospital design and operation is the continuous increase in cost of hospital care since 1940. Statistics from the U.S. Department of Labor demonstrate increases of almost 300 percent in the rates charged by hospitals in this period. This is much greater than the increase in consumer prices and the increase in physicians' fees for the same period.

A survey was made in Rochester in 1955 to determine variations in care required by patients in the two hospitals affiliated with Mayo Clinic. This survey included classification by Mayo Clinic physicians of 1,100 patients for 7,513 patient-days according to the type of care required by each patient. Each day for a week each patient was placed in one of three categories based on the amount of nursing care each required:

Stage 1: Constant observation because of serious illness.

Stage 2: Average care.

Stage 3: Minimal care because of satisfactory progress or a nonserious type of illness.

In brief, analysis of these data revealed that on any given day approximately 20 percent of patients required stage 1 care, 60 percent stage 2 care, and 20

percent stage 3 care. While these percentages will vary somewhat from one hospital to another, this study did quantitate what has been recognized as a fact: Not every patient in a given hospital requires the same amount of care. Patients in stage 1 need more hours of nursing care daily and care of more skilled personnel than patients in stage 2 or stage 3. Patients in stage 3 need fewer hours of nursing care daily and care of less skilled personnel than patients in stage 1 or stage 2. In addition, patients in the convalescent or stage 3 category appeared not to require the extensive equipment and facilities that are necessary for care of seriously ill patients.

The initial studies were directed toward the seriously ill patient who requires constant observation and more than average care since it is this patient that incurs the greatest hospital expense. After consideration of many different designs it was the consensus that this category of patients could be cared for best in a small nursing unit of circular design with the nurses' station centrally located and patient rooms were placed peripherally. The inner wall of each room was made of double doors containing clear glass panels. This design made each of the 12 patients visible to the nurse from her centrally located work station and the patients could at all times see the nurse. It also reduced the distance between the patient and the nurse at her desk.

Funds were collected to build this experimental unit from private foundations and from the Methodist Hospital. A research committee of Mayo Clinic physicians was appointed to supervise controlled research in an effort to determine the effect of hospital design and function on patient care.

Time does not permit review of the considerable mass of information accumulated from these studies of patient care in the circular unit and in the rectangular unit. Detailed data were accumulated and have been published.[1]

Among the many factors studied several stand out. It was shown that the patient was better satisfied with his care in the circular unit, as were the patient's relatives because of the reassurance provided by constant visual contact between the patients and the nurses. Corridor travel by nurses was significantly less. Most surprising was the cost. A patient requiring three special duty nurses around the clock pays $54 a day plus a room charge on an average of $20 or a total of $74. In the circular unit equal or superior care was given for a total of $36 per day—a savings of $38 per day.

We have completed controlled studies of the care required by the patient who is acutely ill and evaluated how it's affected by architectural design. We have, however, only scratched the surface. What will be the effect of design and different methods of operation on the other 80 percent of the population in the hopsital? Some hospitals have considered various phases of progressive patient care but to date there has been no critical evaluation of the quality of care or its cost. This should be done before it is more widely copied. Under ideal and controlled conditions is progressive patient care of a higher quality and lower in cost?

PROPOSED FUTURE HOSPITAL RESEARCH

Committees responsible for studies to date have begun development of a program of study for the future when the experimental hospital is available. The research to be carried out in such a hospital would include:

(1) Comparison of the circular nursing units with rectangular units in care of stage 2 and stage 3 patients to determine whether the circular design is superior for these groups. Both the quality of the care and the cost per patient-day would be evaluated.

(2) Positive determination of the feasibility of progressive patient care of patients in a general hospital. Again both the quality of the care received by the patients and the cost of that care would be ascertained.

(3) Study of other proposed schemes for segregation of patients by clinical service or probable length of stay. Possibly patients admitted for 1 to 3 days for a special diagnostic or therapeutic procedure could be accommodated at lower cost in a special hospital unit.

(4) Consideration of all possible mechanical, electric, and pneumatic devices to reduce hospital labor costs and installation of such devices for actual trial if determined to be of practical value.

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[1] Sturdavant, Madelyne: "Comparisons of Intensive Nursing Service in a Circular and a Rectangular Unit," American Hospital Association, 1960.

Hospital survey, summary, Dec. 5–11, 1955—Distribution by hospital service

	Total patient-days	Type of hospital care, percent		
		Constant	Normal	Convalescent
Surgical	4,507	22.1	58.9	19.0
General	1,873	24.8	47.5	27.7
Neurologic	640	39.2	47.0	13.8
Orthopedic	957	12.7	76.2	11.1
Urology	362	16.3	68.5	15.2
Plastic	303	12.9	75.2	11.9
Ophthalmology	114	34.2	50.9	14.9
Otolaryngology	65	21.5	47.7	30.8
Proctology	130	3.3	86.7	10.0
Vein	53	7.5	88.7	3.8
Oral	20	----	100	----
Medical	2,006	18.9	59.0	22.1
General	1,647	8.7	63.9	27.4
Pediatrics	437	57.2	39.4	3.4
Obstetrics and gynecology	186	16.7	27.4	55.9
Psychiatry	202	34.2	50.0	15.8
Neurology	171	11.1	73.1	15.8
Dermatology	128	22.7	62.5	14.8
Physical medicine	203	13.3	81.3	5.4
Therapeutic radiology	32	----	81.2	18.8
Total	7,513	20.8	59.0	20.2

SUMMARY

Considerable effort has been devoted to the Rochester Methodist Hospital study project by those bearing the local responsibility, and only after such effort had been made did we feel it proper to seek help elsewhere. Many data have been collected, study methods have been developed, and appraisal techniques have been refined, but much work remains to be done before the full significance and potential of the concepts under study can be precisely delineated.

In order to evaluate completely the patient care, costs and patient-relative acceptance of stage care, an experimental hospital is necessary with its design based on function. It will be a "tool" for future studies. If approached with boldness and imagination, one can visualize that critical research might produce contributions in hospital design and patient care that could be prototypes throughout this country for many decades to come.

With the increasing and aging population, with the obvious need for more hospital beds, with inadequate numbers of trained nurses available, and with the increasing cost of hospitalization, it seems reasonable that any effort to solve these problems might produce a worthwhile contribution.

Respectfully submitted.

HAROLD C. MICKEY,
Administrator, Rochester Methodist Hospital.
EDWARD H. WELD,
Vice Chairman, Executive Committee, Rochester Methodist Hospital, and Member of Section of Administration, Mayo Clinic.

Dr. BEAHRS. Mr. Chairman, it is a pleasure to be here this morning in support of section V of the proposed law. The statement, as you mentioned, has been filed with you.

I would like to take approximately 15 minutes to trace the development of the project in Rochester, Minn., and to make comments in reference of the support needed for further research in this field.

The Methodist Hospital in Rochester, Minn., is one of two hospitals associated with the Mayo Clinic in the practice of medicine and the care of sick for over 50 years.

The Mayo Clinic is one of the largest medical institutions in the world. Associated with it, is the Mayo Foundation which is the largest graduate school of medicine in the world. Approximately 600

graduate students are in training in this foundation at the present time.

You might be interested in knowing that this number was about half of that number immediately after World War II. In other words, the training program has expanded about 100 percent since World War II.

In 1955, personnel of the Methodist Hospital, members of its board of directors and members of the Mayo Clinic have studied intensively several aspects of hospital care as far as function and design is concerned in preparation for new hospital facilities.

Preliminary to this study, a review was undertaken of the literature to find out what had been done in recent years in reference to research in hospital design to make the hospital a better unit for the care of the patient.

We found that very little had been done along this line and I think this is important in view of the fact that it is said that the hospital industry is about the third largest industry in the United States. Many billions of dollars have been spent in the construction of hospitals and yet, very little money has been spent to try and determine how the hospital can best serve the patient.

With this in mind, it was thought essential that we carry out some research to determine what type of facilities we might consider for our own use. This is also important in view of the fact as you are well aware, that the hospital costs since 1940 have risen over 300 percent. This is out of proportion to the increase in consumer prices and the increase of the cost of medical care.

First, we felt that we should review the type of patient that was in the hospital. For this purpose, we reviewed over a thousand patients that stayed in the hospital over 7,000 days. We divided these patients into three categories to try and determine the degree of illness and the amount of care they might need.

As you can see by the chart, we classified them as to stage 1, those patients requiring greater than the average or normal amount of care.

Stage 2 as those requiring normal nursing care.

Stage 3 as those that were convalescent or those that required less than the normal amount of care.

I think it is obvious with these definitions that you can see the amount of nursing care that would vary considerably from one stage to the other.

In carrying out this survey, we found that on any one day approximately 20 percent of our patients fell into stage 1; that is patients that required more than the average amount of care.

We found that 60 percent were in stage 2 and 20 percent in stage 3. It is obvious again that the patient in stage 1 required more of the nursing services, more facilities, and for this reason we felt that it was best to study this particular area.

One other reason we did this was the fact that there is a nurses' shortage as you are well aware and anything that we might do to improve the efficiency of our nursing personnel would benefit the patient in the long run as far as service and costs are concerned.

Therefore, we undertook a review of the needs of the patient that required more than the normal amount of care. We considered what the patient needed for his care; what the nurses needed for the care; we considered the conventional type of construction and then tried to

visualize what might improve the services for the patient over and above conventional construction.

After considering the rectangular, the square, the cross, a watermelon shape, we finally settled on the circle as probably providing the best physical area for the care of these patients. It provided observation, shorter distances, and the facilities were naturally within the area.

This chart demonstrates the circle. You see the nurses' station is in the center of the circle. The patients' rooms are at the periphery. The utility room was moved to the periphery which naturally brought the patient closer to the center and closer to the nurse.

This shows the private rooms. The nurse, however, has observation into the room and also important, the patient has observation of the nurse.

This building was built of temporary construction with funds that were obtained from the Ford Foundation, the Hill Family Foundation, the May Association, and the hospital.

As I say, this was a pilot project to determine whether or not this type of construction was feasible. This is merely an illustration of the temporary building that was built.

The next chart illustrates the interior of the building which shows more or less what each and every patient can see from his sickbed.

The patient looks out as you can see, at the nurses' station. The nurse is in the center and the nurse can turn around and see each of her 12 patients at any one time.

The nurse's desk or station is built at such a level that one patient cannot see across the unit into another patient's room or at least, see the other patient.

The next will show what the nurse sees. She sees the patient as illustrated here. The interior wall of the room is formed by a double door with glass in it. The nurse can see the patient at all times except when the drapes are drawn on the doors. That would mean to the nurse in the center of this station that another nurse was inside the room caring for the patient.

After this unit was developed, it was felt essential by many of our associates that this unit be critically evaluated. In other words, controlled research carried out in reference to it. Therefore, this unit was compared with a conventional rectangular unit of the same number of rooms, the same type of patients were hospitalized in each unit. The same nurses that worked in the circular unit were moved to the rectangular unit to try and keep the various factors as constant as possible.

The research that has been carried out on this project has been published by the American Hospital Association and I would like to illustrate just several of the points that were uncovered in the course of this study.

First, you can see that the nurse's activity as far as travel was markedly reduced in the circular unit. As illustrated here, the nurse, as far as percentage of her activity, 5 percent of it was required for travel while the rectangular unit was over 11 percent. The importance of this is obvious, I think. The less the nurse has to travel, the more time she has to spend with the patient.

Converting these distances over into miles, it is interesting to note that in the circular unit, the nurse traveled less than 4 miles; that is

the nursing staff of the day shift traveled less than 4 miles during the day and more than 5 miles in the rectangular unit.

Now, this is important when one considers three shifts a day and 365 days a year. We were naturally interested in the cost of this service, whether or not we could provide sufficient or better care to the patient, at less cost.

At our institution, special duty nurses around the clock cost $54. Therefore, the nursing cost for a 24-hour period for a patient requiring special duty care is $54. We found that these patients could be adequately and better cared for in many instances in the circular unit at a cost of $13.88 for nursing care.

You will be interested in knowing that these savings are now being passed on to the patients that are hospitalized in this unit at the Methodist Hospital.

One of the important factors in this development from our standpoint is observation and I think this illustration will demonstrate what we mean.

The nurse in the center of the circle can see the patient and the patient can see the nurse. The nurse does not have to worry how the patient is.

In the rectangular unit, the nurse at the nursing station, whether in the hallway or at one end, wonders how the patient is. This gives the nurse security in reference to her practice of nursing and it also gives the patient as well as the relatives security.

Well, these were merely several illustrations as to what we have learned in carrying out this research project which is a pilot study.

We feel very strongly that this research should be carried on to cover the other phases of patient care. This development, as I mentioned, was strictly made with private funds. We feel that since the Government is very much interested in hospital construction, in patient care, that it is essential that this research be continued to try and find out where savings might be obtained in research in a total hospital so that these savings can not only be obtained by the Government, but by the patient and by the hospital.

Research should be carried out in a total hospital of new construction, new design, to determine whether or not savings can be made in considering for stage 2 and stage 3 patients, whether or not progressive patient care is feasible in a general hospital; also to study other proposals and schemes of patient segregation; also to evaluate the value of mechanical, electrical, and pneumatic devices in the hospitals.

We might just show you a diagrammatic sketch of what might be considered for future research. Here, we would have a conventional hospital floor of rectangular wards designed and built with all the modern conveniences to compare with a floor of circular design to determine whether or not these savings will carry over into say, stage 2 and 3 as we have already determined in stage 1.

Next is merely an architectural rendering of what such a hospital might look like. With the increase in the aging population, with the obvious need for hospital beds, with inadequate numbers of trained nurses available, and with the increasing cost of hospitalization, it seems reasonable from our standpoint that any effort to solve these problems might produce a worthwhile contribution to the hospital field.

We would be happy to answer any questions that you might have regarding this project and the proposed research that we feel is necessary and should be carried out.

The CHAIRMAN. Thank you, Dr. Beahrs. Any questions?

Mr. Mack?

Mr. MACK. Doctor, your interest is primarily in the special grants proposed in this bill, is that correct?

Dr. BEAHRS. I believe so. I would like to add that we feel we are in a position to carry out this research. However, it would be desirable that such research be carried out in other centers to determine which type of facility might be best built for the future. We feel that a prototype of the new hospital should come out of research of this type.

Mr. MACK. Well, that is section V of this bill.

Dr. BEAHRS. That is correct.

Mr. MACK. I was very interested in the research you have done in this type of construction. You mentioned the cost of savings in nurses, the reduced demand for nurses in some of these institutions.

Dr. BEAHRS. Yes, and I might say this, Mr. Mack, that we have projected what this might mean as far as nursing services are concerned in a 500-bed hospital.

As far as we can determine, based on our experience with stage 1 care, what it might mean in stage 2 and stage 3, we would visualize that research might prove that the nursing staff in a 500-bed hospital would be reduced by about 16 percent which would be 40 or 50 nurses on the nursing staff of that hospital. This would go along toward solving the nurse shortage and also would utilize more efficiently the nurses that are available in the hospitals.

Mr. MACK. It also reduces the cost of operating a hospital, doesn't it?

Dr. BEAHRS. Yes, Mr. Mack. Could I show you several other charts?

Mr. MACK. I just wanted to have it very clear in my mind. It would also reduce the cost to those patients who do not require special nursing care.

Dr. BEAHRS. As far as we visualize, yes, it will, and on the basis of segregating the patients that require more than the amount of care, including those that require special duty care, into one group and the others into several other groups.

I might illustrate these facts. For stage 1 care, approximately 80 percent of the care provided to these patients is required from a registered nurse; 20 percent by the aid or orderly, and the percentages for stage 2 and 3 care are as you see them here—mixed care is this figure and if we convert the percentages over into the cost per hour of nursing service in our institutions, you find that the cost per day for stage 1 is $13.88; stage 2 is $5.13; and mixed care is $7.12.

If we convert these figures over into the experience that might occur in a 500-bed hospital, we find that the savings in nursing costs in a year will be $143,000 plus the cost of special duty nurses for those patients requiring them which in our institution would be a minimum of $40,000 or more.

In other words, in a year, a 500-bed hospital might realize a savings of almost $200,000 in its operation.

Mr. MACK. Thank you; I did want to ask one other question. The savings as I understand it, is on the cost of providing the nursing care primarily.

Dr. BEAHRS. The savings that we have talked about have been primarily in nursing care. However, we feel that factors that go into realizing this savings will also produce savings in housekeeping expense, dietary expense, and so forth.

Mr. MACK. Well, I assumed all the time this morning that I would like to ask if you have also considered the cost of constructing this type of building. It would appear to me at least to be substantially greater than the conventional hospital.

Dr. BEAHRS. I would like to ask Mr. Mickey to answer that if he may.

Mr. MICKEY. We have asked the same question of our architects and the one who made this pilot model for us. They have indicated there is a possibility that this circular unit might be a little more expensive than the conventional, rectangular type.

However, we believe that we might be able to provide a facility whereby the number of square feet per bed might be less. Therefore, one offsets the other.

The thing that concerns us most is that the total construction of a unit of this sort is only a single factor. If we can save in the cost of personnel and pass that savings on to the patients year after year, it more than offsets whatever the additional expense might be, be it 10 percent.

Mr. MACK. Thank you, very much. I have no further questions, Mr. Chairman.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. Just one question, Mr. Chairman. Are you going to supply a reproduction of those statistical charts for the record?

Dr. BEAHRS. We have glossy prints of these charts, sir.

Mr. YOUNGER. Just like the one you showed there, the cost and so forth?

Dr. BEAHRS. Yes.

Mr. YOUNGER. Can they be supplied for the record, Mr. Chairman? I think it would be well to have that in.

The CHAIRMAN. Let them be received, if they can conveniently go into the record. If they cannot be included in the record, they will be available for the benefit of the committee.

Mr. YOUNGER. I think you have made an excellent contribution, Doctor.

The CHAIRMAN. Mr. Moulder?

Mr. MOULDER. Have you submitted these plans to the Department of Health, Education, and Welfare?

Mr. MICKEY. We have not submitted them as such, except that the Surgeon General is acquainted with our program and his Department has visited our community.

Mr. MOULDER. They have made a study of your proposal?

Mr. MICKEY. Whether they have studied it or not, I do not know.

The CHAIRMAN. I might say for the information of the gentleman, I think they have given information to a lot of people on Capitol Hill and other places too because these gentlemen and some of their associates have been very diligent in promoting this plan which they

feel can make a tremendous contribution to the health care of patients in the future.

Mr. Glenn?

Mr. GLENN. No questions.

The CHAIRMAN. Mr. Friedel?

Mr. FRIEDEL. No questions.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. Mr. Chairman, I have been interested in this project. We discussed it about 2 years ago for the first time, and I have discussed it with our subcommittee chairman, and I think there are a few facts that should be brought out for the record.

Now you mentioned that this project was financed with private foundation funds which include the Hill family and Kellogg Foundation.

Have they expressed any attitude further regarding the results of your project that needs to be brought to our attention?

Mr. WELD. Mr. Nelsen, both the Hill Family Foundation and the Kellogg Foundation specifically would be pleased to submit a report to the chairman.

The CHAIRMAN. Please talk a little louder, Mr. Weld.

Mr. WELD. I said the Hill Foundation and the Kellogg Foundation which participated in the financing of this pilot project would be pleased to submit a concise and brief report of their evaluation on what we have done.

The Hill Family Foundation put up a grant of $100,000 and the Ford Foundation moneys were used to the extent of $77,000.

In addition, the Kellogg Foundation participated with a grant of $50,000 the two specifically, Mr. Nelsen, would be pleased to present, if the committee wishes, a concise third party evaluation of the type of work that was done.

Mr. NELSEN. Mr. Chairman, if it would be agreeable I would like to suggest that the report be submitted.

The CHAIRMAN. Will you see that the report is submitted, Mr. Weld?

Mr. WELD. I will do that.

(The reports from the Kellogg Foundation and the Hill Foundation follow:)

W. K. KELLOGG FOUNDATION,
Battle Creek, Mich., May 10, 1961.

Mr. HAROLD C. MICKEY,
Administrator, Rochester Methodist Hospital, Rochester, Minn.

DEAR MR. MICKEY: As you know, the W. K. Kellogg Foundation provided funds in the amount of $50,000 to the Rochester Methodist Hospital to make possible a careful study and evaluation of an experimental intensive patient care nursing unit incorporated in an unusual structural design. The purpose of the foundation's contribution was to provide to the hospital and medical care fields information essential to the appraisal of this experimental project for its possible application to the development of similar services for units in other communities.

The Foundation has also had an interest in the development of certain aspects of the "progressive patient care" concept in other communities. The following excerpt is from our recently published annual report:

"Although such developments as these are mushrooming, perhaps the most dramatic recent impact in the hospital field has been that of a new concept of hospital organization and staffing, popularly termed 'progressive patient care.' This involves an attempt to gear the hospital to the medical and nursing needs of individual patients. The services and facilities range from intensive care units for the seriously ill to self-help units for those individuals able largely to care for their own needs. The complete gamut of progressive patient care encompasses units for long-term patients in the hospital and also provision for

the rendering of hospital services to patients in their own homes. Hundreds of hospitals are presently adopting various facets of this approach, but the great majority are predominantly limited to the intensive care units. Because of the tremendous interest in 'PPC,' there is obvious need for careful analysis of presently functioning programs and the initiation of controlled demonstration projects so that realistic conclusions may be drawn as to the continuing value and practicability of the complete concept. Of great importance are such fundamental concerns as the definition of personnel staffing patterns by gradation of care, variations in cost by differentiated levels of service, and methods for initiation of home care under the auspices of a typical community hospital.

"The Foundation has assisted in three programs involving certain aspects of the new concept of patient care. The Rochester (Minn.) Methodist Hospital-Mayo Clinic received support for a study of an intensive care section utilizing an unconventionally designed unit, a 'hospital in the round.' The results of this investigation were recently released to the field in a publication of the American Hospital Association, 'Comparisons of Intensive Nursing Service in a Circular and a Rectangular Unit.' Community Hospital in Battle Creek, Mich., received aid from the foundation for both the establishment and evaluation (the later by the University of Michigan Bureau of Hospital Administration) of an intensive care section in a more traditional nursing unit design. This analysis, involving 'before' and 'after' studies of the hospital's patient population, will be published in 1961. In Traverse City, Mich., foundation assistance was provided to the James Decker Munson Hospital and the Grand Traverse Board of Supervisors for an integrated chronic disease care program using the resources of both a community voluntary general hospital and a county government-owned medical care facility. It is envisaged that this program, in its ultimate development, will encompass all levels of progressive patient care, including hospital-extended care to patients in their homes."

In conclusion, it is our belief that the experiment undertaken by the Rochester Methodist Hospital and the resultant publication by the American Hospital Association represents valuable information and data in both the organization and design of patient care services and units, and it is our hope that the conclusions will be accorded serious study by the health field.

Sincerely yours,

ANDREW PATTULLO.

LOUIS W. AND MAUD HILL FAMILY FOUNDATION,
St. Paul, Minn., May 8, 1961.

Re H.R. 4998.

Hon. OREN HARRIS,
House of Representatives, Committee on Interstate and Foreign Commerce, Washington, D.C.

DEAR MR. HARRIS: This letter is being sent to you at the request of Representative Ancher Nelsen. It is our understanding that your committee wishes to have our evaluation of the contributions to date to hospital care and management which have resulted from the research in hospital design and function being conducted in Rochester, Minn., under the direction of the Rochester Methodist Hospital and the Mayo Clinic. We indeed are happy to comply with this request.

As a preface to our evaluation, may I say that we in the Hill Family Foundation have been concerned for some years over the rapidly increasing costs of hospital care. Our studies of the problem lead us to these conclusions, namely that: (1) Solutions to this cost problem must not in any way impair the quality of care rendered patients; (2) since the salaries and wages of professional and nonprofessional personnel account for nearly 70 percent of total hospital costs, this is an area needing thorough study to determine whether such personnel is being enabled to work at maximum efficiency; (3) there is a logical relationship between efficient use of personnel and physical design and equipment of hospitals.

Our study of the literature revealed that there had been no major changes in hospital design for many years and that there had been little objective research or study of the relationships between design, function, efficiency of operations, quality of care and costs.

We were pleased, therefore, to have the opportunity to participate financially in the research undertaken by Rochester Methodist Hospital and the Mayo Clinic. Our support for the first phase of this research undertaking, directed to the care of patients needing constant nursing care, totaled $100,000.

We believe that the findings of this research clearly demonstrate that there is a direct relationship between design and cost of care of patients needing constant nursing care. We also believe that the results show that these reductions in costs can be made without impairing the quality of care provided. In fact, there is significant evidence that the quality of care is improved and that patients and their relatives prefer the circular design over the traditional design.

It may seem logical to conclude from this research that the circular design will produce the same savings, improvement in quality of care and patient satisfaction if applied to patients needing normal nursing and even minimal nursing care. This would be our guess. However, we believe that these stages of care should be studied in the same careful, objective manner before large sums of money are invested in new physical plants.

It is our belief that the results of the research at Rochester provide substantial support for the concept of phase care. However, further research is needed to confirm beyond doubt the validity of this concept. We also believe that the research done to date indicates that it is highly desirable to give further study to other phases of hospital functioning such as new designs of equipment and adaptations of new developments in the fields of electronics and engineering to hospital services and patient care. Certainly the results to date of the research conducted at Rochester Methodist Hospital indicate that these are promising areas for more intensive study.

The fact that a number of new hospitals and major additions to existing hospitals are incorporating the circular design is evidence that the research at Rochester has had an impact upon the hospital management fields. It also is a reason why it is urgent that this research be extended as quickly as possible.

Perhaps the best way to summarize our thinking about the contributions to the hospital field which are coming out of the research at Rochester Methodist Hospital is to say that recently Hill Family Foundation made a grant to the hospital to aid it start research on design and function as related to the care of patients needing minimal nursing care. We sincerely believe that the Rochester Methodist Hospital, Mayo Clinic and their consultants have opened up a fertile field needing further scientific research and that they are especially well qualified to conduct this research.

Sincerely yours,

A. A. HECKMAN, *Executive Director.*

Mr. NELSEN. I might call attention to one of the factors that was discussed a year ago and also this year dealing with the Hill-Burton formula that distributes money to States.

I understand that under the provisions of this bill, any money allocated to a research center such as this would not detract from the allocation to the State, or would the formula apply in this particular instance because Rochester, of course, has many hospital beds beyond what is average and therefore, under the provisions of the formula, they would be denied funds, normally. But in this particular research area, that formula as I understand it in the testimony yesterday, would not apply and it would not detract from the State allocations.

I am sure your fears are put to rest relative to that, on that one point.

Mr. WELD. I attended yesterday and that is what Mr. Jones advised us.

Mr. NELSEN. Yes.

Mr. WELD. I might say in amplifying the statement of Dr. Beahrs, Mr. Mack raised the question yesterday of enrollment in medical schools and for emphasis, the graduate school of medicine in Rochester which is part of the university but managed by the Mayo Clinic has increased 100 percent since the war.

Mr. MACK. I would like to take this opportunity, to congratulate you because your school has expanded more than any other medical school in the country.

Mr. WELD. I think the point being, Mr. Mack, that the lessons learned in Rochester through work of the type we have been doing are immediately available by virtue of the large graduate school of medicine to the whole country and indeed, to the whole world because roughly 34 percent of the fellows, graduates, are from foreign countries.

Mr. MACK. Are from where?

Mr. WELD. From foreign countries. Those lessons are almost immediately available before publication.

Mr. MCK. If I could follow through, Mr. Chairman, and mention a fact which I did not mention, a graduate of a university here, tried to get into medical school here and found all of them full about 3 years ago and then entered the medical school at the University of Heidelberg, Germany.

Mr. WELD. Yes.

The CHAIRMAN. Any further questions?

Mr. Weld, thank you very much, and you Dr. Beahrs and Mr. Mickey for your presentation here and the contribution you have made to this hearing. You may supply the additional information on the charts in the next few days.

(The charts, later submitted, are as follows:)

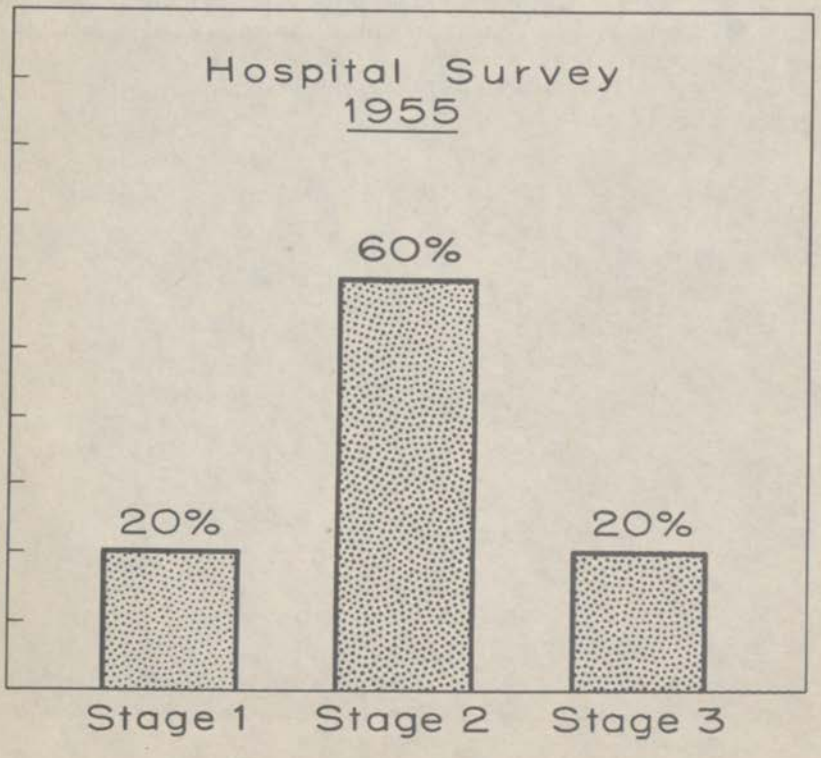
71495 O—61——8

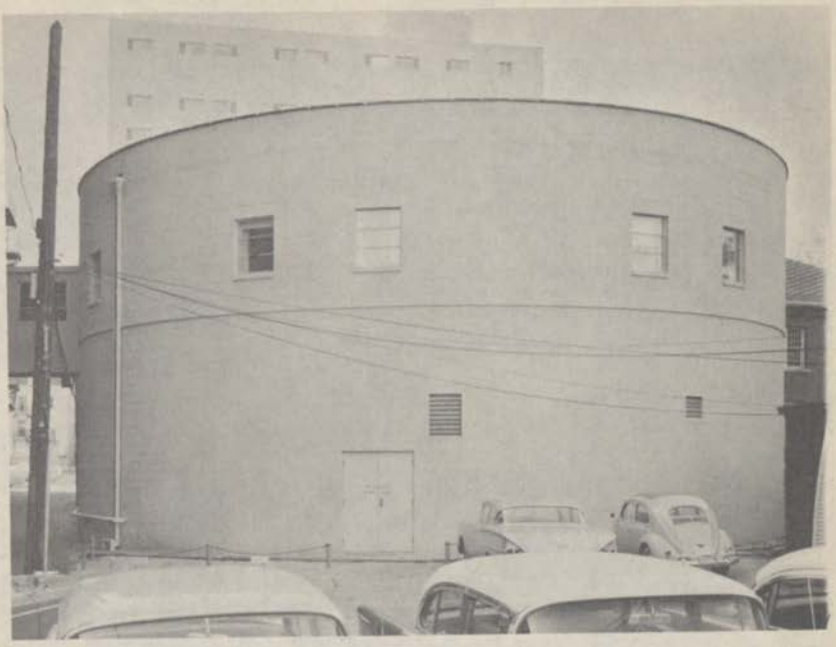
HOSPITAL SURVEY

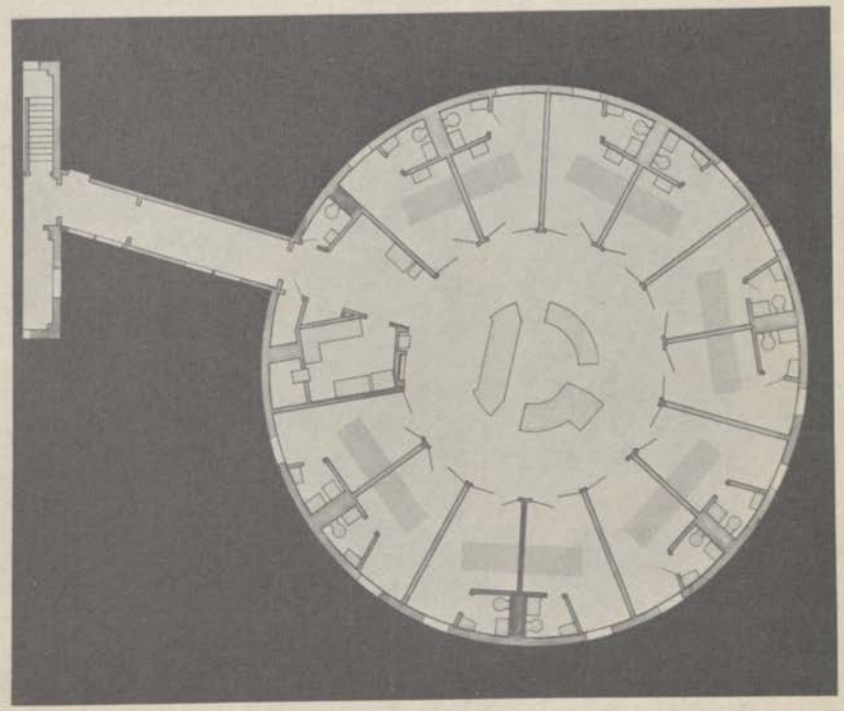
Stage 1. Constant observation: A patient requiring observation, medication or treatment at intervals of 1 hour or less

Stage 2. Normal nursing observation and care: Patients who do not need constant observation but are not able to move into the convalescent section

Stage 3. Convalescent: Patients who need little or no nursing, can dress and care for themselves, go to a dining room for meals, but for whom housing in, or in conjunction with, the hospital is advantageous because of dressing changes, physical medicine or other treatments or diagnostic procedures



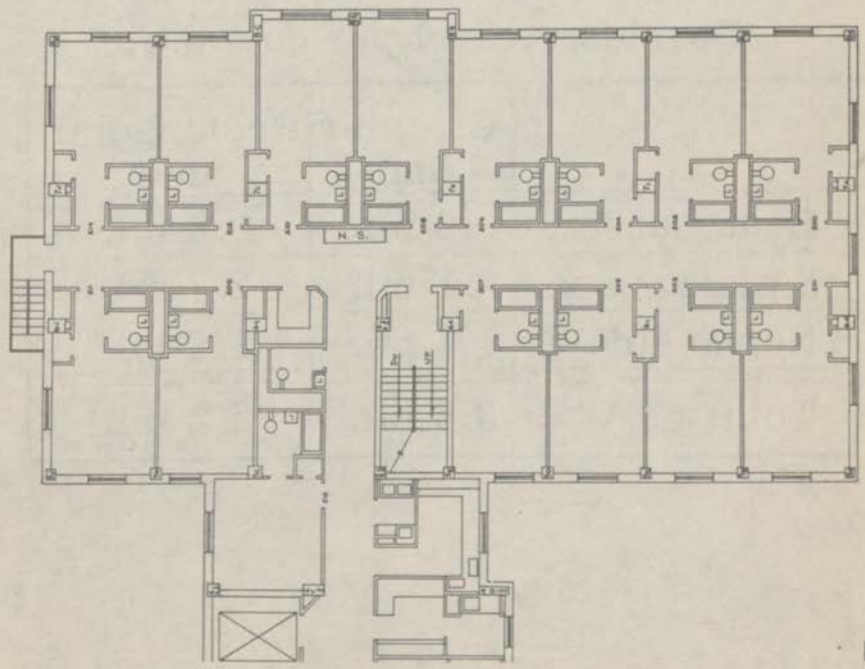









I SEE MR. JONES IS RESTING QUIETLY NOW.
I WONDER HOW MR. JONES IN RM. 11 IS NOW.
CONSTANT OBSERVATION
WITHOUT EFFORT
—YET—
COMPLETE PRIVACY
WHEN DESIRED


N. S.
N

NURSES' ACTIVITY
Travel

Unit	Travel as % of all activity
Circular	5.8
Rectangular	11.3

NURSES' ACTIVITY
Corridor travel per day shift

	Circular unit	Rectangular unit
Head nurse	.6 mi.	.8 mi.
3 staff nurses	2.1 mi.	2.7 mi.
Nurse aide	1.1 mi.	1.7 mi.
Total	3.8 mi.	5.2 mi.

ROCHESTER METHODIST HOSPITAL
Costs of Stage I vs. Private Duty Nursing Care

	Hours of care required*	Cost of nurses, aids, orderlies	
		Per hour	Per day
Stage I care†	7.5	$ 1.85	$13.88
Private duty care	24	2.25	54.00

*Per 24 hours.
†Stage I care in a circular unit is medically as satisfactory as private-duty care.

ROCHESTER METHODIST HOSPITAL
Estimated Costs of Nursing Service

Stage of care	Hours of care required*	Cost of nurses, aids, orderlies	
		Per hour	Per day
I 15-bed unit	7.5	$ 1.85	$13.88
II	3	1.71	5.13
III	1	1.42	1.42
Mixed care	4	1.73	7.12

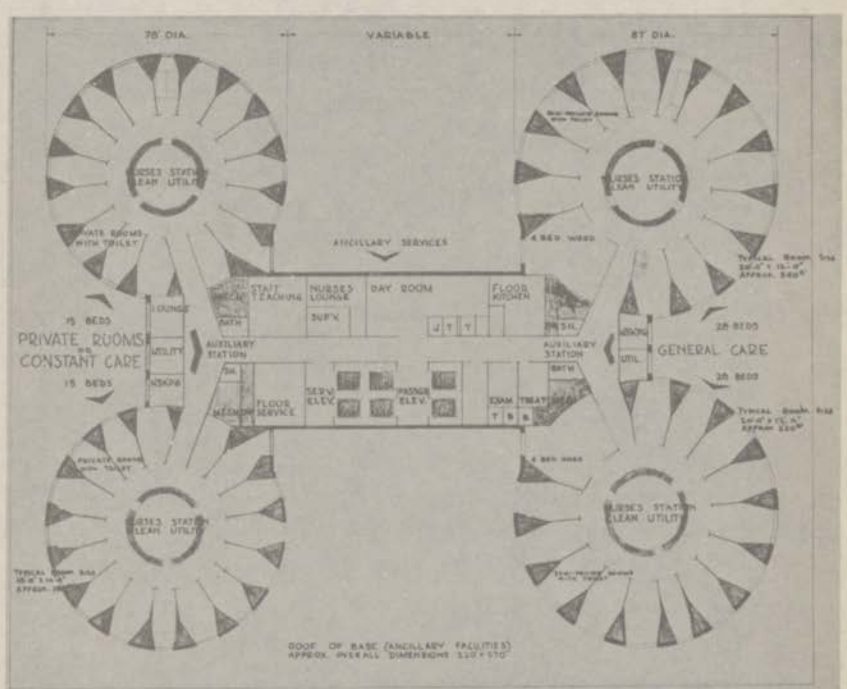
*Per 24 hours.

ROCHESTER METHODIST HOSPITAL
Type of Nursing Care Required

Stage of care	Percentage of care	
	Required from nurse	Possible from aid or orderly
I	80	20
II	60	40
III	20	80
Mixed	70	30

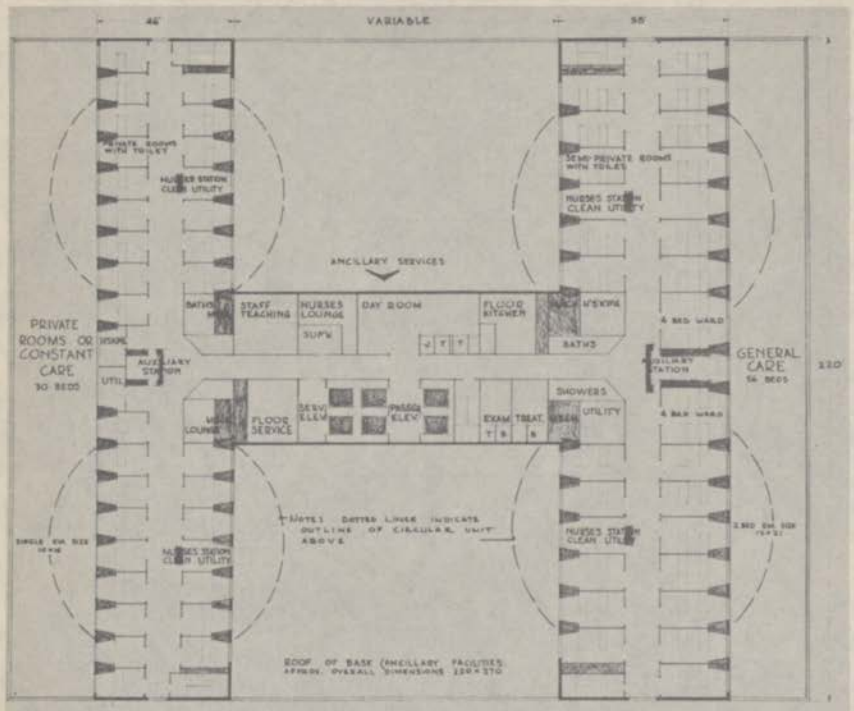
NURSING SERVICE COSTS
500 Bed Hospital; 80% Occupancy
(1955 Stage Distribution)

Type of care	Per cent of patients for each stage	Patient days	Cost per day	Annual cost
Stage I	20	29,200	$13.88	$ 405,296.00
Stage II	60	87,600	5.13	449,388.00
Stage III	20	29,200	1.42	41,464.00
Total staged care	100	146,000		$ 896,148.00
Mixed care	100	146,000	7.12	$1,039,520.00
Difference				$ 143,372.00



86 BED TYPICAL FLOOR PLAN
500 BED "CLOVER-LEAF PLAN" HOSPITAL

ELLERBE & CO. ARCHITECTS & ENGINEERS



86 BED RECTANGULAR CONTROL FLOOR PLAN
500 BED "CLOVER-LEAF PLAN" HOSPITAL

ELLERBE & CO. ARCHITECTS & ENGINEERS



The CHAIRMAN. Mr. Louis Blair, administrator of St. Luke's Hospital in Cedar Rapids, Iowa, is our next witness. He is accompanied by Mr. Kenneth Williamson, associate director of the American Hospital Association of Washington, D.C.

STATEMENT OF LOUIS B. BLAIR, MEMBER, COUNCIL ON GOVERNMENT RELATIONS, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY KENNETH WILLIAMSON, ASSOCIATE DIRECTOR

Mr. BLAIR. For the record, my name is Louis B. Blair. I am superintendent of St. Luke's Methodist Hospital, Cedar Rapids, Iowa. I appear before this committee today in my capacity as a member of the Council on Government Relations of the American Hospital Association. I am, as the chairman indicated, accompanied by Mr. Kenneth Williamson, its associate director.

The American Hospital Association is a voluntary, nonprofit membership organization with over 7,000 members, including the great majority of all types of hospitals. Among these are over 90 percent of the Nation's general hospital beds.

Last year, the Nation's general hospitals admitted more than 23 million patients. Our primary interest, and the reason for the organization of the American Hospital Association, is to promote the public welfare through the development of better hospital care for all the people. We have for many years supported a variety of Federal programs dealing with hospitals and health affairs.

Because of our interest in the health of American people, we are interested in H.R. 4998, the Community Health Service and Facilities Act of 1961 which seeks to expand and improve community facilities and services and health care.

This bill is in part an amendment to the Hospital Survey and Construction Act, familiarly known as the Hill-Burton Act. Though the bill seeks to improve health services to the Nation within the framework of that act, it overlooks what we believe to be a critical area of need. That is the renovation, modernization, or replacement of older hospitals, primarily in urban areas.

There is also a need to make the rehabilitation facilities contemplated by the act more widely available.

Before turning to these matters, I shall discuss the areas touched by the bill and in which we are interested, in the order of their appearance in the bill.

(1) Section 316, entitled, "Special Project Grants for Improving Community Health Services": This new section enables the Surgeon General to make grants to public or nonprofit organizations for "studies, experiments, and demonstrations looking toward development of new or improved methods of providing health services outside of the hospital, particularly for chronically ill or aged persons." The American Hospital Association supports this section. We welcome any new approaches to the problem of providing health care outside the hospital, and believe it is important to make funds available at this time for the study and development of such new approaches.

Hospitals and other community groups have been interested in a wide variety of approaches to the provision of home health services. These programs are aimed at developing community health services,

especially to the aged, which will make unnecessary prolonged hospitalization. We believe that the provision of grants under this section will stimulate the expansion and further development of these needed services.

(2) Increase in grants for construction of nonprofit nursing homes: Section 4 doubles the $10 million amount authorized to be appropriated annually as grants for the construction of public or other nonprofit nursing homes.

The Secretary of Health, Education, and Welfare has estimated that an annual appropriation of $20 million, together with other public and private construction funds, would make a net addition over the next 10 years of one-half a bed per 1,000 population for the care of long-term patients.

Expansion of the capacity of a nursing home is a desirable objective. Nursing homes play a significant role in provision of health care to the Nation. They are designed and equipped to furnish long-term care for aged and chronically ill patients, a role which is supplementary and complementary to that of hospitals.

We should move forward quickly in the construction of nursing home facilities. Any proposals for major expansion in the financing of health services for the Nation contemplates greatly increased numbers of skilled nursing homes.

Many existing nursing homes will not meet a standard of high quality nursing home care. Moreover, it is essential that patients be discharged from expensive general hospital facilities at the earliest possible date, and that there be adequate supplementary facilities to which they may be discharged.

The increasing cost of acute hospital care, and the limitation on the availability of hospital services, demands a rapid turnover of patients and the discharge of many patients suffering with long-term or chronic illnesses. Too many nursing homes do not provide care of sufficient quality to permit transfer of patients from acute facilities.

With the urgent need facing the Nation for great numbers of high quality nursing homes, we feel that the rate of development that would be brought about by an appropriation of $20 million is not adequate. We would urge, therefore, that consideration be given to increasing the estimated annual appropriation proposed in this bill from $20 million to at least $30 million.

(3) Section 5—Research, Experiments, and Demonstrations in Utilization of Medical Facilities: This section would amend section 636 which was added to the Hill-Burton program by amendment in 1949. Section 636 authorizes the Surgeon General to "conduct research, experiments, and demonstrations relating to the development and utilization of hospital services, facilities, and resources." The bill proposes to broaden this section in two ways.

First, it would extend the section to permit research, experiments, and demonstrations relating to "other medical facilities."

The bill does not define "other medical facilities," and it is not clear to what the term refers. If it is intended to limit the research section to the facilities already included in Hill-Burton, the bill should so state. We think it would be inadvisable to broaden the research section beyond the present scope of Hill-Burton.

Second, section 5 proposes to enable the Surgeon General to make project grants for the "construction of experimental and demonstration hospitals or other medical facilities."

These grants may amount to 66⅔ percent of the cost of the project or, in unusual circumstances, even a larger percentage.

The proposal does not conform to the principles which have guided the Hill-Burton program. That bill already makes ample provision for construction projects developing new types of design. There is nothing in the present grant program which prohibits or restricts new design or development of hospital facilities.

In addition, this proposal would make it possible to construct projects outside the priorities established within a State by Hill-Burton.

By permitting the Surgeon General to make direct grants for facility construction, it departs from the underlying principle of State agency administration.

An important advantage of State authority, which is governed by a priority system, has been that it has avoided undue pressure upon the Surgeon General with respect to individual projects.

For these reasons, we do not favor the provision providing for research facility construction as it now appears in the bill.

We believe there is a need for temporary or mockup-type construction related to the development of various service areas within the hospital. That construction may be used to carry out research for the improvement of the organization and operation of services.

Hill-Burton provides for permanent structures. Perhaps the purposes of the proposed amendment could be carried out by the establishment of a special research construction category within the construction program. Thus, State operation and administration of the program would be preserved, and the clear distinction between construction and research now provided for maintained.

The amendment proposes removal of the ceiling of $1.2 million on research funds. Though we have not taken a position on the advisability of completely removing the ceiling, we do strongly favor increasing to $8 million the amount which can be appropriated annually. Such an increase in research funds is long overdue. A growing list of needed projects must be rejected because funds are not available.

Our recommendation for considerable increase in funds is based primarily on the urgent need for study, experiments and demonstrations for urban planning of hospital facilities.

In recommending an increase in the limit on funds which can be appropriated under section 636, we suggest that Congress indicate its intent to have a substantial portion of any increased amount devoted to studies, research, and demonstrations relating to the urban development of hospital facilities.

(4) Renovation, modernization, or replacement of hospitals: I would now like to turn to the subject which is of primary concern to us and which is not dealt with in this bill. This is the renovation, modernization, or replacement of hospital facilities.

The Hill-Burton program has been successful in improving the total number of hospital beds in the Nation. A pattern of modern and efficient small hospitals in rural areas and in areas surrounding metropolitan centers has resulted. Many areas now have hospital facilities providing access to modern medical care not previously available to them. The success of Hill-Burton has been primarily in

the construction fo new hospitals. The major emphasis in the program to date has been placed on rural areas. Not only were their needs greatest, but they received first priority.

Largely left untouched, however, is a serious and rapidly growing need for the restoration or replacement of our older hospital facilities. The plight of these urban hospitals and the growing deficiency of their physical plants are important to the total health picture, not only because of the large population served by these hospitals, but also because, as centers of both medical research and professional training, they exert influences which are felt throughout the Nation.

About 5 years ago, the American Hospital Association conducted a survey of modernization needs of hospitals. This study indicated that it would take in excess of $2 billion at that time to modernize our older hospitals.

Last year, the U.S. Public Health Service conducted a nationwide study on this same subject. It showed there are 2,255 hospitals of all types in the United States needing modernization or replacement. The estimated cost of these projects is $3.6 billion. Even if allowance is to be made for the fact that the Public Health survey was more exhaustive than that of the American Hospital Association, it is quite apparent that the total cost of modernization is increasing at a rapid pace.

There are obsolete facilities in very section of the country, though the proportion of such institutions differs greatly. Of the number of hospitals that need renovation, 1,303 are located in metropolitan areas, 77 are in nonmetropolitan areas, and 175 are State-owned mental hospitals.

The total number of beds involved in these projects total 1,106,000. Obsolescence, moreover, is not merely a matter of age, for the rapid advances in medical techniques have rendered many institutions inefficient despite their relatively recent construction.

In 1958, we estimated the assets of all U.S. hospitals as $15.5 billion. The report by the U.S. Public Health Service points out that—

> the bill for obsolescence is about 20 percent of the total assets. This figure is staggering nationally when considered in relation to this vital national resource, and its local impact may be grave since the distribution of hospital obsolescence is uneven.

A significant conclusion, drawn from our survey 5 years ago is that more large hospitals than small ones are in need of modernization; whereas 40 percent of all private nonprofit hospitals reporting indicated such a need, the figure was 82 percent in the case of hospitals of 500 beds or more. We do not have the up-to-date figures, but it is reasonable to assume that the percentage is even greater now.

Additional evidence of the plight of large urban hospitals is to be found in a more intensive study, made in New York City by the United Hospital Fund, which reported modernization needs of private nonprofit hospitals amounting to about $250 million in that city alone.

We believe there are ways in which this problem can be met under the Hill-Burton Act. The act provides that "special consideration" must be given to "hospitals serving rural communities, and areas with relatively small financial resources."

We believe this priority in favor of rural areas should be removed, thereby permitting urban areas to participate. Removal of the rural priority will enable the States to determine the greatest need and to

allocate funds in accordance with need without regard to geographical location.

In addition, we suggest clarification of the requirement that priorities be based on the needs of areas "lacking adequate hospital facilities."

While we have thought that determination of the adequacy of facilities should take into account qualitative factors such as age, safety, and efficiency, and thus enable the modernization of obsolete facilities to be considered along with new construction, the present regulations of the Public Health Service seem to rest the priority of projects simply on numerical adequacy of acceptable beds. The result is that, with relatively few exceptions, the renovation needs of existing facilities have not been met.

If, as outlined above, increasing emphasis is to be placed on urban needs within the Hill-Burton program, substantial additional financing should be provided. This will require modification of the character of the program as well as the financing available.

We urge that the Hill-Burton program be amended in the following way: The basic authorization for construction grants under part C should be increased from $150 to $200 million a year. The amounts appropriated should be divided into two coequal parts, one of which should be earmarked for renovation, modernization, or replacement, and it will be necessary to provide new grants for surveying renovation, modernization, and replacement needs within each State.

It will also be necessary to make provision for apportioning funds among the States. As to this, particular attention will have to be paid to the extent of need within each State. Because of the size of the sums required for individual projects, the Federal share to be allotted to individual projects will have to take this into account.

We have expressed our belief that if the Nation's needs for hospital facilities are to be satisfied in the foreseeable future, public funds will be required in a much larger amount than that now authorized. Should this committee recommend increasing the funds for the Hill-Burton program, with provision to channel a substantial portion to meet renovation and replacement needs, we could hope to move forward rapidly.

If, however, the committee believes that the grant program should not be expanded along the lines we have suggested, we urge that you consider supplementing this program by a program providing long-term loans, carrying no interest or at most, a very low interest for hospital renovation, modernization, or replacement.

(5) Additional development of rehabilitation facilities: The 1954 amendments to the Hospital Survey and Construction Act set up, in part G of title VI, a new program permitting construction of rehabilitation facilities. The term is defined as meaning a facility providing an—

> integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision * * *.

This broad definition has had the effect of stimulating the development of comprehensive centers providing all aspects of rehabilitation.

The comprehensiveness required in the present definition has discouraged a good many hospitals from participating in rehabilitation because they are not in a position to undertake all aspects mentioned

in the definition. They can, however, make a significant contribution in special areas of rehabilitation. In order to encourage this under the act, the present definition should be amended. We urge adoption of an amendment which would eliminate the requirement that a "rehabilitation facility" encompass all possible aspects of rehabilitation.

The term should be defined to permit either an integrated program, or a program which would provide one or more of the services mentioned in the definition. If this is accomplished, we believe that rehabilitation services will be more widely available throughout the country.

In conclusion, I wish to express our appreciation for the opportunity afforded to discuss this legislation with you.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Blair, thank you very much for your testimony on this subject.

The amendments to the Hill-Burton Act which you have discussed in the latter part of your statement are not part of this proposed legislation. It is important to have your views and recommendations. I have been thinking for some time that I would like to bring about a complete review and study of the so-called Hill-Burton program. I have thought for some time that the act should be modernized so that it will more nearly meet the present-day needs as compared with the needs which existed some 15 years ago.

That, of course, is not the subject of this hearing and naturally we will be unable to go into it, but I do expect to try to arrange for that some time in the foreseeable future.

Mr. Mack, do you have any questions?

Mr. MACK. Mr. Chairman, I just have one very short question.

Mr. Blair, you represent the American Hospital Association?

Mr. BLAIR. Yes, sir.

Mr. MACK. Do you know of any activity to coordinate hospital research, or is that part of your responsibility? Does the association coordinate the research and collect the results and publish them? Is research being done by your hospitals throughout the country?

Mr. BLAIR. The American Hospital Association does have a council on research and education. It encourages this and does conduct some research itself. This, I think, is rather limited and if you would like further detail, I would like to ask Mr. Williamson if he would comment on the amount of it.

Mr. MACK. I don't want to consume any more time, but I was trying to determine whether you rely on the Federal Government for providing this service or the Public Health Service.

Mr. BLAIR. Insofar as the funds, we do not have funds to finance research in any substantial way.

Mr. MACK. I am interested in coordinating the research being done by your member hospitals and collecting and publishing the information for the benefit of all hospitals who are not only members of your association, but all hospitals throughout the country.

Mr. WILLIAMSON. We have been interested in keeping in touch with the Public Health Service and the people on those research grant sections who are also interested in our association so we try to keep aware and abreast of it.

We do rely on the publications which the Health Information Center in New York City publishes each second year which gives a listing of all health research projects in the United States that they can find and this publication is broadcast rather widely and we use that as a sort of bible to follow carefully on what is going on in research areas across the board you might say, in hospital and other matters.

Mr. MACK. How about the Public Health Service or the HEW? Do you rely on them?

Mr. WILLIAMSON. We do, yes.

Mr. MACK. And the National Institutes of Health?

Mr. WILLIAMSON. Yes.

The CHAIRMAN. Mr. Devine?

Mr. DEVINE. No questions.

The CHAIRMAN. Mr. Rhodes?

Mr. RHODES. Mr. Blair, you say your association represents hospitals that have 90 percent of the hospital beds. What about the other 10 percent?

Mr. BLAIR. There are private hospitals, proprietary hospitals. There are some other governmental hospitals. There are some voluntary hospitals that are not members. There are some chronic disease hospitals. There are a few who for their own reasons apparently have not sought to join up.

The CHAIRMAN. Mr. Thomson?

Mr. THOMSON. No questions.

The CHAIRMAN. Mr. Rogers?

Mr. ROGERS of Florida. No questions.

The CHAIRMAN. Mr. Dominick?

Mr. DOMINICK. Yes, sir. In the statement delivered on behalf of the Secretary, Mr. Ribicoff, it was stated that as of January 1, 1960, the State agencies had reported that 80 percent of the general hospital beds needed were available.

Do you agree with that figure and simply say that they need rehabilitation or renovation or do you disagree with the figure?

Mr. BLAIR. I would be in substantial agreement with the figure plus or minus a few percentage points, and I think that the testimony

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that we have given this morning is completely compatible with that.

We have indicated that we feel the need is met in the rural areas and that primarily our urban areas, there is a need for replacement and modernization, bed for bed perhaps, rather than essentially expansion. Of course, there are communities that are growing and will need some more beds.

The CHAIRMAN. Thank you, very much, Mr. Blair, for your testimony and you too, Mr. Williamson, for the contribution you have both made to the hearing.

Our next witness is Dr. Robert Barr, State health officer of the State of Minnesota who is representing the Association of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities.

STATEMENT OF DR. ROBERT BARR, SECRETARY AND EXECUTIVE OFFICER, MINNESOTA STATE BOARD OF HEALTH

Dr. BARR. Mr. Chairman, I have been asked by the chairman of the Association of State and Territorial Hospital and Medical Facilities, Mr. Foster Fowler, to present testimony on H.R. 4998.

I have a prepared statement which I would like to submit in order to make it more brief and I think it would be better that I not read this, but simply give you some of the points that I think are terribly important in this.

The CHAIRMAN. Very well. We will put your prepared statement in the record at this point.

(The full, prepared statement of Dr. Barr is as follows:)

Statement of Robert N. Barr, M.D., M.P.H., Secretary and Executive Officer, Minnesota State Board of Health, representing the State and Territorial Hospital and Medical Facilities Survey and Construction Authorities.

Presented before the Interstate and Foreign Commerce Committee, In support of H.R. 4998, on Wednesday, May 3, 1961

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

My name is Dr. Robert N. Barr. I am Secretary and Executive Officer of the Minnesota State Board of Health. I appear before your Committee today as a representative of the State and Territorial Hospital and Medical Facilities Survey and Construction Authorities to testify concerning H.R. 4998. This association includes the Hospital Construction Authorities of the fifty states, the District of Columbia and the Territories of Guam, Puerto Rico and the Virgin Islands. In the vast majority of instances, the Hospital Construction Authority legally resides in the respective State Departments of Health. I have been requested to represent this organization by Mr. Foster L. Fowler, Chairman of the Executive Committee of the Hospital Construction Authorities, who is also the Executive Director of the Mississippi Commission on Hospital Care.

The Authorities met on January 3, 4, and 5, 1961, at which time they recommended in principle the items included in H.R. 4998. This bill would amend Section 314 (c) of the Public Health Service Act to remove the $30 million ceiling for annual assistance to States and would also remove the $3 million ceiling on the portion now earmarked to enable the Surgeon General to provide demonstrations and to train personnel. The important provisions of the bill include:

1. Community Health Service Grants to States,
2. Special Project Grants,
3. Nursing Home Construction Grants, and
4. Hospital Research Grants.

Certainly almost every one agrees that there are many unmet health needs in America today; that the problems related to aging, mental health and disability are of major importance and that all of us have a part to play in developing the facilities as well as in providing for the trained personnel to staff such services. There is also universal recognition that the economic resources must be provided to finance these needed facilities and services.

I can see disagreement only in the proposed method for paying for health services for the aged and the specific part that government should play at the Federal, state, and local levels in doing so.

I am sure that it is agreed that those individuals unable to pay for medical, hospital, and related care services should not be denied such because of their financial straits, nor should they receive medical care of less adequate quality or quantity simply because society has accepted the responsibility for providing such.

There are some of us who are so provincial as to believe that if such an individual simply wants unnecessary special care, such as a pretty nurse to wait on him and hold his hand during his illness, it is hardly society's responsibility to provide for this kind of care. But, we also would add that if there are not enough nurses, either pretty or otherwise, to provide basic care to all who need it, then perhaps even the individual who has resources sufficient to pay for such attention is doing a disservice to society if he demands it and as a result deprives some other less fortunate individual of nursing service that is critically needed.

In review of S. 1071, I see no items relative to this controversial area of payment for health services. It appears that each of the four

key provisions of this proposed legislation are non-controversial in character and therefore must be considered on their individual merits.

In the development and improvement of nursing home facilities, states have recognized the need for improvement of services and have used their limited funds in every way possible to initiate programs to improve the quality of care as well as to expand these critically needed services. Today it is well recognized that these services, if adequate, are expensive and that costs, like those in hospitals, will continue to increase both because of necessary improvements in staffing and in the quality of services to meet the needs as well as to fill the gaps in the more rural areas where services are meager or non-existent.

It has been demonstrated that the provision of good home nursing services as well as home maker's services may not only reduce to some extent the need to provide nursing home beds but will also retain the individual in a family setting in his own community which, in properly selected cases, is best for the individual and is most economic. Unfortunately, such services which were once provided by neighbors and friends, and are now provided through visiting nursing services in the larger cities, are not available in most areas. Because of this unavailability the stay of the individual in the hospital or nursing home is, in many instances, longer than is necessary. In order to make such services most valuable it is essential that they be under the direction of the family physician and closely integrated with the services of the hospital and nursing home. This will assure a free flow of patients from the home to the proper care facility as the needs of the patients change. There still remains a real question as to the amount of physical and occupational therapy and other specialized services which can be made

available to the patient in his home with the acute shortages of such personnel today.

There are substantial numbers of trained personnel residing in most communities, particularly nurses, whose children are grown or who, because of other reasons, could give part-time services either in this field of home care or to the hospital or nursing home. The development of local rosters of such individuals would also be of tremendous value in case of a community disaster. Health departments are advocating the development of such for Civil Defense purposes. Several states, like Minnesota, have provisions for the development of home nursing services under the direction of the county public health nursing service and for the payments for care from public welfare funds as well as for the acceptance of private fees from those who are able to pay.

There are unquestionably many states which would have acute needs for the use of special project grants to study and demonstrate various methods to expand and improve community health services, to improve the quality of nursing home care and to determine the various types of services which can be provided economically in the home. For Example: the Amherst H. Wilder Foundation in St. Paul, which has recently completed a 140 bed nursing home as the first part of a 500 bed complex which will provide all types of services for the aged including housing, domiciliary care, rehabilitation, and a day care center. This Foundation also operates a complete rehabilitation center for St. Paul and the surrounding area. The Foundation formerly operated an outpatient clinic in connection with Miller Hospital and has developed unusual staffing for evaluation of health and welfare research studies. The Minnesota

Department of Health, through the Hill-Burton Program, has assisted in the construction of the nursing home and in expanding the rehabilitation center. The Department has now been requested to assist in the study and development of the extension of those services now available in the rehabilitation center and the aging complex into patients' homes in the community. Limited funds provided under General Health to the Department have been used to assist the Health Departments of the Cities of Minneapolis and St. Paul in the surveillance and improvement of nursing home services in these cities and in Hennepin and Ramsey Counties and also to expand home nursing services in certain counties and other cities in the State. The Kenny Rehabilitation Institute, with assistance from the Department, has developed an unusual training program in rehabilitation nursing for administrative nurses in hospitals, nursing homes, visiting and public health nursing services. This training program is scheduled well in advance, provides teaching materials and guides for the trainee to use upon returning to her position and has been utilized by nurses from all parts of the country.

A review of the attached, entitled Nursing Homes, Homes for the Aged and Infirmary Units Provided in Minnesota Since 1950, should be ample justification for increasing nursing home construction grants. During this period 207 homes with 8,921 beds have been provided (see page 8). It should be noted that 11% of the beds are publicly owned, 59% are owned by nonprofit associations, and 30% are privately owned (proprietary). It should also be noted that in those beds under construction, the proprietary ownership has fallen to 24%. Estimates of this Department made in 1959 indicate that approximately 1,600 nursing home beds would

be needed each year for the next ten years to provide for deficits, obsolescence and population increases, based on 5 beds per thousand population. These estimates included chronic hospitals, and present information appears to indicate that this estimate of bed need in long-term care facilities may not be adequate.

This trend in the development of nonprofit nursing homes in Minnesota, which represents a large proportion of the new facilities and those being planned, is not representative of the country as a whole. A majority of states have a much higher proportion of proprietary nursing home beds. The proprietary hospital is a thing of the past in this State and it is believed that there will be a gradual attrition of the proprietary nursing homes once the total needs for nursing home beds are met. Minnesota's experience seems to indicate that approximately one-third of the long-term care beds should be provided as units of the community hospital and that all nursing homes should have a close affiliation with the community hospital.

It is recognized that the Hospital Construction Authority has responsibilities far beyond that of the brick and mortar phase of the program. All hospitals and related facilities need help in planning and construction regardless of whether or not they are aided with Hill-Burton funds. All need help in developing coordinated, cooperative programs for the improvement of patient care. This means a close working relationship of all agencies concerned, including:

> Construction and licensing authorities --
> Health departments, hospital and medical associations,
> the nursing home association, welfare departments,
> the fire marshal, the aging associations, as well
> as all professional groups and organizations
> involved in providing care in hospitals and
> related facilities.

It is also recognized today that hospitals in order to provide quality services are faced with a constant spiraling of costs and at the same time must meet uniquely rigid standards which cannot be compromised for the sake of economy, efficiency, or for any other reason. The advances in patient care and treatment save lives and are therefore absolutely essential. When one looks at the cost of training personnel to staff hospitals and related facilities, one finds a very substantial cost borne by a small number of the general hospitals with government providing practically none of the costs of training the needed personnel, yet employing a substantial proportion of those trained. Such training includes medical internships and residencies, registered and practical nurse training, specialized nurse training, - such as rehabilitation nursing and nurse anesthestists, physical therapists and occupational therapists, X-Ray technicians and medical technologists and aides, dietitians, and hospital administrators. These training schools and programs are located almost exclusively in the larger general hospitals which provide more intensive services. Here the patient charges include most of the costs for such training programs.

For example: In Minnesota there are 26 registered nurse training schools graduating approximately 1,000 registered nurses each year It has been estimated that the average net cost of training a registered nurse for one year over and above the tuition and fees she pays and the value of her work during such training varies from $400 to $1,400 per year. Thus these 26 hospitals in Minnesota are expending between $1.2 million and $4.2 million annually in order to provide trained nurses for: the remaining 190 hospitals in Minnesota and the 321 nursing homes, industry, physicians offices and clinics, the official and voluntary public health agencies, the armed forces, the Federal and state hospitals and institutions.

Only three of the 26 registered nurse training schools are governmentally owned, and they graduate approximately 15% of the nurse graduates each year.

There is obviously a real need to study and determine how such training costs can best be removed from the sphere of hospital patient costs.

Much research is needed in the areas of: hospital administration, hospital usage, hospital design and construction, progressive patient care, the very important field of metropolitan planning for hospitals, the relationship between the central city and suburban hospital facilities and services, the economics of hospital modernization and expansion versus replacement, as well as in the coordination of care facilities of all types to make the best use of our limited numbers of trained personnel and expedite the provision of the particular type of care needed. Certainly the development, expansion, and coordination of rehabilitation service has in itself tremendous potentials.

The need for expansion of medical, dental and other related professional training schools in the health field has been emphasized in other legislative proposals. It is, however, recognized that recruitment and training of personnel in the health field are basic requirements for the development of good services.

Certainly the extensive problems in care field and the large sums now being expended to provide services warrant a large increase in the funds now provided for research which will require the removal of the present ceiling of $1.2 million.

Attachment - pp. 1-8.

KANSAS STATE UNIVERSITY
REFERENCE
LIBRARY
DEPARTMENT
MANHATTAN, KANSAS

NURSING HOMES, HOMES FOR THE AGED AND INFIRMARY UNITS PROVIDED IN MINNESOTA SINCE 1950

January 1, 1961

Minnesota Department of Health
Division of Hospital Services
University Campus
Minneapolis 14, Minnesota

MINNESOTA DEPARTMENT OF HEALTH
Division of Hospital Services
October 15, 1958

Nursing Homes, Homes for the Aged & Infirmary Units Provided Since 1950 in Minnesota
(Includes newly-licensed beds in homes and additions which are fire-resistive and beds in converted hospitals and structures which are sprinklered; new construction unless otherwise specified.)

Institutions	County	Location	Ownership	Beds	Type
1950					
1. Eventide Home	Cottonwood	Mountain Lake	NPA	53	H.A. & Inf.
2. Union Mission Farm Inf. (Convers.)	Hennepin	Medicine Lake	NPA	87	N.H.
3. John Field Hall (Ebenezer)	Hennepin	Minneapolis	NPA	100	H.A.
4. St. Joseph's Home (Conv.Co.Home)	Martin	Fairmont	NPA	24	H.A.
5. Lutheran Memorial Home	Norman	Twin Valley	NPA	64	H.A. & Inf.
6. St. Vincent's Home (Conv. Hosp.)	Polk	Crookston	NPA	73*	N.H.
7. Woodrest Nursing Home	Hennepin	Long Lake	Prop.	24	N.H.
			Total	425	
1951					
1. Sunnyside Rest Home(Conv.Tbc.San.)	Becker	Lake Park	Public	55	N.H.
2. Eventide Home	Clay	Moorhead	NPA	50	H.A. & Inf.
3. Union Mission Farm Inf. (Convers.)	Hennepin	Medicine Lake	NPA	65	N.H.
4. Walker Methodist Home Addition	Hennepin	Minneapolis	NPA	100	H.A.
5. Lutheran Home Addition	Scott	Belle Plaine	NPA	20	Inf.
6. Sarepta Home for Aged Addition	Stearns	Sauk Centre	NPA	30	H.A. Inf.
7. Oak Ridge (Conv. School)	Hennepin	Minneapolis	Prop.	92	N.H.
			Total	412	
1952					
1. Cedarbrook Manor (Conv.Tbc.San.)	Crow Wing	Deerwood	Public	32	N.H.
2. Shady Lane (Conv. Tbc. San.)	Wadena	Wadena	Public	40	N.H.
3. Washington County Home(Conv. Co. Home)	Washington	Stillwater	Public	41	N.H.
4. Good Samaritan Home	Clearwater	Clearbrook	NPA	28	H.A.
5. Bethany Home Addition	Douglas	Alexandria	NPA	55	Inf.
6. Jewish Home Addition	Ramsey	St. Paul	NPA	60	H.A.
7. St. Mary's Home(Exist.1st licens.)	Ramsey	St. Paul	NPA	65	H.A.
8. Doege Nursing Home Addition	Swift	Appleton	Prop.	11	N.H.
			Total	332	
1953					
1. Mesabi Home (Conv. Hospital)	St. Louis	Buhl	Public	33*	N.H.
2. Bethesda Nursing Home	Kandiyohi	Willmar	NPA	86	N.H.
3. Lutheran Home Addition	LacQuiParle	Madison	NPA	68	H.A. & Inf.
4. Emmaus Home (Conv. Hospital)	Meeker	Litchfield	NPA	39*	N.H.
5. Minnesota Odd Fellows Home Addn.	Rice	Northfield	NPA	32	Inf.
6. St. Francis Home (Conv. Hospital)	Wilkin	Breckenridge	NPA	108*	N.H.
7. Lake Haven Rest Home (Conv.Hosp.)	St. Louis	Duluth	Prop.	40	N.H.
			Total	406	
1954					
1. Lake Julia N. H. (Conv.Tbc.San.)	Beltrami	Puposky	Public	56	N.H.
2. Mother Frances Rest Home (Conv. Hospital)	Blue Earth	Mankato	NPA	70	H.A.
3. Good Samaritan Home Addition	Clearwater	Clearbrook	NPA	32	Inf.
4. Pioneer Memorial Home Addition	Otter Tail	Fergus Falls	NPA	31	Inf.
5. Bethesda Nurs. Home (Conv.Hosp.)	Polk	Crookston	NPA	57**	N.H.
6. St. Francis Home (Conv. Hosp.)	Scott	Shakopee	NPA	36*	N.H.
7. Good Samaritan Home (Conv. Hosp.)	Sibley	Gaylord	NPA	16*	N.H.
8. Pillsbury Ave. N.H. (Conv. Resid.)	Hennepin	Minneapolis	Prop.	33	N.H.
9. Lake Haven Rest Home (Conv.Hosp.)	St. Louis	Duluth	Prop.	8	N.H.
			Total	339	

* Sprinklered beds.
** Includes 33 sprinklered beds.

10/58 HS-1051.1

Minnesota Department of Health, Division of Hospital Services
Nursing Homes, Homes for the Aged & Infirmary Units Provided since 1950 in Minnesota, Continued.

Institution	County	Location	Ownership	Beds	Type
1955					
1. OtterTail Co. N.H. (Conv.Tbc.San.)	Otter Tail	Battle Lake	Public	50*	N.H.
2. Oakland Park N.H.(Conv.Tbc.San.)	Pennington	Thief River Falls	Public	75	N.H.
3. Nightingale N.H. (Conv.Nurses'H.)	Carver	Waconia	NPA	16	N.H.
4. Eventide Home Addition	Clay	Moorhead	NPA	15	H.A. & Inf.
5. Franklin N.H. (Reclassified)	Hennepin	Minneapolis	NPA	75**	N.H.
6. Parkview N.H. (Conv. Hospital)	Hennepin	Minneapolis	NPA	154	N.H.
7. No.Mem.Hosp.Unit(Conv.Nurses'H.)	Hennepin	Robbinsdale	NPA	36	N.H.
8. Presbyterian Home	Ramsey	St. Paul	NPA	30	H.A.
9. Mary Rondorf Home Addition	Todd	Staples	NPA	49	N.H.
10. Fairview Rest Home	Beltrami	Bemidji	Prop.	20	N.H.
11. Carlton Health Center	Carlton	Carlton	Prop.	40	N.H.
12. Daley Nursing Home #1 Addition	Goodhue	Red Wing	Prop.	20	N.H.
13. Woodrest Nuring Home Addition	Hennepin	Long Lake	Prop.	40	N.H.
14. Cedar Pines Nursing Home	Hennepin	Minneapolis	Prop.	28	N.H.
15. Crystal Lake Rest Home Addition	Hennepin	Robbinsdale	Prop.	42	N.H.
16. Hubbard County Nursing Home	Hubbard	Park Rapids	Prop.	36	N.H.
17. Lake Haven (Conv. Hospital)	St. Louis	Duluth	Prop.	27	N.H.
18. Doege Nursing Home Addition	Swift	Appleton	Prop.	10	N.H.
			Total	763	
1956					
1. Green Acres Nursing Home Add'n	Chisago	North Branch	Public	20	N.H.
2. Buena Vista Rest Home (Conv. Tbc. San.)	Wabasha	Wabasha	Public	34	N.H.
3. Queen Nursing Home (Conv. Hosp.)	Hennepin	Minneapolis	NPA	47	N.H.
4. Good Samaritan Home	Jackson	Jackson	NPA	47	N.H.
5. Samaritan (Conv. Hospital)	Olmsted	Rochester	NPA	113*	N.H.
6. Jewish Home for Aged Addition	Ramsey	St. Paul	NPA	38	H.A.
7. Eventide Home (Conv.Nurses'H.)	Roseau	Roseau	NPA	16	H.A.
8. Good Samaritan Home (Conv.Hosp.)	Stearns	Paynesville	NPA	15*	N.H.
9. Pleasant Nursing Home Addition	Hennepin	Minneapolis	Prop.	18	N.H.
10. Riverview Nursing Home	Hennepin	Minneapolis	Prop.	30	N.H.
11. Osseo Rest Home	Hennepin	Osseo	Prop.	60	N.H.
12. Crestview Nursing Home	Martin	Fairmont	Prop.	23	N.H.
13. Arrowhead (Conv. Hospital)	St. Louis	Eveleth	Prop.	45*	N.H.
14. Etta-Del Nursing Home Addition	Winona	Lewiston	Prop.	10	N.H.
			Total	516	
1957					
1. Cedarbrook Manor Addition	Crow Wing	Deerwood	Public	20	N.H.
2. Nopeming Tbc. San. Conv. (Trudeau)	St. Louis	Nopeming	Public	42	N.H.
3. Union Hosp. N.H. Unit(Conv.Hosp.)	Brown	New Ulm	NPA	12	N.H.
4. Jones-Harrison Home Addition	Hennepin	Minneapolis	NPA	25	Inf. Add.
5. Walker Meth. Home Addition	Hennepin	Minneapolis	NPA	104	H.A.
6. Broen Mem. Home (Conv.School)	Otter Tail	Fergus Falls	NPA	75*	N.H.
7. Comm. Health Center N.H. (Conv. Hosp.)	St. Louis	Two Harbors	NPA	40*	N.H.
8. Osseo Nursing Home Addition	Hennepin	Osseo	Prop.	40	N.H.
9. Leirfallom Nursing Home	Ramsey	White Bear Lake	Prop.	42	N.H.
10. Geselle Nursing Home	Renville	Olivia	Prop.	10	N.H.
			Total	410	

* Sprinklered beds.
** Includes 44 sprinklered beds.

Minnesota Department of Health, Division of Hospital Services
Nursing Homes, Homes for the Aged and Infirmary Units Provided Since 1950 in Minnesota - Continued (Revised January 22, 1959)

Institutions	County	Location	Ownership	Beds	Type
1958					
1. Masonic Cancer Hosp. (Nurs.Home)	Hennepin	Minneapolis	State	80	N.H. #
2. Cannon Hosp. Nursing Home Unit	Goodhue	Cannon Falls	Village	24	N.H.
3. Mankato Lutheran Addition	Blue Earth	Mankato	NPA	16	Inf.
4. St. John's Luth. Home (Conv.Hosp.)	Brown	Springfield	NPA	42*	N.H.
5. Sogge Memorial Home	Cottonwood	Windom	NPA	44	N.H.
6. Knute Nelson Home Addition	Douglas	Alexandria	NPA	30	Inf.
7. Kenyon Sunset Home Addition	Goodhue	Kenyon	NPA	16	Inf.
8. Red Wing Seminary Mem. Home Addn.	Goodhue	Red Wing	NPA	20	Inf.
9. Masonic Home Addition	Hennepin	Bloomington	NPA	44	H.A.
10. Lutheran Memorial Home Addition	Norman	Twin Valley	NPA	9	H.A.
11. Presbyterian Home Addition	Ramsey	Arden Hills	NPA	15	Inf.
12. Sholom Residence	Ramsey	St. Paul	NPA	38	N.H.
13. St. Mary's Home (Conv. Hosp.)	Todd	Long Prairie	NPA	27*	N.H.
14. Helgeson Nursing Home Addition	Benton	Sauk Rapids	Prop.	12	N.H.**
15. Bloomington Nursing Home	Hennepin	Bloomington	Prop.	54	N.H.
16. Heldwood Nursing Home	Hennepin	GoldenValley	Prop.	58	N.H.
17. Cedar Pines Home Addition	Hennepin	Minneapolis	Prop.	17	N.H.
18. Highland Park N.H. Addition	Hennepin	Minneapolis	Prop.	40	N.H.
19. Hillcrest Nursing Home	Hennepin	Minnetonka	Prop.	40	N.H.
20. Homestead Nursing Home	Hennepin	Minneapolis	Prop.	56	N.H.
21. Glenhaven Home	McLeod	Glencoe	Prop.	62	N.H.**
22. Fauskee Nursing Home Addition	Nobles	Worthington	Prop.	7	N.H.
23. Leirfallom Nursing Home Addition	Ramsey	White Bear Lake	Prop.	28	N.H.
24. Revere Rest Home Addition	Redwood	Revere	Prop.	20	N.H.
25. Lincoln Nursing Home Addition	Renville	Olivia	Prop.	9	N.H.
26. Arlington Convalescent Home #2	Sibley	Arlington	Prop.	49	N.H.**
27. Erickson Nursing Home	Swift	Benson	Prop.	29	N.H.**
			Total	886	

* Sprinklered beds. ** S.P.A. Loan #Hill-Burton Aid

1/59 HS-1051.3

Minnesota Department of Health, Division of Hospital Services
Nursing Homes, Homes for the Aged and Infirmary Units Provided Since 1950 in Minnesota - Continued. (Includes newly-licensed beds in (a) fire-resistive structures and (b) sprinklered buildings which arrange for care purposes.) Revised July 1, 1960.

Institutions	County	Location	Ownership	Beds	Type
1959					
1. Kittson Co. Home (Conv.)	Kittson	Hallock	Public	30*	N.H.
2. St. Peter Hosp. N.H. (Conv.)	Nicollet	St. Peter	Public	25	N.H.
3. Traverse Co. N.H. (New)	Traverse	Wheaton	Public	60	N.H.
4. Good Samaritan (Conv. Hosp. & Addn.)	Cass	Pine River	NPA	18	N.H.
5. Stevens Square (Addn.)	Hennepin	Minneapolis	NPA	36	H.A.(21) Inf.(15
6. Hendricks Retirement (Conv. Hosp.)	Lincoln	Hendricks	NPA	31*	N.H.
7. Good Samaritan (New)	Nicollet	Lafayette	NPA	27	N.H.
8. Good Samaritan (Conv. Hosp.)	Pipestone	Pipestone	NPA	33	N.H.
9. Minn. Odd Fellows (Addn.)	Rice	Northfield	NPA	40	Inf.
10. Mary Jane Brown N.H. (New)	Rock	Luverne	NPA	36	N.H.
11. Mother of Mercy N.H. (New)	Stearns	Albany	NPA	59	N.H.
12. Lutheran Mem. Home (New)	Watonwan	Madelia	NPA	58	H.A.(20) Inf.(38)
13. Highland Manor (New)	Brown	New Ulm	Prop.	60	N.H.
14. Brookview (New)	Hennepin	St. Louis Pk.	Prop.	16	N.H.
15. Homestead (Alt.)	Hennepin	Minneapolis	Prop.	15	N.H.
16. Holtan N.H. (New)	Lac Qui Parle	Dawson	Prop.	34	N.H.
17. Glenhaven (Alt.)	McLeod	Glencoe	Prop.	15	N.H.
18. Commonwealth N.H. (Conv.)	Ramsey	St. Paul	Prop.	69*	N.H.
19. Fairday N.H. (Addn.)	Ramsey	St. Paul	Prop.	14*	N.H.
20. Golden Age Nursing (New)	Ramsey	Roseville	Prop.	58	N.H.
21. Southview (Addn.)	Dakota	W. St. Paul	Prop.	24	N.H.
22. Buchanan (Conv.)	St. Louis	Chisholm	Prop.	27*	N.H.
23. Owatonna N.H. (New)	Steele	Owatonna	Prop.	64	N.H.**
			Total	849	

* Sprinklered beds
** Small Business Administration Loan

Minnesota Department of Health, Div. of Hosp. Serv. - Nursing Homes, Homes for the Aged and Infirmary Units Provided Since 1950 in Minnesota - Cont. (Includes newly-licensed beds in (a) fire-resistive structures and (b) sprinklered buildings which arrange for care purposes.) Revised 1-1-61.

Institutions	County	Location	Ownership	Beds	Type
1960					
1. Green Acres (Addn.)	Chisago	North Branch	Public	12	N.H.
2. Glen Lake N.H. Unit (Conv.)	Hennepin	Minneapolis	Public	28	N.H.
3. Tyler N.H. (Hosp. Unit - Conv.)	Lincoln	Tyler	Public	27*	N.H.
4. Ramsey Co. Home (Addn. & Conv.)	Ramsey	St. Paul	Public	30	N.H.
5. Red Lake Falls (New)	Red Lake	Red Lake Falls	Public	44	N.H.
6. Shady Lane (Addn.)	Wadena	Wadena	Public	8	N.H.
7. Granite Falls Hosp. Unit (New)	Yellow Med.	Granite Falls	Public	58	N.H.#
8. Sleepy Eye Com. N.H. (New)	Brown	Sleepy Eye	NPA	40	N.H.
9. St. John's Luth. Home (Conv.)	Brown	Springfield	NPA	40*	N.H.
10. Glenwood Hills (Hosp. Unit-New)	Hennepin	Golden Valley	NPA	118	N.H.
11. Swedish Hosp. (Hosp. Unit-Conv.)	Hennepin	Minneapolis	NPA	32	N.H.
12. Field Hall (Conv.)	Hennepin	Minneapolis	NPA	34	N.H.
13. Luther Hall, Ebenezer (Addn.)	Hennepin	Minneapolis	NPA	103	N.H.
14. Mount Olivet (New)	Hennepin	Minneapolis	NPA	73	B.C.H.***
15. Good Samaritan (New & Conv.)	Jackson	Jackson	NPA	6	N.H.
16. LeSueur N.H. (Hosp. Unit - New)	LeSueur	LeSueur	NPA	17	N.H.
17. Emmaus Luth. Home (Conv. Hosp.- second floor)	Marshall	Warren	NPA	17*	N.H.
18. St. Mary's N.H. (Hosp. Unit-New)	McLeod	Winsted	NPA	40	N.H.
19. St. James Home (Hosp. Unit-Conv.)	Otter Tail	Perham	NPA	30*	Inf.(20) B.C.H.(10)
20. Elder's N.H. (New)	Otter Tail	New York Mills	NPA	62	N.H.***
21. Bethesda N.H. (Hosp. Unit-New)	Ramsey	St. Paul	NPA	102	N.H.#
22. Tuff Memorial (New)	Rock	Hills	NPA	30	N.H.
23. Eventide B.C.H. (New - Alt.)	Roseau	Roseau	NPA	44*	N.H.(11) B.C.H.(33)
24. Lake Crystal (New)	Blue Earth	Lake Crystal	Prop.	60	N.H.**
25. Cornick N.H. (New)	Freeborn	Albert Lea	Prop.	28	N.H.
26. Angelus N.H. (New)	Hennepin	Minneapolis	Prop.	84	N.H.
27. Homestead (Addn.)	Hennepin	Minneapolis	Prop.	33	N.H.
28. Hopkins N.H. (New)	Hennepin	Hopkins	Prop.	78	N.H.
29. Kenwood N.H. (Addn.)	Hennepin	Minneapolis	Prop.	20*	N.H.
30. Osseo N.H. (Addn.)	Hennepin	Osseo	Prop.	24*	N.H.
31. Cambridge N.H. (New)	Isanti	Cambridge	Prop.	54	N.H.
32. Adelman (Addn.)	Meeker	Watkins	Prop.	15	N.H.
33. Comforcare (New)	Mower	Austin	Prop.	45	N.H.
34. Surf and Sand (New)	St. Louis	Duluth	Prop.	42	N.H.
35. Lake Shore N.H. (New)	Waseca	Waseca	Prop.	60	N.H.
36. Clarkfield N.H. (New)	Yellow Med.	Clarkfield	Prop.	28	N.H.
		Total		1,566	

* Sprinklered beds
** Small Business Administration Loan
*** Federal Housing Administration
\# Hill-Burton Aid

1/61 HS-1051.5

Minnesota Department of Health, Division of Hospital Services
Nursing Homes, Homes for the Aged and Infirmary Units Provided Since 1950 (Continued). (Includes newly-licensed beds in (a) fire-resistive structures and (b) sprinklered buildings which arrange for care purposes.) Revised January 1, 1961.

UNDER CONSTRUCTION (Not Licensed)

	Institutions	County	Location	Ownership	Beds	Type
1.	Hubbard County Home	Hubbard	Park Rapids	Public	60	N.H.
2.	Chateau Bldg. (Conv. Hosp.)	St. Louis	Nopeming	Public	68	N.H.
3.	Bethel N.H. Unit (Conv.)	Cottonwood	Mountain Lake	NPA	23	N.H.
4.	Sogge N.H. (Addn.)	Cottonwood	Windom	NPA	33	N.H.
5.	Knute Nelson H.A. (Addn.)	Douglas	Alexandria	NPA	17	B.C.H.
6.	St. John's Home (New)	Freeborn	Albert Lea	NPA	72	N.H. (57)#
						B.C.H. (15)
7.	Elbow Lake N.H. Unit (New)	Grant	Elbow Lake	NPA	24	N.H.
8.	Alliance #2 (Addn.)	Hennepin	Minneapolis	NPA	43	N.H.
9.	Augustana Home (Addn.)	Hennepin	Minneapolis	NPA	99	N.H.#
10.	Bethany Covenant (New)	Hennepin	Minneapolis	NPA	61	N.H.
11.	Martin Luther (New)	Hennepin	Bloomington	NPA	84	N.H. (24)
						B.C.H. (60)
12.	Bethesda (Addn.)	Kandiyohi	Willmar	NPA	66	N.H. (24)
						B.C.H. (42)
13.	Emmaus Luth. Home (Conv. Hosp.)	Marshall	Warren	NPA	27*	N.H. (16)
						B.C.H. (11)
14.	Elim Home (Addn.)	Mille Lacs	Princeton	NPA	52	N.H.
15.	St. Mary's Villa (New)	Morrison	Pierz	NPA	54	N.H.
16.	Bethesda Home for Aged (New)	Polk	Crookston	NPA	18	H.A.
17.	Minnewaska Luth. (New)	Pope	Starbuck	NPA	38	N.H.
18.	St. Paul's Church Home (Addn.)	Ramsey	St. Paul	NPA	54	N.H.
19.	Wilder N.H. (New)	Ramsey	St. Paul	NPA	141	N.H.#
20.	Morgan N.H. (New)	Redwood	Morgan	NPA	45	N.H. (22)
						B.C.H. (23)
21.	St. Lucas N.H. (Conv. Hosp. & Addn.)	Rice	Faribault	NPA	59	N.H.#
22.	Viewcrest N.H. (New)	St. Louis	Duluth	NPA	40	N.H.
23.	Evangelical Luth. Home (Addn.)	Scott	Belle Plaine	NPA	36	N.H.
24.	St. Elizabeth N.H. (Conv.)	Wabasha	Wabasha	NPA	63	N.H.
25.	Croixdale N.H. (New)	Washington	Bayport	NPA	46	N.H.
26.	Paul Watkins (New)	Winona	Winona	NPA	87	B.C.H.
27.	St. Anne Hospice (New)	Winona	Winona	NPA	105	N.H.# (68)
						B.C.H. (37)
28.	Ebenezer Home (Addn.)	Wright	Buffalo	NPA	26	N.H.

(See next page)

1/61 HS-1051.6

Minnesota Department of Health, Division of Hospital Services
Nursing Homes, Homes for the Aged and Infirmary Units Provided Since 1950 (Continued). (Includes newly-licensed beds in (a) fire-resistive structures and (b) sprinklered buildings which arrange for care purposes.) Revised January 1, 1961. (Continued)

	Institutions	County	Location	Ownership	Beds	Type
29.	Camelia N.H. (New)	Hennepin	Minneapolis	Prop.	96	N.H.
30.	LaSalle (Addn.)	Hennepin	Minneapolis	Prop.	39	N.H.
31.	Park N.H. (New)	Hennepin	Minneapolis	Prop.	78	N.H.
32.	Martin N.H. (Addn.)	Kanabec	Mora	Prop.	20	N.H.
33.	Poppenhagen N.H. (New)	Otter Tail	Fergus Falls	Prop.	34	N.H.
34.	Henning N.H. (New)	Otter Tail	Henning	Prop.	42	N.H.
35.	Welcome Home (New)	Ramsey	St. Paul	Prop.	24	N.H.
36.	Buffalo Lake N.H. (New)	Renville	Buffalo Lake	Prop.	36	N.H.
37.	Franklin N.H. (New)	Renville	Franklin	Prop.	36	N.H.
38.	Geselle N.H. (Addn.)	Renville	Olivia	Prop.	14	N.H.
39.	Valley View San. (Conv.)	Scott	Jordan	Prop.	25*	N.H.
40.	Lindberg N.H. (Addn.)	Swift	Kerkhoven	Prop.	14	B.C.H.
41.	Elm Rest Home (Addn.)	Washington	Stillwater	Prop.	18	N.H.
			Total		2,017	

* Sprinklered beds
** F.H.A. Loan
# Hill-Burton Aid

Table I - Distrib. of Beds Newly-Licensed and Under Construction, 1950 Through 1960

Year	Total Beds	Hennepin Co.	Ramsey Co.	Remainder of State
1950	425	211	0	214
1951	412	257	0	155
1952	332	0	125	207
1953	406	0	0	406
1954	339	33	0	306
1955	763	375	30	358
1956	516	155	38	323
1957	410	169	42	199
1958	886	389	81	416
1959	849	67	141	641
1960	1,566	627	132	807
Under Const.	2,017	500	219	1,298
Totals & %	8,921 (100%)	2,783 (31%)	808 (9%)	5,330 (60%)
Lic. Beds (5/1/60) & %	15,673 (100%)	4,876 (31%)	1,867 (12%)	8,930 (57%)

Minnesota Department of Health, Division of Hospital Services
Nursing Homes, Homes for the Aged and Infirmary Units Provided Since 1950 in Minnesota - Continued (Revised January 1, 1961)

SUMMARY

Table II - Newly Licensed Beds in Fire-Resistive and Sprinklered Structures, 1950 through 1960

Year	New Homes or Additions - Completed			Beds Provided			Beds by Type of Ownership								
							Public			NPA			Proprietary		
	Total	New	Conv.	Total	New	Conv.	Total	New	Conv.	Total	New	Conv.	Total	New	Conv.
1950	7	4	3	425	241	184	0	0	0	401	217	184	24	24	0
1951	7	4	3	412	200	212	55	0	55	265	200	65	92	0	92
1952	8	5	3	332	219	113	113	0	113	208	208	0	11	11	0
1953	7	3	4	406	186	220	0	0	0	366	186	180	40	0	40
1954	9	2	7	339	63	276	56	0	56	242	63	179	41	0	41
1955	18	11	7	763	330	433	125	0	125	375	94	281	263	236	27
1956	14	8	6	516	246	270	54	20	34	276	85	191	186	141	45
1957	10	6	4	410	241	169	62	20	42	256	129	127	92	92	0
1958	27	25	2	886	817	69	104	104	0	301	232	69	481	481	0
1959	23	16	7	849	616	233	115	60	55	338	256	82	396	300	96
1960	36	29	7	1,566	1,358	208	207	152	55	788	635	153	571	571	0
Totals	166	113	53	6,904	4,517	2,387	891	356	535	3,816	2,305	1,511	2,197	1,856	341
Per cent	100	68	32	100	65	35	13	5	8	55	33	22	32	27	5
Under Const.	41	36	5	2,017	1,811	206	128	60	68	1,413	1,300	113	476	451	25
Per cent	100	88	12	100	90	10	6	3	3	70	64	6	24	22	1
Total Completed & Under Const.	207	149	58	8,921	6,328	2,593	1,019	416	603	5,229	3,605	1,624	2,673	2,307	366
Per cent	100	72	28	100	71	29	11	5	7	59	40	18	30	26	4

Total Facilities Licensed on 5-1-60	Public	NPA	Proprietary
449 Homes 15,673 Beds	29 Homes = 6% 2,300 Beds = 15%	117 Homes = 26% 6,954 Beds = 44%	303 Homes = 68% 6,419 Beds = 41%

1/61 HS-1051.8

Dr. BARR. I would like to state that this association particularly emphasized at its meetings of last January with the Surgeon General the additional funds for research and demonstration in the hospital field and the increased need for increasing funds for the construction of long term care facilities.

They also added to their recommendations which I am sure will eventually be filed with you by the Public Health Service. As these recommendations are made to the Surgeon General, the recommendations relative to the total Hill-Burton program are made known.

In following this, I would like to bring to your attention the very important problem of nursing home care with its association with hospitals, nursing homes, and the home nursing services and the need to relate these together so that we are providing a better service and in doing so, I think it would be worth your while if I gave you just a little information what has happened in Minnesota in this particular field.

Some 15 years ago, Minnesota provided, under the old-age assistance in the categorical age grants, unlimited medical nursing home care to all the people who were included in these various groups.

This means old-age assistance, crippled and disabled, blind, widows, orphans, and that sort that are included under the Social Security Act.

These funds that were expended for medical services increased in that 15 years from $500,000 to $25 million.

Now when I say medical services, I mean hospitals, nursing home care, drugs, medical care, which represents only 10 percent of this. Nursing home is 37 percent; hospital care, 34 percent; and nursing home care in the community. What I am trying to say is that this represented approximately the amount included in the Kerr-Mills bill as passed by Congress last year because under old-age assistance it was the policy of the State of Minnesota to transfer an individual who is receiving old-age insurance or some other type of insurance, capable within his normal needs, but move him into old-age assistance if he required nursing home care.

Now, out of our 330,000 people over 65, there are approximately 49,000 of these people who are on old-age assistance. One half of this number are receiving some kind of medical services because of that, and about 16 percent of this 24,000 are actually people who have old-age insurance or some other resources and have been transferred into old-age assistance because of the fact that they had medical needs which they could not meet with their present resources.

As a result of this, we have embarked over the years with Hill-Burton on a rather extended program in developing hospitals throughout the State, but at the same time in building nursing homes in the State of Minnesota.

Six years ago it was proposed in our State legislature that we appropriate $20 million and we nearly passed the bill to subsidize the construction of nursing homes and homes for the aged. We failed to pass that only because of the opposition of the private industry and because certain groups felt this was really pouring it on pretty thick and they asked us to wait for the next 2-year session.

It did pass the house there but did not pass the senate. They said wait 2 years and see what happens. We had been building at that time and they are listed, Mr. Chairman, in the summary attached to this statement.

Now we have been building about 400 beds a year. This next year, this will jump to about 800. It will increase to about a thousand beds. This past year we have 2,000 nursing home beds under construction.

The thing that has happened in this is that these are not small nursing homes now. These are modern, large 40- to 100-bed nursing homes, different from what we find throughout the country. Over 70 percent of these beds being built are built by nonprofit groups or the cities and counties.

Last year, it was 73 percent and only 23 or 24 percent are being built by private enterprise or for a profit.

The small, non-fire-resistant ones, the converted homes, are being either replaced completely or else they are being turned into homes that we call boarding and care homes or homes for the aged.

At the same time, the State has made provisions, if I can jump to this, for what we call foster homes. In other words, where old people need supervision but don't need nursing care. They can be placed in a home that is not licensed and live as a member of the family, one or two people on one of these foster homes and therefore, receive this type of care that they may need if they do not have one of their own.

We have now something like 16,500 beds as you will find listed in the statement in the State of Minnesota which represents slightly more than 5 beds per thousand of which over 12,000 of these are either chronically, long-term care beds or they are nursing home beds.

In addition to that, some 20 of these facilities are built as nursing home units of hospitals.

Now then, I want to drop, if I may, to another subject and give you a picture to show that we have not met our needs. If we are going to have what we believe are to be the needs of these people, we are going to have to provide to keep up with the population growth of our older people; to replace the ones that have become antiquated with modern and good facilities and to replace and build up to meet the needs which we estimate as 5 per thousand nursing homes and we are going to have to build about 1,600 beds a year for the next 10 years.

Obviously, the amount of appropriations that have been made to subsidize nursing homes is very small and so we have used the diagnostic and treatment money as allowed under part G and have used the funds allowed under chronic units and put these together to build units in most instances that are examples of good ones, some that are units of hospitals; some that are free standing and some that are units of large homes for the aged.

Obviously, we have been only able to assist a small number and usually that being the full category of 45 percent under the Hill-Burton in Minnesota, this runs 15 to 18 percent. But we have been able to develop over the period of time, some 10 or 12 of these which are good examples of fine services in the State and they are being used as models to be followed by other people who are doing it on their own with voluntary moneys or moneys that they are using as private enterprise.

Now then, I think the other thing we must recognize is that too many of our nursing homes in the past have been simply houses that were converted to take care of people. They were small, and because of their size they were not adequate for the kind of service they were able to give because of the shortage of staff, nursing, and all the things that go into it and the lack of rehabilitation service.

By placing these units in larger units as we are developing today in the communities, we are able to provide and tie them in across the State closely with the hospitals. We are able to provide good rehabilitation services so these people can be put back on their feet at least in a certain number so they can take care of themselves.

We have been able to develop better nutrition services for them and been able to take advantage of all the things that were in the hospital, whether attached or in the communities.

The State of Minnesota has also received some research grants under the $1.2 million item in which we have been doing work to try to improve the quality of the patients' services and we have done surveys of X-ray and laboratory services.

We have been pushing the development of physical and occupational therapy and finding out how many people we have.

We have been trying to develop better rehabilitation service centers. The Kinney Institute has a school in which they are pulling in the chief nurses from the hospital and from the large nursing homes for a period of 3 weeks, teaching her and giving her teaching material and telling her how to handle what we call rehabilitation nursing—handling people; not to restore them completely, but develop these people and keep them from developing further disabilities when they are in a nursing home.

Too much of our hospital services today in the acute hospitals are providing everything for the patient when the person can be cared for elsewhere. The older person will have a stroke or something else and we must see to it that he himself learns to use his hands and is actively cooperating in it rather than let him lie in bed and develop further deformities and further paralysis of this arm or leg.

Now, then, I think the other thing is, it was only a few years ago—and I can say this from my own personal experience that my mother, who at 80 years of age developed a stroke and after getting this squared off and getting her back on her feet, she fell and fractured her hip. She again was in bed too long and developed some senility, and at 86 she wound up by staying in a nursing home most of the time, flat on her back in bed, and gradually decreasing in her vitality to the point where she didn't recognize any of us.

This is the thing we are trying to say we want to escape from, if possible. We must put these people back on their feet so that they can be enjoying the things they are doing; so that they do not deteriorate; so they do not develop additional deformities—and this is one of the important phases of nursing homes and one of the important things that the nursing home does.

I can tell you the costs in Minnesota for this will run about from $9 to $10 a day where they get all of these things, and this is what we consider very intensive nursing home care—around the clock.

We also must have the free standing nursing home, that unit of an old people's home where, if nothing more can be done for these people, they get good nursing care and they get protection so they don't decrease any further.

We think a third of the nursing home beds should be units of hospitals, because we are trying to tie things in there. We also think they ought to be larger than they have been.

You see in your reports about the average size of the nursing home and where it is 18 patients. They need to be 40 or 50 if we are going to justify the nursing services.

The CHAIRMAN. Doctor, if you will pardon me for interrupting. We do have another witness and we will have a House call in about 10 minutes.

Dr. BARR. I am sorry, sir, but in connection with this, we see a real need for home nursing services and the homemakers services to keep these people in their homes as long as possible. If they get to the point in a nursing home or hospital where they don't need that, to help them get along in their own homes.

These are the important things, sir. I know that some of the other witnesses will discuss some of the other topics.

The CHAIRMAN. Doctor, we appreciate your testimony. Your statement which I have had occasion to go over is quite thorough, and it certainly will add to this record.

I want to commend you and your State for the progress that you have made in providing nursing home facilities. You are doing an outstanding job. Obviously, your State has exercised leadership in providing these facilities.

Dr. BARR. Thank you, sir.

The CHAIRMAN. We appreciate having your testimony.

Are there any questions?

If not, the committee will now adjorn, to reconvene at 10 o'clock in the morning when our first witness will be Dr. Wilson T. Sowder, State health officer, Florida State Board of Health.

(Whereupon, at 12 o'clock noon, the committee adjourned, to reconvene at 10 a.m., Thursday, May 4, 1961.)

COMMUNITY HEALTH SERVICES AND FACILITIES ACT OF 1961

THURSDAY, MAY 4, 1961

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMRCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 1334, New House Office Building, Hon. Oren Harris presiding.

Present: Representatives Harris (chairman), Williams, Mack, Friedel, Rhodes, Rogers of Florida, Hemphill, Rostenkowski, Devine, Nelsen, Keith, Curtin, Sibal, Thomson, and Dominick.

The CHAIRMAN. The committee will come to order.

When the committee adjourned yesterday, Dr. Wilson T. Sowder was about to give his statement. I believe, Doctor, you were identified for the record yesterday so you may now proceed.

STATEMENT OF DR. WILSON T. SOWDER, STATE HEALTH OFFICER, FLORIDA STATE BOARD OF HEALTH

Dr. SOWDER. I would like to remind the committee that I represent the Association of State Health Officers of the 50 States.

We think this is one of the best bills that you gentlemen have had under consideration up here for the past several years. We endorse all of the four major features of the bill.

We think that feature of the bill lifting the ceiling on hospital research grants is a good thing. We endorse this. We endorse the increase in the authorization for grants for construction of nursing homes from $10 to $20 million but we think that is a rather small amount to really get very much construction done.

We endorse the feature of the bill which has to do with special grants made by the U.S. Public Health Service for increasing and finding better ways and means of rendering health care and medical care in the various States and communities of the country. We think that is a good technique; is time tested, and the few million dollars that is envisioned in this program we think will be well spent.

We favor the 314–Me feature of the bill, a new feature that would allow, under the regular grant-in-aid program, the Public Health Service to furnish personnel in lieu of money and subtract it from the grant.

I want, however, to speak mainly on behalf of that section of the bill which would propose to amend section 314(C) of the U.S. Public Health Service Act.

We think that this is the major feature of the whole bill and it is the most important one. It may be that we are prejudiced because that

money would come to us; but aside from that, we think that that section of the bill which would take away the present $30 million ceiling on grants-in-aid to States could do more and could do it more efficiently and for less money han any other thing that Congress could do.

We believe however, that medical care, and however you do it, whether privately, by the public or what, is an expensive undertaking and we know that you are interested in keeping people well and getting those who are sick well again in the most economical way.

The CHAIRMAN. Just illustrate for us the service that you refer to that is provided by this section of the bill.

Dr. SOWDER. Yes, sir; that is just what I was going on to do.

The services envisioned in this section would be primarily non-institutional services. It would build up services in the States and organize facilities to keep people out of hospitals and to take care of them at home.

This, in my own State at least, would be flexible. In Florida, the money would be spent primarily to employ nurses to visit the sick at home and at their bedside and keep them well there and keep them out of nursing homes and keep them out of hospitals insofar as possible.

You all listened to the gentleman from the Mayo Clinic yesterday talk about the virtues of the round versus the square hospital. We would spend this money to keep people out of all hospitals, round or square, insofar as possible if they weren't sick enough to be there.

We made a survey of our hospitals in our State and we got the opinions of the hospital administrators to the effect that about 1 out of 10 of the people in the hospital didn't need to be there. That amounts, countrywide, to a lot of money. Half of those they said could have been taken care of in a nursing home. The other half didn't even need to be in a nursing home. They could have just as well have stayed at home. That is 1 out of every 20, which is 5 percent. Three out of those five would need home nursing care.

Now that is the way it is in Florida at least, and I believe in most of the States they would spend at least a part of the money that would be provided under this increased Federal grant.

The CHAIRMAN. How would they go about providing this service at home?

Dr. SOWDER. We are already doing it, sir, in about 12 or 15 of our larger counties. We do it through the health departments, through the visiting nurse services which are allied with the health departments.

The CHAIRMAN. Let's go back. How do you start out; how does the man first get his name before the proper agency to get this consideration? Does he go to the local health office? Is he referred by a doctor, or just how does he go about it?

Dr. SOWDER. He is referred by a doctor, sir. However, we do have, in Florida and most of the States, health departments with pretty good coverage and we have nurses in those health departments who are in the larger counties, at least, where they have it divided up into districts and they are pretty well aware of who is sick or not sick. But this particular kind of service would be on a doctor's order and would be in cooperation with the attending physician and would work with the hospital people. A person that is in the hospital could go home a week earlier if the nurse could go and see him and give him some shots or whatever he might need.

In Florida, we have what we call the VNA—Visiting Nurse Association—in two separate counties, separate from the health department. That is about a third of the 12 counties where we have it set up. In the others, they are supervised by the health department, but the money from those who can pay is collected in the name of a nonprofit organization.

Through the machinery that we are building there and which we could build further and extend to our other 55 counties we would provide a community service for taking care of the rich and the poor alike.

Now, visiting nurse services, home nursing, and home health care should be available to both rich and poor alike, but those who can pay for it should pay for it and our plan there, and it is followed in most of the States, is designed so that you can take care of the poor folks for free and those that can pay, do pay.

Now, the relative costs paid for by the patient varies from about 20 percent to about 50 percent of the total cost. It has to be subsidized as it won't pay for itself.

The CHAIRMAN. You are not helping me a whole lot, doctor. I am trying to find out for my own information and for this record, what the procedure is. Let us suppose you have an individual, whether he has been in a hospital, or whether he has been to see a doctor in his own office, or whether he has been in a private clinic and that individual feels that he should be given some assistance as a noninstitutional patient. Do you know what I have in mind?

Dr. SOWDER. Yes, sir.

The CHAIRMAN. How does he go about getting the benefit of the service?

Dr. SOWDER. His physician arranges it for him.

The CHAIRMAN. Arranges it with whom?

Dr. SOWDER. With the home nursing service.

The CHAIRMAN. The home nursing service under that?

Dr. SOWDER. It could be in the health department or outside the health department, but every physician in any locality would know about this service just as he would know what hospitals are in the community. He would know that here is a place in the health department or in the Home Nursing Service, Inc., or at the visiting nurse service where a nurse is available to go to that person's home.

The CHAIRMAN. Now, would that come through the local welfare office or how would it operate?

Dr. SOWDER. In our State, it is paid to the nursing service itself.

The CHAIRMAN. The nursing service?

Dr. SOWDER. Home Nursing Service, Inc.—that is the visiting nurse service collects the money.

The CHAIRMAN. Is this nursing service a State or Government operated facility?

Dr. SOWDER. It is a private, incorporated business subsidized in my State.

The CHAIRMAN. In other words, you have a private organization, a nursing service.

Dr. SOWDER. That is right.

The CHAIRMAN. Which is organized for profit.

Dr. SOWDER. Not for profit; no, sir.

The CHAIRMAN. It is a nonprofit organization?

Dr. SOWDER. It can't pay more than half at best, of its expenses. It is doing very well if it can pay half.

The CHAIRMAN. Who subsidizes the other 50 percent?

Dr. SOWDER. The Community Chest, and the taxpayers.

Mr. WILLIAMS. Might I interrupt, Mr. Chairman?

The CHAIRMAN. Yes.

Mr. WILLIAMS. Is that the State taxpayers?

Dr. SOWDER. We do in Florida; yes, sir, and we are proposing that that would be how we could use some of this money if it comes to Florida, to extend that service. In fact, we are already doing it.

Mr. WILLIAMS. I see.

Dr. SOWDER. We are doing it in a few of the smaller rural counties. We hire a nurse to develop this service and there are some people here from Kentucky who are nurses and who can tell you more exactly how it works.

The CHAIRMAN. Very well. I will wait until I hear from them.

Dr. SOWDER. But it is the cheapest and best way to keep people out of the hospital and to provide them with services at a minimum of cost. In addition, we feel in my State that we need to subsidize and build up outpatient clinics as another means of keeping people out of the hospital and out of the nursing homes.

Our physicians are ready for it. Our hospital people are ready for this and our communities are ready also. We would enlarge community health services that we are already rendering to patients going to and coming from the mental hospitals. We feel that there are many ways that the time spent in mental hospitals can be cut down if there is some organization for them to come back to.

We are now building that up in my State and under this bill, more of that could be done in more of the States. We are also doing that for the institutions for the State. The health departments are the hands and feet of the institutions in the State so that they have somebody to refer sick people back to and to follow up on.

I think that this bill envisions the most economical and the cheapest way to keep the cost of medical care down, that it will cost a lot of money and I think that at least the proposed amount of appropriations in the next few years, that for every $1 million spent by the Federal Government and State government in matching this, that we will save $5 million in institutional care.

I do hope that you gentlemen will give it thoughtful and prayerful consideration and pass it.

Thank you, sir.

The CHAIRMAN. Your statement as you have presented it to us, Doctor Sowder, will be included in the record at this point.

(The full, prepared statement of Dr. Sowder is as follows:)

I am Wilson T. Sowder, M.D. For the past 16 years, I have been health officer of the State of Florida. Currently, I am a member of the executive board of the American Public Health Association, chairman of the sectoin on preventive medicine of the American Medical Association, a member of the National Advisory Committee on Chronic Diseases and the Health of the Aged of the U.S. Public Health Service and a consultant on medical matters to the Bureau of Public Assistance of the Department of Health, Education, and Welfare. I am also the immediate past president of the State and Territorial Health Officers Association. Though familiar with the interests and policies of all of these agencies and committees, and though usually in agreement with my medical and public health associates, I come to you as a representative of the State and

Territorial Health Officers Association. I believe that the opinions expressed here will be endorsed by the great majority of my fellow health officers.

Before commenting on specific provisions of H.R. 4998, may I indicate the basic considerations which determine the nature of my recommendations.

Since World War II, Congress has displayed commendable concern with the advancement of medical and health knowledge through research. Appropriations to the National Institutes of Health were increased from $8.4 million in 1947 to $560 million for fiscal year 1961. But research can benefit our citizens only insofar as findings are effectively applied. To this end, research related programs have been established to improve undergraduate and graduate teaching of physicians, dentists, medical scientists, and auxiliary medical personnel. The provision of more and better hospitals has received understanding attention. But in our State and in other States, broad authority for the protection and promotion of human health is vested legally in the official public health agency with its State and associated local health departments. These agencies, in line with their legal charge, are concerned with the effective application of available medical and health knowledge. But every day we are reminded of the problem of inadequate application of knowledge. In polio immunization, the concern is with the hard-to-reach segment of the population; in cancer, there are the many unnecessary deaths; in heart disease, there is the unsolved problem of motivating large population groups in regard to lifelong habits or practices affecting health. These are illustrative. If the benefits made possible through research are to be attained by our citizens, more attention to the application of knowledge will be required.

Concerning facilities for the care of the ill and disabled, the long-established Hill-Burton legislation has contributed substantially, particularly for the building of hospitals. Most of these are designed for the provision of intensive, short-term care for the acutely ill. A recent survey of the hospitals in Florida elicited the opinion that of those then in hospital, approximately 75 percent required intensive hospital care, 16 percent needed only minimum care, 4 percent could be cared for adequately in a nursing home, and 5 percent needed only the care which could be provided at home, though two out of three of the latter were considered to need (at least temporarily) visiting nurse service. It has been observed by my associates and by others that a varying but substantial percentage of those in nursing homes could be cared for at home if conditions were reasonably favorable. Hospitals and nursing homes are needed for those with chronic illnesses and disabilities of the aged, but much more commonly than at present, assistance should be directed toward making it possible for suitable continuing care to be provided in the familiar environment of the home.

Thus, the highly effective congressional action in providing for the accumulation of new knowledge has not been balanced by programs to assure an effective utilization of the findings of research. Also, the building of hospitals to care for short-term acute illness has not been balanced by an equally needed increase in nursing homes, and there has been scarcely any national encouragement to efforts designed to encourage home care of the aged and those with chronic illness. My concern and that of my colleagues in public health is to obtain congressional action which will attain better balance in these essential and interrelated efforts. H.R. 4998 is an encouraging move in this direction.

Concerning the specific provisions of this bill, let me comment first on section 316 relating to "Special Project Grants for Improving Community Health Services." This is a particularly important section. The objective is to develop more effective procedures for the application of accumulated knowledge. It is essential if official public health agencies are to be prepared to carry out the broad legal mandates for the protection and promotion of health.

In the early development of public health, the major concerns were with epidemic diseases, the welfare of mothers and infants, and with sanitation, particularly sewage disposal and the provision of safe supplies of water and milk. In these, accomplishments have surpassed the most optimistic hopes of but a few years ago. The unfinished business here, important as it is, seems of minor proportion as compared with the succession of new problems which are falling to community health agencies. The health care of the aging and public health programs in chronic diseases, for example, may well grow into the major public health programs. But to date there has been almost no effort directed toward developing public health programs to meet the health needs of the aging and the scientific assessment of public health programs in chronic disease is largely a task for the future. The provision of section 316 would encourage and make possible essential study projects and pilot programs.

It may be questioned as to whether these indicated studies could not be supported as a part of the NIH research grant program. Research grants have been highly effective in expanding basic laboratory research and clinical investigations. But this grant program has been orientated predominantly toward universities, hospitals, and research centers; community orientated research with which health departments is concerned has not prospered. There has been every incentive to improving the treatment of specific diseases in individual patients, but there has been no comparable attention to developing new and better means of delivering health services to communities. One of the problems has been that in the development and study of new public health programs, service must be given in order that the practicability and efficacy of programs may be evaluated. Funds for such service activities rarely have been made available to health agencies through research grants. The project grants feature of H.R. 4998 is well designed to satisfy this need.

Section 316 authorizes the appropriation for each fiscal years of "such sums as the Congress may determine." May I respectfully urge the need for a generous appropriation. Studies envisioned by this section are long overdue. To assure progress in the application of new knowledge to population groups comparable to the advances in the clinical care of the individual patient, there will need to be an extensive development of community-centered projects. These could be funded best through the proposed project grants for improving community health services. It is hoped that in addition there may evolve in the NIH a concern for community-centered research comparable to that evidenced for laboratory and clinical research.

In the improvement of community facilities and services for the health care of aged and other persons, the development of more effective public health methods is of first importance; to apply these procedures health services will need to be expanded.

For guidance in the development of specialized health programs to meet the needs of our citizens, there is the extensive and successful experience of the Children's Bureau in maternal and child health. As an administrator, I lament the rigidity of categorical grants, but there can be no doubt that the grant program of the Children's Bureau accounts for the general acceptance and wide application of the broad public health programs for mothers and children. The rapidity of development and degree of acceptance of special public health programs to better meet the health needs of the aged or to initiate other indicated new programs will vary directly with the availability of grant funds for these purposes.

I shall illustrate the importance of grant funds by reference to one high priority program. In Florida, each of its 67 counties has an organized public health unit. Nursing service extending into the home is an established program in every county of the State. Currently, 542 public health nurses are employed, but these devote a major portion of their time to meeting the needs of mothers and children and providing services related to the control of communicable diseases. In major urban centers, an additional 71 VNA (Visiting Nurse Association) nurses devote attention chiefly to those with chronic illnesses or disabilities. In recent years in our State, there has been a trend toward the organization of what we speak of as combined home nursing service. Here one nurse assigned to a district is prepared to provide the preventive, educational, and rehabilitation services ordinarily given by the public health nurse and also the bedside services required for the continuation of care of the ill and disabled in their homes. This reorganization of nursing services is essential if home-nursing needs are to be satisfied in rural areas and less populous counties. This combined nursing program is no longer an experimental activity. The need is for aid in extending this type of service to all parts of the State. For this purpose, we requested supplementary funds from our State legislature in 1959, and again in 1961. A token increase was provided in 1959 and present indications are that tax resources available in the State will not permit approval of the modest request for $130,855 for the next biennium to aid in this program. This combined home nursing program is readily accepted when established with a community, and soon derives local support. Thus, the need is for supplementary funds for the introduction of the program in order that its value may be demonstrated to the community. With Federal grant funds in substantial amount for a period of possibly 5 years, a home nursing program to include the usual activities of the public health nurse and the bedside care characteristically provided by the VNA could be extended gradually to all parts

of our State. Without the assistance of Federal grants, progress will be painfully slow.

Time does not permit individual consideration of other indicated extensions of public health programs. Where there has been adequate study of the needs of those with chronic illness and the aged, there is emphasis on the importance of a central referral (and planning) activity. Through cooperative effort there would be planning of curative, restorative, and supportive care best designed to meet the needs of individual cases. The purpose would be to limit hospitalization to the minimum time required; to encourage transfer to limited care facilities or to nursing homes during convalescence, and insofar as possible, to prepare the patient for, and to aid the patient in, independent living in the familiar environment of the home. The attainment of these goals appears essential both in the interest of economy and the welfare of patients.

Nutrition is a health problem requiring increased emphasis. More and more State and local health departments are adding public health nutritionists to their staffs. Substantial expansion of this service is indicated. In promoting the health of the young, the "well baby clinic" is an established activity. Though one must reason by analogy rather than experience, there is reason to believe that clinic services designed to maintain and improve the health of the older adult should be an important future public health activity. As one further illustration of indicated programs, the practicing physician today needs guidance and encouragement in improving services for the care of the chronically ill and the disabled. Organized educational programs for practitioners provided by and at the expense of public health agencies but in cooperation with organized medical societies proved very effective in improving health care of mothers and children. Comparable programs for the improvement of the care of the aged and those with chronic illness is an unmet need. These and other programs would be effectively fostered with the availability of Federal funds granted for specific purposes.

With the initial passage of social security legislation, there was in 1936 and the years immediately following a rapid expansion of public health in the United States. In recent years, there has been a plateau in the growth of community health activities. There is need for a new stimulus to added growth. We are satisfied that this will come if the Congress displays the same concern for the application of new medical and health knowledge, as it has for its accumulation, and authorizes comparably adequate budgetary assistance.

I shall comment briefly on the remaining provisions of this proposed bill. The amendment permitting an expansion of grants for construction of nonprofit nursing homes is needed and endorsed. Furthermore, the expansion of research, experiments, and demonstrations in utilization of medical facilities appears to be sound. In considering these, the importance of moving toward a well-balanced total program is emphasized again. We in public health are of the opinion that in health legislation of recent years attention has been focused too much on the university, the hospital, and the research center, and not enough on the community, both as a focus for important health studies and as the site of the application of medical and health knowledge. Public health is hopeful that Congress may provide the stimulus and the funds needed for the expansion of community centered research and service. We are of the opinion that H.R. 4998 will provide sound legislative authorization for this expansion.

Thus, in summary, this bill "To assist in expanding and improving community facilities and services for the health care of aged and other persons and for other purposes" is endorsed and commended for the following reasons:

(1) It provides for project grants and for research, experiments, and demonstrations in areas of study directed to attaining a more effective application of accumulated knowledge. Such studies have not been effectively encouraged by the NIH research grant program and are required to assure that the benefits of research are made widely available to those in need.

(2) Increased grants to the States will serve to strengthen the basic structure of public health and prepare public health to better meet new and more difficult problems such as health care of the aging.

(3) It will favor a better balance in programs. Nursing home beds must be made available if there is to be a reasonable limitation of stay in hospitals designed to provide intensive treatment; and home care services must be developed if there is to be a sound balance between home and institutional care.

Speaking for State health officers, we hope that this bill will be endorsed by Congress and that the legislation will be activated by substantial Federal appropriations.

The CHAIRMAN. Are there questions?

Mr. WILLIAMS. Doctor, I am sorry I didn't get to hear all of your testimony, but I was very much interested in the part that I did hear with reference to local clinics and outpatient care, noninstitutional care, et cetera.

You indicated that is now being financed by the Community Chest and through contributions on the part of citizens and also by the State government.

Dr. SOWDER. Yes, sir.

Mr. WILLIAMS. Is it your contention that you need additional money?

Dr. SOWDER. I think that this chart is an indication. You see on the colored areas here, the places where we have that service now in Florida.

Mr. WILLIAMS. Yes.

Dr. SOWDER. And it is very inadequate in those places. Mr. Rogers will recognize that light purple area around Lake Okeechobee. That is a migratory labor area. With money provided we have set up a home nursing service in that little corner of Palm Beach County. The rest of the county has home nursing services out of other funds.

Mr. WILLIAMS. Then it is your thought that this will be expanded if you can receive this Federal money?

Dr. SOWDER. Yes. Let me say that home nursing in health departments has grown very little, in the last 10 years.

The total number of nurses in State and local health departments in the last 10 years has only grown about 6,000 in all. Practically none in the very essential field of providing services at home for older people.

Five thousand out of the six thousand increase was public health services for schoolchildren which is fine enough, but they are the healthiest segment of the whole population. That is how little thinking some of us are doing.

Mr. WILLIAMS. Well now, Doctor, you have a program for expanding this service.

Dr. SOWDER. We do, yes.

Mr. WILLIAMS. Have you presented that program to the Florida State Legislature?

Dr. SOWDER. Absolutely. We present it every year and get a little more money each time.

Mr. WILLIAMS. Have you been refused the necessary funds by the Florida State Legislature?

Dr. SOWDER. Always refused what we ask for yes, but we have got some State tax money for this purpose. We have 71 nurses in Florida doing this very type of work.

Mr. WILLIAMS. Is it your contention that the State of Florida is not able to finance this program?

Dr. SOWDER. I would say that under the present tax set up, that money is easier to raise in Washington and we are having a hard time in Florida. They could, if they wanted to, divert it for something else, but my theory is that this is a partnership deal and I don't think if you are putting up $50 million you would be paying more than 20 percent of the cost of what is needed. I think it is a role of the Federal Government to explore and to help and I think this is a much more important thing than even the Hill-Burton program for the

construction of hospitals. This is an essentially needed community service. It is economical, it is efficient, and it is a cheap way of keeping people at home where they would rather be than in these beautiful hospitals that we are building. We do need the hospitals, of course.

Mr. WILLIAMS. I think you let the cat out of the bag when you said it is easier to come to Washington and get money than it is to go to the Florida State Legislature. If you get part of the money from Washington, why not come to Washington and get all of it?

Dr. SOWDER. It is a matter of principle. I think that Florida should put up the major share.

Let me illustrate, sir, what we are doing now. In my own department, we spend $17 million a year on health services and this is a list, about eight pages, of the services we render.

Mr. WILLIAMS. How much would you expect Florida to get out of this?

Dr. SOWDER. Let me finish this. Out of this $17 million the Federal Government now furnishes $1.3 million. I said what I did and the facts do bear that out. I would expect Florida to get 2½ percent.

Mr. WILLIAMS. Two and a half percent?

Dr. SOWDER. Yes.

Mr. WILLIAMS. Of what?

Dr. SOWDER. Of whatever the appropriation is because on a population basis, that is what the proportion would be of a grant-in-aid fund and if you appropriated $1 million we would get $25,000.

Mr. WILLIAMS. Well, are you suggesting that the State of Florida can't appropriate $25,000 for these purposes?

Dr. SOWDER. I am not suggesting that. They have already appropriated $25,000.

I am suggesting that you appropriate about $50 million and that we get whatever our pro rata share is. What I am talking about is a $10 million effort for Florida alone to provide outpatient clinic services, nursing services for some 5 million people and that is what it will cost and it will save money and take away a multimillion dollar effort of warehousing people into nursing homes and into hospitals.

Mr. WILLIAMS. What is the per capita public debt of the State of Florida?

Dr. SOWDER. We don't have a debt.

Mr. WILLIAMS. You don't have a debt?

Dr. SOWDER. Except these—whatever they are on the bonds that we sell.

Mr. WILLIAMS. The per capita debt of the U.S. Government runs into the thousands of dollars. It just seems somewhat incongruous to me that you should be here asking a bankrupt Federal Government to subsidize a solvent State. Can you reconcile that position?

Dr. SOWDER. Well, if I had the complete say on how taxes were raised I would say you are right. But the Federal Government has the tax sources and they tell me and also Congressmen and the people of the country, acting behind Congress, have established as a principle over at least 40 years a partnership, at least in public health and preventive health services.

Mr. WILLIAMS. Do you have a State income tax in Florida?

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Dr. SOWDER. We don't. We have many other kinds of taxes though and I think our total taxes per capita range up to the other States.

Let me ask Mr. Rogers if that is not so.

Mr. ROGERS of Florida. As a matter of fact, I think probably even more than Mississippi. However, I do want to point out that on this question of States' participation perhaps the gentleman from Mississippi is overlooking the fact that the people of Florida pay into the Federal Government their taxes, also, and they want to have some say as to how those moneys are spent by the Federal Government. That is all the doctor is saying, I think.

Dr. SOWDER. That is right.

Mr. ROGERS of Florida. Since we pay taxes to the Federal Government, we ought to have a say so in how those taxes are spent. Perhaps we would like to have some of them spent in Florida, and that is all he is asking about the proportionate share that we would have as any other State. I am sympathetic with the gentleman that the States ought to do as much as they can, but I do think under the circumstances, the doctor is merely saying it is just from the taxes that we in Florida pay, and we pay between $1 billion to $2 billion to the Federal Government.

Dr. SOWDER. I would like to reemphasize the fact that I am representing 50 States at the moment in this particular field.

Mr. WILLIAMS. Doctor, you mentioned the Federal Government has preempted the State tax sources already, and which is quite true.

Isn't it a fact that the more of these programs you load on the Federal Government that we are going to have to preempt the State sources of revenue in order to pay for them and that you are actually whittling away at the prerogatives of the States by this type of program?

Dr. SOWDER. Well, if you could assure me that the Federal Government would not expand in any way and you wouldn't spend this money that we are paying up here for something else that I think is less worthy, I would be very well satisfied.

Mr. WILLIAMS. I wish I could give you that assurance.

Dr. SOWDER. I will trade with you. I believe you are going to appropriate some money for health purposes and I am saying, being in public health for 20 or so years, and I think I am speaking what a lot of other people think, that this is the best way for you to spend that money that you are going to spend anyway. It is the cheapest way for you to spend it. You do get better results from it.

Mr. WILLIAMS. Doctor, this is to meet purely local circumstances and needs; isn't it?

Dr. SOWDER. Sir?

Mr. WILLIAMS. The purpose of this is to meet local circumstances and needs.

As a matter of fact, the very title of the bill is the Community Facilities and Health Services Act which denotes a local operation; doesn't it?

Dr. SOWDER. It would be a local operation, but insofar as my State or any other State people are so migratory that, my goodness, we get a million or so people there every year and they get sick and we take care of them.

Mr. WILLIAMS. Doctor, going on that premise and recognizing, if you do—and I don't know whether you do or not—but recognizing

that if you read the Constitution carefully, that the powers of Congress to tax and spend are limited, limited by the 10th amendment to the Constitution which I am sure you are familiar with. But can you give me the constitutional premise for an expenditure of Federal money for local purposes?

Dr. SOWDER. I think the word "local" there was not intended. I think this is a grant-in-aid program to the States. I certainly wouldn't want to go into the constitutional principles because I am a States righter myself. I don't know how the degree would compare with yours, but I really am, sir.

Mr. WILLIAMS. I am, too, but I believe in the States assuming the obligations that they owe their own people and I think you should sweat this thing out before the State legislature before you come to the Federal Government.

Dr. SOWDER. I have. We have made a start as I tried to show you.

Mr. WILLIAMS. Yes.

Dr. SOWDER. But the 50 States of the Union need the leadership, the coordination and help, the technical help of the Federal Government and to some extent, the stimulatory effect of these appropriations in this bill to really do a good job and, honestly, you need it in Mississippi, too.

Mr. WILLIAMS. That is the very thing that disturbs me about this type of program—the suggestion that the States need the leadership of the Federal Government to get them to discharge responsibilities that they are much better able to discharge themselves as I think they should, and that is a thing that concerns me about this type of program.

The State of Mississippi knows its needs much better than the Federal Government here in Washington. The State of Florida knows the needs of the State of Florida much better than does the Federal Government here in Washington.

I am afraid if you continue this trend that even in our time we will live to see the day when the idea of independent States will become meaningless and when they will be merely subdivisions of the Federal Government. I am quite certain that is not what you want to see.

Dr. SOWDER. No; certainly not.

Mr. WILLIAMS. You don't want to see this type of thing happen, I am sure.

Dr. SOWDER. Certainly not. But I would think that we certainly know our needs better than the people in Washington, but at the same time I have worked at the Federal level, at the State level, and the local level and I know from my long experience at the State level that you do get a certain viewpoint, looking at 67 counties, that you can be a help and also the people from the 67 counties getting together can see themselves and see their problems better by getting together. That is what I am talking about and the majority of the money we are proposing is our money in the first place. We just want some of it back for this purpose. I think it is one of the best things that you could do, to appropriate money for, and I think it is certainly one of the best in the health field.

Now, I don't know of anything more important than health.

Mr. WILLIAMS. Well, I don't either, and I am not trying to argue this with you, although I do want to get your thinking on it.

Dr. SOWDER. I am very much of a States righter myself.

Mr. WILLIAMS. If the Federal Government had an obligation to assist in the financing of local operations of this character in this field, then isn't the Federal Government likewise obligated to assist the States in paying the salary of the Governor and the salary of the State highway patrol, building the county roads, and other purely local functions?

What is the difference there?

Dr. SOWDER. I think you have to draw a line there. For State health officers, at one time—and this was many, many years ago—Federal funds were at times used to pay the salaries of the State health officers. Some 20 years ago, before I was a State health officer—and your Dr. Underwood from Mississippi took part in this decision—they decided that was a bad practice and the State health officers are no longer paid by the Federal Government, in whole or in part. We have $17 million and only $1 million of it comes from the Federal Government.

The CHAIRMAN. Mr. Devine?

Mr. DEVINE. No questions.

The CHAIRMAN. Mr. Mack?

Mr. MACK. No questions.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. No questions.

The CHAIRMAN. Mr. Dominick?

Mr. DOMINICK. Doctor, I don't want to carry Mr. Williams' argument too far, but in Colorado we have personal income taxes, corporate income taxes, real estate taxes, personal property taxes, and a sales tax—all levied by the State.

Do you think we should be contributing more money to the Federal Government than does Florida, to distribute to Florida?

Dr. SOWDER. I think Florida is just raising its money in a different way, the most practicable way for Florida. I don't think you ought to pay any more in Colorado, and I doubt if you are, into the Federal Treasury.

Mr. DOMINICK. Doctor, in this bill there is a provision for providing funds for construction of referral centers. Would you give me your thoughts on that?

Dr. SOWDER. I don't believe physical facilities were envisioned. I think it was for the building up of offices and personnel.

Now in my own State, the county health department is that referral center. We have that now. Where that service is not available, I think the idea is to provide an informational service, because lots of times in our complex moderm life things are available that people just don't know where to go to get them.

Mr. DOMINICK. What people don't know where to get them?

Dr. SOWDER. The patients.

Mr. DOMINICK. Don't the patients go to the doctors or the hospitals?

Dr. SOWDER. Sometimes. Most of the time they do, but sometimes they don't, and many times the physicians themselves don't know where some community services are or where it is available. They don't know how to get a patient into a mental hospital, and they will call me.

Mr. DOMINICK. Well, you act as a referral center.

Dr. SOWDER. To some extent; yes, sir. Our whole health department system in my State acts as the information and referral center.

Mr. DOMINICK. I would suspect this is true in the other States, that the Public Health Service does act in this way on many occasions.

Dr. SOWDER. Oh, yes; except that they only have national and regional offices.

Mr. DOMINICK. There are also State public health services in each one of the States, are there not?

Dr. SOWDER. Yes, sir.

Mr. DOMINICK. Don't you think that they act as referral services?

Dr. SOWDER. Oh, absolutely. I told somebody yesterday that we get about 15,000 pieces of mail each week.

Mr. DOMINICK. What I am wondering is why we should provide funds for additional referral services when we already have the State health departments, the doctors and the hospitals who are acting in this way already, together with the visiting nurse associations.

Dr. SOWDER. Sir, that whole system—and I am talking about State and local health departments and the visiting nurse services—they are in a very anemic state, they lack nutrition, and this is a bill that would give them a transfusion. We are not doing the job nationally in State and local health departments or in the Public Health Service that needs to be done in this field.

Mr. DOMINICK. In the referral service field, specifically.

Dr. SOWDER. In the referral service, too, sir.

Mr. DOMINICK. I am talking specifically about this. This bill provides for a specific project for the creation of referral services over and beyond a visiting nurse association, the State hospital association, a public health association, and over and beyond a medical association and everything else.

Dr. SOWDER. Well, insofar as my particular State is concerned, I wouldn't mind if you just closed that out, but I am sure that there are some other States that believe that they need that because that bill was carefully drawn up. I believe that Dr. Bauer or some of the Public Health Service people could answer that better than I.

We have that satisfactorily covered in my State, but I think it is only meant to be one of the things that a State could do with the money: that the bill is flexible and it does provide that each State could, within certain limits, do what it needs to do the most.

Mr. DOMINICK. Do you know specifically of any State where a patient is unable to determine whether he should go, of where he should go, in the event that he is sick?

Dr. SOWDER. Oh, my. I would say we have 50 of them where there are patients who don't know where to go and don't know what to do. There might be one in a hundred, but there are situations in every State where a patient or even the doctor treating the patient doesn't know that you can send a patient somewhere. We have a premature center in Miami and there are other examples of this sort of thing.

Mr. DOMINICK. Excuse me for interrupting, but what you are saying is that the patient is so dumb he doesn't know how to get to anybody that has the information.

If you have a referral source of information, how do you think that this is going to improve his intelligence so that he is going to go to that any more than the fact he doesn't go now?

Dr. SOWDER. As I say, you could cross that out and it wouldn't bother me a bit, but there must be a need for it and there are others who can defend that feature much better than I. But we think we don't need new referral centers in my own particular State.

However, I do believe it is one of the things that the authors of this bill felt would be needed and they had to put it in there in case there was only one State where it was needed.

Mr. DOMINICK. That is all.

The CHAIRMAN. Any further questions?

Thank you very much, Doctor.

Dr. SOWDER. Thank you, sir.

The CHAIRMAN. Our next witness is Dr. Hugh R. Leavell of the Association of Schools of Public Health, Harvard University.

You may proceed, Doctor.

STATEMENT OF DR. HUGH L. LEAVELL, PRESIDENT, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH, INC.

Dr. LEAVELL. Mr. Chairman and gentlemen, I am Hugh R. Leavell, president of the Association of Schools of Public Health, Inc. I represent a small group of 12 schools of public health in our country and which are well known to this committee, which has been extremely helpful in the past in working with us to face the problems with which our schools are confronted.

I am teaching at the Harvard School of Public Health; have been in public health for about 30 years following a period in private practice. I have worked as a local health officer and with the Rockefeller Foundation and Ford Foundation and have had some experience in international health problems.

We in the schools of public health feel very strongly that the intent of H.R. 4998 is a very important one. The provision of grants-in-aid to the States for general health services is something that has been proved in practice very well. These grants have not only stimulated important new programs but have actually induced the State and local goverments to very significantly raise their own health appropriations.

I was serving as a member of the medical task force of the Hoover Commission a few years ago. Some figures were compiled on the development of State and local appropriations in relationship to Federal appropriations in these grants-in-aid and I know that the Public Health Service can provide figures which will bring this information up to date and it demonstrates, I think without question, that a small amount of Federal money invested in a program of this kind serves demonstrably to stimulate State and local contributions.

At the time we were making our study, the growth of this relative percentage of State and local money was something very striking indeed and Mr. Kimball of the Public Health Service informs me now that the State and local contributions amount to 8 percent or better.

We have seen in the past few years a tremendous growth in funds for basic research and we think this is a fine thing. But the actual application of this knowledge in the States has been very much neglected, relatively speaking. And as Dr. Sowder was just pointing

out, this is something that those of us concerned with the public health of the country as a whole, are very much concerned about.

Another item in H.R. 4998 is the training carried on by State and local health departments. Now we, in the schools of public health are concerned with a comprehensive, perhaps more academic type of training, but we recognize also that the kind of training which can be carried on in the State and local departments, a practical sort of training, is a very essential element and we would hope, for example, that some of these funds might be used to provide residences as in other specialities of medicine.

Public health is a speciality and we must have residency training, which is a practical thing. Instead of working in a hospital, our people have to work in a community and this would help to set up the kind of residency program that is needed for that.

I am sure you have had already presented to you the problem of the care of chronic illness outside of the hospitals. This chronic illness area is our major health problem in the country today, certainly, and with the skyrocketing of costs of hospital care, one wants to do everything possible to take care of people on the outside.

Now this measure, as I understand it, is intended not so much to actually provide this care as to carry on research to determine how it can be provided in a more economical sort of way.

To do this kind of research, one needs to think in terms of a region of the Nation as a whole, because we have the problems of organization and we need to be able to study this on a broad enough national basis so that some valuable conclusions can be drawn from it.

As to the nursing homes and referral centers and things of that sort, you have had a good deal of evidence presented already. I happen to have been here and heard Mr. Dominick's question I believe in relationship to referral centers and we will say that in Massachusetts we have felt it very necessary to have referral centers.

We certainly don't have the worst medical facilities in the country in Massachusetts, and I think not the most stupid people in the country in Massachusetts, but we find that many people, a great percentage of these older people do need help. They need the counsel of the social worker who can sit down with them.

Doctor Sowder can't spend his personal time sitting down with an older person and working out the details of how they must do this.

I have taught in medical schools and I know that the physicians of our country do not have nearly the amount of instruction in what I would call the sociopharmacopoeia. We feel in the complex society we have today, instruction is needed in both sociopharmacopoeia and medical pharmacopoeia.

Until we can get our physicians 20 years from now equipped with this information we can't depend on people being able to know where they can go to use even the facilities that are already available.

I would like now to point out that there is in our opinion, an important element missing in H.R. 4998 as it now stands. This relates to the provision of trained public health leadership such as we have in the Public Health Service and in our State and local health departments.

To carry on this experimental work and to plan these important programs, we must have people with vision and training and exper-

ience in devising and conducting experiments so that the results of these may be put into practice.

Now, the 12 schools of public health that we have are really the only places that provide comprehensive training for the kind of leadership that we must have.

Your Subcommittee on Health and Safety is very familiar with this problem. Congressman Rhodes has been able to take time off and attend one of our meetings of the Association of Schools of Public Health so that he could become familiar with our problem.

Congressman John Williams, when he was chairman of the Committee on Health and Science, as it was then called, and later Congressman Roberts, as chairman of your present Health Committee, have given us an opportunity to present the problem of the schools of public health and we are very grateful for the opportunity to appear here today.

Let me review very briefly with you what the Congress has done in working with us.

In January 1958 testimony was presented from a good many sources. I won't list them here as to the essential job the schools of public health are doing for training people for governmental health services.

It was pointed out that this training is expensive, costing about $5,000 per student, per year. That tuition covers only about 11 percent of the cost and the discrepancy between the 11 percent and the 100 percent was having to be made up by the schools of public health, remembering that there are only 12 of these working on a regional and national basis and it was shown at that time that there were about $3 million of deficit, the difference between the tuition and the cost of training.

Following this testimony, the original version of the Hill-Rhodes Act, sponsored by Congressman Rhodes in the House and by Senators Hill, Cooper, Ives, Kennedy, and McNamara, was passed unanimously and signed by the President.

Now, this act provided grants not exceeding $1 million to be distributed among the schools of public health for the fiscal years 1959–60 to provide this kind of comprehensive care, comprehensive training that I am speaking about, and by regulation, the schools, the division was made 25 percent to each school and then 75 percent based on the number of federally sponsored students.

In testifying on this bill, the administration recommended that action be postponed until a conference on training was held. This conference was held later on. However, your subcommittee recommended and recognized that an emergency existed and that the $1 million appropriation ought to be set up on a 2-year limit of time.

The conference met, recommended continuation of the program, removal of the time limit, and removal of the $1 million ceiling.

The 86th Congress passed the second Hill-Rhodes Act and did remove this time limit but the ceiling was not changed.

At this time, project grants, and by project grants I mean a school would make a project that we wanted to set up a special kind of teaching, radiological health, how medical care ought to be organized, things of this kind, $2 million for these project grants was authorized. In addition to the schools of public health, other institutions giving graduate training in nursing and engineering were made eligible.

In the present act or present bill that you have under consideration, there would be a logical place we feel to carry out the third recommendation of the conference; namely, the removal of the $1 million ceiling.

Now, the bill as it now stands provides for the removal or two ceilings. You have a removal of the ceiling of $30 million on the total authorization for grants to the States.

A second removal of ceiling relates to the $3 million of funds earmarked for public health training by the States.

The third ceiling, namely, $1 million to be distributed among the schols of public health is not provided for in the bill as it now stands and we feel that it would be highly justifiable to do this.

The number of schools has increased since the authorization was originally set up with a new school in California at Los Angeles.

I should point out to you that less than one-third of the $3 million, greater than $3 million deficit is now met by the $1 million. So that the continuing deficit in cost of training per student is now on the average $3,690 which the schools must find somewhere or other to provide this sort of training.

Now we should report, and we are very grateful for the $1 million, that it has been extremely valuable to us in enabling us to fill posts that have very long been vacant because of lack of funds to establish continuation education programs with State and local health departments, to increase our relationships with them, to launch teaching in new fields such as rediological health, medical care, and so on, and certainly it has boosted our morale.

We were beginning to fel that we were very much a neglected part of the national picture and to have the tangible expresion of appreciation which you have given us is certainly something that we are very grateful for. We don't want to appear to be ungrateful for this or greedy, but it has been pointed out to us that if we don't speak for ourselves, no one else is likely to speak for us. It is quite true that we need to expand. We want to expand and we hope that it will be possible to get more than the $1 million as something to provide opportunities to grow on in the future.

We would like to point out also that the $2 million authorization for project grants for teaching has again been doing a useful job, but at the present time there are 124 applications and those pending seem to be, and which have been certified as useful by the special committee set up for this purpose, the available funds will provide for only about half of it so that it would be entirely logical to increase this ceiling to perhaps the $4 million which was originally suggested by the administration at the time they proposed these project grants.

We would like to point out that these project grants are not substitutes for the formula type; that is the $1 million and our feeling is from the experience we have had that a given amount of dollars is more valuable to the schools in formula grants than it is in project type of grants.

This is certainly true to a point well beyond the $1 million which we now have. We have the feeling that many people do not understand really what schools of public health do. Some people think of us as being like medical colleges, but we are more than that. Some, who have seen public health nurses visiting in the homes, think our job is training nurses, but we are more than that as well. Some who have

seen a public health engineer or a sanitarian making the environment safe, controlling milk, water, or clams as we have them in New Jersey now, think of us as training engineers and sanitarians. Some, who think of health education think that our job is primarily training people to educate the public, but we are more than that too.

We really take all of these different types of professional groups who previously qualified themselves in medicine or whatever it may be and teach them to go beyond this and deal with the community as a whole and immediately when they are trained to work for the community, they become government workers. They are not people who are able to make salaries which are reasonably lucrative in private practice these days and this is really where our financial problems begin because we are training these people for the government service.

Our graduates, 70 percent of them work in State, local, Federal, and international health activities. About 22 percent work in voluntary agencies such as heart associations, tuberculosis associations, and so on. None of these can charge fees. We can't go to our alumni and say "come and help us" the way a business school or something like this can do.

Most of these people are married and their average age is about 34 years, quite different from the situation in medical school where you have people of 21.

What do these public health people do? Well, they are interested in the whole community, keeping records on what causes sickness and death, looking for the earliest signs of epidemic, diagnosing the communities health problems.

I just happen to have had the opportunity this morning of being in the office of Congressman Williams and had the opportunity last fall to come down and see the very excellent facilities they have in the State of Mississippi for public health work and for training medical people.

I was just struck at a couple of little quotations, I would like to read to you here about one relating to the lag between scientific knowledge and its implementation. This is the quotation:

> There is a considerable lag between the information available on maintaining health and its application and teaching in the schools of the Nation. This represents a new challenge to the medical profession. Unfortunately, medicine is only recently turned its attention to the customs and attitudes of society which have acted in a detrimental manner on old people.

One other quotation that I thought was very interesting related to the diagnosis of cancer of the cervix, the neck of the womb, the uterus and there is an article here describing how a clinic has been set up in the University of Mississippi Hospital to make an early diagnosis of this kind of thing.

Now, the State health commissioner of Mississippi, Dr. Gray and others working with him, are instituting things of this sort in various parts of the country. But Mississippi, for example, has no school of public health. They had some graduates from schools of public health this past year. This situation prevails all over the country.

I have a list here of the graduates of schools of public health by State of residence this past year, and would point out that Illinois had 18, no school of public health in Illinois.

In Ohio, they had 30 and no school of public health in Ohio, and one can go on down the list. These are national, regional schools.

We also have the problem of training people who come to us from other countries. About a third of our students are from other countries. That is an important part of this Nation's international program.

Take the situation in the Congo. When this arose a year ago, Russia was able to say, "We will provide doctors to go out and work in the Congo." We couldn't make any such offer as this because we didn't have the supply of trained people. We have a shortage and always have had. We are importing these kinds of people into our country now, but all of these things require planning, vision, ability to see the total community picture.

Now this is the kind of thing that we in the schools of public health have tried to do. It is a post, postgraduate training; it is expensive because we must have people from all these different disciplines in our schools. We must be able to train people not by lectures, but by small groups, seminars, discussions. We must provide community laboratories in which they must work. We just can't use sick patients in a hospital.

Now, of our 12 schools, 6 are in State universities. California has 2 at Berkeley and Los Angeles; Michigan, Minnesota, North Carolina, and Puerto Rico, and 6 are in private universities, Columbia, Harvard, Johns Hopkins, Pittsburgh, Tulane, and Yale.

These universities are interested in what we do, but they have enormous demands other than those relating to the schools of public health and we are about their most expensive child, and they say why should we provide this money when you are doing a regional, national, and international job?

Only about 25 percent of the graduates of these schools work in the State where they had their public health training. Many people have compared our job to that of the service academies, West Point, Annapolis, and the Air Force.

Some people have said why can't we raise our tuition? Well, some of the private schools, particularly have been able to do this, but the possibility of wiping out this big discrepancy between tuition and cost is just not something that can be done and since the majority of our students receive a Federal tuition subsidy, if we raise the tuition, it wouldn't make much difference anyhow. It would simply be putting it out of one Federal pocket into another.

People say, "why don't you go to the private foundations?" Many of our schools were started with the help of the private foundations. Only last week, I went to one of these private foundations, one with which I had formerly been associated as an employee and asked for a very small grant. They said, well, this is public health. Public health is of national concern.

The foundations have demonstrated its importance. Now the Government must take up this problem.

In summary, our association wishes very strongly to endorse H.R. 4998 as a measure important to general State programs, to inservice and field training, to the further development of nonprofit nursing homes, and to encourage research and I think most of the impetus of this bill really relates to research and administrative kinds of research as distinguished from the laboratory kind of research to enable us to provide better care for the chronically ill and their needs, especially outside the hospital.

. Finally, we suggest as you consider this bill that you consider the possibility which certainly we feel is a highly desirable and important one, of removing the $1 million ceiling on the Hill-Rhodes formula grants to schools of public health and consider also the removal of the $2 million ceiling or a raising of that ceiling on the project grants to schools of public health, nursing, and engineering.

The comprhensive kind of training given in our schools will be required to provide personnel to implement not only the purposes of H.R. 4998, but essentially all of the health activities that relate to the application of knowledge and to the direct provision of this knowledge to the people in our communities.

Thank you, Mr. Chairman.

Mr. MACK (presiding). Mr. Williams?

Mr. WILLIAMS. I don't have any questions, but I would like to congratulate Doctor Leavell on a very splendid statement.

Doctor, as you know from our many conversations we have had and from the questions that have posed in committee, I am a firm believer in protecting the rights of the sovereign States and I am an opponent of federalization.

I would possibly take exception to certain parts of your testimony with reference to Federal responsibility in certain fields. However, I recognize that schools of public health train exclusively people for public health service, State, local and Federal and as you mentioned, also international.

Because of this, I recognize the responsibility of the Federal Government in this field. I think perhaps the primary responsibility here is local, but I also recognize a Federal responsibility and for that reason, I certainly am not inclined to oppose the suggestion that the Federal Government continue its assistance to these public health schools.

I think Mr. Rhodes, Mr. Roberts and others have done a magnificent job in this field and I am very happy to say I give it my full support.

Dr. LEAVELL. We appreciate that very much, sir.

Mr. MACK. Mr. Devine?

Mr. DEVINE. No questions.

Mr. MACK. Mr. Rhodes?

Mr. RHODES. Mr. Chairman, I want to pay a personal tribute to Doctor Leavell. He is a man of great ability and one who has made a substantial contribution to our country and to public health.

I always have felt that the Nation owes a debt of gratitude to the capable and dedicated physicians and experts who could receive much greater financial rewards in private practice, but who are willing to use their talents in public service.

Like Dr. Leavell I want to also commend our colleague, Congressman John Bell Williams for his valuable assistance in the enactment of legislation authorizing grants for the schools of public health.

Dr. LEAVELL. Thank you very much, Mr. Rhodes.

May I take this not as a personal tribute, but as a tribute to the public health people in general? They are all deserving of what you have said.

Mr. MACK. Any other questions? Mr. Keith?

Mr. KEITH. No questions.

Mr. MACK. Thank you, very much. Let me ask one question of you before you leave.

You mentioned the referral centers. What is the function of the referral center?

Dr. LEAVELL. These referral centers, sir, as they have worked out, they are generally staffed by a social worker, somebody who understands very well all of the facilities in the community, both in the health and welfare and recreational fields; recreation sometimes for the older people—the Golden Age Club, that they didn't know about—or something like this might be just what they need.

Mr. MACK. Is this for public aid recipients?

Dr. LEAVELL. This would be for any older person. Some of the more wealthy people just don't know what the community has to offer. They don't know maybe how to get to Florida perhaps, or whatever is necessary.

Mr. MACK. Well, isn't this a function normally performed by the family physician?

Dr. LEAVELL. Sir, I have been a family physician for a good many years and I was not taught how to do this kind of thing, and I am afraid our physicians are not taught as much about it, even now, as they ought to be. We are learning how to do this, however.

Mr. MACK. The physician's function would be to refer his patient to the referral center?

Dr. LEAVELL. Yes. This would not be a big operation.

As I understand it, the main job of this act is not so much to help set up a great network of these referral centers, but to study how they can be done most effectively; what kind of worker needs to be there; what sort of training this worker ought to have; how she can make liaison with the doctors in the community and that kind of thing.

As I say, the research that has been sponsored has been so much in the laboratory and so little in the community and this measure I think would help equalize this imbalance.

Mr. MACK. Thank you, sir.

Our next witness is Mr. Andrew J. Biemiller, legislative representative of the AFL–CIO.

Mr. Biemiller, we are very happy to have you come before our committee and testify on the bill to be considered by the committee.

STATEMENT OF ANDREW J. BIEMILLER, LEGISLATIVE REPRESENTATIVE OF THE AFL–CIO, WASHINGTON, D.C., ACCOMPANIED BY MISS LISBETH BAMBERGER, ASSISTANT DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL–CIO

Mr. BIEMILLER. Thank you, Mr. Chairman. I am accompanied by Miss Lisbeth Bamberger, Assistant Director of our Department of Social Security and at the appropriate place in this discussion, I may wish to call upon her.

Mr. Chairman, I am director of the AFL–CIO Department of Legislation and I am happy to have this opportunity to appear before you on behalf of that organization.

In a magazine article published only last week a leading British authority on old-age medical care said the principal problem of his patients was not illness— "They are suffering from neglect," he said.

It seems to me that this statement could be applied to the whole field of medical care for the chronically sick. I am not implying, of course, any "neglect" in the professional sense on the part of the doctors or nurses, but it seems to me that we, as a nation, have assumed for too many years that medical care would take care of itself. Not enough of us have taken a hard, realistic look at the many aspects of the problem.

Fortunately, there is evidence of a change for the better. The 86th Congress devoted considerable time to the question. There is greater awareness among the American people that shortcomings do exist, and ought to be corrected. So we hope that these hearings, and the legislation that will emerge from them, will mark a real turning point toward a healthier nation.

The labor movement believes that every man, woman, and child in the Nation should have ready access to the best of modern medical care. To realize this goal, we must have action on three fronts:

(1) The economic barrier that stands between many persons and the care they need must be removed. We have sought and will continue to seek this objective for our own members through collective bargaining—improving our existing health plans and creating new ones. But such arrangements can't do the whole job; they must be supplemented by legislation as in financing health care of the aged. We are, as you know, actively supporting the President's proposal, incorporated in the Anderson-King bill, to enable people to contribute through the social security system, while they are working, toward health benefits to which they would be entitled when they reach 65.

(2) The professional personnel to provide needed health care must be vastly increased. Legislation providing Federal assistance to expand the number of trained health personnel has been introduced and should be enacted by this Congress. We hope to appear before your committee in support of this legislation in the near future.

(3) The facilities in which care is given must be expanded and there must be a vast improvement in the organization of medical services, if the care that the health professions are now capable of providing is actually to reach the people who need it. The bill you have before you now, H.R. 4998 is designed to meet this very crucial need.

Nursing home construction grants: The Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare recently reported on "The Condition of American Nursing Homes." The report begins with this statement:

> Every troubled son or daughter, anxious to find a good nursing home for a father or mother, is dismayed, and often shocked, by the inadequacy, the hopelessness, inherent in most nursing homes. Those who have wandered from home to home seeking decent facilities, a therapeutic environment, and a life-restoring force pulsing through its system too often have given up in frustration.

The experience of our members fully supports this contention.

Hill-Burton figures show a deficit of 261,054 nursing-home beds. Out of 307,681 existing beds, 134,030 were classified as "nonacceptable," merely on the basis of fire and health hazards.

This classification, we are told, does not include beds nonacceptable because inadequate medical care is given, or because of a shortage of staff, or failure to provide the services that would restore patients to a productive or self-sufficient life. Hill-Burton figures further

indicate that as of July 1960 there were no beds at all for 127,024 persons in need of nursing-home care.

The proposed increase of $10 million in Hill-Burton financing of nursing homes seems woefully inadequate to meet so great a need. Department figures show that if the full $20 million authorized under this bill were to be appropriated, only 5,840 beds, or 2.2 percent of the number needed, would be constructed each year with Hill-Burton funds.

Your committee heard testimony earlier this week from representatives of the Department of Health, Education, and Welfare to the effect that as of January 1961, the States had indicated that they could use $61 million in Federal funds for the construction of nursing-home beds. How, under such circumstances, can an increase of only $10 million be justified?

We, as a nation, simply must face up to the fact that a high proportion of our citizens who need nursing-home care have no decent place to go. Last winter we had a tragic fire right here in Washington. How many more fires must we have, how many more heartbreaks, how many more deaths from neglect before we give real priority to the building of high quality, clean, and cheerful nursing homes?

The most recent AFL–CIO convention recommended that Federal support in the field of health should include assistance to programs and projects which are aimed at finding new ways of making the benefits of progress in medical research more widely available. Sections 2, 3, and 5 of H.R. 4998 are well-designed to accomplish this objective.

It has become quite clear that the organization of health services, especially for the chronically ill and the aged, and particularly in the area of out-of-hospital care, is extremely inadequate in most communities.

This is a matter of crucial concern today as the number of the aged and chronically ill continues to increase and as medical science develops new techniques to reduce the burden of chronic illness and to improve the health of the aging.

There is a great need for experimentation and demonstrations on the local level, as to how the organization and quality of services can be improved. This is not only a matter of financing the care, but also of providing the necessary facilities.

Organized home care under hospital supervision is an established program in only a handful of communities. The vast majority of the population could not get simple home nursing or homemaker services, money aside, because no such services exist in their community. All over the country there are people who never leave institutions, not because their medical needs keep them there, but because there are no alternative facilities.

The potentialities for improving the services available to the elderly and chronically ill are most dramatic, and of almost infinite variety.

A recent pamphlet issued by the Department of Health, Education, and Welfare reported a study made in Essex County, N.J., of 177 severely disabled old people—the kind who most communities remain helpless invalids until they die. They were put on a carefully designed medical restorative program and all of them learned to take care of their personal needs. There was a cost saving of $196 per patient

per month. Who can estimate the saving in human dignity and serenity?

The Saturday Evening Post, in the article from which I quoted earlier, describes the work of England's Dr. Lionel Cosin, long recognized by geriatrics experts in this country as one of the world's imaginative innovators in getting old people, once given up for lost, back on their feet. Dr. Cosin has undertaken some of the types of projects that would be made possible under the terms of H.R. 4998. In the chronic disease hospital which he heads, the average length of stay was reduced from more than a year to 45 days.

"Actually," Dr. Cosin is quoted as saying, "most of these patients were not suffering from old age or even from chronic disease. They were suffering from neglect."

The same can be said of far too many of those we call chronically ill in this country too.

With the stimulation of the Federal grants in H.R. 4998 State and local health departments and voluntary agencies and institutions could go far toward developing the services needed.

The proposed hospital research and demonstration grants would, in our view, be most helpful in ultimately improving hospital services and in achieving their more rational utilization.

I should like to point out to the committee an area of need which has been left untouched in the proposed legislation. A well-rounded program of Federal support for community health facilities should include long-term Federal loans to nonprofit, prepaid group practice plans, as provided in H.R. 5887, introduced by Congressman Rhodes of Pennsylvania.

We fully endorse the statement made by Congressman Rhodes in introducing the bill, that "if we are to make the best use of our health resources and facilities, and thus improve the health of the Nation's citizens, we must look to the expansion of comprehensive prepayment plans allied with the group practice of medicine."

Mr. Rhodes went on to say that "one of the major factors that has impeded such expansion is the difficulty that these plans face in obtaining financing for needed facilities."

I urge this committee to consider most seriously the addition of H.R. 5887 to the legislation it will report to the House. It would provide a most important supplement to H.R. 4998.

In his health message to the Congress, President Kennedy said that there are "major deficiencies in the quality and distribution" of health services. He said:

> The dramatic results of new medicines and new methods—opening the way to a fuller and more useful life—are too often beyond the reach of those who need them most.

The passage of H.R. 4998 will contribute significantly to that end, and we hope your committee will give the bill prompt and favorable consideration.

The CHAIRMAN. Thank you, Mr. Biemiller. Does that conclude your statement?

Mr. BIEMILLER. Yes, sir.

The CHAIRMAN. Mr. Williams?

Mr. WILLIAMS. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Devine?

Mr. DEVINE. No questions.

The CHAIRMAN. Mr. Rhodes?

Mr. RHODES. Mr. Chairman, I want to compliment Mr. Biemiller on his very fine statement. I approve of it wholeheartedly.

I might say at this time that I have had the pleasure of knowing Mr. Biemiller for many years, before he was the legislative representative of the AFL–CIO, before he was a Member of Congress, and before there was a Social Security Act.

I know of his interest in legislation of this kind. I know of the work he did to help bring about legislation such as social security.

In this field of public health we have a big job to do. Some people try to give legislation of this kind a bad name. They say it is communistic or socialistic. I feel that legislation of this kind is effective in fighting communism. It helps to wipe out the breeding places where the Communist seeds take root.

The CHAIRMAN. Mr. Keith?

Mr. KEITH. Mr. Chairman, you referred in your introductory remarks to the pending legislation I believe, pertaining to social security and hospital care.

Is there not specific provisions to provide for assistance in nursing homes following the expiration of their hospital care in that bill?

Mr. BIEMILLER. Yes, the benefits would cover that type of care and, in fact, one of the points that we hope would be developed through a social security approach would be that people would be able to be cared for in good, sound nursing homes, so that many older people would not be left in hospitals, but could go to nursing homes which are much more appropriate for many of the illnesses to which older people are prone.

Mr. KEITH. We have such a substantial investment in nursing homes of a private nature which would not be adversely affected by the social security program where the individual would have the freedom of choice and would have the funds available through this prepaid insurance plan to find that kind of assistance.

It seems to me that there are some good points in that approach contrasted to this one which would inject the Government more in the operation of the homes than would be the case if you had the individual economically able to choose a home of his own.

Do you have any comment on that?

Mr. BIEMILLER. The benefits in the Anderson-King bill would pay for nursing-home care. But there is nothing in the pending legislation before the Ways and Means Committee to deal with costs of construction of nursing homes.

Mr. KEITH. I know that. But if the man can pay for the care, it seems to me that the market for homes would be expanded.

Mr. BIEMILLER. But at the present time there are by no means a sufficient number of nursing homes available for the demand which is now present, and which would be presumably increased if, through the social security approach, more people were able to afford the care they need.

Mr. KEITH. If the demand is there and if the individual, through a social security system had a paidup hospital and nursing-home-care policy, would it not be more profitable for private enterprise to furnish these nursing homes?

Mr. BIEMILLER. Miss Bamberger, do you want to comment?

Miss BAMBERGER. Mr. Biemiller's statement contained the figures on the number of nursing-home beds that are today needed that are not now in existence.

You are quite right in suggesting that once people are better able to pay for care in nursing homes, it will be easier for these homes to operate. However, the construction funds which they will need in order to get started, in order to provide the beds for these people to get their care, would not be available. You can't expect that the payment for care would cover the expenses of getting a home constructed and into operation, and these capital expenses should not be borne by the old people themselves who are in need of nursing-home care.

Mr. KEITH. I am not certain that I agree with you. I know that there are banks that have confidence in the construction and operation of nursing homes in local communities where they are run by responsible people and where there is a demand accompanied by the means to pay for it.

They are profitable businesses in many instances and I think that there would be a natural increase of interest in such a thing if there were the funds available on the part of the patient to pay for them. Certainly the need for the Government to furnish the capital would be substantially reduced if the individual had a nominal amount that could be made available under the social security program.

Miss BAMBERGER. I think you are suggesting the question of whether the proprietary homes are the only appropriate kind of institutions in which to care for people. The hospital system that we have in this country is predominantly a community hospital system. Most of the hospitals in the country are run by nonprofit community boards.

I think there is very good reason to believe that this is the best way to provide health care—by agencies that are not in this for a profit motive.

Mr. KEITH. You shifted from hospital care to health care. I think that the nursing homes in New England by and large are doing a good job, but that by and large there are adequate interests in these homes so that if the social security system was expanded there would not be the need for the Government participation in the phase of their health care.

Mr. BIEMILLER. Mr. Congressman, on the other hand the pending applications before the Hill-Burton procedures in HEW show that there is tremendous interest in many parts of the country in building community nursing homes and I don't think you would find hopeless controversy developing between proprietary homes and other types of nursing homes of a nonprofit variety.

Religious orders and religious groups, for example, would like to build more nursing homes and I think that the moneys which are provided by this bill, even though I don't think they go far enough, would at least stimulate the building of more good nursing homes.

Now on the proprietary side, I am willing to admit there are many fine proprietary nursing homes. There are also a lot of them that are pretty bad, as I am sure you are well aware, and I do think part of the problem will have to be met by the States taking a more stringent attitude on standards for nursing homes, if throughout the country

there is to be the faith in proprietary nursing homes that you state is excellent in New England.

Mr. KEITH. In New England, we don't hesitate to lend money to charitable organizations that want to build a rest home or nursing home for elderly people. We would feel that we had a better opportunity for service to the community, using this medium to invest their money if the social security system assured the individual of the funds necessary to pay. I think it would have an impact on this bill should your social security approach succeed. You would diminish the need for funds under this proposal.

Mr. BIEMILLER. Well, I would think that the logic of your position leads you into open support for the Anderson-King bill and I hope we have you working with us when the time comes.

Mr. KEITH. I thought you might reach this conclusion and I am glad you brought it up. I have an open mind on that subject.

Mr. BIEMILLER. Good. I am delighted to hear it.

Mr. KEITH. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Sibal?

Mr. SIBAL. No questions.

The CHAIRMAN. Mr. Thomson?

Mr. THOMSON. Mr. Chairman, I have had the privilege of listening to Mr. Biemiller for many years. He was a contemporary of mine in the Wisconsin Legislature. I am glad to note that he has lost none of his vigor or enthusiasm for public health legislation and I am, of course, glad to have the opportunity to be here this morning to hear him again.

Mr. BIEMILLER. Well, thank you, Congressman. Mr. Chairman, I would like to say that I too have enjoyed many long years of association with Congressman Thomson who has served with distinction as both majority and minority leader of the Wisconsin Legislature, as speaker of the assembly, as attorney general, and as Governor of Wisconsin.

He is one of our distinguished citizens and while the Congressman and I haven't always agreed on legislation, I think we have always enjoyed sparring with each other.

I was the opposition leader at one time in the legislature and I look back at those days with a great deal of interest and pleasure and sometimes, I think they are the happiest days I will ever have.

May I say for the record I appreciate the kind remarks made by Congressman Rhodes. He is an old acquaintance of mine, we have fought many battles together and I hope we will continue to do so as time goes on. He is a distinguished Representative not only of his own State, but is a leader in the labor movement of Pennsylvania, and we are proud to have a man from the labor movement serving with so much distinction in the Congress.

The CHAIRMAN. After these accolades Mr. Dominick, do you have any questions?

Mr. DOMINICK. I have only two questions, one of which I think can be answered with a "Yes" or "No."

Have you made any estimate in your studies of whether or not the creation of nonprofit nursing homes would put out of business the existing, proprietary homes and thereby cut down on the number of available beds?

Mr. BIEMILLER. I am not sure I caught the last part of your question.

Miss BAMBERGER. The need for nursing-home beds is so great at this time that a vast expansion in both nonprofit nursing homes and in proprietary nursing homes will not satiate the market.

Mr. DOMINICK. That is all I have.

Mr. WILLIAMS. Mr. Chairman, I don't want to ask any questions, but I would like to compliment the witness on the very splendid presentation of his viewpoint and position on this legislation.

As the gentleman knows, he and I have crosed swords several times and he is a very worthy adversary. I don't know of many times when we have been together. The reason I passed over questioning him is that, my primary concern with this type of legislation is the question of where your local responsibility ends and Federal responsibility begins.

Since the gentleman and I have different viewpoints on the subject of local responsibility and Federal responsibility, I see nothing that could be accomplished by examining the witness. However, I have, as I say, heard a splendid presentation of his viewpoint on this legislation.

Mr. BIEMILLER. Thank you, Mr. Congressman.

The CHAIRMAN. Mr. Biemiller, thank you so much for your appearance and your testimony on this legislation.

Mr. BIEMILLER. We appreciate the opportunity to appear.

The CHAIRMAN. We always welcome you back before this committee.

Mr. BIEMILLER. Thank you, Mr. Chairman.

The CHAIRMAN. Obviously, it is approaching the noon hour and we will not be able to complete the witness list for this morning. I do think, however, for the benefit of the two gentlemen who cannot be here tomorrow, that we might hear them at this time.

Doctor Kandle?

STATEMENT OF DR. ROSCOE KANDLE, NEW JERSEY STATE COMMISSIONER OF HEALTH, NEWARK, N.J.

Dr. KANDLE. Mr. Chairman, I am Dr. Roscoe P. Kandle, State commissioner of health for the State of New Jersey. I appreciate your courtesy in hearing me now, sir.

I am filing my complete statement.

The CHAIRMAN. I am sorry about the limitation of time.

Dr. KANDLE. This testimony is enthusiastically and unqualifiedly given in support of H.R. 4998, the Community Health Services and Facilities Act.

I have submitted two examples which it seems to me to be pertinent of the kind of things which can be done nationwide if this kind of legislation is enacted. One of them is in support of the kind of thing that New Jersey has been doing, and I would like, if I may, even with this short time, read one paragraph of New Jersey law, the Chronic Disease Control Act of 1952 and this is the declaration of policy which is now State law in New Jersey:

> The growing problem of prevention, detection and care of chronic illness which is of such character as not to be exclusively medical, education or welfare has now reached such proportion in this State as to require the participation

of the State and of the agencies administering public health education and welfare within the State and be it hereby declared to be the public policy of this State, that the responsibility therefore must be shared by the State and the counties and the several municipalities and health districts and the voluntary agencies within the State and the public at large.

This is the way we are practicing. We have a grant-in-aid program which has run for 7 years now. It has been modest, but I think it has been particularly successful.

The episode which Mr. Biemiller talked about in Essex County was initiated by this kind of practice and has been supported in part.

The other thing to which we would like to direct your attention is the homemaker service. The homemaker service in New Jersey is a service of part-time people. These people are people who, by using them part time, only get paid when they work. This has opened up a reservoir of women power which would not have been possible under any other circumstances.

After 7 years, this service is now expending a half million dollars. That is to say, a half-million dollars' worth of services are purchased in New Jersey for homemaker service and of these, 76 percent are collected from the persons themselves or their agents.

The overhead here is one of the lowest we have ever had in the health service.

There is a chart appended to my testimony on this. It is a remarkable service and the examples in the testimony will bear witness to this.

The other example is the things which were done so far with $48,000 or rather a part of that, some $38,000 of funds available through the public health service this year for improving care in nursing homes and this has been a real shot in the arm. It has allowed us to go forward in the basic things we lacked previously.

These things are itemized and I wish I had had the opportunity of speaking for them more directly. I wish I had the opportunity to show you in person. I think you would be enthusiastic about this.

We believe this sort of small grant-in-aid money is the kind of thing which moves us ahead most rapidly.

I appreciate this opportunity to be here, sir.

The CHAIRMAN. Doctor, your entire statement will be included in the record at this point so the committee can have the benefit of the examples referred to and the additional information contained in your statement.

Dr. KANDLE. Thank you, sir.

(The full, prepared statement of Dr. Kandle is as follows:)

STATEMENT BY ROSCOE P. KANDLE, M.D., NEW JERSEY STATE COMMISSIONER OF HEALTH, FOR THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS ON H.R. 4998

This presentation deals mainly with homemaker services and with experience with funds allocated to States to improve care in nursing homes as examples of potential nationwide accomplishments through the resources of leadership, training, and aid proposed to be provided by the Community Health Services and Facilities Act of 1961.

As background, may I have the privilege of reading one short paragraph entitled, "The Declaration of Public Policy" of the Prevention of Chronic Illness Act of New Jersey which was passed in April 1952. In a variety of ways it resembles many of the aims and mechanisms of the proposed Community Health Services and Facilities Act of 1961.

"The growing problem of prevention, detection, and care of chronic illness which is of such character as not to be exclusively medical, educational, or welfare, has now reached such proportions in this State as to require the participation of the State and of the agencies administering public health, education, and welfare within the State and it is hereby declared to be the public policy of this State that the responsibility therefor must be shared by the State and the counties and the several municipalities and health districts and the voluntary agencies and institutions within the State and the public at large."

The grant-in-aid utilized under this New Jersey law has been modest but it has been remarkably effective. Seventy-five hospitals and community health agencies have been helped to secure equipment, employ staff, serve patients for such functions as comprehensive rehabilitation and restoration, rehabilitation of alcoholics, speech and hearing centers, cardiac prevention, diagnosis, surgery, and treatment, early detection of cancer, diabetes, glaucoma, tuberculosis, etc.

Because of the great need and demand for services in the home, special efforts were made to develop homemaker services throughout the State. This has not yet been adequately done but much progress has been made. Homemakers are mature women selected for their personality, dependability, good health, and special interest in working with families where there is illness. They have had chest X-rays, blood tests, and are issued health cards by the local health offices; are covered by workmen's compensation and public liability insurance. In addition to experience in their own homes, the applicants who have been accepted by the local committee, receive a special training course. This is arranged with the cooperation of the Division of Chronic Illness Control, New Jersey State Department of Health and the Extension Division of Rutgers University. The course helps them to adjust quickly to the family they are helping, to be familiar with special diets, child care, and the usual appliances. They cooperate as part of a team with the physician and nurse. There are now about 3,000 homemakers in the United States in organized programs and over 1,000 of them are in New Jersey. The expenditures for all homemaker services in New Jersey are now more than a half million dollars ($509,758) annually. Of this, 76 percent are paid for by the patient or his agent. The attached chart illustrates the high percentage of payment of costs by fees and the low cost of administration. The State health department spends about $8,000 a year to maintain the training of new homemakers and subsidizes new or expanding services on a declining aid basis to about 4 percent only of the total expenditures.

In New Jersey, all the services are local, voluntary agencies. They are run by local, responsible citizens through their own boards with only guidance and technical assistance from the State. At present, 15 of the 21 counties have some service.

Last year almost 250,000 hours of services were provided to 4,300 patients and their homes and families; 516 persons were discharged from hospitals because of the availability of homemaker service, and 296 were not institutionalized because of the availability of homemaker services.

Patients with heart disease and strokes, homes with new babies, postoperative care, accidents, cancer, aging, arthritis, diabetes, cataracts, etc., were served in roughly that order.

Perhaps brief, actual case summaries just as they come in from reports will illustrate better what these wonderful homemakers mean to the people.

Age 83, fractured hip: Lives with daughter who works at bank, 8:30 to 1:30. Get her breakfast, get her up and dressed, tidy apartment, get lunch, put her to bed for afternoon rest until daughter comes home, 4:30. Later, when daughter had to be hospitalized, patient went to stay with another daughter who had her own family to look after and who picked up the homemaker and took her home so she could continue helping. After patient's return to her own home, the former routine was established with a change of hours, 9 to 1. Continuing service: able to pay $1 an hour first few weeks because patient was under doctor's care for a rash, with homemaker to prepare warm water in basin for patient to make and apply pad regularly. The rash cleared up and doctor discharged patient. After that, daughter increased pay to $1.25 per hour. Unable to pay administrative charge. Daughter says service is a godsend to both of them.

Age 45 female, multiple sclerosis: Helps herself, takes own medicine, has speech difficulty. Husband puts her in wheelchair before he leaves at 8:30 after breakfast. He returns home at 4:30. Homemaker arrives at 10, stays until 2, 4 days a week. Mother-in-law comes on Friday to visit and relieve expense of homemaker. Does light housekeeping, prepares lunch, gets patient in bed before she leaves.

Two elderly ladies (sisters 78 and 80) and a brother 83: The ladies came to live with brother and look after him. He had severe heart condition. Then one sister had a heart attack and was hospitalized and homemaker was needed to assist other sister with meals for brother who stayed upstairs. Service given here sporadically for 2 or 3 years. Then brother died, one sister went to hospital with intestinal ailment. Since August 1960, homemaker helping here regularly 5 days a week from 10 to 2 p.m. Kept in own home. Ladies now 83 and 86.

Age 79, arteriosclerosis: Lives alone. Married daughter lives in same town but teaches nursery school. Patient is not alert and needs homemaker to change bed, cook, and do picking up. Is able to take care of her personal needs. Has no income; is living on savings. Cost is a consideration. Daughter will see that she has what she needs, but they must consider the cost. Homemaker getting along fine with patient. Patient eats her hot meal every noon and enjoys it; she is working along with homemaker very nicely.

Age 66, Parkinson disease operation: Patient is home from hospital and would have to go to nursing home if homemaker could not come in to help her. Husband is able to continue to work since wife has homemaker to care for her and the home.

Age 81, husband 83, cardiac and old-age complications of husband. Need homemaker to tidy house and prepare meals. Patient is unable to do the usual daily pickup and cooking. Homemaker is taking care of the household tasks and preparing the meals. The family are eating well and are able to remain in their own home with this help.

During this fiscal year, New Jersey received $48,000 from the Public Health Service to improve care in nursing homes. These activities have so far been provided through these funds:

1. A grant has been provided to a Jersey City Hospital to assist in underwriting the cost of team members for diagnostic evaluation and screening of patients at the county institution for geriatric care.

2. A contract has been negotiated with a medical center for the development of a home care program for senior citizens in conjunction with a nursing home.

3. A full-time nurse who has participated in the two training courses for nurses at the hospital center at Orange has been trained and is presently on the staff. At the present time, this nurse is spending 2 days a week providing consultation services to a county hospital, 1 day a week at a nursing home, and 1 day a week coordinating the activities of the VNA nurses who are providing services in three nursing homes.

4. Two 2-week educational and training courses of 10 days each for nurses have been provided at the hospital center at Orange. A third course is scheduled for the weeks of May 15 and 22. These courses were afforded to nurses from three visiting nurse associations. The department is underwriting the cost of providing 1 day a week, for the next 5 months, by each of these organizations to three nursing homes.

5. A symposium for physicians has been planned, utilizing the services of a physiatrist of New York University, and in conjunction with Kessler Institute, to be held May 17.

6. The program has purchased and distributed approximately $2,000 worth of brochures and books.

7. Through the dental health program, a screening and service program is being developed in Monmouth County in surveying the needs of the senior citizens in the nursing homes of that county. A similar survey is being planned for Middlesex County.

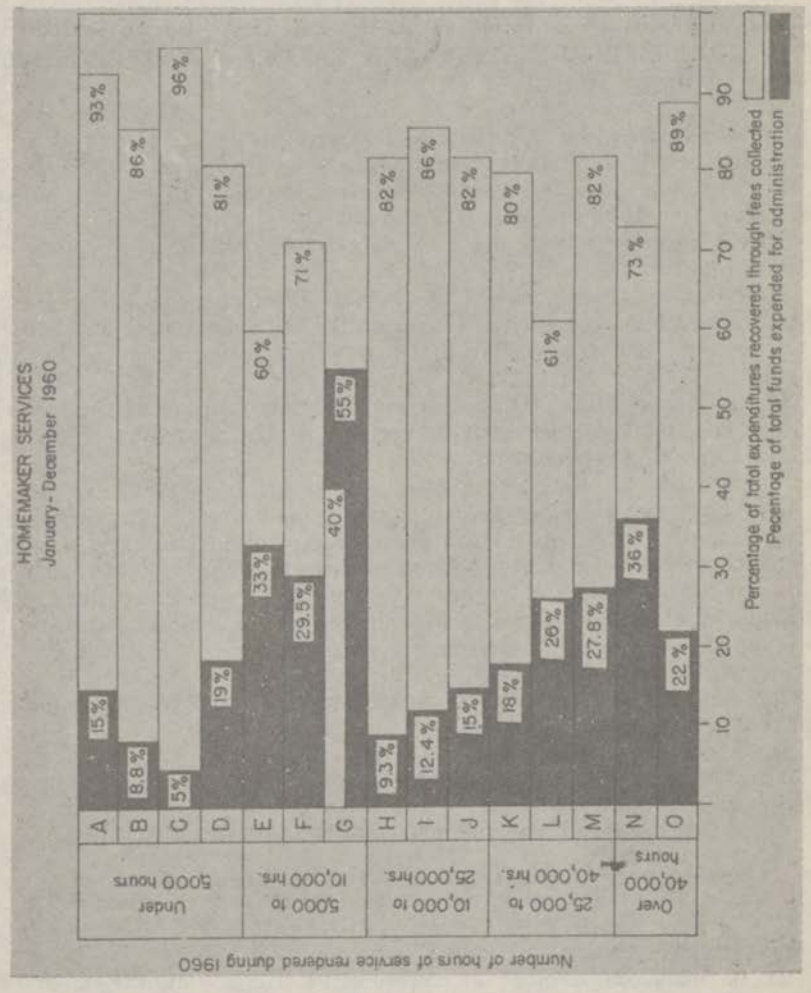
8. The program is working with the Educational Committee of the Licensed Nursing Homes Associated of New Jersey, Inc., in developing a training program for nursing home administrators.

9. Through our nutritional program in the division of consultation services, and in cooperation with the Nutritional Division of the U.S. Public Health Service, a study is being made of the nutritional services being provided in 12 nursing homes for the development of a short and valid questionnaire which can be used by persons with no formal training in dietetics to evaluate the quality of food service in nursing homes.

10. The program, in connection with the Division of Chronic Diseases of the U.S. Public Health Service, acted as a catalyst for two hospitals and two nursing homes to coordinate their activities in affording nursing homes consultation services.

All of these funds have gone directly into services. In no case do they pay for more than the smaller share of the costs—most, offer only seed moneys. The hospitals, patients, professions, and agencies who are aided are expending considerable sums. The services to people are expanding and are being provided through integrated, commonsense mechanisms which bring the specific service needed at that particular time to the patient and his family.

Other means, including payment of costs by the recipients are available increasingly to pay for medical care but the stimulus, help, initial investment, and training and direction must come from the community Health Services and Facilities Act.


HOMEMAKER SERVICES
January - December 1960
Number of hours of service rendered during 1960
Under 5,000 hours
5,000 to 10,000 hrs.
10,000 to 25,000 hrs.
25,000 to 40,000 hrs.
Over 40,000 hours
A
B
C
D
E
F
G
H
I
J
K
L
M
N
O
15%
8.8%
5%
19%
33%
29.5%
40%
9.3%
12.4%
15%
18%
26%
27.8%
36%
22%
93%
86%
96%
81%
60%
71%
55%
82%
86%
82%
80%
61%
82%
73%
89%
10
20
30
40
50
60
70
80
90
Percentage of total expenditures recovered through fees collected
Percentage of total funds expended for administration

The CHAIRMAN. Are there any questions?

Mr. Sibal?

Mr. SIBAL. No questions, Mr. Chairman.

The CHAIRMAN. Thank you very much, doctor, for your testimony.

Dr. McGavran will be our next witness, and is chairman of the Council on Graduate Education and Training, American College of Preventive Medicine, dean, School of Public Health, University of North Carolina.

STATEMENT OF DR. E. G. McGAVRAN, CHAIRMAN OF THE COUNCIL ON GRADUATE EDUCATION AND TRAINING, UNIVERSITY OF NORTH CAROLINA

Dr. McGAVRAN. Mr. Chairman, I appreciate the pressure of your time and would like merely to present the statement I have made and which you have before you representing the American College of Preventive Medicine which is the board statement, board of medical practictioners. They are particularly competent in this field of community health.

We heartily endorse, as you see in this statement, the bill with two minor amendments which we would like to recommend and which appear here that are similar to those which were presented by Dr. Leavell.

The evidence I have to present is merely in support of that which you have already heard and further carries the approval of the organization that I represent.

I would be glad to try to answer any questions if you have any.

The CHAIRMAN. Doctor, you suggest amendments removing the present ceiling of $1 million on grants for graduates in public health application under the Taylor-Rhodes formula and give your justification for it and also an amendment to remove the present ceiling of $2 million on the project grants for graduate public health training in schools of public health, nursing, and engineering.

Dr. McGAVRAN. That is right.

The CHAIRMAN. And also the justification for your recommendation on that amendment.

Dr. McGAVRAN. Yes, sir.

The CHAIRMAN. Your entire statement will be included in the record at this point.

(The full prepared statement of Dr. McGavran is as follows:)

STATEMENT BY E. G. McGAVRAN, M.D., M.P.H., CHAIRMAN OF THE COUNCIL ON GRADUATE EDUCATION AND TRAINING, AMERICAN COLLEGE OF PREVENTIVE MEDICINE, DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, N.C.

Mr. Chairman and members of the committee, I appreciate the opportunity to appear before this committee today on behalf of the American College of Preventive Medicine in support of H.R. 4998 (S. 1071). This bill to expand and improve community services and facilities for the health care of the aged and chronically ill is directed at one of the most crucial and challenging community health problems of the day.

The American College of Preventive Medicine, which I represent, is composed of 1,100 board-certified community health specialists. Seventy-five percent of all community health specialists in the United States who are board certified in the medical profession belong to the American College of Preventive Medicine. I, therefore, represent the majority of the individuals and the only organization of medical specialists competent in this field of community health, and I repeat,

this bill deals with one of the most pressing community health problems of today.

The population of the United States is an aging population. That people are living longer today is to a large extent the successful result of preventive medicine and public health or community health. Through the prevention and control of communicable disease and the reduction of infant and maternal mortality, deaths in the earlier years of life have been remarkably reduced and the people who otherwise would have died young are living to middle and old age.

These successes of community health have magnified the health problems associated with older people. Fortunately, however, our vast programs of health research have given us the technical knowledge to deal with many of these problems. Furthermore, we have confidence that this body of knowledge will continue to expand and enable us in the near future to overcome many more of the problems.

It is a deplorable fact, however, that the benefits of modern health practices are not widely available to the people who need them. Although there are a number of factors which limit the availability of high quality comprehensive health care, one of the most important of these is that the community services and facilities through which such care can be provided are nonexistent or inadequate. This is particularly true with respect to out-of-hospital facilities and services such as skilled nursing homes, homemaker services, home nursing services, health information and referral centers, and outpatient diagnostic services.

Modern health services are expensive and they will probably become more expensive. But such services are unnecessarily expensive if patients are treated in a hospital when the type of services they need could be provided in a skilled nursing home or if patients are kept in a hospital or skilled nursing home when they could receive proper health services at home. These less expensive and more satisfactory arrangements for health care cannot be used, however, when the community facilities and services to provide them are not available.

An equally distressing situation exists with respect to the quality and scope of health care available today in many of the nursing homes in this country. Although some skilled nursing homes provide excellent health care, most of them provide what amounts to only custodial care—and this in unsafe, insanitary buildings staffed with inadequately trained staff. Such care not only contributes little to the health of the patient, but in many cases it actually retards or prevents full potential recovery. Major public attention and action are needed to upgrade the quality and scope of health services in nursing homes so that they can truly become a vital and effective community health resource.

Community services upon which the physicians and patients can call to provide auxiliary health care to the patient in his home are also very scarce. While the physician's patient is in the hospital, these auxiliary services, upon which so much of modern medicine depends, are made available as a matter of course. Nursing, nutrition, physical therapy, laboratory, and other such services are continuously available in the hospital, and they are organized and coordinated in such a way as to serve the needs of the patient when he needs them and in an effective manner. But when a patient returns to his home or if he does not require hospitalization, these needed services are not available in most communities.

H.R. 4998 (S. 1071) is designed to assist in providing more and better community health services and facilities in order that the health needs of the older people and the chronically ill may have access to the kinds of high quality, effective, and coordinated health services they need. The provisions of the bill emphasize a four-pronged approach:

1. To make funds available on a matching basis to assist States and communities in establishing and improving comprehensive out-of-hospital community health services.

2. To make funds available for studies and demonstrations of new and better ways of providing such services.

3. To increase the funds available for constructing skilled nursing homes and thus provide more high quality facilities for nursing home services.

4. To increase the funds for necessary research related to the development, use, and coordination of hospital services.

This bill has one minor weakness which can be remedied by a slight modification. The "making available" and "increasing funds" for all the above purposes will only aggravate the acute national shortage of public health-trained personnel, adequately documented by the National Conference on Public Health Training in 1958, unless it also provides increase of funds for training. The

removal of the ceiling of $3 million of earmarked funds for public health training by the States is fine, but this does not solve the chief training problem.

We, therefore, recommend two amendments:

Amendment 1: *Remove the present ceiling of $1 million on grants for graduate public health education under the Hill-Rhodes formula. See 314(c) PHS Act, Public Law 86–720.*

Justification:

(*a*) Present Hill-Rhodes funds, although helpful, reimburse the schools of public health for less than one-third of the deficit incurred by the schools for training of federally sponsored students.

(*b*) With increasing number of schools of public health and increasing enrollments, the deficit per student increases and more funds are urgently needed.

(*c*) Removal of Hill-Rhodes ceiling was recommended by the National Conference of Public Health Training in 1958.

Amendment 2: *Remove the present ceiling of $2 million on project grants for graduate public health training in schools of public health, nursing, and engineering. See 309 PHS Act, Public Law 86–720.*

Justification:

Seventy-one schools in over half the States have projects for graduate training in public health; only a relatively few of the projects can be financed with present limitations.

With these two amendments, such an approach to this crucial health problem will work. It is an approach that has been and is being effective in meeting and overcoming other health problems. It is an approach which aims at assisting State, local, and private agencies rather than at an assumption of these responsibilities by the Federal Government itself. We can be confident on the basis of experience with other comparable health legislation that the programs and funds envisaged by this bill will stimulate increasing State and community action and funds for these activities.

The American College of Preventive Medicine urges, therefore, that the Congress take prompt and favorable action on this bill with the two amendments suggested so that these community programs may be initiated within the next few months.

The CHAIRMAN. Are there any questions?

We appreciate your appearance here and your fine presentation, doctor.

Dr. MCGAVRAN. I am sorry I cannot come back.

The CHAIRMAN. For the record, I knew this was going to happen. That bell is a call to the House and we, of course, have to go but we are glad to have had your expression of interest and your statement on this and regret the time has not been sufficient to hear you further.

The committee will adjourn now until tomorrow morning at 10 o'clock.

(Whereupon, at 12:05 p.m., the committee recessed, to reconvene at 10 a.m., Friday, May 5, 1961.)

COMMUNITY HEALTH SERVICES AND FACILITIES ACT OF 1961

FRIDAY, MAY 5, 1961

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 1334, New House Office Building, Hon. Oren Harris (chairman) presiding.

Present: Representatives Harris, Mack, Hemphill, Younger, Rostenkowski, Keith, and Curtin.

The CHAIRMAN. The committee will come to order.

Dr. Milton Terris is our first witness. Would you please identify yourself for the record, Doctor?

STATEMENT OF DR. MILTON TERRIS, AMERICAN PUBLIC HEALTH ASSOCIATION, NEW YORK CITY; ACCOMPANIED BY GENEVA VANCE, PUBLIC HEALTH NURSE, SCOTT COUNTY, KY.

Dr. TERRIS. My name is Milton Terris. I represent the American Public Health Association and with me is Mrs. Geneva A. Vance, a public health nurse also representing the association.

We have two statements which we would like to file: the statement from me and one from Mrs. Vance.

The CHAIRMAN. The statements which you are submitting, Dr. Terris, will be included in the record following your comments that you are about to make. Mrs. Vance's statement may be included at the same time.

Dr. TERRIS. I would like to discusse briefly some of the points made in my statement and then introduce Mrs. Vance to you because she represents an actual, ongoing program.

As far as we in the American Public Health Association see it, the real problem which this bill tries to face up to is the fact that our present health services are well organized to meet the health problems of 1900. Our hospitals are admirably well equipped to treat the acutely ill and our public health agencies have a right to be proud of their great success in protecting the public from infectious diseases.

Conversely, I am afraid we are remarkably unorganized to meet the health problems of 1960. Our hospitals, with a few notable exceptions such as the Veterans' Administration facilities, are simply not geared to serve the need of chronically ill patients requiring long-term care.

The facilities for such patients are hopelessly inadequate. We can offer them for the most part beds, and provide beds and proprietary nursing homes, many of which do not meet even minimal

standards of care. Home care service is hardly existent in many communities.

Home nursing, which is perhaps the most basic of such services, is provided to only a limited extent.

Organized home care programs which furnish a variety of needed services are available only in a handful of communities.

Preventive medical services, as such, in adult-type clinics are few and far between. The situation can only be described as one of pitiful inadequacy. I think that what is happening is that we, as a nation, have refused to face up to the problems of the chronically ill and aged. We have sort of hoped that the difficult problems which they pose for us would go away; instead of going away, they increase every day and the problems remain largely unsolved.

But for these reasons, the American Public Health Association gives very strong support to H.R. 4998, the Community Health Services and Facilities Act. We believe this provides an essential basis for the development of sound community programs to meet the health needs of the public. We support the bill in its entirety.

We would like to use a few minutes to talk about the problems of out-of-hospital services. Now the reason we emphasize out-of-hospital services so much is that whereas in 1903 the leading causes of death were pneumonia and influenza, tuberculosis and diarrhea, in 1960 they were heart disease, cancer, and cerebral vascular disease, or strokes. What has happened is that because of our success with the communicable diseases, the infectious diseases, we have allowed our population to grow to ages at which they would be attacked by heart disease, cancer, strokes, arthritis, and so on. We now have a situation with a progressively aging population which means really that the problem of chronic illness is not only with us, but we can look forward to this rather grim prospect. While chronic illness occurs in all age groups, it is most common in the older people.

As our population gets older, this means we are going to have more and more chronic illness and a greater and greater burden of chronic illness on our health services.

If we look at this whole question only in terms of hospital care, then I think the prospect is indeed a grim one because what this means is that we can look forward during the next 50 years to building more and more hospitals that will be more and more inadequate to take care of the ever-increasing numbers of the chronically ill who will be clamoring for admission to hospitals. This is why we put so much emphasis on out-of-hospital services.

We really don't think the Nation can afford to take the position of providing purely hospital services for the chronically ill. Now this is not a new idea. I wouldn't say this was the first time, but this problem was recognized and there was formulated a short policy statement by the four major organizations in the field and published in 1947. It was adopted as an official policy by the American Public Health Association, the American Public Welfare Association, the American Medical Association, and the American Hospital Association.

Our four associations adopted this statement on planning for the chronically ill and I would like to quote just two pertinent excerpts from that statement and to ask also, Mr. Chairman, if I may, that this attached copy of the statement be included in the record of the hearing.

The CHAIRMAN. It may be included.

(The document referred to is as follows:)

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Published by the American Public Health Association, 1790 Broadway, New York, N. Y.

Planning for the Chronically Ill*

Joint Statement of Recommendations by the American Hospital Association, American Medical Association, American Public Health Association, and American Public Welfare Association

INTRODUCTION

THE conquest of many of the acute communicable diseases has focused increasing attention on chronic diseases[1] as the major causes of death and disability. Numerous communities are now awakening to their responsibilities for the chronically ill. In eight states and at least four cities, action to meet the problem of chronic illness has already been taken or is in the planning stage.[2]

There is a great need for comprehensive planning to insure that the widespread interest in chronic disease is channeled into sound and effective activity. Such planning requires the mutual cooperation of the agencies and professions most vitally concerned with the problem. For this reason, representatives of the American Hospital Association, the American Medical Association, the American Public Health Association, and the American Public Welfare Association have considered the experience already accumulated and have prepared this statement as a guide in the development of community programs. Although planning to meet the economic needs of the chronically ill is of vital importance, primary consideration is given here to the health and medical aspects of the total problem, including prevention, research, treatment, and rehabilitation.

It is hoped that the general public, as well as legislators and members of the health and welfare professions, will find this statement a useful guide and stimulus to planning for the chronically ill.

EXTENT OF CHRONIC ILLNESS

Chronic illness affects nearly every family. It has been conservatively estimated that about 25 million persons, more than a sixth of the population, have a chronic disease.[3] Some 7 million of these have appreciable disability from their illness,[4] while 1½ million are invalids.[5] The most important of the chronic diseases are heart disease, arteriosclerosis, high blood pressure, nervous and mental disease, arthritis, kidney disease, tuberculosis, cancer, diabetes, and asthma.[6] Because special provisions have been made for patients with tuberculosis and mental disease, they are not included in the scope of this statement.

Each year chronic diseases cause nearly a million deaths, and are responsible for the loss of almost a billion days from productive activity.[3] Appropriate action can prevent much of this staggering loss to our economy.

Although the prevalence of chronic diseases increases with age, and the progressive aging of our population is one of the factors responsible for the growing importance of the problem, it

* This report has been approved by the A.P.H.A. Committee on Administrative Practice, upon recommendation of the Subcommittee on Medical Care, and approved by the Executive Board of the A.P.H.A. It has been adopted as an Official Statement of the four associations.

must be borne in mind that chronic illness occurs at all ages. Fully one-half of the chronically ill are below the age of 45, and 16 per cent of them are under 25. More than three-quarters are persons in the productive years from 15 to 64.[3]

Chronic illnesses in childhood and adolescence are particularly important because they influence the period of growth as well as the entire period of adult life. They may have serious effects on the emotional development and social adjustment as well as the education of their young victims.

PREVENTION

The basic approach to chronic disease must be preventive. Otherwise the problems created by chronic diseases will grow larger with time, and the hope of any substantial decline in their incidence and severity will be postponed for many years.

There is a need to intensify health department programs to control chronic communicable diseases such as tuberculosis, syphilis, hookworm, and malaria. Accident prevention programs—in industry, on the farm, and in the home—should be greatly expanded to reduce the incidence of physical handicaps.

The promotion of optimal health throughout life is an important factor in the prevention of chronic illness. Child and school health programs need to be strengthened. Wide expansion of nutrition, mental health, and housing programs can have important effects in decreasing the incidence of chronic illness.

The success of programs to conserve the health of infants and children suggests the possibility of achieving effective health programs directed to adolescents as well as adults. The health programs of our high schools and colleges, including medical examinations and correction of defects, physical fitness and recreational programs, and health education require intensive development.

The periodic medical examination of apparently well persons needs to be explored on a new basis, including selective laboratory and clinical examinations chosen for particular age, sex, geographical, and occupational groups. These include serology, chest x-ray, urinalysis, electrocardiography, ophthalmoscopic and other examinations.[7]

Industry and labor can play an important constructive role in this connection by encouraging health examinations of employees, including laboratory procedures, on a much larger scale than at present.

The recent development of special phases of the health examination, particularly in the fields of tuberculosis control and cancer detection, is especially noteworthy. The great interest shown by the medical profession and the public in chest x-ray surveys and in the establishment of diagnostic centers to examine apparently well persons for early signs of cancer represents a distinct advance in preventive medicine. It may well initiate a basic shift in emphasis in the medical care of adults comparable to that which has occurred in obstetrics and pediatrics, in which preventive supervision and examination of presumably well persons is a major requirement of good medical practice. There is a need to explore the practical possibilities of preventive examinations to discover all possible disease, making full use of the diagnostic aids developed by modern medical technology.

RESEARCH

Further advances in the prevention as well as the treatment of many chronic diseases are dependent on research. Although a good deal of research is now being carried on in chronic diseases, only a fraction of the total need is being met.

War experience in medical research

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has made it clear that we must broaden our vision and think in terms of research planned and organized on a much larger scale than any now contemplated. This requires the training and support of a much larger corps of medical scientists, and the development of teams of research workers to carry forward coördinated programs. The greatest emphasis must be placed on those diseases which are the most important causes of death and disability, such as heart disease, high blood pressure, arteriosclerosis, arthritis, kidney disease, cancer, diabetes, and asthma.

Research institutes in chronic diseases, associated with clinical facilities, may well become the basic units of such a program. In New York City, the research services of the Goldwater Memorial Hospital have carried on important research in kidney disease, arteriosclerosis, malaria, and cirrhosis of the liver.[8] In Illinois, the State Commission on the Care of Chronically Ill Persons is considering the advisability of developing a state supported university research institute for the study of chronic illness which would, in addition to suitable research facilities, provide beds for 200 patients and an outpatient service for 15,000 patients a year.[9] The National Institute of Health is formulating plans for intensive laboratory and clinical research in heart disease, geriatrics, cancer, and mental disease.

There is a great need for administrative research, for more precise information on methods of providing the necessary services for the chronically ill. Basic research on some of the administrative problems is already being undertaken,[10] but the field is a relatively new one and requires intensive study and development.

Research is also necessary in the social and psychological aspects of chronic illness. The influence of these factors in the development of specific chronic diseases needs to be more fully determined, while the effect of chronic illness on the individual's social relationships needs further study.

MEDICAL CARE

In the past, the approach to chronic illness has been primarily concerned with institutional care for advanced stages of disease. There is need for a new orientation which places major emphasis on the early stages of chronic illness with a view to preventing or at least delaying the progress of the disease process.

Diagnosis and treatment of illness at its inception is essential to the control of chronic disease. Competent medical supervision, if brought into play early enough, can have an important preventive effect. The most dramatic expression of this fact is found in cancer control, where diagnosis of early symptoms and prompt treatment may be a life-saving measure. Early diagnosis and proper management of diabetes prevents the serious complications of infection, gangrene, and coma. Similarly, early diagnosis and treatment may prevent complications or prolong the lives of persons with heart disease, hypertension, rheumatic fever, peptic ulcer, and other chronic diseases.

The barriers to early competent diagnosis and treatment must be removed. This requires the construction of hospital and laboratory facilities to cover all our communities, with coordination of facilities to insure a maximum of diagnostic and therapeutic effectiveness for the individual patient. Health and medical agencies need to plan to fill the great needs for personnel as rapidly as possible. Means must be found to remove the basic economic barriers to early diagnosis and therapy.

Health departments, which have carried on excellent educational activities in communicable disease, should turn in increasing numbers to the larger field of chronic illness and teach

the public the facts about heart disease, cancer, diabetes, and other chronic diseases, with special emphasis on early signs and symptoms and the importance of early and continued medical supervision.

The concept of medical care must be broadened to include the social factors which play a vital role in the progress of chronic illness. Physicians have learned, for example, that it is not enough to cure a patient with minimal tuberculosis and send him back into the community. On the contrary, he must be observed carefully over a long period of time for signs of reactivation of the disease process. Even more important, the physician must draw on community resources in order to change the patient's environment to prevent breakdown. If the patient's previous occupation called for strenuous physical exertion, he should be retrained for office work or some other light occupation so that he can live with his tuberculosis or other chronic disease. Occupational retraining and job placement are essential therapeutic and preventive measures.

Several general considerations should be borne in mind in planning to provide adequate medical care for the chronically ill.

First, the care of the chronically ill is inseparable from general medical care. While it presents certain special aspects, it cannot be medically isolated without running serious dangers of deterioration of quality of care and medical stagnation.

Second, major emphasis must be given to coördination and integration of services. The person who is chronically ill will receive the type of care which he specifically needs only if provision has been made for the highest possible degree of coördination. Since the medical condition of the chronically ill person is not static but changes with [illegible] it is essential to develop smoothly operating mechanisms for referral from one type of care to another.

Third, facilities for the care of the chronically ill should be planned for the community as a whole and not for the indigent alone. Chronic disease strikes all sections of the population, and the lack of facilities is as great for those who are able to pay as for those who are not. The facilities for chronic disease should be community institutions serving all sections of the population. They will in this way achieve a greater degree of financial stability because of the additional income from those able to pay, and will be able to furnish a higher quality of care.

Fourth, the services and facilities necessary for the medical care of the chronically ill require considerable and continuing financial expenditures in order to maintain the quantity and quality of care offered. Good medical care for chronic illness cannot be purchased on an "economy" basis.

Fifth, and most important, the goal of medical care is to maintain and restore the chronically ill as independent and self-supporting members of the community. Major emphasis should be placed on home and office care, with hospital care, convalescent care, and rehabilitation serving where possible to return the chronically ill to productive community life, and with nursing home facilities providing for those whose medical condition is such that they cannot remain in their home environment.

HOME CARE

The majority of persons who are chronically ill can best be cared for in home, office, and clinic.

It is unwise as well as impractical to consider a separate home, office, or clinic service for the chronically ill; their needs are best met by inclusion in the general community medical care program.

Ready access to diagnostic and specialist service is essential to adequate care for chronic diseases, since many of them are difficult to diagnose and treat.

One of the most pressing needs is for an expansion of public health nursing service to provide bedside and other nursing services for the chronically ill. Most rural communities and small cities do not have sufficient public health nurses to provide adequate bedside nursing care. Some of the larger cities have well organized bedside nursing programs, but even here the number of nurses is generally below the estimated minimum of one nurse per 2,000 persons to carry out all public health nursing activities including bedside care.[11] In addition to increasing the number of public health nurses, there is need to train them to provide valuable assistance to physicians in the time-consuming task of educating the individual patient in the proper understanding and management of his chronic illness.

Much wider use should be made of practical nurses and nurses' aides, working under the supervision of the public health nurse, for duties which do not require the training and experience of a graduate nurse.

Housekeeper service should be widely encouraged; there has already accumulated ample experience to show the value of the visiting housekeeper in the home care of chronic illness.[12] Housekeeper service performs the important social function of enabling the chronically ill patient to remain at home, and has an economic value in helping to reduce the need for expensive institutional facilities.

Other measures which enable chronically ill persons to be cared for at home include improved housing, supervised boarding homes, medical-social service, recreational and occupational therapy, and vocational rehabilitation. Social security measures to maintain income such as disability insurance, old-age insurance, and public assistance are likewise of vital importance.

HOSPITAL CARE

The large number of chronically ill persons in general hospitals who require long-term care represents a serious problem to hospital administrators.[13] The general hospital as at present constituted is often unsuited to the care of long-term patients, since it is geared primarily to the therapeutic and general requirements of the acutely ill. It may lack adequate departments for physiotherapy, occupational therapy, and rehabilitation, as well as sun porches, recreational facilities, educational facilities for children, and an understanding of the social and psychological needs of the chronically ill.

The average long-term patient requires less costly care than that provided in the acute general hospital.[14] To continue to care for the long-term patient in the acute general hospital is wasteful; it provides care which is more expensive than he actually needs, and which is often unsuited to his requirements.

The construction of hospital facilities for the chronically ill has been encouraged by the passage of the Hospital Survey and Construction Act, which provides federal aid for such facilities up to a maximum of two beds per 1,000 population.[15]

There is already evident a tendency in some localities to build chronic disease hospitals in areas remote from the medical center and the general hospital and with no relation to them. This trend unfortunately follows the pattern already laid down in the construction of our tuberculosis and mental hospitals, a pattern which has resulted in many instances in the medical isolation and stagnation of these special institutions.

Hospital facilities for long-term illness should be built in the very closest re-

lation to teaching centers and general hospitals.

The specialized chronic disease hospital is suitable in large cities, where it can be located on the grounds of or very closely related to a medical school or teaching general hospital. Special consideration should be given to planning the facilities for children who are chronically ill. While an official or voluntary organization may be responsible for the construction and maintenance costs, the medical school should provide the attending and resident staff and utilize the facilities for research and medical education in chronic disease.

It is important that the specialized chronic disease hospital serve as the consultation center for chronic disease in its medical service region.[16] It should maintain formal professional affiliation with general hospitals in the region that care for chronic patients, in order to provide consultation and teaching visits from the center to the general hospitals as well as the referral of patients to the center for special study.

Most patients with chronic illness who require hospitalization are best cared for in a unit of the general hospital especially designed to meet their needs. This arrangement encourages patients to seek and use care since it is near their homes, families, and friends; makes available to them the existing facilities of general hospitals; provides opportunity to internes, nurses, and staff for experience and teaching in chronic disease; avoids expensive duplication of existing general hospital facilities; and affords the most ready means of transfer to and from the acute and chronic disease sections of the hospital when needed. Further, it allows for greater flexibility in hospital planning by making it possible for future, unforeseen shifts in the relative proportions of patients with acute and chronic diseases to be met by changing the designated use of either chronic or acute beds in the same hospitals.

Many advantages of this plan would be lost if the chronically ill were simply intermingled with all other patients in general hospitals. The provision of a special wing or floor devoted to long-term patients insures that the special needs and problems of chronic disease are not lost sight of in competition with the more urgent and dramatic needs of the acutely ill. It makes possible the planning of the special unit in conformity with its special purpose, both as to architecture and staff. It makes it easier to provide occupational and recreational therapy, special physical therapy, rehabilitation and other services essential to the care of long-term patients. It facilitates a more economical use of nursing personnel, the utilization of a larger proportion of attendants, and less intensive medical staff attendance than is needed in the section of the hospital devoted to patients with acute illnesses.

Under no circumstances should chronic disease hospitals or units be limited to the indigent. The lack of facilities is felt by all sections of the population. High standards will be maintained most effectively if the facilities are geared to meet the requirements of the entire community. Also, the admission of patients who are able to pay will reduce the need for tax funds. It must be recognized, however, that prolonged illness exhausts the financial resources of many patients, necessitating payment from tax funds for their care.

CARE IN NURSING HOMES

Chronically ill persons who need active and continuous medical care should be treated in a hospital. On the other hand, there are many chronically ill persons who are more or less disabled by their illness, whose requirements for care can be met by practical nurses and attendants with medical and nursing

supervision, and who cannot or should not remain at home. Care for such persons should be provided in nursing homes.

The following example may make the difference clear. A person who has suffered a cerebral hemorrhage with paralysis of one side of his body requires hospital care. This care will extend over a period of weeks and months during which time he will receive intensive physical therapy to restore the maximum possible use of his muscular system. When no further improvement can be obtained by medical treatment, and he is left with a good deal of disability which makes it impossible for him to be cared for at home, he is eligible for care in a nursing home.

Nursing homes, both private and public, should be brought under state licensure laws in which provision is made for minimum standards and regular inspection. The minimum standards should require continuing medical supervision, including complete medical examinations of patients prior to admission to the nursing home and follow-up examinations at definite intervals, as well as physician visits on a regular basis and on call. The standards should call for a sufficient number of practical nurses and attendants to meet the full needs of the patients. They should provide for at least one full-time graduate nurse in charge of nursing care.[17] The standards should require facilities for recreation and occupational therapy, for a maximum of privacy and individual attention, and for cheerful and homelike surroundings. Construction should meet adequate standards of safety and sanitation.[18]

Private Nursing Homes

Experience has demonstrated that improvement in the quality of private nursing homes cannot be obtained merely by passage of a licensure law. The power to inspect and license nursing homes carries with it the responsibility for carrying on an intensive educational campaign, working with the individual nursing homes to improve the care given. The device of placing each new nursing home on a six month probationary period, during which time there is a great deal of educational assistance from the licensing agency, has been demonstrated to be an effective method of raising standards.[19]

It is suggested that wherever possible, the quality of medical and nursing supervision can be greatly improved through arrangement with the medical board of a nearby hospital to provide the necessary medical services.

One of the most serious drawbacks to adequate care by private nursing homes is the low payments made by welfare agencies for clients requiring nursing home care. A sharp upward revision of payments by welfare agencies, to bring them up to the actual cost of care, is an indispensable prerequisite to raising standards. At the federal and state levels, liberalization or elimination of the ceiling on payments for public assistants clients is indicated.

Public Nursing Homes

The realization that a large proportion of the population of county homes or almshouses consists of chronically ill adults has led to a widespread movement to convert them into public nursing homes.

It is clear that such conversion does not make the almshouse a chronic disease hospital, but rather a nursing home for the chronically ill.

County homes should be converted into public nursing homes only if their physical facilities are adequate, if they are within reasonable distance of general hospitals with which close medical relationships are maintained, and if the responsible authorities are prepared to meet the minimum standards described previously: namely, adequate medical

and graduate nursing supervision; sufficient personnel to meet the full needs of the patients, including medical-social service if possible; provision for privacy, a cheerful and homelike atmosphere, recreational and occupational therapy; and construction which meets safety and sanitation requirements. Many county homes cannot meet these conditions and should therefore not be considered for conversion.

It is suggested that conversion be planned on a state-wide basis, with the most careful evaluation of the suitability of individual almshouses for conversion. Financial and technical assistance by the State to localities planning conversion will make it possible to achieve higher standards of care. Public nursing homes should be included in the provisions of nursing home licensure laws.

A factor which will help obtain increased community interest, better administration, and higher quality care in public nursing homes is the admission of patients able to pay part or all of the cost of care. There is a considerable demand for public nursing home care on the part of patients able to pay. By opening its facilities to such patients the public nursing home will not only improve its financial position but will perhaps begin to free itself from the almshouse tradition and serve as a public facility for the entire community.

The Social Security Act should be amended to allow federal matching to states for assistance to patients who wish to enter public medical institutions, including nursing homes, that meet adequate standards. Payment for nursing care in public as well as private homes should be commensurate with the actual cost.

New Institutions

The shortage of institutions for nursing home care of the chronically ill cannot be met by present facilities or by the conversion of county homes. There is a definite need for new construction.

It is recommended that voluntary and governmental general hospitals which have chronic disease pavilions give serious consideration to establishing nursing home facilities for the chronically ill. These facilities should be built on the grounds of the general hospital or within a reasonable distance. There should be close administrative, medical, and nursing relationships between the hospital and the nursing home.

The specialized chronic disease hospitals located in teaching centers should likewise maintain nursing homes which can be utilized for research and training and will set standards of quality of nursing home care.

The construction of new institutions should be closely integrated with state plans for reconversion of public homes and utilization of private nursing homes in order to prevent an overabundance of facilities in some areas and lack of facilities in others.

CONVALESCENCE AND REHABILITATION

Undoubtedly the most neglected aspect of chronic illness is that of convalescence and rehabilitation.

Only recently has there been recognition of the fact that convalescent care is an important feature of the care of the chronically ill. Chronic diseases often run a course of many years, with periods of relative well-being alternating with periods of illness. Following a flare-up of illness adequate convalescent care may lead to complete or partial rehabilitation, and may help delay the progress of the underlying chronic disease. Such convalescent care undoubtedly conserves hospital beds and performs important therapeutic and preventive functions. Examples of chronically ill persons requiring convalescent care would include those recovering from a period of heart failure,

an attack of acute rheumatic fever, or a flare-up of arthritis. Then there are persons who have a chronic illness such as diabetes or heart disease, and develop pneumonia or some other acute illness, and need convalescent care after recovery from the acute illness.[20]

There has been a large growth of convalescent homes for children with rheumatic heart disease and other crippling conditions. It is essential that such convalescent homes be located near enough to general hospitals to permit close professional relationships and adequate medical supervision.

Convalescent homes for adults have never been developed to any appreciable extent in the United States. Most convalescent care for adults is now provided in nursing homes which also care for non-convalescent patients. On the whole, there has been insufficient appreciation of the value of convalescent care and rehabilitation in the care of the chronically ill.

Recent experience with planned convalescence and rehabilitation in the armed forces has demonstrated their great potential usefulness. By providing physical reconditioning, educational training, recreational activities, and vocational guidance, it was found possible to shorten the period of hospitalization, reduce the incidence of recurrences, and return a larger proportion of men to active duty.[21]

Planned convalescence and rehabilitation are particularly important in chronic disease. The chronically ill have to be made conscious of their limitations early in the course of the disease, and many of them must be retrained for new occupations so that they may stay within the limits of activity prescribed by their illness and yet maintain their economic independence.

Probably the first steps along these lines will be taken by university hospitals, some of which have already made plans for rehabilitation centers as an integral part of their medical program.

In 1943, Congress broadened the scope of the national rehabilitation program. As a result, state rehabilitation agencies were able to rehabilitate successfully nearly 42,000 persons in 1945. These were generally persons with long standing chronic impairments and illnesses—orthopedic disabilities, speech, hearing, and sight defects, poliomyelitis, tuberculosis, mental disease, heart disease, asthma, hernia, and other conditions.[22] That the need is still far from being met is indicated by the fact that the estimated backlog of persons in need of and entitled to such service is between 1½ and 2 millions.[23]

Of the 42,000 disabled persons who were successfully rehabilitated in 1945, nearly 79 per cent were unemployed at the time of applying for rehabilitation service, and 18 per cent had never been employed. The average yearly income before rehabilitation, including those who received assistance from public or private sources, was $288. The average annual wage after rehabilitation was $1,764. The total income of the group was increased by rehabilitation from 12 million dollars a year to 74 million, a sixfold increase.

In the past, many of the disabled have had to be supported by public or private assistance at a cost up to $500 a person each year. Vocational rehabilitation costs an average of only $300 a person, and this cost is not repeated.[22] On the contrary, rehabilitation changes the individual into a self-sustaining productive member of the community. It is clear that rehabilitation is economically and socially sound.

The results achieved with long standing chronic impairments and diseases point up the great potentialities of rehabilitation instituted early in the course of chronic illness.

COÖRDINATION OF SERVICES

The problem of chronic disease pre-

sents many aspects—prevention, research, medical care in home, hospital and nursing home, and convalescence and rehabilitation.

Undue emphasis on any one aspect would be unwise, uneconomical, and ineffectual. For example, to concentrate on the provision of medical care without paying serious attention to prevention and research would postpone for many years any basic attack on the problem. On the other hand, it is impossible to focus sole attention on research because of the very urgent need for medical care. Likewise, to provide hospital beds for chronic disease without making nursing home facilities available would result in many beds being occupied by patients who do not need hospital care. Too great an emphasis on nursing homes would deprive many patients of the specialized hospital care which is necessary for their improvement. Failure to plan adequately for home care or for convalescent care and rehabilitation would defeat the purpose of the program—to maintain and restore the individual as a self-supporting productive member of his community.

There is a great need for coöperation and coördination of the numerous agencies concerned with chronic disease: health, welfare, and education departments, hospitals, medical societies, medical schools, social agencies, rehabilitation services, nursing homes, etc. In some communities this coördination has been achieved through the establishment of central planning and coördinating bodies which study the various aspects of the problem, make the facts known to authorities and the public, stimulate needed services, assist in securing necessary facilities, and act as information centers for patients, physicians, and health and social agencies.[24]

The total problem of chronic disease is not a series of separate problems which can be solved one by one, but rather a complex of interrelated problems which require simultaneous solution. It is recommended, therefore, that coördinated and comprehensive planning be undertaken at all levels in order to achieve effective action to meet the challenge of chronic illness.

REFERENCES

1. The term "chronic disease" is susceptible to various definitions. An administrative definition of chronic disease has been suggested as follows: "A disease that may be expected to require an extended period of medical supervision and/or hospital, institutional, nursing, or supervisory care." (Rogers, E. S. Chronic Disease: A Problem That Must Be Faced, *A.J.P.H.*, 36:345 (Apr.), 1946.) In the National Health Survey, chronic disease was defined for statistical purposes as "a disabling or non-disabling chronic pathological condition known to the informant, the symptoms of which had been recognized for at least three months." (Perrott, G. St. J. The Problem of Chronic Disease, *Psychosom. Med.*, 7:22 (Jan.), 1945.) Another definition is that used for survey purposes by the Public Welfare Council of Connecticut, "A disease or condition of the body or personality which has been present at least six months or which may be expected to continue at least six months and which interferes with one's occupation and normal physical and social life." (*Need for a State Infirmary for the Care and Treatment of Aged, Infirm, and Chronically Ill Persons*, Public Welfare Council, Hartford, 1944, p. 4.)

2. The states referred to are California, Connecticut, Illinois, Indiana, Maryland, Massachusetts, New Jersey, and New York. The cities are Chicago, Cleveland, Milwaukee, and New York.

3. Perrott, G. St. J. The Problem of Chronic Disease. *Psychosom. Med.*, 7:22 (Jan.), 1945. The estimates given are admittedly low because of the survey technique used.

4. *National Health Survey, Some General Findings as to Disease, Accidents and Impairments in Urban Areas. Pub. Health Rep., Reprint No. 2143*, p. 2 ff. The frequency of chronic illnesses causing disability of at least seven consecutive days in a 12 month period was found to be 48 per 1,000 persons, or approximately 7 million for the total population.

5. *The Magnitude of the Chronic Disease Problem in the United States.* National Health Survey, Sickness and Medical Care Series, *Bull. 6*, p. 6.

6. Importance was determined by the combined indices of prevalence, mortality, disability, and invalidism. See Reference 5, p. 7.

7. Roemer, M. I. A Program of Preventive Medicine for the Individual. *Milbank Quart.*, 23:209 (July), 1945.

8. *Research, An Experiment in Municipal Organization.* Department of Hospitals, New York City, 1945, p. 48 ff.

9. Communication from R. M. Hilliard, Public Aid Director, State of Illinois.

10. The Central Service for the Chronically Ill in Chicago is making a detailed study of the needs and costs of care of different categories of nursing patients.

11. Resolution of the National Organization for Public Health Nursing, June, 1944. *Pub. Health Nurs.*, 37, 3 (Jan.), 1945.

12. Jarrett, M. C. *Housekeeping Service for Home Care of Chronic Patients.* Welfare Council of New York City, Dec. 31, 1938.

13. The percentage ranges from 7 to 20 per cent,

depending on the area surveyed. In New York City, in 1928, a fifth of the ward beds in both private and municipal general hospitals were occupied by chronic patients. (Jarrett, M. C. *Chronic Illness in New York City*, Columbia Univ. Press, 1933, Vol. 1, p. 119.) In New Jersey, in 1940, 38 general hospitals reported that 7 per cent of the total number of patients were chronically ill. (Frankel, Emil. New Jersey Studies Problems of Care for the Chronically Ill. *Hospital Management*, 50:19 (Aug.), 1940.) The findings to date in the Illinois State Health Department's survey of hospital facilities indicate that about 15 per cent of the beds in the general hospitals of the state are occupied by chronically ill patients (unpublished data).

14. The cost at Montefiore Hospital, a high standard voluntary chronic disease hospital in New York City, is more than two-thirds the cost in acute general hospitals. (Communication from Dr. E. M. Bluestone, Director.) In 1945, the cost at Goldwater Memorial Hospital, a municipal chronic disease hospital in New York City, was one-half the average cost in the acute general municipal hospitals (Communication from Dr. E. M. Bernecker, Commissioner of Hospitals of New York City).

15. Public Law 725, 79th Congress, Sec. 622 (b).

16. *Planning for the Care of the Chronically Ill in New York State—Regional Aspects.* New York State Health Preparedness Commission, Albany, 1946.

Health Service Areas, Pub. Health Bull. No. 292, U. S. Public Health Service, Washington, 1945.

17. The present shortage of nursing personnel makes it impossible in many instances to meet this requirement. The New Jersey State Department of Institutions and Agencies has met the situation by helping nursing home operators to make arrangements for a daily supervisory visit from the local visiting nurse association. The plan seems to be working very well.

18. A detailed description of minimum standards of nursing home care is given in *Institutional Care of the Chronically Ill*, a report issued by a joint committee of the American Hospital Association and American Public Welfare Association in January, 1940.

19. Potter, E. C., *et al.* Inspection and the Power of License as Tools in the Care of the Chronically Ill. *Public Welfare*, 2:100 (Apr.), 1944.

20. Boas, E. P. Convalescence and Chronic Illness. From *Proceedings of Conference on Convalescent Care*, New York Academy of Medicine, Nov. 9, 1939, p. 38.

21. Rusk, H. A. Planned Convalescence. *Bulletin of the New York Academy of Medicine*, 22:465 ff (Sept.), 1946.

22. *Annual Report of the Federal Security Agency, Office of Vocational Rehabilitation*, 1945, p. 15 ff.

23. Rusk, H. A. *New York Times Magazine*, May 12, 1946.

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Jarrett, M. C. *Care of the Chronically Ill of Cleveland and Cuyahoga County.* Benjamin Rose Institute, Cleveland, 1944, p. 36.

Dr. TERRIS. Now the 1947 policy statements of these organizations said, and I quote:

> The basic approach to chronic disease must be preventive. Otherwise, the problems created by chronic diseases will grow larger with time and the hope of any substantial decline in their incidence and severity will be postponed for many years.

We also went on to say, and I quote again:

> This is the past approach to chronic illness and has been primarily concerned with institutional care for advanced stages of disease. There is need for a new orientation which places major emphasis on the early stages of chronic illness with a view to preventing, or at least delaying the progress of the disease process.

Finally, we said, and I will quote again:

> Failure to plan adequately for home care or for convalescent care and rehabilitation would defeat the purpose of the program which is to maintain and restore the individual as a self-supporting productive member of his community.

Now health departments and also voluntary agencies throughout the country are very much concerned with trying to develop preventive measures in the chronic diseases.

There is a good deal of epidemiology, a study of the heart disease, cancer, and other heart diseases going on. Work in these areas have been carried on in the health departments of California, New York, Connecticut, Ohio, and the local health departments in Chicago, Los Angeles, and New York City, but so far I am afraid we haven't quite arrived for most of the chronic diseases. We don't have adequate measures to prevent these diseases and we have to place reliance on a second line of defense; namely, to discover disease before it becomes illness so that the prompt treatment can prevent or delay its progress. That is why the public health agencies have put so much emphasis on things like diabetes detection programs, glaucoma detection programs.

Sight allotment—that is multiphasic eye screening which combines a number of laboratory tests, and you have a program like that right here in the District of Columbia where the Health Department has a multiphasic screening program, they include a battery of serological test for syphilis, for instance, the white blood test, the hemoglobin test, complete urinalysis, chest X-ray, and so on and so forth.

These examinations are given to all who request them and they are followed by a referral to the doctor, the participating physician, or to a hospital clinic if he doesn't have a physician so that the physician or the clinic can make the definitive diagnosis if they find some abnormality on the laboratory test.

I think we are entering an area in which we will probably want to experiment with well adult clinics which would include a regular medical examination, nutrition services, social work, and so on so we can find out to what extent the success the public health agencies have had and also in that connection the well baby clinics which can be repeated at the other end of the aid scale.

The most important of the services which we can provide outside the hospital relates to home care. A considerable number of patients who are in hospitals today really don't belong there. They are receiving a type of care which is inappropriate to their needs, but they are getting it because they have nowhere else to go.

Now many of these people could be cared for at home with proper nursing service, but in many communities such service is either not available or it is very limited.

We feel that there will have to be a large increase in the number of public health nurses; and the use of practical nurses and nurses' aids to provide this type of service. Not only do we have to improve the amount of nursing service, we have to supplement this with a lot of other services. It is what we call comprehensive home care programs, or organized home care programs, and here we include such things as physical and occupational therapy in the home, medical, and social worker visits in the home, X-ray and laboratory services for these people, housekeeper services, transportation, sick room equipment, supplies and appliances, and so on.

Now this will take a good deal of money and there is no question that a good deal of Federal stimulation will be essential to realize them. I think this represents what we would like to say about out-of-hospital services.

I would like to introduce to you Mrs. Geneva A. Vance who is a staff public health nurse in Scott County, Ky.

In 20 Kentucky counties they have home care programs for the chronically ill, organized by the local health department and I think you can probably understand better what we are talking about when we talk about home care programs if we can give you some idea of what actually goes on in this kind of program.

Mrs. VANCE. Thank you. I am Geneva Vance, public health nurse in Scott County Health Department, Georgetown, Ky., appearing here for the American Public Health Association.

It is my privilege to discuss with you some aspects of the Kentucky home care program.

The Kentucky home care program started about 3 years ago in our county when special funds were made available to the States for the purpose of expanding services to the chronically ill and aging.

We added to our staff one full-time public health nurse, one part-time nutritionist, one physical therapist.

The population of our county is around 15,000; 5,000 city, 10,000 rural. It is located in the Bluegrass region, 12 miles north of Lexington.

Local doctors refer patients to the health department for the home care service.

Our program is aimed toward teaching the patient or member of the family to care for themselves as much as possible. The nursing aspects of the home care program include nursing service to the sick in the home, teaching members of the family to care for the sick and the handicapped in the home, demonstrating and teaching physical therapy techniques, helping patients and families with emotional problems associated with chronic disease, teaching the patient self-care as soon as possible, helping to attain maximum rehabilitation, coordinating the services of allied personnel such as doctors, physical therapists, nutritionists, social workers, welfare agencies and all related paramedical workers, and instructing the patient concerning good nutrition and planning and preparing special diets.

In assisting them in the difficult period of adjustment to a special diet we work with nursing home administrators to improve the nursing care for patients in nursing homes and Scott County is one of 20 counties in Kentucky that has added the home care services to their overall program.

I would like to tell you about some patients we have helped in our home care service. For instance, we have a woman 49 years of age who had not been out of her home for 20 years. She had developed varicose ulcers and was emotionally upset. She had two sons who had lived with her until a tragedy caused the death of one son and the hospitalization of another.

The public health nurse went into the home and dressed the ulcers on her legs daily and talked with the patient, winning her confidence. The patient was able to do the dressing of the ulcers on her legs after a few weeks of daily visiting and teaching. Then the public health nurse started to talk to her about taking a ride. She was so emotionally upset that they decided it would be good for her to get out and go into the community. It took several weeks and many visits for her to agree.

After her first trip outside, she became interested in community activities and later when we had a cancer drive in the community, she called and asked if she could help with the cancer drive. This she did, and collected $39 on her street for the cancer drive.

Another case was a man 37 years of age who has multiple sclerosis. On my first visit, I found him very unsteady on his feet, wearing a hearing aid, wearing very heavy lens glasses. His blood pressure was extremely high and he appeared very depressed.

After talking to him and his wife, I learned that he had tried to commit suicide on several occasions. He was unable to speak clearly and he forgets what he has said after he has spoken.

I have been visiting him two or three times a week, giving him shots and listening to him talk. Now he feels free to discuss with me a lot of his problems and his condition. Since I have been visiting in the home they have dismissed their housekeeper who had been taking care of him.

The patient now takes care of his own home. He washes the dishes for his wife; he mows the lawn and he, at present, is planting a little garden and is planting flowers around the house. His attitude has changed, and he has improved very much but the sad thing about this disease—multiple sclerosis—it does not usually kill a patient of this age. They may live from 20 to 30 years and they die with something else. It is just a long-drawn-out process with the patient who has multiple sclerosis.

Usually a person with multiple sclerosis doesn't develop the disease after they are 40 years of age.

Another patient I had was a woman 73 years of age who weighed 300 pounds. She had a stroke and was hospitalized for a few days. Then she was referred for home care after she was taken home. On our first visit, I found her in a cold room. There was a clothes line stretched from one wall to the other with wet dripping clothes across her bed. She was lying in a pool of urine. She had bed sores and she was in a terrible mess. She had no one to take care of her except a daughter who wasn't married that lived in the home with her.

I put in a retention catheter, taught the daughter to bathe the patient, change the bed, and she was also put on a special diet.

We asked the nutritionist who was a part-time nutritionist, to help her with a special diet. She was given diet instructions.

We also asked the physical therapist if he would go in and help with her exercise. All of this was started and, after several weeks

of hard work and a lot of home visits, the patient lost 100 pounds, regained the use of an arm and a leg.

Recently, on a visit to our local hospital, I talked with the director of nurses. She told me that since we had had the home-care program in Scott County that her chronic wards had been empty. The patients that had been there so long were able to go home under the care of the health department nurses.

She thought this was quite a compliment to the home-care program being able to get all of these patients out into their homes or into nursing homes.

We, in Kentucky, would like H.R. 4998 to be passed. Our experience in the home-care program has convinced us that there is an urgent need for this type of service for handicapped persons in the home.

I would like to read you a letter that we received from one of our patient's daughter. She says:

I want to express to you my sincere appreciation for the work done by the health department in helping older people. My mother, age 87, had requested that her last days be spent at home rather than in a hospital. This request would not have been possible to grant had it not been for the untiring efforts of your health department nurses. I am indebted to the nurses. Mother actually awaits her visit each day as she brings a ray of sunshine with her. She has shown me many ways that made the nursing job easier here. I think this home visitation by the nurses is the most wonderful thing that has happened to Scott County for the physical welfare of the aged.

Again, may I congratulate you and your staff for the wonderful work that you are doing.

Best regards.

The CHAIRMAN. Does that conclude your statement?

Mrs. VANCE. Yes.

The CHAIRMAN. I believe I have already given permission for your full statements to be included in the record at this point.

(The full, prepared statements of Dr. Milton Terris and Mrs. Geneva Vance are as follows:)

STATEMENT BY MILTON TERRIS, M.D., FOR AMERICAN PUBLIC HEALTH ASSOCIATION

My name is Milton Terris. I am a physician with a background of district health work in the New York State Department of Health; staff director of the Subcommittee on Medical Care of the American Public Health Association; assistant dean for postgraduate education of the University of Buffalo School of Medicine; professor of epidemiology, department of tropical medicine and public health, Tulane University School of Medicine; and now head of the chronic disease unit, division of epidemiology, Public Health Research Institute of the City of New York.

The American Public Health Association, which I represent as a member of its executive board, is the largest organization of public health workers in the world. We are unique in that our 13,000 members and 20,000 more in 50 State and regional affiliates, come from many different professions, including physicians, dentists, nurses, engineers, laboratory and social scientists, statisticians, nutritionists, health educators, social workers, psychologists, and medical care and hospital administrators. They come from both official and voluntary health agencies at the local, State, and National levels. For these reasons the American Public Health Association approaches problems of Federal health legislation not from the viewpoint of a single professional group, but rather from a broad-gaged concern with the health of the public. We speak on the basis of our day-to-day experiences in trying to meet the health needs of the American people—experiences which have brought home to us the dangerous lag in our country's provision of health services for the chronically ill and aged.

Let us state the issue as clearly and bluntly as possible. The present health services in the United States are superbly organized to handle the health problems of 1900. Our hospitals are admirably well equipped to treat the acutely ill,

while our public health agencies have a right to be proud of their tremendous successes in protecting the public from the ravages of infectious diseases.

Conversely, we are remarkably unorganized to meet the health problems of 1960. Our hospitals—with a few notable exceptions such as the Veterans' Administration facilities—are simply not geared to serve the needs of chronically ill patients requiring long-term care. Facilities for such patients are hopelessly inadequate; we can offer them, for the most part, beds in proprietary nursing homes, many of which do not meet even minimal standards of care. Home-care services hardly exist in many communities; home nursing, perhaps the most basic of such services, is provided to only a limited extent, and organized home-care programs, which furnish a variety of needed services, are available only in a handful of communities. Preventive medical services such as "well adult clinics" are few and far between, while modern rehabilitation services do not exist in most communities. The situation can only be described as one of pitiful inadequacy.

What has happened is that we as a Nation have been content to bury our heads in the sand. We have refused to look at the new health problems which were growing all around us. We waited and we temporized, hoping that somehow these difficult problems of the chronically ill and aged would go away. But they have not disappeared; on the contrary, they grow in magnitude every day and they are still unsolved.

The American Public Health Association believes that it is the responsibility of the Congress to provide the necessary support of State and community leadership to solve the health problems engendered by chronic illness. We strongly urge immediate enactment of H.R. 4998, the Community Health Services and Facilities Act of 1961, as an essential basis for the development of sound community programs to meet these health needs of the public.

THE CHANGING DISEASE PICTURE

In 1900, the three leading causes of death were pneumonia and influenzia, tuberculosis, and diarrhea and enteritis. In 1960, they were heart disease, cancer, and cerebral vascular disease (strokes).

In 1900, 4 percent of our population was 65 or older. In 1940, this had risen to 7 percent, and in 1960 to 9 percent.

These two sets of facts are interrelated. The great achievements of public health and medical science in conquering pneumonia, tuberculosis, diarrhea and enteritis, and other infectious diseases have permitted an ever larger proportion of the population to reach the ages at which they could be attacked by heart disease, cancer, and other chronic diseases.

Furthermore, the progressive aging of the population as a very important bearing on the practical approaches which we take to deal with the problems of chronic disease. According to the U.S. National Health Survey, the incidence of acute conditions is highest in childhood and lowest in the older age groups. For chronic conditions, however, the situation is completely reversed. Two out of every five Americans have one or more chronic conditions, but this is true for four out of five of the 65-year-and-older group. About a twelfth of all Americans have three or more chronic conditions, but this is true of almost a third of those 65 years or older. Only a tenth of all Americans are limited in their activity by chronic disease, but this is true for close to half of those age 65 or more.

This means that the progressive aging of our population will result inevitably in a continually increasing and eventually staggering burden of illness and disability due to chronic disease. This is a grim perspective, but unfortunately a realistic one. Unless it is faced and its implications understood, we shall be powerless to take intelligent action to meet the problem.

MORE AND MORE BEDS?

If we think of the chronic disease problem only in terms of institutional care of the long-term patient, then we can look forward to a future of building more and more institutions which will be more and more inadequate to cope with the ever-increasing numbers of the chronically ill who will be clamoring for admission.

Such a policy is not only shortsighted: we cannot afford it. Sound economic as well as public health policy demands that we make every effort to develop other approaches to chronic disease and disability.

This was fully recognized more than 13 years ago, when the American Public Health Association, the American Public Welfare Association, the American Medical Association, and the American Hospital Association adopted an official statement on "Planning for the Chronically Ill" in 1947. I served as secretary of the joint committee which drafted the statement and am therefore quite familiar with the thinking that went into it. I should like to quote some pertinent excerpts here and to ask also that this attached copy of the statement be included in the record of this hearing.

The 1947 policy statement of these four major organizations states:

"The basic approach to chronic disease must be preventive. Otherwise the problems created by chronic diseases will grow larger with time, and the hope of any substantial decline in their incidence and severity will be postponed for many years. * * *

"Further advances in the prevention as well as the treatment of many chronic diseases are dependent on research. Although a good deal of research is now being carried on in chronic diseases, only a fraction of the total need is being met. * * *

"There is a great need for administrative research, for more precise information on methods of providing the necessary services for the chronically ill. Basic research on some of the administrative problems is already being undertaken, but the field is a relatively new one and requires intensive study and development. * * *

"In the past, the approach to chronic illness has been primarily concerned with institutional care for advanced stages of disease. There is need for a new orientation which places major emphasis on the early stages of chronic illness with a view to preventing or at least delaying the progress of the disease process. * * *"

And finally: "The problem of chronic disease presents many aspects—prevention, research, medical care in home, hospital, and nursing home, and convalescence and rehabilitation. Undue emphasis on any one aspect would be unwise, uneconomical, and ineffectual. For example, to concentrate on the provision of medical care without paying serious attention to prevention and research would postpone for many years any basic attack on the problem. On the other hand, it is impossible to focus sole attention on research because of the very urgent need for medical care. Likewise, to provide hospital beds for chronic disease without making nursing home facilities available would result in many beds being occupied by patients who do not need hospital care. Too great an emphasis on nursing homes would deprive many patients of the specialized hospital care which is necessary for their improvement. Failure to plan adequately for home care or for convalescent care and rehabilitation would defeat the purpose of the program—to maintain and restore the individual as a self-supporting productive member of his community."

Several years ago I served as medical consultant for a study of chronic illness in Monroe County, N.Y. The study resulted from the fact that the board of supervisors, having already previously increased the size of the county infirmary, was under pressure to build another addition. We recommended that services be provided instead of bricks and mortar; among others, the development, on the one hand, of organized home care programs in the community and, on the other hand, an active rehabilitation program at the county infirmary which would return as many patients as possible to the community. The latter recommendation has strong precedents; effective rehabilitation programs in county infirmaries have already been demonstrated by the work of Dr. Herbert Notkin of the Department of Welfare of Onondaga County, N.Y., and of Dr. Harold Chope of the Department of Public Health and Welfare of San Mateo, Calif. This is the kind of thinking and program which has been so sadly lacking, and which will be enormously stimulated by the passage of H.R. 4998.

PREVENTIVE MEASURES

Increasingly, health departments are developing epidemiologic studies of heart disease, cancer, and other chronic diseases in order to find their causes and methods of control. Important work in these areas has been carried out by the State health departments of California, New York, Connecticut, and Ohio, and by local health departments in Chicago and Los Angeles. Most recently, the New York City Department of Health has developed a pilot project to demonstrate the feasibility of lowering serum cholesterol by diet as a possible method for the control of coronary artery disease.

In the absence of adequate measures to prevent most of the chronic diseases, reliance must be placed on a second line of defense, to discover disease before it becomes illness so that prompt treatment can prevent or delay its progress. The issue was well stated in "Planning for the Chronically Ill."

"The periodic medical examination of apparently well persons needs to be explored on a new basis, including selective laboratory and clinical examinations chosen for particular age, sex, geographical, and occupational groups. These include serology, chest X-ray, urinalysis, electrocardiography, ophthalmoscopic and other examinations. * * *

"The recent development of special phases of the health examination, particularly in the fields of tuberculosis control and cancer detection, is especially noteworthy. The great interest shown by the medical profession and the public in chest X-ray surveys and in the establishment of diagnostic centers to examine apparently well persons for early signs of cancer represents a distinct advance in preventive medicine. It may well initiate a basic shift in the medical care of adults comparable to that which has occurred in obstetrics and pediatrics, in which preventive supervision and examination of presumably well persons is a major requirement of good medical practice. There is a need to explore the practical possibilities of preventive examinations to discover all possible disease, making full use of the diagnostic aids developed by modern medical technology."

A variety of methods has been developed to achieve this goal. Diabetes detection programs have become common, but need to be made more intensive. Cytological examinations for cancer detection have proved their value, but only a small fraction of the women in this country who should have this service are receiving it.

Multiphasic screening has been used in a number of communities, yet the tremendous case-finding potentialities of this method have only begun to be exploited. You will be interested to know that here in the District of Columbia the Health Department has carried on a multiphasic screening program which includes the Cornell questionnaire, serological test for syphilis, diabetic screening, white blood count, hemoglobin test, complete urinalysis, chest X-ray, proctoscopy, Papanicolaou smears, anosigmoidoscopy, and tonometry . These examinations are given to all who request them and are followed by referral to the participant's physician or to a hospital clinic for definitive diagnosis if some abnormality is found.

Finally, "well adult clinics"—including regular medical examinations, nutrition services, and social work—should be developed to determine to what extent the successes of the well baby clinics can be repeated at the other end of the age scale.

All of these preventive services can be greatly strengthened and extended through the passage of H.R. 4998.

HOME CARE

A considerable number of chronically ill patients who today occupy hospital beds do not belong there. They are receiving a type of care which is inappropriate to their needs but is used because they have nowhere else to go.

Many such patients can be cared for at home with proper nursing service. But in numerous communities such service is either not available or very limited. At present almost half of the cities with a population of from 25,000 to 100,000 and the majority of cities and towns of 25,000 and under have no visiting nurse services. Health departments, already understaffed, can provide this type of service to a considerable extent only with a corresponding increase in numbers of nurses. One hundred and eighty cities with populations of 25,000 and over are without home nursing services of any kind. These deficiencies are felt even more keenly in the smaller towns and villages and the rural areas of our country.

It should be added that even where a visiting nurse service exists in a community, this should not be taken to mean that the personnel and services are adequate. I can recall from my own personal experience as a recent member of the faculty of the department of tropical medicine and public health at Tulane University, learning of the incredibly difficult situation of the visiting nurse service in the city of New Orleans, where a minuscule staff is attempting to cope with overwhelming needs for home nursing care.

It has been conservatively estimated that 1 public health nurse per 2,000 persons is sufficient to provide complete public health nursing service, including bedside nursing care. Our current requirement for the approximately 180 mil-

lion persons in our population is 90,000 community nurses. There now exist only 34,000 public health nurses in the United States, of whom about a third are school nurses unavailable for general community nursing.

To satisfy the needs for home nursing care of the chronically ill, a large increase in the number of public health nurses is necessary. Furthermore, much wider use needs to be made of practical nurses and nurses' aids, working under supervision, for duties which do not require the training and experience of the public health nurse.

Finally, the services of the community nurse must be supplemented to satisfy the need for comprehensive home care programs. Such programs, which have already demonstrated their effectiveness in a number of communities—including both large urban centers and rural areas—provide the practicing physician with all necessary services and equipment to enable him to give adequate care to those chronically ill patients for whom home care is feasible. These include, in addition to various types of nursing care, such services as physical and occupational therapy, medical social work, X-ray and laboratory service, housekeeper service, transportation, sickroom equipment, supplies, and appliances. Considerable expenditures of funds are needed to develop these necessary services and programs in our local communities, and large-scale Federal support is essential to their realization.

STUDIES, EXPERIMENTS, AND DEMONSTRATIONS

The American Public Health Association strongly endorses the provision in H.R. 4998 of special project grants "to State or other public or nonprofit private agencies or organizations for studies, experiments, and demonstrations looking toward development of new or improved methods of providing health services outside the hospital, particularly for chronically ill or aged persons."

In a letter to Representative Harris, which was sent on January 15, 1960 by Dr. Malcolm Merrill, then president of the association, the A.P.H.A. stated:

"Health services across the Nation need to be supplied with the stimulus of funds for development of additional, refined, and improved constructive programs of prevention, care, and rehabilitation for older persons.

"Effective programs and services would develop further if many communities engaged in planning and programing first examined questions such as the following: Should communities continue to view the problem in terms of constructing more and more institutions for the chronically ill? Should the emphasis be placed on services designed to keep the chronically ill and aged out of institutions, such as preventive measures, health supervision programs for the aged, medical rehabilitation services, and organized home care for the chronically ill? How can a proper balance be struck between institutional and noninstitutional services? How can the various services and facilities be coordinated in the interest of those needing service—to assure that individuals, families, and practicing physicians can know where to go for the particular service needed, and can get it at the time it is needed?

"The American Public Health Association has noted with great satisfaction the emphasis which the Congress has placed on research in chronic disease and aging. We believe it necessary at the present time to expand our approach to the problem to include substantial support to developmental programs with patterns of constructive, rather than just custodial care, in accordance with knowledge now available."

The special project grants proposed in H.R. 4998 will enable communities to pioneer in the development of new and better methods of providing health services for the chronically ill and aged. A great deal of knowledge of how to provide these services is now available, but it would be foolhardy to claim that we have all the answers. Experiments, studies, demonstrations—these are necessary to extend our knowledge of how best to organize and coordinate such services. Some of the types of demonstrations are indicated in the following list which Dr. Merrill included with the aforementioned letter to Representative Harris:

SOME CURRENT CHRONIC DISEASE PREVENTION, CASEFINDING AND REHABILITATION PROGRAM DEMONSTRATIONS

Rehabilitation of patients in chronic disease hospitals with followup, outpatient, and home care by Maryland State Health Department.

Synchronized outpatient services for epileptics by Maryland State Health Department.

Rehabilitation for patients with long-term illnesses and/or physical disabilities by San Mateo County (Calif.) Department of Public Health and Welfare.

Rehabilitation program and pilot projects, e.g., with a day hospital by New York State Health Department.

Improved quality of care in nursing homes with emphasis on physical restoration and self-help, Washington State Health Department.

Project allocations for improvement of quality and scope of preventive medicine through the stimulation of health measures for older persons, the prevention and control of chronic disease, and occupational health services by California Department of Public Health.

Program for the prevention of blindness by glaucoma screening and other measures by California Department of Public Health.

Rheumatic fever control program by Michigan State and local health departments and Michigan Crippled Children's Commission.

Chronic disease detection program by multiple screening by District of Columbia Health Department.

It is of interest in this connection that in 1957, the California State Department of Public Health set aside part of the Federal general health funds for just such demonstrations and studies in chronic disease and health of the aging. The response was very gratifying; in a 2-year period, 18 projects were submitted by local agencies. Due to limitations of funds, only seven were accepted and placed in operation. These were:

1. Selective area multiphasic screening.
2. Rehabilitation nursing—a program for the disabled and elderly.
3. Home nursing programs.
4. Home care research and demonstration project.
5. Heart study—determination of the present status of the sample population selected in 1949.
6. An investigation of the effect of management factors on nutritive value and acceptance of food in nursing homes.
7. Institutional care of the aged and chronically ill—development and evaluation of an educational program for institutional management and staff.

CONSTRUCTION OF NONPROFIT NURSING HOMES

The American Public Health Association considers that the increase proposed in H.R. 4998 in grants for construction of nonprofit nursing homes is essential to meet pressing needs. As of July 1960, there were approximately 310,000 nursing home beds in the United States, of which only 175,000 were acceptable. At least 260,000 additional beds are needed, according to the approved State plans. Furthermore, the 175,000 "acceptable" beds are acceptable only on the basis of avoidance of fire and health hazards. Considerations of adequacy of staff and quality of services do not enter into this definition.

Such considerations, however, are of paramount importance. In the February 1960 report of the Senate Subcommittee on Problems of the Aged and Aging, some of the major criticisms of the present level of nursing home care were outlined as follows:

1. Physical plants and equipment are substandard and outmoded.
2. Home operators often lack proper qualifications to assure the provision of proper service.
3. Nursing personnel lack proper experience and training to supervise or render skilled nursing care.
4. Types of services provided are too limited to meet the needs of patients.
5. Management of the patients in nursing homes by physicians is either lacking or inadequate.
6. Licensure standards differ greatly and are either too low or are not being enforced because of the practical problem of finding a place to put the patient.
7. Licensure agencies lack sufficient personnel to do a really effective job of inspection and consultation work even where standards exist.
8. The "storage-bin" philosophy still prevails in spirit or in fact in most nursing homes.

The subcommittee report comes to the following conclusion: "This is the discouraging picture of nursing homes and their patients painted by knowledgeable people in the year 1959. One cannot see this picture as often as did the subcommittee without wondering for how many people—too well to die but too disabled to live independently or with their families—the future holds only

needless relegation to such a limbo here on earth and whether that society which has created the situation has a responsibility for corrective action."

Currently, 91 percent of skilled nursing homes are proprietary institutions with 71 percent of the beds; 6 percent are operated by voluntary nonprofit agencies and have 14 percent of the beds; and 3 percent are public institutions with 15 percent of the beds. On the basis of the long experience of public health workers in nursing home licensure, and our knowledge of the kinds and quality of service provided in these different types of facilities, the American Public Health Association is convinced that a rapid and decisive increase in the proportion of nursing home beds under nonproprietary auspices is today an essential precondition for any substantial improvement in nursing home care. Otherwise we shall continue to countenance a situation, where, for too many of the old and chronically ill, "the future holds only needless relegation to such a limbo here on earth."

RESEARCH IN UTILIZATION OF MEDICAL FACILITIES

This section of H.R. 4998 is of major importance. It will make possible the research, experiments, and demonstrations which are necessary to determine how our hospital and health services can be reorganized to provide proper care for the chronically ill. Many questions need to be answered. What are the advantages and disadvantages of separate chronic disease hospitals? Should we construct chronic illness sections of general hospitals, and how should they differ from those for acute illness? What kinds of relationships can be developed between general hospitals on the one hand, and homes for the aged and nursing homes on the other? What are the best methods of organizing home care program and rehabilitation services? How can the various types of services and facilities be coordinated so that the chronically ill person gets the right kind of care at the right time? Should we reconstruct entirely our present concepts of hospital care, and begin to develop integrated medical centers which bring together the facilities for acute hospital care, chronic hospital care, rehabilitation, nursing home care, and organized home care?

We can no longer keep our heads in the sand. The hospital and health services of our country must be reorganized to meet the health needs of a changed population. On the other hand, it will do little good for the chronically ill and aged if we proceed to put our heads in the clouds and spend the next 20 years in theoretical discussions of grandiose schemes to provide ideal services. What we need is what H.R. 4998 proposes: assistance in expanding community services and facilities for the health care of the aged and chronically ill, as well as improvement of those services and facilities through studies, experiments, and demonstrations, with enough financial support available to build experimental facilities—community laboratories, as it were—where we can develop better methods by testing them in actual practice.

Several years ago a British hospital architect who was visiting me remarked on the extraordinary vigor and willingness to experiment and break new ground which he had noted in the United States in his own field of interest. These are qualities which we associate with the American temper; they should be put to work, now, to expand and modernize our health services so they can meet the urgent needs of the public.

STATEMENT OF MRS. GENEVA VANCE, PUBLIC HEALTH NURSE, SCOTT COUNTY, KY., ON BEHALF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

I am Mrs. Geneva Vance, public health nurse in the Scott County Health Department, Georgetown, Ky., appearing here for the American Public Health Association. It is my privilege to discuss with you some aspects of the Kentucky home care program. In this discussion I hope to provide information which will be useful to you in your deliberations on the legislation under consideration at this time.

The home care program in Kentucky started about 3 years ago when special funds were made available to the States for the purpose of expanding services to the chronically ill and aging.

The home care program is a part of our overall public health program. This is not traditional with all public health programs.

Local physicians refer patients to the Health Department for home care services.

The nursing aspects of the home care services include:

1. Nursing service to the sick in the home.
2. Teaching members of the family to give care to sick and handicapped persons in the home.
3. Demonstrating and teaching physical therapy techniques.
4. Helping patients and families with emotional problems associated with chronic and debilitating illness.
5. Teaching the patient self-care as soon as possible and helping him to attain maximum rehabilitation.
6. Coordinating the services of allied personnel, such as physician, physical therapist, nutritionist, social worker, welfare agency, and other related paramedical workers.
7. Instructing patients concerning good nutrition, in planning and preparing special diets, and assisting them in the difficult period of adjustment to a special diet.
8. Working with nursing home administrators to improve nursing care for patients in nursing homes.

Scott County is 1 of about 20 counties in Kentucky that has added home care services to their overall public health program in the past 3 years.

All patients are referred to us by their physicians and they remain under his care while receiving home care services. We report back to the physician as often as we feel it is necessary concerning the patients condition or progress.

I would like to tell you about some patients who have been helped by our home care program:

1. A couple—wife, age 89, bedridden from an old stroke and heart disease was referred for home care services. The public health nurse taught the daughter to bathe her and give good skin care. She gave injections two or three times a week. The nurse reassured the couple during each visit as she was the only person with whom they had outside contact. The husband was 93 years of age, paralyzed from his rips down and partially bedridden. The nurse helped him gradually to be up in a wheelchair all day and encouraged him to go for a short ride with his daughter and to do other things to occupy his time. He was quite deaf, but learned to play and enjoy an antique music box.

2. Male, age 77, with a bone disease which caused a severe crippling condition, and ulcers of the stomach was referred for home care services. The public health nurse gave him fluids and medications intravenously and taught his wife to bathe him and care for pressure sores which healed readily. She taught the wife how to get the patient from the bed to the weelchair and improvised a board at the foot of his bed to prevent foot drop. The nurse with the help of the nutritionist instructedt he patien and his wife concerning his special diet.

3. Female, age 49 who had not been out of her home for 20 years had developed varicose ulcers and was emotionally upset. She had two sons who had lived with her until a tragedy caused the death of one and hospitalization of the other. The public health nurse dressed the ulcers daily in the beginning and talked with the patient. After the nurse won her condfience she was able to teach the patient to do the dressing. The nurse helped her to get public assistance. She encouraged and succeeded in getting the patient to get out for short rides and to visit in the community. This took several weeks with many visits and at the present time the patient is beginning to take part in community activities—for example, she asked and did work in the cancer drive last year and collected $39.

4. A male, 89 years of age had been in bed for 8 months with a fractured hip. He was in the home of a niece who had six small children and was requiring a good deal of care, and much of her time. The public health nurse taught the niece how to get the patient from the bed to the wheelchair and from the wheelchair to the toilet seat and taught the patient to do many things for himself. Afer several weeks of help and encouragement he was able to use a walker and could partially care for himself.

5. Female, 86 years of age, totally blind and in bed most of the time. The public health nurse checked her blood pressure, gave reassurance and helped with feeding problems. The patient improved steadily and enjoyed the nurse's visits. Later she became seriously ill and refused to go to the hospital. The nurse gave her fluids and medications intravenously for several days. The nurse anchored a catherer, taught the daughter to irrigate it and to give the patient enemas. The patient died soon thereafter. It would not have been possible for the patient to have spent her last days at home without the home care services.

6. Male, age 67, who had a stroke with paralysis of one arm and leg—the public health nurse used the book "Strike Back at Stroke," published by the U.S. Public Health Service, to teach a neighbor to give recommended exercises and general care. The neighbor then was able to teach the patient to care for himself and take his own exercises. His wife was an invalid, in bed in the same room, a victim of arthritis. The patient gradually became able to care for himself and his wife for a period of time, but later suffered another stroke. His wife died a few months later and he is now in a nursing home and gradually improving.

7. Male, age 37, had multiple sclerosis, wears a hearing aid and glasses with a very heavy lens. He was unsteady on his feet, his blood pressure was extremely high, and he appeared quite depressed. The public health nurse learned he had attempted suicide several times. He was unable to speak clearly and was hesitant to talk at first. After a few visits the nurse gained his confidence and now he seems to feel free to discuss his illness with her. The nurse gave him injections twice weekly and spent a good deal of time reassuring him. His attitude has improved steadily, the housekeeper has been dismissed, and he is now able to care for the house and mow the lawn. The nurse helped his wife and 15-year-old son to understand his illness and encourage him to take part in outside activities, such as gardening and things he can do with his hands.

8. A female, age 68, had diabetes. The public health nurse taught her to give her own insulin, to test her urine, and to prepare her special diet. She taught her the importance of good skin care to prevent infections. The nurse succeeded in getting all members of the family examined for diabetes.

9. Male, age 74, was discharged from a mental hospital. His family refused to care for him. The public health nurse made arrangements for the patient to be placed in a nursing home in another county. Later he was brought to a nursing home in his own county where the nurse visited him regularly. He was malnourished, pale, weak, and semiconscious when visited in the second nursing hom. The nurse assisted in getting dentures, glasses, clothing, and personal articles for the patient. The nurse gave him injections and urged him to take other medications as ordered. After he was given an adequate diet his appetite improved and he is now able to be up and about and can partially care for himself.

10. Female, 73 years of age, weighing 300 pounds had a stroke which caused paralysis of her left arm and leg. The public health nurse anchored a retention catheter and taught the daughter to irrigate it. The nurse and nutritionist instructed the patient and the daughter concerning diet and she lost 100 pounds. The nurse demonstrated and taught recommended exercises for the patient. She gained good use of the left arm and leg and was able to be up and about.

Our experience in the home care program has convinced us that there is an urgent need for this type of service for sick and handicapped persons in the home.

The CHAIRMAN. I notice in your statement, Mrs. Vance, that you have a bulletin of the Kentucky State Department of Health for March and April of 1959, January and February of 1961, and then an article by May Frazer of Kentucky's program for the chronically ill.

These may be received for the files of the committee for reference.

(The documents referred to will be found in the files of the committee.)

The CHAIRMAN. Mr. Mack?

Mr. MACK. Mrs. Vance, the home care program you have in Kentucky is quite interesting. I don't think we have anything similar to that in Illinois, at least to the best of my knowledge. It seems you are rendering a very worthwhile service.

Mrs. VANCE. We are quite proud of it.

Mr. MACK. I presume it is more or less on an experimental basis today; is that true?

Mrs. VANCE. Yes.

Mr. MACK. Now, how does one secure your services in the county?

Mrs. VANCE. They are referred by the local physician.

Mr. MACK. Could I receive the services if I were a resident of Kentucky?

Mrs. VANCE. Yes; you could.

Mr. MACK. Would there be any charge?

Mrs. VANCE. No; there wouldn't be any charge.

Mr. MACK. You don't charge anything at all for your services?

Mrs. VANCE. No, sir.

Mr. MACK. Well, if the program is successful and relieves the hospitals and, as you indicated, the hospitals are empty there, it would become quite expensive after some time as the program became more successful; would it not?

Mrs. VANCE. I don't quite understand your question.

Mr. MACK. There is considerable expense involved in this service; is there not?

Mrs. VANCE. The only money that is involved is what was appropriated by the Federal Government.

Dr. TERRIS. That is right.

Mr. MACK. I am speaking of your service today. You understand that; do you not?

Mrs. VANCE. Yes.

Mr. MACK. How much money is being spent today on your program in Kentucky?

Mrs. VANCE. I cannot answer that.

Dr. TERRIS. I would say offhand it is not a very expensive service and, as a matter of fact, one of the things this bill would do would be to permit them to have somewhat more intensive service than they can give now.

They have one physical therapist for the 20 counties. They really need one physical therapist per five counties to give more adequate service. But when you compare the cost of this kind of service with the cost of providing hospital care, of keeping a patient with multiple sclerosis in the hospital for 10 or 15 years, there is very little doubt about the tremendous difference in cost. I don't want to say that this does not cost money. Of course it costs money.

Mr. MACK. I want to be certain I understand the service. I indicated I was quite impressed with the testimony you have given this morning and it seems to be reversing a trend. Doctors used to come out and call on patients in their homes but now you have to go to the doctor's office. You have a tendency to usually go down to his office and he gives you a shot of penicillin and you go home to bed. Now this service seems to be reversing that trend. The same is true of the hospitals. Many of the doctors there will admit you if there is any doubt at all and so this seems to be reversing the trend and I think it is a very fine thing.

But I felt that it might become very expensive to provide these services in the homes and that is the reason for my question.

Mrs. VANCE. May I explain that most of the families are able to buy what is needed and, if not, some social agency will take care of it. There is very little expense other than just what medication there is.

Dr. TERRIS. You are thinking of supplies?

Mrs. VANCE. Yes.

Mr. MACK. I was thinking of the cost of transportation and the salary of the nurses, physicians where needed.

Dr. TERRIS. Actually, this is being grafted on to an existing program. The nurses' cars are there and the nurses are there. You will need more nurses for this kind of program, naturally. That will cost money. You will need more physical therapists and this will cost money. You will need social workers and that costs money, but I would submit that the costs involved are still small in comparison to the cost that you would have if you relied on hospital care. Furthermore, even forgetting the cost issue, a hospital isn't always a good place for people. They are much better off at home with their families. They will do much better at home.

Mr. MACK. The reason I was confused is because it is very expensive in a hospital to the individual or to the insurance company and you are transferring them at private expense to the public agencies and I guess it will substantially reduce the cost, but you will still be transferring from the private industry to the public agency.

Mrs. VANCE. Actually, the program is just integrated into the overall program. It is just an added service of public health nurses for the past 3 years along with the others.

Mr. MACK. Thank you very much.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. Just one question, Mrs. Vance. I am somewhat surprised that you render service to everybody, whether they are financially rich as Mr. Mack suggested and perfectly capable of paying for the services in going to the hospital or anything else, but they can call you up and get the service for nothing; isn't that so?

Mrs. VANCE. Yes, sir.

Mr. YOUNGER. You think that is a proper public expense?

Mrs. VANCE. Well, they are not referred until they are dismissed from the hospital and the doctor feels they are able to be at home.

Mr. YOUNGER. Well, let's assume that here is a man with ample income, let us say that he has $20,000 to $25,000 a year and is perfectly capable of hiring a private nurse or nurses. Do you think that the care of that individual ought to be put on the backs of the taxpayers?

Dr. TERRIS. May I reply? I don't know Scott County, but my impression is there would be no nurses in Scott County to hire in the first place.

Mrs. VANCE. That is true.

Dr. TERRIS. There isn't anyone to hire. The only nurses available are the nurses in the hospital and I presume they are understaffed and the nurses in the health department.

I would like to say that my impression is that this pattern is based on a legal aspect. I don't believe the health department is allowed to take fees for their services. However, there is a growing tendency in the country to develop what we call combination services where we amalgamate the visiting nurse services, which is a private nonprofit service, and the health department nurse services and when that is done arrangements are made so that people who can afford to pay for services do pay, and those that cannot pay are paid for through some other method and that handles the problem.

Mr. YOUNGER. That is all, Mr. Chairman.

The CHAIRMAN. Mr. Curtin?

Mr. CURTIN. Mrs. Vance, do I understand you to say that all of the funds to finance this project come out of Federal moneys?

Mrs. VANCE. I am not really sure.

Mr. CURTIN. I thought you said that it did.

Mrs. VANCE. It was by grant in the beginning, I feel sure.

Dr. TERRIS. It was Federal money that made this possible, but they are using nurses who are on local salary, you see, so it is a combination of Federal and State and local moneys that is in the program.

Mr. CURTIN. And in Scott County if someone needs attention, the doctor refers the matter to you, is that right?

Mrs. VANCE. Yes, sir.

Mr. CURTIN. Is that referral to an office in the county seat?

Mrs. VANCE. No, sir; it is referred directly to the nurses in the health department. We talk with the doctor and he tells us what to do. We go into the home and carry out his orders.

Mr. CURTIN. You have offices in all of the towns in Scott County?

Mrs. VANCE. Well, Georgetown is the county seat and our county is small, the population of the county is 15,000 and we only have one health department.

Mr. CURTIN. Dr. Terris, in my State we have public health associations which are nonprofit corporations.

Dr. TERRIS. What State is that, sir?

Mr. CURTIN. In Pennsylvania we have these nonprofit corporations who employ these nurses to go out and they are helped by Red Feather as well as county and State funds and, I presume, by some Federal funds, although I am not sure of the latter. These nurses go to these various homes and help the people and, if the people can pay, they are expected to pay a fee to the nurse which goes into the common pot. Don't you think that is a good idea?

Dr. TERRIS. Yes, this is the pattern in the cities, largely, the Visiting Nurse Association type of program.

In the rural areas, you just don't have that kind of voluntary organization and you tend to have the health department which is really the only agency which can carry on because there is no visiting nurse service. I make no brief for one as against the other. I think both agencies can do this job, and as I said there is a tendency for them to get together and provide a single nursing service.

Mr. CURTIN. Don't you think that if a patient comes from a family that is well able to pay for services that they should contribute to some extent for those services?

Dr. TERRIS. Yes.

Mr. CURTIN. Rather than the full amount being paid by the taxpayer, whether it be a local, State or Federal taxpayer, which, after all, is really the same person.

Dr. TERRIS. I would agree with you on that. The problems we get into with the health department is that there are legal barriers to their accepting money and they tend to operate the other way.

Mr. CURTIN. That is all, Mr. Chairman.

The CHAIRMAN. Mr. Keith, do you have any questions?

Mr. KEITH. No questions.

The CHAIRMAN. Thank you very much, Dr. Terris and Mrs. Vance for your very fine statement and testimony on this legislation.

Our next witness this morning will be Dr. V. Eugene McCrary, who is appearing on behalf of the American Optometric Association.

STATEMENT OF DR. V. EUGENE McCRARY, COLLEGE PARK, MD., APPEARING ON BEHALF OF THE AMERICAN OPTOMETRIC ASSOCIATION

Dr. McCRARY. Mr. Chairman and members of the committee, my name is V. Eugene McCrary. I am an optometrist and practicing in College Park, Md.

For the past 4 years I have been a member of the Department of National Affairs of the American Optometric Association and am appearing on their behalf. I am also president of the Maryland Optometric Association and am serving as a member of the Maryland State Board of Examiners in Optometry, and in compliance with your request, Mr. Chairman, I would like to have my statement filed for the record and I would like to just comment on two or three highlights from the statement, if you will.

The CHAIRMAN. Very well. You may have your statement filed and the committee will, of course, have occasion to read it and then we will have your additional comments.

Dr. McCRARY. Fine.

First of all, I would like to point out that in numerical strength, between 18,000 to 20,000 optometrists are licensed to practice optometry in the 50 States and the District of Columbia. There is less than one-fourth that number of board certified ophthalmologists who are physicians who specialize in eye care, medically.

Secondly, with the matter of referrals there was some discussion I believe yesterday about referral centers possibly being a part of these community health facilities.

The graduates of optometry are specially trained to detect, but not to treat. When an optometrist detects a pathological condition he is dutybound to refer the patient to the medical or other health care practitioner.

I would like to refer at this point to a paper which was presented to the American Public Health Association at its convention in 1960 to the medical care section thereof. The title of the paper is "Optometry's Role in Health," and maintains a study of referrals.

The study indicates that the optometrists nationally refer over 800,000 patients yearly to other health care practitioners.

With your permission, Mr. Chairman, I would like to have a copy of this paper also filed with the record.

The CHAIRMAN. Do you have copies of it?

Dr. McCRARY. I have only one copy, sir, which I will leave with you.

The CHAIRMAN. Well, you may file that one copy with the committee and we will decide whether or not to let it go in.

(The document referred to will be found in the committee files.)

Dr. McCRARY. There are 10 schools and colleges of optometry in the United States and all of these are operated as nonprofit institutions.

Associated with the schools and colleges are outpatient clinic where individuals may receive optometric care and these are also operated on a nonprofit basis.

There is an institution in New York City which I would like to mention to you just briefly, and this is the Optometric Center of New York.

The Optometric Center of New York is a nonprofit, tax-exempt institution chartered by the board of regents of the University of the State of New York. It is devoted to the study and care of the problems of human vision. The institution is in continuation of the superlative work in vision care developed and carried on by the Department of Optometry, Columbia University, during the 46 years of its existence. This vital service upon which thousands of citizens depended might otherwise have been interrupted when the department closed its doors in 1956. The Optometric Center of New York was founded on April 16, 1956.

In addition to the general optometric services, departments devoted to orthoptics and vision training, contact lenses, special devices and aids for the partially blind and people with very poor vision, aniseikonia, visual fields, visual disabilities associated with impaired reading abilities and remedial reading are in operation. A visual science library and current periodicals in the basic and clinical visual sciences is open to the public.

In addition to the general program of clinical care, the Optometric Center maintains an indigent visual care program for needy persons in the community referred by the various social welfare and social service agencies. This program is in part supported by interested community philanthropy and by the institution itself. All professional care in this program is donated by the optometrists and no charge is ever made to the patient or to the referring agency.

The Optometric Center maintains a regular program of postgraduate instruction for optometrists as well as symposia, conferences, and seminars on subjects relating to vision. The program of endowed basic and clinical research involves several projects which, it is hoped, will advance significantly the knowledge of visual perception.

All of these facilities have been founded and are maintained by members of the optometric profession as their contribution to the welfare of the people of New York.

I would like to mention a current research project which is going on in Indiana, at the Indiana University investigating the effect and causes of the visual factors of night vision with relation to the frequency of accidents which occur after dark, and also that optometry has taken part in the White House Conference on Children and Youth more recently in the White House Conference on the Aging and we are vitally interested in serving the visual needs of the American people.

Mr. Chairman, I believe that concludes my statement.

The CHAIRMAN. Thank you very much, Doctor, for your testimony. Your full statement will be printed in the record at this point.

(The full prepared statement of Mr. McCrary is as follows:)

STATEMENT OF DR. V. EUGENE MCCRARY, COLLEGE PARK, MD., ON BEHALF OF THE AMERICAN OPTOMETRIC ASSOCIATION

Mr. Chairman and members of the committee, my name is V. Eugene McCrary. I am an optometrist practicing in College Park, Md. For the past 4 years I have been a member of the Department of National Affairs of the American Optometric Association, and am appearing on their behalf. I am also president of the Maryland Optometric Association, and am serving as a member of the Maryland State Board of Examiners (in optometry) under an appointment by Governor Tawes.

There are some 18,000 to 20,000 persons licensed to practice optometry in the 50 States and the District of Columbia, and less than one-fourth that number of board-certified ophthalmologists.

In each of the foregoing jurisdictions, to qualify to take the examination for licensure, an applicant either by statute or regulation having the force of law must be a graduate of an accredited school or college of optometry. Each of these schools, now and for the past 10 years or more, has required their graduates to successfully complete a minimum of 2 years of preoptometric study at the college level, and an additional 3 years of study in subjects devoted or related to optometry. Our graduates are specially trained to detect pathology but not to treat it. When an optometrist detects a pathological condiion, he is in duty-bound to refer the patient to a medical practitioner.

All of our schools and colleges are nonprofit, and have outpatient clinics where indigent individuals may receive optometric care. These clinics are also nonprofit.

I should like to call the attention of the committee particularly to the Optometric Center of New York. It is located in New York City, is a nonprofit tax-exempt institution, chartered by the Board of Regents of the University of the State of New York. This clinic last year handled some 6,000 cases. If funds were available to expand the facilities and employ additional personnel, they would probably handle two to three times that number. As of April 16, 1961, their financial statement showed assets of $53,526.36. Their total receipts for the fiscal year April 16, 1960, to April 15, 1961, including contributions, were $63,528.69, and their total operating and administrative expenses were $62,877.95, which gave them an excess of income over expenses of $650.74; but this does not include a depreciation item of $1,420.41. When that is taken into consideration, their net operating loss for the year was $769.67.

Approximately one-third of their patients are charity cases. About 10 percent of the total number are referred to the clinic by the Health Department of New York City; another 15 percent are referred by other charity organizations. Most of the remaining are persons who have come to them from the former clinic conducted by the School of Optometry of Columbia University. Those patients who are able to pay are charged what is known as an institutional fee, which goes to bear the expense of the clinic and the cost of the ophthalmic materials dispensed there. At least one-quarter of their income is in the form of contributions, most of which is donated by optometric organizations. Federal funds for community facilities and services we believe should be made available for nonprofit optometric centers such as the one I have just described and those connected with our schools and colleges of optometry.

The bill now being considered by the committee for the most part is very broad in its terms; but in section 5 particularly the emphasis is placed upon hospitals or other "medical facilities." Unless this language is broadened, nonprofit optometric centers would, we feel certain, be barred from participating in the benefits. We, therefore, recommend that in section 5, wherever the word "medical" appears, the bill be amended by striking out the word "medical" and inserting in lieu thereof the word "health," and that the report of the committee include a statement to the effect that this amendment was made in order that such funds as Congress may appropriate for grants to public or nonprofit private agencies, should be made available for services and facilities providing optometric vision care.

The bill is also particularly designed for the aged. Practically every one of our aged citizens has a visual problem. One of the more common visual defects of the aged is that of cataract. This requires medical care, but well over 50 percent of the cataract cases are detected by optometrists and then referred to ophthalmologists. Were it not for the hostile attitude of the American Medical Association, and particularly its section on ophthalmology towards optometry, it would not be necessary for us to appeal to Congress to see that optometric services and facilities qualify for Federal grants, but unfortunately such is the case. In at least three instances Congress has found it necessary, by a special law, to amend a Federal statute so as to expressly make optometric services available in the public interest.

Before closing, I should like to point out that earlier this year, the American Optometric Association participated in the White House Conference on the Aged and submitted a report which received much favorable comment.

Our association also submitted a 35-page printed report through its committee on visual problems on children and youth to the 1960 White House Conference on Children and Youth.

A year ago, our association received an award from the U.S. Chamber of Commerce for the work which it had done in promoting highway safety. Vision is an important factor in that field. Members of this committee have devoted a

great deal of time and effort to cut down the terrific slaughter which occurs each year on our highways.

Our profession is financing a research project at the University of Indiana School of Optometry in vision for night driving. Approximately only one-third of the automobile mileage is driven at night, and yet there are three times as many fatal accidents between sunset and dawn as there are between dawn and darkness.

In the light of the foregoing, we recommend that the language of this bill should be broadened so as to make certain that Federal funds which it authorizes are specifically made available for community facilities and services which are constructed and maintained to provide vision care by members of the optometric profession.

The CHAIRMAN. Mr. Mack, do you have any questions?

Mr. MACK. I have no questions.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. No questions.

The CHAIRMAN. Mr. Keith?

Mr. KEITH. No questions.

The CHAIRMAN. Mr. Curtin?

Mr. CURTIN. No questions.

The CHAIRMAN. Doctor, I am quite interested in this matter. There has been a great deal of interest manifested in this proposal. I am a little concerned about the effect of broadening the proposal to the extent that you would in connection with your suggestion.

Now as I understand it, the purpose of this legislation is to provide services that will be made available to people in certain categories and it is all, of course, tied into programs under the Public Health Service Act. The theory behind this is that the services to be provided come within the basic concept of medical treatment.

In your statement you referred to the fact that optometry will mean "health maintenance." But it would seem to me that if the suggestion you make were to be adopted it would go far beyond the concept of "health maintenance" and conceivably could include most everything that could qualify or attempt to qualify as having something to do with health. Not only would it include what you intend to include, but it appears to me that it could very likely include a lot of things that in my judgment you wouldn't want included.

Now the theory behind this is—and I make this statement because I want too get your comments—that the Federal Government would cooperate with the States in providing these services and facilities.

Now you are familiar with that are you not?

Dr. MCCRARY. Yes, sir.

The CHAIRMAN. In other words, the Federal Government is extending its assistance. This is not a new concept. This program has been in effect on a limited basis for some years. This is extending the program on a rather modest basis but the concept is extending it in order to assist these States in carrying out this program.

Now obviously, the various States have laws governing their programs within the States. You are familiar with that?

Dr. MCCRARY. Yes, sir.

The CHAIRMAN. You do not suggest that your profession would want the Federal Government to encroach upon the right and prerogatives of the States in that regard, do you?

Dr. MCCRARY. No, sir, not at all.

The CHAIRMAN. Well, if a State then considers the profession of optometry as a medical service there is nothing in the provision of law that prevents your profession from being included, is it?

Dr. McCrary. No, sir, but on that point there is a general trend not to include optometry as a medical service.

I might cite to you an example from my home State of Maryland which is the one I am naturally most familiar with.

In the State of Maryland we have had for years aid to indigents and the carrier for the program has been the State health department. Now as this program has been implemented, indigent individuals who may be optometric patients and who then fall under the indigent program cannot go to the optometrist for vision care. They are required by ruling to seek the services of a medical practitioner so that is a very practical problem here which on the grassroots level, does exist, is a discriminatory type of thing which concerns us in optometry very much.

The Chairman. You mean that is true with reference to some ailment or disease or something wrong with the eyes, is that right?

Dr. McCrary. In other words, statistics show that 2 to 3 percent of all individual patients seen as far as eye care is concerned, manifest some symptoms of disease. These people, as I stated earlier, when they come to see the optometrist he is bound legally to refer these patients to some other health care practitioners. If it is an ocular sign of diabetes or advanced arteriosclerosis or if there is an indication of tumor or whatever the indication may be inside of the eye, the optometrist refers this patient to the appropriate health care practitioner.

What I am talking about now is the other 98 percent, those who have functional problems of vision such as presbyopia.

The Chairman. What?

Dr. McCrary. Presbyopia. That is a condition where the arms, at around age 40 or later, begin to get shorter and shorter and you have to back a newspaper out to see it.

The Chairman. That is just a matter of correcting the vision, isn't it?

Dr. McCrary. Yes, sir.

The Chairman. Does that become then a medical problem?

Dr. McCrary. No, sir; the distinction between the services rendered by optometry and the services rendered by the medical practitioner in the eye care field are that the optometrist is a specialist in functional vision problems.

The Chairman. Yes.

Dr. McCrary. Those problems which interfere with normal visual functioning and this includes not only the physiological changes that occur as a result of aging, but also many other types of visual problems which have a bearing on an individual's perceptive ability, on the child's ability to effectively learn through the visual sense, and there are many ramifications of the complexities of adequate vision care.

The optometrist is specifically trained and licensed to render functional vision care.

Now optometry does not treat disease. Optometry is a separate profession and is not a part of the medical profession and when we find a patient who needs services of another health care practitioner, we refer that patient for that service.

The CHAIRMAN. Well now, are you contending or is your profession contending that the man who fits glasses, just to use an example and sells them, is a part or should be a part of this program?

Dr. MCCRARY. I am not sure that I fully understand what you mean, Mr. Chairman.

The CHAIRMAN. Well, assume that what you are saying here is that under the present trend that you have observed, ophthalmologists are included in this program, are they not?

Dr. MCCRARY. Yes, sir.

The CHAIRMAN. Optometrists are not.

Dr. MCCRARY. That is correct.

The CHAIRMAN. And that you think they should be included?

Dr. MCCRARY. Yes, sir.

The CHAIRMAN. An optician is not included.

Dr. MCCRARY. An optician is a professional person.

The CHAIRMAN. And you think they should be included also?

Dr. MCCRARY. I do not feel that the public should not have the services of an optician who is a skilled artisan, who fills prescriptions. I feel that the public should certainly have access to the services of an optician if they so desire.

The CHAIRMAN. In other words, you feel that by striking out "medical facilities" and including "health facilities" that that would include optometrists—and I could name many other health professions.

Dr. MCCRARY. There is one distinction that I would like to point out, Mr. Chairman. The relationship of the optician to both the optometrist and the ophthalmologist is the same as the pharmacist relation with the physician. He is responsible, legally, for the proper compounding of prescriptions which are referred to him but he does not make the professional decision nor is he responsible for the efficacious use necessary for that prescription so far as solving a particular problem. He is an artisan, but does not operate on the professional level.

The CHAIRMAN. Do the States have laws applicable to this particular problem?

Mr. MCCRARY. Well, the States have laws which specifically license optometrists to care for the visual needs of citizens; that is all 50 States and the District of Columbia have these laws.

The CHAIRMAN. Well, this provision of assistance to the States would be such in this particular field that the Federal Government would cooperate with the States under their procedures and programs. Would it satisfy your profession if the programs would permit the inclusion of your profession?

Dr. MCCRARY. If the program is implemented with the spirit of helpfulness and with a spirit of justice and if it does not exclude groups of licensed practitioners who are duly licensed by the individual States to render a particular service, then I would say "yes, that would satisfy us."

The CHAIRMAN. And which are acceptable by that State?

Dr. MCCRARY. Yes, sir.

The CHAIRMAN. All right, thank you very much. We are glad to have had your testimony.

(The following letter was received for the record:)

THE AMERICAN OPTOMETRIC ASSOCIATION, INC.,
DEPARTMENT OF PUBLIC INFORMATION,
Fayetteville, Ark., April 29, 1961.

Hon. OREN HARRIS,
House of Representatives, Washington, D.C.

DEAR MR. HARRIS: Mr. Bill MacCracken has informed me that hearings will be held next week on H.R. 4998. I understand that Dr. Harold Oyster will appear before the committee on Thursday, and I am sure that he will ably present the facts, but I did want to take this opportunity to remind you of my interest in H.R. 4998. It is very desirous that the language in this bill be broadened to include optometric facilities, and not be limited to strictly the medical agencies and institutions.

Thank you for your consideration.

Sincerely yours,

JOHN G. SUGG, *O.D.*

The CHAIRMAN. Our next witness will be Dr. George James, acting commissioner of health, New York City Department of Health who will present the testimony of Dr. Leona Baumgartner.

Dr. Baumgartner called me by telephone a few days ago and advised me that she wished to present a statement for the record and expressed regret that she was unable to be here because of a commitment.

STATEMENT OF DR. LEONA BAUMGARTNER, COMMISSIONER OF HEALTH, CITY OF NEW YORK, AS PRESENTED BY GEORGE JAMES, FIRST DEPUTY COMMISSIONER OF HEALTH OF THE CITY OF NEW YORK

Mr. JAMES. I am George James, first deputy commissioner of health of the city of New York. I am a public health physician and before coming to New York City 5 years ago, I did public health work in Connecticut, Maryland, rural New York State, Tennessee, and Ohio.

I am here to present the testimony prepared by Dr. Leona Baumgartner, commissioner of health of the city of New York, in support of H.R. 4998 and S. 1071. After the presentation of this testimony, I shall be pleased to answer any questions which members of the committee may wish to direct to me.

Congressman Harris, it gives me great pleasure to appear in support of H.R. 4998. Every objective of this proposed legislation represents an item we in New York City are trying to accomplish with meager resources or it is one we have wanted to undertake. All too often we have been unable to start worthwhile demonstration projects because we could not find the limited funds required even for a trial run.

There are esentially four parts to the problem of health and medical care in the United States:

1. How to get new knowledge—for this we need research.

2. How to provide for the payment of health and medical care—a problem now under congressional consideration and study.

3. How to get the personnel to do the job—this involves aid to medical and nursing education and is the subject of another bill before the Congress.

4. How to organize health services in an effective fashion, avoiding costly inefficiencies and duplications. This bill, H.R. 4998, deals with part four, the problem of updating our technical knowledge for organizing and delivering medical care.

You can boil it down almost to these two simple statements:

We must have the hospial beds and the staff to man them for the people who should be in hospital beds. We also must have other ways of providing medical care for people who need it but who should not be in hospital beds.

At the moment we are woefully short of good diagnostic and ambulatory care clinics, good nursing homes, good home care, good referral services, good rehabilitation programs. A chief reason for the lack of coordinated services for the nonhospitalized patient lies in the fact that we have been slow to develop and test new methods for providing these services. This bill would provide the stimulation and the funds so that those who have the know-how can put to work the new medical discoveries from our research laboratories. The Congress has shown great wisdom in providing funds for medical research. Now it is time to help the communities demonstrate how this new medical knowledge can best be put to practical use. In the sciences, you have supported both basic and applied research and development. There is an equal need to do this in the field of the application of medical knowledge and you can expect equally dramatic results.

Dr. Baumgartner is commissioner of health of New York City but grew up in Kansas and still sees health problems in terms of the Middle West as well as in those of a great metropolitan area. As president of the American Public Health Association, she has talked with public health workers in the towns and villages of almost every State in the Union. She can tell you that there are scores of communities where there are no organized home care services, no rehabilitation centers, no such thing as a visiting nurse. Moreover, she can tell you that there are many physicians—good, dedicated, conscientious, hard-working physicians—who simply are not aware of some of the latest developments in medicine. Speaking as a former president of the American Public Health Association, I am convinced of the enormous need existing throughout the Nation for Federal leadership such as this bill would supply.

Let me now speak for her, as commissioner of health of New York City, where we have been trying, within the limits of our available resources, to develop and test new methods for bringing the benefits of the latest medical knowledge to the people. On the basis of our experience, we know it is possible to develop and test such methods and to obtain experimental data from which you can work out the formulas for an effective operational program to provide these services to all who need them.

Permit me to explain what she means by the phrase "all who need them." In the report of President Eisenhower's Commission on National Goals, it was pointed out that the responsibility of a community health department is not only to provide direct medical services to persons who would not otherwise be served but that, in addition, a health department must identify the community's needs for medical care and evaluate continuously the quality of its health practices and the adequacy of health facilities and manpower as related to the needs of the whole community.

The services which this bill would enable our communities to develop, test and put into operation are needed not only by the medically

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indigent. They are needed as much by the chronically ill patient who can afford to pay for them but who cannot do so because they simply do not exist. We in New York City were initially prompted to study improved community services to the chronically ill because the city is the purchaser of these services for the medically indigent. We found we could no longer afford to meet the needs of the increasing number of chronically ill and the aged persons in this category by using the old fashioned methods of hospital and custodial care. These are adequate to deal with communicable diseases and episodic health needs, but they are extravagant, expensive and—most important—quite unsatisfactory for meeting the needs of the chronically ill. We soon found that the need was equally great for those who are able to pay for services out of their own resources.

When we consider that of the 20 leading causes of death in New York City, medical science provides a definite care for only two, we can realize that this need will continue. Although we do have some promising tools, none of them has as yet been able to make a major impact upon the specific disease problem. The other 18 we simply don't know how to cure. This is why we need much emphasis upon medical research. But we can do a great deal to minimize the disabling conditions associated with these diseases even before we learn how to prevent or cure them. Prevention or correction of disability depends upon early detection, accurate diagnosis and the provision of adequate services for rehabilitation, together with the continuous and comprehensive medical supervision of the patient.

At present, medical care by and large is geared to one-shot treatment and hence episodes of unrelated bits of medical care are often the rule. How to convert our health service structure to deal with the long-term patients, to diagnose their illnesses, minimize their disabilities, care for them at home or in appropriate institutions and maintain continuity of care for them—this is the problem.

In the old days the hospital bed was the best we could do for the chronically ill patient. Today, there are many such patients for whom inhospital care is not at all, or only part of, what is required. Hospital care is far too expensive an item to be used needlessly.

How are we to develop effective ways to provide skilled services outside hospital walls? What services are required? Home nursing, physical therapy, occupational therapy, speech therapy, social service, dental treatment, podiatry, diet therapy, and the other skills that go into the care of the sick are prominent in the list. In some instances these can be delivered on an ambulatory basis in the outpatient clinic, in others they must be brought to the home. In the development of home-care programs for the chronically ill, it is particularly important to organize and expand homemaker service. This part-time assistance with household responsibilities often provides the margin of difference between enabling the patient to remain at home and his having to enter a hospital.

Much needs to be done. We need to—

1. Reorganize and improve our outpatient clinics by substituting coordinated, comprehensive care for the present fragmented and piecemeal treatment.

2. Experiment with ways in which home-care services can be provided where they do not now exist and study the ways in

which they can be most effectively coordinated in those areas in which they are provided.

3. Develop information and referral methods so that the patient and his physician will know where to find appropriate sources of care.

4. Coordinate facilities so that patients can move more easily from one type of care to another as their medical needs change.

For many patients who do not require hospital bed care but nevertheless do need suitable institutional care, the nursing home undoubtedly is the answer. I will not belabor the deplorable conditions that exist in all too many of the nursing homes in this country. In the care of the chronically ill, this is our No. 1 national problem. Proprietary interests have taken the lead in the provision of nursing home facilities, yet history has shown that high standards of medical care have been established primarily by nonprofit institutions. The construction and operation of proprietary nursing homes have become extremely attractive to private capital. There are strong indications that syndicates are being organized to exploit these opportunities for profit.

In New York City, 63 percent of the nursing home beds are under proprietary auspices. Inevitably, we run head on into the conflict between the cost of good service and the desire of nursing home owners to make money. The number of proprietary beds in New York City has increased 77 percent between 1955 and 1961. In contrast, there has been only a 37 percent increase in public infirmary beds and a smaller increase in voluntary beds.

Funds for the expansion of nonprofit nursing homes are in short supply. But let me assure you that the tricks of Hill-Burton money for nursing home construction that has been available in New York City in the past—and which this legislation will double—as small as it was, has sparked the expenditure of funds from other sources so that in the end we have achieved these things:

1. A modern infirmary unit attached to a voluntary home for the aged.

2. A new unit for a nonprofit nursing home affiliated with a major hospital.

3. Two nursing home units to be constructed and operated by high-quality general hospitals.

Thus even small Federal seed money stimulated desirable local expansion. I would vigorously support this legislation if for no other reason than that it would make available more money to enable us to construct more nursing homes under nonprofit auspices, preferably hospital-based, where we are able to emphasize high-quality care. In these we can apply the knowledge we now have about how to operate a reasonable and decent kind of nursing home and set a standard which proprietary nursing homes can then be asked to follow. You can be sure that this proposed money is needed and that it will be wisely and productively spent.

I cannot too strongly state my convictions, based on the facts as I know them, that this aspect of the proposed bill alone would permit this country to move toward solving the nursing home dilemma. If we don't act, I am afraid that the national dilemma may become a national disgrace. The nursing home which first evolved as a hopeful

solution to the needs of the increasing number of aged chronically ill now is in danger of becoming as evil as anything in Charles Dickens.

Better than using even the best nursing home, of course, would be to do the kind of prevention and rehabilitation that would keep people from needing to be institutionalized at all. We in New York City have been tremendously concerned with rehabilitation, with the lag between modern rehabilitation knowledge and the degree to which New Yorkers were receiving the benefit of this knowledge.

We in New York City have a favorite story and it is a true story, about Mrs. Flannigan who lived across the street from Howard Rusk's Institute of Physical Medicine and Rehabilitation on First Avenue. Mrs. Flannigan had a stroke and for 3 years thereafter she was the width of one avenue away from the wealth of services that Dr. Rusk's Institute could have provided her and which she needed. But she didn't know this, and so did not find her way across the street to get this essential care until 3 crucial years had passed.

We cannot afford to wait for the Mrs. Flannigans to cross the street. We have to develop new ways to bring needed rehabilitation services across that street ourselves. These are the ways we are trying to develop in New York City. This story illustrates the kind of absurd waste which could be corrected through the legislation you are considering this morning. Mrs. Flannigan could have received these services whether she was indigent or able to pay for them. It happens that Mrs. Flannigan could have paid. In either case, the fact that the service was available and unknown to her, and that her situation was unknown to anybody in the city of New York who knew how to provide the help she needed—that is the point of this story.

We therefore undertook 3 years ago to design a demonstration rehabilitation program in one area of the city. The objectives are:

1. To find what we call the hidden handicapped, those who could benefit by but were not receiving rehabilitation services. We were especially concerned with stroke patients but also with other neuromuscular disabilities.

2. To make available a central agency to which such individuals could be referred, where all the resources of the community for providing needed service would be listed, and where the necessary procedures between referral center and service-providing agencies were available to speed the patient to the right agency.

3. To take steps to see that the doctors in the community know of these resources and how to make use of them on behalf of their patients.

New York City probably has more rehabilitation resources than any other community in the world. If in this city we are nevertheless confronted with the problem of individuals who could be helped but who do not know it, who do not know where to seek help even when they are aware that it may be available to them then imagine how much more urgent are the needs in this field in other communities. We are finding in this demonstration that roughly 3 percent of the people surveyed in the community need and apparently could benefit by rehabilitation, and that of these about half are helped by existing resources. These percentages may appear small, but please note that in New York City this means that one-quarter million persons are possible candidates for major rehabilitation effort and will fail to receive these benefits unless we organize our resources to see that people and serv-

ices are brought together. The cost of failure to provide this needed rehabilitation care is enormous.

Where to get the remaining resources needed, and how to translate what we have learned in our study into a program that will meet total community need is the problem to which we must now give our attention. The legislation you are considering would be of immediate benefit in this connection, and I assure you that New York City and other communities would move immediately to take advantage of the opportunity it would afford.

I cannot refrain from citing for you two of the cases of people who have benefited by our rehabilitation project.

One is the story of a 77-year-old homebound victim of a stroke who for 5 years was unable to get up or even sit up without assistance. Unavoidably she was a heavy burden on her elderly sister and brother-in-law. Now, after receiving physical therapy, she is able to get up, dress herself, and take care of her personal needs. She is on the way to complete physical independence. Of course she is happier, and a great strain has been lifted from her family.

Then there is the remarkable achievement of a 28-year-old girl, severely crippled since childhood with rheumatoid arthritis. After some months of rehabilitation efforts, she became able to travel by public transportation. Recently she found a job as clerk and switchboard operator and has been dating a young man she met while receiving vocational training.

Not only do these two sample cases suggest the significant economic savings which can result from rehabilitative effort, but they illustrate graphically the great human values which can be restored to the afflicted.

In order to improve the medical care of the 350,000 welfare recipients in our city, a number of demonstration programs have been begun. Much of the present difficulty arises from a serious fragmentation of medical care. Instead of a smooth continuous flow of medical services by the same team of physicians and nurses each welfare patient is subjected to a series of pieces of care, usually unrelated. It is often far easier to repeat a gastrointestinal X-ray series several times on a patient than it is to provide that the records of previous examinations are made available to the team currently responsible for his care.

Cornell Medical School has therefore undertaken to provide complete medical care for 1,000 welfare families in one area of Manhattan, adjacent to the school. The team of physicians, nurses, social workers, physical therapists, and related medical personnel will provide service to patients in the hospital, in a chronic disease hospital, in a nursing home, in the outpatient department or in the patient's own home. Medical records will be continuous and an attempt will be made to insure that the patient is sent to the particular facility required by his condition at any given time. This project is being done as a research effort and a control group of welfare clients receiving care under the regular system will be used for comparison purposes. A particular attempt is being made to study the costs of this continuous care program and a careful cost accounting system has been built into the program. One of the earliest reports coming out of this project indicates that only 20 percent of the patients listed on the walfare roster at the beginning of a year remain as welfare patients contin-

uously throughout the entire year. Hence, in welfare medical care not only do we have the problem of fragmentation when they remain on welfare but many of them move off the welfare rolls during the year. This further complicates our ability to arrange for medical care for this deprived group of our citizens who though they may no longer require welfare funds are still, in most cases, medically indigent.

I believe that the testimony you have heard on this legislation in the last few days agrees with the general observations which I have made in this report. We in New York City know how urgently this measure is needed because of a whole series of specific local studies which document the serious duplications and gaps in the organization of medical services. We know that we have much to learn if we are to be able to apply current knowledge adequately to the problem of disease control.

Our local studies include:

1. The Gulick report. The Mayor's Committee on Management Survey in 1952 which reviewed the health and hospital services in the health, welfare, and hospital departments in New York City underscored the fragmentation, the waste, and the medical neglect that occurs because of the antiquated structure for providing health care. New York City is not unique in this, it has just studied itself more than most areas.

2. The local medical society and health commission reports of medical care in nursing homes indicate clearly the lack of high standards in the absence of the rehabilitation point of view in patient care.

3. A New York City task force appointed in 1959, to make recommendations for the improvement of welfare medical care found that while the number of welfare clients who are patients in nursing homes has grown from a handful, 400 in 1951, to more than 5,000 today, no corresponding changes have been made in the methods of providing medical services to this vastly increased caseload. A panel physician system, improvised in the depression years to pay for physician visits to an individual patient in his own home has simply been transferred to the nursing home. It has not been adapted in any way either to meet the changed requirements of an institutional setting or to take advantage of new opportunities for improved care that are potentially present in an institutional setting. Nor does the present system provide any mechanism by which the Department of Welfare can establish and enforce reasonable standards for the quality of medical care it purchases for these clients, or even assess the quality of this care.

These reports have been widely circulated and I am sure you are familiar with their contents. They add up to an exhaustive documentation of the need in New York City to develop and test new ways to organize health services in the community if we are to attempt to prevent crippling disabilities and provide effective care at a reasonable cost for the chronically ill.

In New York City we have already begun to do some of the things which comprise the objectives of the legislation you are considering this morning. On the basis of our experience, I think we can give you assurance that it is possible to develop and test out successful methods of organizing health services in the community and outside the hospital, of improving coordination of these services, of setting

up referral centers that will permit people to find the services that they need, and, in cooperation with the medical profession, of helping the practicing physician to keep abreast of new developments in medical science and in knowing about and using the community services that will bring these new benefits to his patients.

In our rehabilitation project, in the Cornell Medical School demonstration to provide comprehensive medical care for welfare recipients, in the development of a new nonprofit nursing home to be affiliated with Montefiore Hospital in the newly established liaison between health department district health centers and welfare department welfare centers, in all of these undertakings we are already doing the kinds of demonstrations that would be supported by the funds which this legislation will make available.

Finally, lest you think that we in New York do not need your legislative and financial support in order to carry on this kind of effort, let me assure you that our efforts have only just scratched the surface. We cannot believe that enough has been done until the problems are solved. The evaluation of our efforts lies in final results, not in pious hopes and promising leads. We have a stockpile of equally important, equally imaginative, equally urgent demonstrations which we cannot start because we cannot find the funds with which to support them. As we and other areas are given the tools we need to explore these problems, it is important to remember that the entire Nation will benefit from the successes of any one locality. The current struggle against the ravages of chronic disease must be waged across the Nation. We are looking everywhere for clues to the prevention and control of disease and the rehabilitation of our disabled citizens.

The problem is so vast, so intricate and so complex that every State requires the help offered by H. R. 4998 if there is to be hope of providing practical solutions available to all.

The CHAIRMAN. Does that conclude your statement?

Dr. JAMES. Yes.

The CHAIRMAN. Any questions, Mr. Mack?

Mr. MACK. Well, just one short question. You mentioned this was a true story about Mrs. Flannigan.

Dr. JAMES. Except for the name, sir.

Mr. MACK. Well, I understand that.

Dr. JAMES. Yes.

Mr. MACK. But there is such a case, I presume.

Dr. JAMES. Yes.

Mr. MACK. What is wrong with the medical profession when her physician was not aware of the services available?

Dr. JAMES. Rehabilitation services have become such a new part of medicine, not much is known about it.

Mr. MACK. You mean that the doctors don't know about it?

Dr. JAMES. And the average practicing physician is not fully aware of the services that are available, the manner of taking advantage of them nor are there enough available for everyone. There are many Mrs. Flannigans that would know about the service but there are not enough of these services available for them.

Mr. MACK. It seems to me that you need to have some type of Government program to educate the doctors about these services.

Dr. JAMES. This is part of our rehabilitation project. The doctors are being given inservice training. They are having physical medicine

consultants visit the patient with them together so they can follow through with the care once they work with the specialist and how to develop these services.

Mr. MACK. Thank you very much.

The CHAIRMAN. Mr. Keith?

Mr. KEITH. No questions.

The CHAIRMAN. Doctor, do you feel that if the Congress were to approve the program as presented here in this legislation that it would be an incentive for the States to increase their own activities and services in this field?

Dr. JAMES. I certainly do, Mr. Harris. We, New York City, can go just so far with our own efforts and we can get so much State help for such efforts and we have, I believe more than reached our ceiling. There is much more that we could do and we would match help if we could get it.

The CHAIRMAN. Now, by requiring special matching, would the services that would be provided under this program be far greater than they would be without special matching?

Dr. JAMES. Yes, because the legislation would stress the desirability of using these funds for demonstration projects in this field of care of the patient outside the hospital.

The other matching funds we get are more general. They are often absorbed in routine programs. We have our major day-to-day problems to contend with.

This bill does provide these funds should be used for the new program, the developmental project which will give us the tools we need in the future.

The CHAIRMAN. In other words, for example, where the authority is doubled as it is in the case of the nursing homes, matching may go beyond the doubling of the amounts that would be authorized.

Dr. JAMES. Yes, sir.

The CHAIRMAN. It might be manifold.

Dr. JAMES. Very much so. We have built four nursing homes, the voluntary homes and in each case with the Hill-Burton aid which was far less than one-third of the total amount. The community will raise the funds over and beyond their share when given the incentive.

The CHAIRMAN. Thank you very much, Doctor. We are glad to have your testimony and the statement from Dr. Baumgartner.

Our next witness is Miss Julia C. Thompson, Washington representative of the American Nurses Association.

STATEMENT OF JULIA C. THOMPSON, REGISTERED NURSE, WASHINGTON REPRESENTATIVE OF THE AMERICAN NURSES ASSOCIATION

Miss THOMPSON. The American Nurses Association, the national organization of registered professional nurses, is an association with 54 constituent State and territorial associations, with a membership of 171,000.

The overall purposes of the organization are to—

foster high standards of nursing practice, promote the professional and educational advancement of nurses and to promote the welfare of nurses to the end that all people may have better nursing care.

We appear here in support of H.R. 4998.

For many years the Congress has concerned itself with initiating and supporting programs which will improve the health of the people of the United States; and with supplying the necessary facilities for providing preventive and curative health care. The ANA has consistently supported the Congress in these efforts.

Much of the emphasis in health care has been on furnishing the physical plants which are vitally important. However, more thought and planning should be applied to the type of facility which can best serve the needs of the public, particularly those in the older age group.

Also more attention should be given to the great need for personnel to staff the physical plants. We realize, of course, that there is a continuing need for more hospital facilities, but we also believe that hospital beds alone cannot solve the health problems of persons 65 or older.

Reports from the national health survey, and other studies, reveal that persons in advancing years have greater need for medical services and health care facilities and that their illnesses are usually of longer duration. Funds provided in H.R. 4998 for demonstration projects where these services would be furnished could point up the types of facilities and services best suited to this age group.

Some studies and demonstrations have already been done to test various ways of providing adequate health facilities and services. These include the extension of hospital care and the rearrangement of hospital services and physical plant into units that are specifically organized for the type of care needed. Payment for nursing care in the home has also been studied and successful programs have been instituted. One of these is a report of a pilot project in Denver, Colo., entitled "Home Nursing Care Program." Findings of already completed studies would be valuable to communities that are interested in setting up new programs or expanding existing services.

In communities where there are agencies giving home nursing care they have reported that there is an increasing number of older people being served. The Chicago VNA in 1958 stated:

> Our records reflect an ever-changing health picture in the community. The senior citizen is receiving most of the nursing care: 71,822 visits were made to patients over 65 years of age. This is 38 percent of their total visits. Fifty-seven percent of our visits went to patients over 45 years of age. Most of these are patients who have some form of crippling disease which requires long-term nursing care. In addition to the physical problem, these people have many social, nutritional, and emotional needs.

It appears that there is considerable demand for this type of service where it is available, but there are many communities that are without home nursing care. A survey made by the Regional Nurse Consultants of the Public Health Service reports that:

> A decided relationship was found between the size of the city and the location of visiting nurse associations and combination agencies. All except two cities with a population of 200,000 and over had the services of one of the two types of agencies, but the proportion of cities having such service became progressively smaller as the population decreased.
>
> It is felt that a study of communities of less than 25,000 population would probably show a relatively small proportion of them with either a visiting nurse service or a combination agency. Exceptions might be in the northeastern part of the United States and perhaps in a few areas in the Great Lakes region.

At the present time sick and disabled persons in almost half of the cities with a population of from 25,000 to 100,000, and in the majority of cities and towns of under 25,000, can be expected to receive nursing care at home only if it is provided by a health department. Also, it is believed that any widespread expansion of this service will need to be carried out by or through health departments. If this type of program is undertaken, additional nurses will be required as well as changes in program emphasis.

We would agree that where there is a local health department, expansion or initiation of services be carried out by that agency. County and local health departments could be financially assisted by H.R. 4998 with the development of home nursing care programs. Consultants could be supplied to help the local community set up such a program, with the expectation that as the service developed it could become partially self-supporting. Nurses could be recruited from among those retired in the community who would be interested and willing to work on a full-time or part-time basis. Refresher courses or in-service education would have to be provided for retired nurses returning to the field.

Expanded services of any kind will require more personnel. In order to utilize those persons in local areas who have not been employed for a period of years, it will be necessary to have well-qualified supervisors and directors for the successful operation of any program. The numbers of nurses with specialized preparation in public health nursing must be markedly increased. At present there is a definite shortage of public health nurses, especially those with specialized preparation in the field. Only 22.8 percent [1] of employed public health nurses have a bachelor's degree, the U.S. Public Health Service minimum requirement for first-level positions.

Representative Harley O. Staggers, of West Virginia, who is a member of your committee, introduced a bill, H.R. 5682, which will provide Federal aid to collegiate schools of nursing. The bill, which is assigned to your committee would make a substantial contribution toward meeting the demand for public health nurses. Increased appropriations for traineeships for public health nurses will also help to meet the expanded needs. The project grants for schools of public health and schools of nursing and engineering, introduced by Representative Rhodes, of Pennsylvania, approved by this committee, and passed by the 86th Congress, has also contributed to closing the gaps in supplying well-qualified personnel. We would recommend that the committee give early and serious consideration to H.R. 5682 as another step in creating qualified personnel.

The rapid growth of nursing homes poses many problems. Standards for the physical plants need to be determined, put into operation, and enforced. Standards for care in many of these facilities also need to be upgraded. The ANA has developed a Statement of Standards for Nursing Care in Nursing Homes as a guide to persons establishing these services.

Some States have made considerable progress in regulating the nursing homes, but there is much room for improvement. Studies, demonstrations, and experiments to determine the type of plant needed to care for persons with long-term illness, disability, or in need of custodial care, are very definitely indicated. It is possible that with the development and expansion of nursing care services in the home,

[1] "Facts About Nursing," 1960 ed., p. 31.

there will be less need for an acceleration in the building of nursing homes.

We see the provisions of this bill can be of inestimable value in assisting communities who need financial help in developing needed resources for health care, particularly for the older age group.

I thank the committee for the opportunity to appear before you to present the views of the American Nurses Association. It is always a privilege and pleasure to appear before this committee which has always received our witnesses with the utmost courtesy.

The CHAIRMAN. Does that conclude your statement?

Miss THOMPSON. Yes, it does, Mr. Harris.

The CHAIRMAN. Mr. Mack, any questions?

Mr. MACK. Do you represent the nurses' association?

Miss THOMPSON. The American Nurses' Association.

Mr. MACK. Is that for registered nurses?

Miss THOMPSON. That is correct; professional nurses.

Mr. MACK. Do you have practical nurses in your association?

Miss THOMPSON. No; we do not. They have their own organization.

Mr. MACK. Now, what qualifications do you need to become a registered nurse?

Miss THOMPSON. You must be a graduate of an approved school of nursing and have passed the State board examination and have a license in good standing.

Mr. MACK. What is the difference between the registered nurses graduated from approved schools of nursing and those who have a college degree?

Miss THOMPSON. They all have to meet the same minimum requirements set up by law. The persons who complete a collegiate program usually have had the benefit of other courses that are given in college which adds to their knowledge and ability and they usually are prepared to assume positions of more responsibility when they complete their training.

Mr. MACK. You indicated some need for public aid for Federal assistance.

Miss THOMPSON. Yes, sir.

Mr. MACK. For the training of nurses or supporting a collegiate nursing school.

Miss THOMPSON. That is correct. At the present time we are graduating only around 3,500, on an average, each year, from the collegiate schools and if we are going to have expanded health facilities we do need more persons in this category.

Most of the persons who receive public health nurse training come from our collegiate schools because they provide that preparation and most of the hospital schools do not.

Mr. MACK. And they are classified as registered nurses whether they have the degree or do not have the degree; is that right?

Miss THOMPSON. That is correct. The State law requires a minimum from everyone and what they have over and above that prepares them for positions of additional responsibility.

Mr. MACK. Well, is it your idea to have all of the nurses in the collegiate program at a certain time? I want to know about your interest in this proposal.

Miss THOMPSON. Professional people are usually educated in institutions of higher education and I do not believe that hospitals are considered educational institutions. Therefore, it would be reasonable to assume that persons are considered professional who are graduates of educational institutions.

Mr. MACK. They have done a very effective job of training nurses.

Miss THOMPSON. Yes, and it would be presumptuous to assume that this changeover could possibly take place within a relatively short period of time.

Mr. MACK. Did you receive your nurse's training in a hospital or a university?

Miss THOMPSON. I received my training at Cook County Hospital in Chicago but it took me 3 years to get a bachelor's degree after I had my 3 years of basic preparation. We hospital nurses get 1 year of academic credit, generally.

Mr. MACK. You are not complaining about the education you received in Cook County Hospital are you?

Miss THOMPSON. It was very good.

Mr. MACK. I wanted to ask you what the standards were for the practical nurses or would you know?

Miss THOMPSON. The practical nurse's education primarily takes place in vocational educational schools, and the courses are approximately 9 months to 12 months. Following that, they also take a State board examination and become qualified as licensed, practical nurses.

Mr. MACK. Well, they are quite limited in numbers today; aren't they?

Miss THOMPSON. We have no very good count of persons who call themselves practical nurses.

Mr. MACK. I am talking about the ones who have been approved, like you have been approved, by the States, and they are practical nurses.

Miss THOMPSON. We have some figures.

Mr. MACK. A lot of them call themselves nurses who are not registered nurses.

Miss THOMPSON. That is correct. In 1956–57, there were 378,528 practical nurses and auxiliary workers in hospitals. However, only about a half of those are licensed practical nurses.

Mr. MACK. In recent years they have given the practical nurses additional responsibilities in these hospitals to relieve the registered nurses and I understand they have been doing quite well and have been quite successful.

Miss THOMPSON. Yes. The use of increasing numbers of practical nurses is another reason why we need persons with more preparation in the professional nurse category. If we are going to use these persons with lesser preparation, the person who supervises them and delegates work to them must be able to make judgment about their capacity to carry out certain responsibilities.

Mr. MACK. Thank you very much.

The CHAIRMAN. Thank you very much, Miss Thompson, for your testimony and your interest in this legislation.

The final witness we have is Dr. Caldwell B. Esselstyn.

Doctor, you are president of the Group Health Association of America, I believe.

STATEMENT OF DR. CALDWELL BLAKEMAN ESSELSTYN, PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, HUDSON, N.Y.

Dr. ESSELSTYN. My name is Caldwell Blakeman Esselstyn. I am a surgeon practicing in a rural area in upper New York State. I am medical director of the Rip Van Winkle Clinic, chairman of the Medical Care Section of the American Public Health Association, a member of the New York State Public Health Council, associate in community health and special lecturer in preventive medicine and public health at Albany Medical College, and president of the Group Health Association of America.

Mr. Chairman, on behalf of the Group Health Association of America, I want to thank you for this privilege of appearing before the House Interstate and Foreign Commerce Committee to testify concerning H.R. 4998.

The Group Health Association of America is an organization composed of prepayment health plans and individual members. The health plans include indemnity insurance plans, as well as direct service plans, providing comprehensive care through group practice. The individual membership is made up of administrators of labor health plans, as well as professional and lay persons who are primarily interested in the evaluation of our present methods of providing health services, and of ways and means of making available better medical care for the American people, particularly through consumer-sponsored prepaid comprehensive direct service plans. Today, Group Health Association of America is representing the health interests of between 4½ to 5 million individuals throughout the United States. It is an organization which is primarily concerned with the problems of the consumer of medical care, and represents a unique forum where free and open discussions between producers and consumers have resulted in many constructive plans and a united front in regard to our concern over the dilemma of providing health care for our senior citizens.

Throughout the week you have heard from experts dealing with many of the facets of H.R. 4998, and although at this late date some of the things which I am going to mention may be repetitious, I believe it is justifiable for the sake of emphasis. The Group Health Association of America believes that the legislation under consideration by your committee at this time is of tremendous significance, and is bound to have a profound effect on the shape of things to come.

We are particularly interested in H.R. 4998 because it will help to meet the critical existing needs in providing care to our millions of aged and chronically ill.

Over the years, increasing emphasis has been placed on the construction of necessary hospital beds throughout the country. The effectiveness of the Hill-Burton program which has been implemented with such outstanding success is well known, but the time has come when there must be a reorientation in our thinking, and a change in existing patterns of medical care. The hospital has an important place in the shape of things to come, but it is only a link in the chain. We have been placing great emphasis on this link, but we have sadly neglected the other links which are vitally necessary to strengthen the chain. H.R. 4998 will do much to stimulate the interest and provide the means to develop programs in these undeveloped areas.

I would like to comment specifically on the four categories covered by the community health services and facilities bill in order:

1. COMMUNITY HEALTH SERVICE GRANTS TO STATES

Group Health Association of America is composed of many group-practice units whose driving force is to provide comprehensive services outside of the hospital. The fact is well known that the present number of hospital beds would much more adequately meet the needs of the country if the use of these beds were to be restricted to the peculiar needs for which they were designed. Unfortunately, because of the lack of emphasis on services outside of the hospital, a great deal of medical care which could be taken care of, not just as well, but perhaps even better, outside of the hospital is being herded into our crowed facilities so expensive to build and even more expensive to maintain, because they are designed and operated primarily for the care of the acutely ill.

Recognizing the importance of the hospital link in the medical care chain, we prefer to think of this link not as the last word, but as the last resort.

H.R. 4998 will do much to provide health services for the aged and chronically ill outside the hospital. Just as technological advances have made medicine more effective, improved nursing techniques and the increasing effectiveness of the art of rehabilitation make it possible today to restore many patients to independent living formerly considered hopelessly disabled.

Let us never forget that disability is still the No. 1 cause of dependency. Although these improved techniques are known today, many patients are denied the benefits of care because of lack of qualified personnel. In a great many instances help is needed only to get patients and families to learn how to take care of themselves; yet, even this is often impossible, especially in rural areas with which I am familiar.

This is true the country over. The majority of towns under 25,000 have no visiting nurse association and health departments, where present, are hopelessly understaffed, if they are to assume in addition to traditional health department services the responsibility of caring for the sick and disabled. H.R. 4998 would help to alleviate these shortages.

We are also impressed with the fact that this bill provides for the community approach. All too frequently we find a complete lack of coordination between the various health facilities in an area. The time has come when there must be an integration of these separate agencies through health information and referral services which would be provided. Under this bill it also would be possible to increase the number and quality of diagnostic facilities not necessarily connected with hospitals. In this connection I would like to draw your attention also to the Rhodes bill, H.R. 5887.

This extremely important legislation will do much to help stimulate the formation of comprehensive group practice facilities. It has been reliably documented that the existence of these services substantially reduces the necessity of hospital services.

For instance, the recent report of the medical care program for steelworkers and their families showed that the people taken care of

by a team of doctors providing comprehensive care under direct service benefits required 90 hospital admissions per 1,000 population, as compared with 135 under the conventional organization of services; and only 570 hospital days compared with 1,032—and all this, mostly because adequate services were available, again, outside the hospital. Imagine the impact these facilities would have on the need for hospital beds if applied on a nationwide basis.

2. SPECIAL PROJECT GRANTS

Hundreds of various patterns of providing home services are in operation today throughout the country, but surprisingly few have been studied or evaluated. Many of these plans show great promise but have been unable to develop because of lack of funds. In the years to come, there will be a decreasing doctor-patient ratio throughout the country. It is imperative, as rapidly as possible, to develop ways and means of lengthening the shadow of the professional personnel and of highly skilled ancillary personnel by developing organizational patterns which will provide for making use of less highly specialized individuals working under careful supervision.

Here, again, the emphasis of providing health service outside of the hospital will help to strengthen the existing weak links in the medical care chain and will encourage the provision of services in the patients' homes. The overcentralization of all services in the hospital will be taken into the community close to where people live, where it belongs because this is where it can be most effective.

There is a rich opportunity to conduct studies and demonstrations and experiments which will provide a new look in the overall medical care picture.

3. NURSING HOME CONSTRUCTION GRANTS

The Group Health Association of America is particularly pleased to see that the bill would increase the appropriation authorized for grants for the construction of public and nonprofit nursing homes. Over the past few years we have viewed with increasing alarm and concern the mushrooming of proprietary nursing home syndicates from coast to coast. We are disturbed over the spectacular financial returns these syndicates are returning speculators.

Although we believe the profit motive to be honorable it is our feeling that the care of the aged and disabled should not be entrusted to the hands of institutions whose driving force, of necessity, is to make money. Yet, some 90 percent of our nursing homes providing approximately 70 percent of the available beds belong to this category. H.R. 4998 will do much to reverse this trend.

The provision of nonprofit and public nursing home beds which would be integrated with restorative and rehabilitative services would help redirect the emphasis toward making the patient more independent in contrast to the all too frequent tendency in proprietary or commercial nursing homes to allow patients to become bedridden. This is because bed patients produce higher financial returns and are more profitable than ambulatory patients, providing little incentive to encourage rehabilitation training.

I would like to remind you of the report of the Senate Subcommittee on Problems of the Aged and Aging which mentioned among many

deplorable situations and conditions in existing nursing homes that the "storage big" philosophy is still present in most of these facilities.

Because of the changing patterns of disease, there is need today according to reliable hospital authorities for 513,000 additional beds where skilled nursing care can be made available.

4. HOSPITAL RESEARCH GRANTS

Although there has been outstanding but sporadic development throughout the country of revolutionary changes in hospital design, by far the majority of the hospitals being built today do not reflect the current needs which the changes in the practice of medicine have created. Great strides can be made in implementing economies in hospital operation and in increasing the efficiency of hospital workers by stimulating research in the whole area of the functional design of hospital buildings.

There is also an equal, if not greater, need for research in the development of ambulatory diagnostic facilities, and testing their most efficient relationship to hospitals. Where should the organized home care program be based? Should chronic disease hospitals be separate or integrated?

These are only a few of the many problems which will help to be answered through the hospital research grants provisions of this bill.

In conclusion, the time has come when there are increasing discrepancies between what can be done and what is being done to provide adequate out-of-hospital care for the chronically ill and disabled. Currently, the misuse of the highly specialized and expensive to operate hospitals is placing an unnecessary and growing burden on our crowded institutions and finances.

The time has come when we need a brandnew overall program which will provide comprehensive care to our chronically ill and disabled outside of the hospital walls and which will bring about new thinking and new approaches to the problems of medicine that exist today. May I remind you that each day 3,000 of our citizens pass the age of 65.

I would like to thank you on behalf of the Group Health Association of America for this opportunity of appearing before your committee, and to say that because of the pressing need for H.R. 4998, because it embodies so many of the principles for which our association stands, we sincerely hope this committee will expedite the passage of this bill immediately.

The CHAIRMAN. Thank you, Doctor.

Mr. Mack, any questions?

Mr. MACK. Doctor, are you a member of the American Medical Association?

Dr. ESSELSTYN. Yes, I am.

Mr. MACK. You didn't sound like it.

Dr. ESSELSTYN. Thank you.

Mr. MACK. You represent the Group Health Association of America; is that true?

Dr. ESSELSTYN. Yes.

Mr. MACK. What type of service do these people perform?

Dr. ESSELSTYN. Well, the Group Health Association is an organization which is made up of comprehensive medical care plans. It

was started by the cooperative movement and then the labor people with the labor health groups became interested and today, it includes insurance companies which provide indemnity insurance and comprehensive, direct service benefits and consumers who are interested in the problems of medical care.

Mr. MACK. It does not include Blue Shield?

Dr. ESSELSTYN. It does not include Blue Shield or Blue Cross.

Mr. MACK. These companies operate similar to the Blue Shield and Blue Cross and perform the same service?

Dr. ESSELSTYN. That is right. It includes a cooperative movement in the country as far as the medical care field is concerned.

Mr. MACK. And of course, they have different-type plans. I guess all of your companies or groups or associations or whatever you wish to call them have different plans, different medical insurance plans for the individual.

Dr. ESSELSTYN. They vary tremendously.

Mr. MACK. That is what I mean. Some of these, I guess, would reimburse the doctor for home calls; would they not?

Dr. ESSELSTYN. Very definitely.

Mr. MACK. Well, do these same plans reimburse a nurse when she makes a call?

Dr. ESSELSTYN. One of our plans which I am sure you are familiar with does, and that is the Health Insurance Plan of Greater New York where, through comprehensive benefits and an arrangement with VNA, a home nursing call is made available.

This is also true with the cooperative in Puget Sound in Seattle, Wash.

Mr. MACK. The nurses and the others have a very good case I think for expanding their services. There have been several witnesses that have appeared before us with regard to home nursing service and it seems to me that this ought to be included in the insurance programs that we have at the present time.

Dr. ESSELSTYN. I would think that through the stimulation given by this bill this kind of thing could be demonstrated to be possible right now.

I come from an area where the median family income is $2,399, not the median, but the median family income and it is very difficult for people like this to add to the increasing cost of medical care.

I think the inclusion of comprehensive care and nursing benefits eventually will be accepted more and more by both voluntary and commercial insurance plans.

Mr. MACK. It seems to me that these companies would be interested in that because it would reduce their cost.

Dr. ESSELSTYN. The cost of what?

Mr. MACK. Would it not reduce the cost to the insurance companies if they could substitute a nurse for a doctor?

Dr. ESSELSTYN. I think so and I believe some very worthwhile experimentation has been done in New York City in Kings County, for instance, which showed that if Blue Cross patients were sent home on their second day and then taken care of by home care services, the cost was appreciably diminished.

71495 O—61——16

Mr. MACK. I think some of the witnesses have left the impression before the committee and therefore, it seems to me that the insurance companies ought to be interested in developing this program.

Dr. ESSELSTYN. I think we need seed money to start demonstration programs to make everybody aware of this, especially in rural areas.

Mr. MACK. Thank you very much, Doctor.

The CHAIRMAN. Doctor, on behalf of the committee, let me thank you very much for your testimony in relation to this proposed legislation.

This concludes the hearings on bill, H.R. 4998. The record will be held open for 5 legislative days for the filing of appropriate and acceptable statements.

The Chair would like to thank all of those who have appeared and testified on behalf of or in relation to this proposed legislation and for the contribution they have made to this proposed program.

The committee will now adjourn.

(The following information was submitted for the record:)

BALTIMORE, MD., *May 3, 1961.*

Hon. OREN HARRIS,
Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.:

May I call your attention to the importance of the proposed Community Health Services and Facilities Act, 1961, H.R. 4998. Your support for legislation resulting in Public Law 86-720 providing formula grants for schools of public health was greatly appreciated. H.R. 4998 appropriately amends section 314c of the Public Health Service Act to provide much needed community health services. If the schools of public health are to provide the manpower to implement the proposed expansion of community health services the ceiling on section 314c should be removed. This ceiling is in direct conflict with the intent to increase enrollment in schools of public health. Your support for H.R. 4998 with the amendment which has been proposed is of vital importance.

ERNEST L. STEBBINS, M.D.,
Dean, School of Hygiene and Public Health,
The Johns Hopkins University.

WASHINGTON, D.C., *May 11, 1961.*

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
U.S. House of Representatives, Washington, D.C.:

On behalf of the more than 450,000 members of our two associations, we urge your favorable action on H.R. 4998, to assist in expanding and improving community facilities and services for the health care of aged and other persons, and for other purposes.

We consider this bill to be one of the most urgently needed and constructive approaches toward developing positive action to overcome the health problems defined by the delegates to the White House Conference on Aging.

The community health service grants to States, the special project grants, the nursing home construction grants and the hospital research grants make possible the kind of program and research that could detect early diagnosis of illness, facilitate prompt treatment, avoid haphazard referrals, and provide out-of-hospital health services that are more efficient, less costly, and more conducive to coordinated community planning of medical facilities and services.

Until the goals that are possible through this bill are achieved, our Nation will have failed to meet its obligation to our aged and others equally in need of such health care.

We respectfully request that this statement be entered in the record to document the desire of our associations for passage of H.R. 4998.

Sincerely yours,

ETHEL PERCY ANDRUS,
President,
WILLIAM C. FITCH,
Executive Director,
National Retired Teachers Association, and American Association of Retired Persons.

THE UNIVERSITY OF MICHIGAN,
SCHOOL OF PUBLIC HEALTH,
Ann Arbor, Mich., May 3, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I am writing at this time to express my strong support for passage of H.R. 4998, the community health services and facilities bill. Your introduction of this bill fills a vital need. The schools of public health are deeply interested in every aspect of this bill since we are acutely aware, both in our teaching and service functions, of the need to improve and extend community health services.

May I direct your attention specifically to two problems in connection with H.R. 4998 dealing directly with assistance to instruction at schools of public health?

As you know, our schools of public health are truly national schools in that even at a State institution like the University of Michigan 75 percent of the students are from out of State and a number of these from out of the country. The university is pleased to have these students but you will understand that the State legislature is loath to support the educational costs necessary when this should not rightfully be a charge against the people of Michigan. In the present session of the State legislature great question has been raised concerning the number of out-of-State students enrolled in the university and the university appropriation request for the ensuing year is threatened with an alarming reduction. The school of public health is in a vulnerable position since our school has the highest percentage of out-of-State students of any unit on the campus.

We believe, therefore, that it is urgently necessary to remove the present ceiling of $1 million annually under Public Law 86–720 for general support of teaching at schools of public health. Increased level of general support is exceedingly important if the basic functions of the schools are to be carried out satisfactorily.

Furthermore, we would urge removal of the present ceiling of $2 million annually on project grants for postbaccalaureate public health training in schools of public health, nursing and engineering. These grants have been most useful in filling special training needs at the various institutions and we at the University of Michigan have been grateful for the aid received. On the other hand, we know that the number of pending applications for project grant funds far exceed available resources. In our own case applications in several specific fields of great importance to the development of a complete training program have not been awarded for lack of funds.

Passage of the bill with the two modifications suggested will be a major step forward in the improvement of the health of the people of our country.

Respectfully yours,

MYRON E. WEGMAN, M.D., *Dean.*

STATEMENT OF CHARLES D. SHIELDS, M.D., GEORGETOWN UNIVERSITY MEDICAL CENTER

I am Charles D. Shields, M.D., professor and chairman of the department of physical medicine and rehabilitation, Georgetown University Medical Center.

I have served as a member of the Veterans' Administration Special Medical Advisory Group and for the U.S. Public Health Service as a member of the National Advisory Committee for Chronic Diseases and Health of the Aged and the Committee for Restorative Services.

Studies have shown that there is an increased need for medical care at age 40 and for hospitalization at age 45. With the present increase in numbers within these age groups, we cannot build enough hospitals or provide enough trained people to render complete services to all who need them.

It is hoped that our research efforts will soon prevent long-term illness, or at least delay its onset. In the meantime, we must utilize and improve our community health services. In my opinion, the most important of these is home care. These programs should be centrally administered and provide coordinated medical, nursing, rehabilitation, social, and related services to selected patients at home, under medical supervision. Government assistance here might well be in the area of demonstration, with provision that services be purchased by the consumer, a third party, or by the community in the case of the indigent. Special project grants might well be used for this purpose.

Sick people cannot be housed indefinitely in hospitals. These institutions are highly specialized centers designed to establish a diagnosis or alter the course of disease. When a patient enters the hospital, plans should be made for early discharge and home care. In this connection, additional nursing-home facilities are necessary, and construction grants for this purpose are sorely needed.

Research along clinical lines is needed to improve our rehabilitation and restorative services to provide more satisfactory and more productive lives for people with physical disabilities.

The American people have been conditioned to the use of hospitals for every purpose through prepayment insurance plans. This is also a convenience for the physician. The average person expects to enter the hospital with the slightest departure from health and return to his home when he has completely recovered. This deprives the family of the responsibility and pleasure that comes from caring for one another and is reflected in our national character.

Prepayment insurance plans should place less emphasis on hospitalization and the few other limited services that they offer. They should place more emphasis on home-care services along with rehabilitation and restorative services for those who purchase this protection. Adequate community health services would make this possible.

I am particularly concerned with the medical student of today who is usually exposed to illness only within the walls of the hospital. Until community health services are improved and expanded, young physicians and paramedical specialists will not be trained beyond the hospital area.

It is in the interest of our national economy and national character that H.R. 4998 should provide additional funds for the many broad purposes of improved community health services.

COUNCIL OF JEWISH FEDERATIONS & WELFARE FUNDS, INC.,
New York, N.Y., May 1, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR MR. HARRIS: I am very pleased to inform you that our national board of directors has unanimously endorsed the proposal for establishment of a Bureau of Community Health in the U.S. Public Health Service with an initial appropriation of $10 million, and unanimously supports also the proposal for an increase in matching grants to the States for construction of skilled nursing homes from $10 million to $20 million. We understand both of these proposals are embodied in S. 1071.

We have just heard that your committee will be holding hearings on these proposals this week. If these hearings extend into next week and if it is possible to present testimony directly in support of these measures, we shall be happy to do so.

In advocating the enactment of such legislation, our council is reflecting the experience of our 210 member organizations throughout the country, serving close to 800 communities, and embracing a network of hospitals, homes for the aged, nursing institutions, and other agencies in the full range of health and welfare services.

That experience and the special studies we have made of these problems in many communities have emphasized that effective health services cannot be limited to hospitals alone. It has been brought to us with increasing urgency that such a program requires also organized home care services for the chronically ill and aged, information and referral centers, better nursing-home care, personnel training in nonhospital types of care, and demonstration programs which can bring new advances in the quality and effectiveness of health services.

We are increasingly aware, too, that agencies such as homes for the aged, family welfare organizations, and vocational agencies serve many people with chronic illnesses.

The Bureau of Community Health can serve a most important and necessary purpose in stimulating the development of this full range of community health services and their coordination.

Our experience has convinced us also of the importance of the proposed increase in Federal matching grants for construction of skilled nursing homes. We have found that there are many people remaining for long-term care in general hospitals at great expense who should be in skilled nursing homes at far less cost, but who cannot be moved simply because such nursing home facilities do not exist. It has not been possible to overcome that deficiency through voluntary philanthropy or private enterprise alone. Government participation is vitally necessary to help assure the needed facilities and the high quality of service in the use of such facilities. The problems of chronic illness have been growing in importance, and with them the need for skilled nursing homes. The increase in Federal grants for this purpose would be a most important step in dealing with these problems.

We hope that your committee will favorably recommend the enactment of such legislation.

Sincerely yours,

IRVING KANE, *President.*

GRADUATE SCHOOL OF PUBLIC HEALTH,
UNIVERSITY OF PITTSBURGH,
Pittsburgh, Pa., April 28, 1961.

Hon. OREN HARRIS,
Chairman, House Interstate and Foreign Commerce Committee,
Old House Office Building, Washington, D.C.

DEAR SIR: I am writing you in order to express support for the passage of H.R. 4998. I should like very much to have the opportunity of testifying on behalf of the passage of this bill. As I understand it, hearings are planned for next week. Unfortunately for me, my commitments that week are such that I cannot come to Washington. Should hearings continue into later weeks, I would very much appreciate the opportunity to appear before your committee.

My interest in the above-mentioned bill is based upon a quarter century of professional activity in medical care, public health, and research and education in medicine and public health. Just before coming to this university last year to direct the program in medical and hospital administration, I was, for 7 years, the general director for the Beth Israel Hospital in Boston and clinical professor of preventive medicine at the Harvard Medical School. I was a member of the hospital facilities research study section when it was first set up in 1955 and became the chairman of that study section 3 years ago (recently reconstituted as the health services research study section). This is the expert committee which evaluates research proposals for pertinency and scientific merit.

I should like to say, first of all, that it is difficult to overestimate the importance of providing support for the expansion and improvement of community health services on an out-of-hospital basis. This is the most neglected area in the field of care for the chronically ill and the aged. The few demonstrations that we have had indicate rather clearly that this is an area of great potential for progressive development which will provide care which finds the proper balance between effectiveness and economy. In relation to this the provision for special project grants is, of course, fundamental because this will help launch vital experimentation for which funds are only too rarely available on the local basis.

Because of my experience as a teacher of medical and public health students, I know something of the great gaps that there are in our knowledge about how best to organize and administer health services. Furthermore, with my experience on the study section which has received, reviewed, and watched the progress of research proposals and activities in this general field for almost 6 years now, I should like to stress the crucial importance of removing the limitation which currently exists on financial support for research in hospital services. It would appear that, from all sources, there is only approximately $3 million now being provided annually for research in this field. This is an infinitesimal proportion of the total annual expenditure of some $8 billion for hospital care in this country. The support of research is venture capital and when one can only find funds to support the top-ranking projects, it is impossible to know whether the next ones in the rank would not be more fruitful than those who were judged to be just a little better. Greater support would provide greater assurance that all the good ideas will be explored.

There is one provision in the current bill which I believe should be modified, and this is the provision that the full succeeding year's costs of Federal participation in a project, as approved, be included in each grant for any fiscal year. Research and experimentation in this field is, in general, relatively expensive. The effect of this provision would be to sharply limit the number of projects that could be launched in any one year.

It would appear to me to be wiser to make it possible to fund the largest number of projects so that they may have an opportunity to start. Provision could be made for review at the end of, say, 2 or 3 years, by which time there is usually sufficient evidence to indicate whether or not fruitful progress is being made.

I hope your committee will soon report favorably on this bill—an important and timely next step in the development of America's health services.

Yours sincerely,

CECIL G. SHEPS, M.D., M.P.H.,
Professor of Medical and Hospital Administration.

TULANE UNIVERSITY,
SCHOOL OF MEDICINE,
New Orleans, La., April 28, 1961.

HON. OREN HARRIS,
Chairman, House Committee on Interstate and Foreign Commerce,
Congress of the United States, Washington, D.C.

DEAR MR. HARRIS: I would first take this opportunity of expressing to you and to your colleagues our very great appreciation of your sympathetic understanding of the needs of schools of public health and the assistance that has been given during the past few years. A great deal has been done but much more remains to do, and we would again wish to have your support in the passage of H.R. 4998 which, I understand, will soon come before your committee for hearings. We are especially concerned that the amendments be passed that would remove the ceiling of $1 million on grants for graduate public health education under the Hill-Rhodes formula, section 314(c), Public Health Service Act, Public Law 86–720, and the ceiling of $2 millions on the Hill-Rhodes project grants for graduate public health training in schools of public health, nursing, and engineering, section 309, Public Health Service Act, Public Law 86–720.

There is little doubt but that the Hill-Rhodes formula funds, in particular, have been of very real help to schools of public health in assisting them to train more public health workers, and in helping them meet, in part, some of the annual deficit incurred in so doing. The need for expanison of the training facilities was clearly demonstrated by the National Conference on Public Health Training in 1956. This need is being met by increasing the number of schools and by enlarging existing schools. The present ceiling, were it to remain fixed, means that more schools will share the same amount of money, and this is in itself a step backward and not forward, and hence a return to the state of affairs that prevailed prior to the passage of the Hill-Rhodes act.

From our own standpoint, the division of graduate public health at Tulane is a small school in a private endowed university. It is, however, the only school providing training in public health at the graduate level in the South. And its problems are those one might exepect in a small school. We consider that we are able to provide a sound training in the basic science aspects of public health, biostatistics, epidemiology, microbiology, parasitology, and public health administration. What we need, above all, is to increase our capabilities in the fields

of maternal and child health, public health nursing, and mental hygiene. The university is doing what it can to meet these needs, but we must look to the Federal Government for assistance. Therefore, I would seek most earnestly that you will support these amendments and would assure you of our intention of making the fullest use of such financial support that may become available in the future.

I am, sir,

Yours sincerely,

J. C. S. PATERSON, M.D., M.R.C.P.,
Director, Division of Graduate Public Health.

STATEMENT OF AMERICAN NURSING HOME ASSOCIATION, WASHINGTON, D.C., BY ALFRED S. ERCOLANO, EXECUTIVE DIRECTOR

The American Nursing Home Association which represents approximately 4,000 licensed nursing homes in the United States, strongly recommends the adoption of this legislation.

There is a tremendous need for programs which will help the individual States to improve and expand the services which they can offer community health facilities. Many of the nursing homes in the United States do not have the financial resources that would be necessary to employ full-time, trained personnel and, therefore, must either not offer a service to the aged patient or must offer service on a limited basis. However, with the assistance of trained consultants operating under the direction of the State health department or other reponsible agency, many of these services could be offered.

SENIOR CITIZENS OF AMERICA,
Washington, D.C., May 12, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I am writing on behalf of H.R. 4998—a bill designed to improve community health services—and would appreciate having this letter made a part of the record of the hearing.

The situation which concerns our elderly citizens is developing rapidly and there is urgent need for coordination and experiment in the various communities to the end that the best results may be had with the least expenditure of money.

We favor provision of health insurance for persons over 65 under the OASI system. But whatever provision may be made for insurance, the need for coordinated community services in the health field will remain urgent for years to come. H.R. 4998 will be a long step toward providing this coordination and professional leadership.

Sincerely,

JOY ELMER MORGAN, *President.*

[Senior Citizens News, No. 5]

SENIOR CITIZENS MONTH, 1961

The fifth nationwide Senior Citizens Month, May 1961, will be observed under the sponsorship of Senior Citizens of America and supporting organizations. This observance is built on the experiences of the past 4 years when 47 State Governors, the Commissioners of the District of Columbia, Puerto Rico, and mayors of various cities issued proclamations designating May as Senior Citizens Month. The month acts as a stimulus for year round activities and as a forum for the exchange of information. A flexible plan is desirable in order to afford opportunities for the programs that best fit a month or any shorter period of time during May.

The general purpose of Senior Citizens Month is to focus attention on the increase in life expectancy and the obligation of society to include older people in the social, economic, and spiritual life of the community. Among specific purposes to be emphasized are:

1. To make effective use of the talents, education, and wisdom of older citizens in ways that contribute to the common good.

2. To discourage procedures that tend to segregate older people into unnatural or distasteful groupings.

3. To emphasize the importance of beginning early in life to prepare for successful living in later years.

4. To point out that life is an entity that cannot consistently be departmentalized into isolated sections, for there is a common pattern running through all the years of man.

5. To know that active, intelligent, patriotic older people want to be on the team of progress that advances the interests of their country.

6. To teach youth to recognize and honor the inherent courage, gallantry, and pride of elder citizens.

7. To locate and aid the "lost people" of the older generation who may be poorly housed, undernourished, ill and lonely.

8. To be aware of unethical leaders who for selfish purposes would exploit the poverty, insecurity, and desire of older people to better their situation.

9. To spread information about services available in such fields as employment, medical care, hospitalization, recreation, housing, and social security.

10. To encourage all agencies and groups who work for the welfare of senior citizens to unite in a program of mutual helpfulness and an exchange of ideas that will be important to all.

Each State and community will work out its own program. Some suggestions are: Establish a committee representing all agencies in the community that deal with older people. Obtain a proclamation from the Governor for Senior Citizens Month. Build programs that deal with current issues around this proclamation. Publish news and special features in local papers. Provide for radio and TV programs featuring the activities of Senior Citizens Clubs and other organizations.

Suggestions for the observance of senior citizens month and background material will appear in Senior Citizens magazine. Persons wishing further information may write to Miss Anna Leahy, director of Senior Citizens Month, 1129 Vermont Avenue NW., Washington, D.C.

THE AMERICAN OPTOMETRIC ASSOCIATION, INC.,
Washington, D.C., May 9, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: It has come to my attention that the Surgeon General, of the Public Health Service, has assured the committee that the utilization of optometrists "is not precluded by either the existing or the proposed legislation."

The fact remains that any law passed by Congress, which does not expressly provide for the utilization of the services of optometrists, is administered so as to exclude them.

This was true with the social security law up until 1950 when Congress, by the amendments passed that year, expressly provided that services of optometrists should be made available to those beneficiaries of the aid to the blind program who desired to utilize them.

Notwithstanding the contribution which the optometric profession made to the 1960 White House Conference on Children and Youth, the 1961 White House Conference on Aging, and the fact that there are 10 institutions of higher learning awarding postgraduate optometric degrees, the Department of Health, Education, and Welfare has not seen fit to appoint a single optometric consultant, nor to commission an optometrist in the Public Health Service.

When Congress established the Department of Medicine and Surgery in the Veterans' Administration following World War II, the language there was broad enough to permit the utilization of optometrists both in the veterans' facilities and on an outpatient basis; but it was not until 1960, when Congress passed Public Law 86–598, that the Veterans' Administration made available to veterans entitled to outpatient vision care the services of optometrists. Congressman Teague of Texas, who introduced the bill, can tell you something of the difficulties which were encountered. I might add we are still having difficulty in connection with the administration of this new law.

Under these circumstances, I trust that you and the other members of the committee will see your way clear to either put into H.R. 4998 some express

provision to the effect that the services of optometrists shall be made available, to those desiring to utilize them, in all Federal financed health programs, or strike out the word "medical" and explain in the report that the action was taken in order to avoid an interpretation which would bar the utilization of optometric services.

Respectfully yours,

WILLIAM P. MACCRACKEN, Jr.

AMERICAN DENTAL ASSOCIATION,
Washington, D.C., May 5, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. HARRIS: On behalf of the American Dental Association, I should like to take this opportunity to submit the following brief comments on H.R. 4998, which is now pending before your committee.

This association is interested primarily in those sections of the bill which would (1) amend section 314 of the Public Health Services Act to remove the ceiling on the authorization of appropriations and authorize earmarking of part of the appropriations for particular activities and (2) authorize the Surgeon General to make grants to public or other nonprofit organizations for studies, experiments, and demonstration projects designed to develop new or improved methods or providing health services outside the hospital, particularly for chronically ill or aged persons.

The American Dental Association recognizes the special problems of chronically ill, aged, handicapped children and other institutionalized or homebound persons and believes that insufficient consideration has been given to identifying specific needs of persons in these categories and to assessing the adequacy of personnel, facilities, and resources to meet their needs. This is particularly true in the case of dental health care.

While preliminary studies have given some indication of the particular needs of the chronically ill and aged, considerable additional investigation is needed. At the present time, it is estimated roughly that at least one-third of the chronically ill and aged are in need of immediate dental care. Most, if not all persons in this category have special problems making treatment complex and uncertain.

In many cases portable dental equipment and specialized treatment technics are essential. Unlike conventional dental care, treatment must be brought to the patients at the places where they reside, in their homes, in hospitals, nursing homes, and other institutions. The cost of such care is difficult to estimate, and there is a lack of the coordinated programing at the community level which is needed to train personnel and make special facilities available.

Of equal seriousness with the dental care problem of the aged and chronically ill are the problems of providing dental services for handicapped children. While it is estimated that there are nearly 15 million children in the country today who are suffering from physical or mental disability, not enough is being done for their dental problems on an organized basis.

Despite the fact that there are now available advanced technics making it possible to provide dental care to afflicted children, slow progress is being made in transferring such technics into practical utilization.

The association believes there is much basic work to be done in meeting the dental care problems of unfortunate people who by infirmity of age, crippling disease, or congenital malformity must be confined to their homes or to institutions. It is believed further that these problems can best be solved at the community level.

In concept, therefore, the community approach envisioned in H.R. 4998 is consistent with American Dental Association policy.

It is believed, however, that in the dental area, the special nature of the problems and the urgent need for establishment of basic program support requires specific legislative action. It is for this reason that the American Dental Association is in complete support of H.R. 4742, which also is pending before this committee. H.R. 4742 would amend section 314 of the Public Health Service Act to provide earmarked appropriations and to authorize project grants specifically for State and community public dental health programs and would go far toward alleviating many of the serious deficiencies now existing in these areas.

Without expressing a view on or detracting from the need for strengthening programs in other fields of health as might be accomplished under H.R. 4998,

the American Dental Association respectfully commends the attention of the committee to the critical need for establishment of a program of assistance to State and community public dental health activities as provided in H.R. 4742.

The American Dental Association appreciates this opportunity to present its views on this important subject and requests that this letter be included in the record of your hearings.

Sincerely yours,

MATHEW BESDINE, D.D.S.,
Chairman, Council on Legislation.

AMERICAN PUBLIC WELFARE ASSOCIATION,
Washington, D.C., May 10, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I should like to express the support of the American Public Welfare Association for the principles embodied in the proposed Community Health Services and Facilities Act of 1961, H.R. 4998, which is now before your committee.

As the national membership organization representing the field of public welfare, the American Public Welfare Association develops positions and recommendations on a variety of subjects designed to meet the recognized social welfare needs of our Nation. Among these is a statement of "Federal Legislative Objectives" which is revised each year by our board of directors in line with changing needs and the achievements of Congress. While our primary interests and competences are concerned with the improvement of public welfare programs, we fully recognize that the attainment of our objectives is dependent also upon the effective and complementary functioning of related services such as those which would be affected by the measure now being considered.

Our "Federal Legislative Objectives for 1961" recognizes the importance of adequate support for those services in the following points:

Preamble, section C: "The benefits of modern medical science should be available to all, and to the extent that individuals cannot secure them for themselves, governmental or other social measures should assure their availability."

Objective No. 10: "Specific provision should be made for Federal financial assistance to States to stimulate and support services and facilities to promote the health and welfare of the aged, irrespective of financial need."

Objective No. 36: "The Federal Government should provide leadership, funds, and research for the promotion of health and the prevention of sickness and disability contributing to dependency. Federal health programs should establish guides to encourage and enable State and local health departments to make a more effective contribution to broad programs of physical restoration * * *."

Public welfare agencies throughout the country are responsible not only for extending assistance to people in need but also in the prevention of dependency, in social rehabilitation, and in the restoration of as many persons as possible to support and care for themselves. Special efforts by public welfare agencies are being directed along these lines in behalf of our older citizens, persons who are disabled, and children and youth whose well-being is impaired or threatened.

The attainment of these purposes involves such measures as improved methods and techniques for the maintenance of adequate community health facilities for the aged and chronically ill, nursing homes of good standards which are available in sufficient numbers, and other services such as homemaker and home nursing services.

I am, therefore, pleased, Mr. Chairman, to state that the provisions of the community health services and facilities bill are generally consistent with the objectives of our association and would, in our opinion, promote and safeguard the well-being of individuals and families who are urgently in need of these services.

Sincerely,

HAROLD HAGEN, *Washington Representative.*

YALE UNIVERSITY SCHOOL OF MEDICINE,
DEPARTMENT OF EPIDEMIOLOGY AND PUBLIC HEALTH,
New Haven, Conn., April 27, 1961.

Hon. OREN HARRIS,
House of Representatives, Washington, D.C.

MY DEAR MR. HARRIS: I am informed by Dr. Hugh R. Leavell, chairman of the Association of Schools of Public Health, that the full House Commerce Committee hearing on H.R. 4998 takes place on May 4. On behalf of Yale University School of Public Health I wish strongly to endorse this legislation and earnestly to solicit your support of the Community Health Services and Facilities Act of 1961. This act would be a major step forward toward meeting many of the problems of community health services. However its impact would be greatly increased at relatively small cost by two amendments. The first would be to remove the present ceiling of $1 million annually on grants for comprehensive professional training in accredited schools of public health under the Hill-Rhodes formula (Public Law 86–720) which gives primary consideration to the training of federally sponsored students. This formula has proved one of the most effective forms of assistance to public health training, training which alone can provide the personnel now in critically short supply which is needed to carry out effectively programs already established by Congress or proposed in S. 1071 and H.R. 4998 and other pending legislation. However the effect of the Hill-Rhodes formula is limited by the recent addition to the number of accredited schools, so that less is available for each school, and by the fact that, in effect, the schools are subsidizing the training of federally sponsored students to the extent of more than $2 million annually. In 1959–60 for example the total cost of teaching federally sponsored students amounted to over $3.8 million whereas tuition and Hill-Rhodes funds amounted to only about $1½ million leaving a deficit of over $2 million which was borne by the schools. It is therefore urged that the act be amended to remove the present ceiling of $1 million of the Hill-Rhodes formula. I would add that this was recommended by the National Conference on Public Health Training in 1958. Secondly it is urged that the present ceiling of $2 million annually on project grants for postbaccalaureate public health training schools of public health, nursing, and engineering should be removed. Pending applications from the 12 public health schools in 10 States and Puerto Rico, the 21 nursing schools in 10 States and the 38 engineering schools in 25 States justify an increase in this authorization.

May I respectfully request that this letter be included in the hearing records.

Sincerely yours,

A. M.-M. PAYNE, M.D., M.R.C.P.,
Chairman.

CHICAGO, ILL., *May 17, 1961.*

Re House Bill 4998.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.:

The national society understands testimony of Senate bill 1071 and House bill 4998 is closed. We are sorry we were unable to testify and wish to be recorded as favoring this legislation since we believe through the provisions of the bill many aged and chronically ill citizens could have been provided with needed rehabilitation services.

JOSEPH J. FOSS,
President, National Society for Crippled Children and Adults.

GROUP HEALTH ASSOCIATION OF AMERICA, INC.,
Chicago, Ill., May 19, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: A few days ago I write you a general letter enclosing a copy of Resolution No. 3 which was unanimously adopted at the annual meeting of our organization on May 10. I enclose herewith another copy of that same resolution.

This letter is written for the purpose of expressing specifically our support for the community health services and facilities bill, H.R. 4998.

The president of our organization, Dr. Caldwell B. Esselstyn, has testified before the Committee on Interstate and Foreign Commerce in support of this legislation. The Group Health Association of America is deeply concerned that this legislation become law at the earliest possible time because we are convinced that it would have the effect of filling to a degree at least the gap which now exists between full hospital care on the one hand and lack of care on the other. The bill, we are convinced, would bring about important use of out of hospital health services particularly for the chonically disabled and the aged. It would bring about improved home care programs and lead to reduction of the length of hospitalization for many people as well as to improve the chances for their restoration to full health. These are areas of health care in which our organization has a deep interest, committed as it is to the improved health standards of all of the American people.

We appreciate deeply your leadership in this matter and we hope our letter can be included in the records of htis committee and if possible, in the published hearings.

Sincerely yours,

JERRY VOORHIS,
Executive Secretary.

RESOLUTION NO. 3

Whereas to make the benefits of modern medicine available to all Americans requires, in addition to better arrangements in the financing of health care, a substantial increase in the number of professional health personnel, and a significant expansion of community health facilities and services; and

Whereas Federal action is urgently required to bring about these critically needed improvements, since:

(1) Existing sources of financial support cannot meet the costs of a construction, expansion, and scholarship program adequate to the Nation's need for more physicians and other health personnel; and

(2) Local communities need Federal financial aid to develop better services for the aged and chronically ill, such as organized home care, and other services not now widely available; and

(3) The improvement of the abysmal state of currently available nursing home care requires an increase in the funds available through the Hill-Burton program for the construction of high quality nonprofit nursing homes; and

(4) The combination of comprehensive prepayment with the group practice of medicine holds great promise for making high quality care more readily available, but the difficulty of financing needed facilities has been a major obstacle in the further development and expansion of such plans; and

Whereas legislation has been introduced in the Congress of the United States to provide for effective Federal action toward these ends: Therefore be it

Resolved, That the Group Health Association of America convey to the members of the Senate Committee on Labor and Public Welfare, and the House Committee on Interstate and Foreign Commerce, and other Members of Congress the

unanimous belief of its members and affiliates that favorable action is urgently required this year on the following three legislative proposals:

(1) S. 1072 and H.R. 4999, Health Professions Educational Assistance Act, to provide grants to medical and dental schools for construction, expansion, cost of education and for scholarships to gifted students in health professions who are in need of Federal assistance; and

(2) S. 1071 and H.R. 4998, the Community Health Services and Facilities Act, to provide funds for the construction of nursing homes; grants to State and local governments, and voluntary agencies and institutions to stimulate the development, improvement, and expansion of health services, particularly for the aged and chronically ill; and to provide funds for research and demonstration in the utilization and provision of hospital services; and

(3) S. 1158 and H.R. 5887, the Health Services Facilities Act, to provide long-term, low-interest loans to comprehensive medical care plans for financing of necessary facilities.

Unanimously adopted at the annual meeting of Group Health Association of America in Portland, Oreg., on May 10, 1961.

(Whereupon, at 12:15 p.m., the committee adjourned.)

APPENDIXES

Appendix A

(Letter from Chairman Harris to Governors of States and replies thereto.)

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., May 10, 1961.

Hon. ——— ———,
Governor of ———.

DEAR GOVERNOR: The Interstate and Foreign Commerce Committee has before it for action a bill, H.R. 4998, to assist the States and local communities in making available more and better community health services and facilities, particularly for the aged and the chronically ill. The programs proposed in the bill would be conducted by States and local communities, and they would be financed with funds made available for such purposes by States, local communities, and the Federal Government, on a matching basis under the same cooperative arrangements as now exists with respect to the public health programs.

In order to assist families and physicians in the care of patients with long-term illnesses, States and local communities would develop and operate home nursing programs and other types of home care health activities such as homemaker services and physical and occupational therapy services.

Witnesses appearing before the committee have testified that if more such home health services were available in communities, it would be possible for many patients now in hospitals to be cared for better and more economically in their homes. We have also heard testimony that such services should be available not only to the indigent but also to patients who can afford to pay for such services, with provision being made in accordance with State and local laws and practice for full or partial payment for such services by those patients who can afford to do so.

The bill would also double available Federal funds under the Hill-Burton program to assist communities on a matching basis to construct public and private nonprofit skilled nursing homes. The committee has been told that there is a nationwide shortage of over 500,000 skilled nursing home and chronic disease beds at the present time, and that many of the existing homes are not now able to provide the scope and quality of health care necessary to insure maximum early recovery and rehabilitation of patients.

The bill also contains provisions for Federal demonstration and research grants for the purpose of developing and testing new and better methods of organizing and providing community health services outside the hospital, particularly for the aged and the chronically ill.

Another provision of the bill would increase the amount of Federal funds available for research directed at improving the quality, efficiency, and economy of hospital operations throughout the Nation.

In order to enable the committee to reach informed decisions on this bill, we would like to have your views on the proposed legislation in relation to the needs of your State. Specifically, we would appreciate having information on the following questions:

(1) Is there a need, and what is the magnitude of the need, in your State for more community home health services, for the construction of more skilled nursing homes, and for improving the quality of existing nursing homes?

(2) Do you consider that additional Federal financial assistance to your State and its communities would help stimulate programs designed to meet these needs?

(3) If this bill is enacted, how would your State utilize available Federal funds and would State and local funds be made available to establish and expand community health services and facilities?

I would appreciate your early response on these points in order to enable the committee to take prompt action on this bill, copy of which I am enclosing for your information.

With my expression of esteem, I am,

Sincerely yours,

OREN HARRIS, *Chairman.*

STATE OF ALABAMA,
GOVERNOR'S OFFICE,
Montgomery, May 22, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: H.R. 4998 is a bill that, if enacted, could have a profound effect on the health status of the people of this Nation. Insofar as Alabama is concerned, I believe the need is great and that the approach of this legislation is sound. There are many people who would be benefited materially if homemaker services were available. Likewise, there is need for public nursing homes.

You ask three specific questions which I would answer as follows:

(1) This embraces really three phases: (*a*) Community home health services: With the exception of a visiting nurse association in three areas no organized home nursing service is available. Spasmodic attempts are made, using all available personnel to answer individual needs, but this is not beginning to answer the need. (*b*) Skilled nursing homes: Based on a ratio of three nursing home beds per 1,000 population Alabama should have 9,729 skilled nursing home beds. Actually there are 1,163 acceptable beds now in existence—a shortage of 8,416 beds in this category. (*c*) Quality of existing nursing homes: Of the acceptable beds there are 145 that should be replaced. They are classed as acceptable only because of the overwhelming need. The State health department estimates that it would take $70 million to build the facilities needed and to improve the existing beds.

(2) Additional Federal funds would definitely stimulate programs. For nursing homes alone the health department has on file 19 applications embracing 480 beds and with an estimated cost of $4,671,000. Many others would be interested if funds might be available to supplement local efforts.

(3) The nursing home construction program would immediately be accelerated. Thirty-seven of the sixty-seven counties in the State have some form of taxation earmarked for hospitals and related facilities, and others have funds available to them. The establishment of home nursing services is a dream of the health department which present inadequate nurses cannot implement. Availability of Federal funds would be the stimulus needed.

I appreciate the opportunity of reviewing H.R. 4998 and of expressing my viewpoint.

Very sincerely,

JOHN PATTERSON, *Governor.*

OFFICE OF THE GOVERNOR,
STATE HOUSE,
Phoenix, Ariz., June 9, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

MY DEAR MR. CHAIRMAN: Your good letter of recent date, regarding H.R. 4998, a bill introduced by yourself and now before your committee, is gratefully acknowledged.

This matter has been discussed with the commissioner of the Arizona State Department of Health, who has jurisdiction over the nursing homes in this State.

Dr. C. G. Salsbury, the commissioner, has stated the State department of health has adopted a ratio of one nursing home bed per 1,000 population. The

1961 nonmilitary population of 1,283,000 indicates a need for 1,283 beds with continuous skilled nursing care. At present, there are 11 nursing homes with 518 beds giving this type of care.

Dr. Salsbury further informs me that at present there are requests totaling approximately $600,000 for two additional nursing homes—one in Phoenix and one in Tucson.

Several other organizations have also inquired about the possibility of securing Federal funds.

The last annual allocation for nursing homes was $86,193.

It is hoped this information will prove of assistance to you in your consideration of this measure.

Sincerely,

PAUL FANNIN.

STATE OF ARKANSAS,
OFFICE OF THE GOVERNOR,
Little Rock, May 15, 1961.

Congressman OREN HARRIS,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: In reply to your letter of May 10 about H.R. 4998:

1. There is a considerable need for more community home health services in the State, especially in the field of nursing homes. The old people—and we have more of them than ever before—are not taken care of in the home of relatives as they once were. There must be an expansion of nursing home facilities to provide for their care or else the individual grants must be expanded in order that they may pay for their own care.

2. It is my opinion that additional Federal financial assistance to Arkansas and other States to assist in this field would be a much wiser use of our Federal tax money than some uses to which it is now being put, especially in the field of foreign aid.

3. If this bill is enacted, I am of the opinion that our State would utilize available Federal funds to provide for better care of the aged people in this State.

Most sincerely,

ORVAL E. FAUBUS, *Governor.*

STATE OF CALIFORNIA,
GOVERNOR'S OFFICE,
Sacramento, June 9, 1961.

Hon. OREN HARRIS,
House of Representatives, House Office Building,
Washington, D.C.

MY DEAR CONGRESSMAN: I am pleased to have this opportunity to comment on H.R. 4998, Community Health Services and Facilities Act of 1961, which currently is being considered by the committee which you chair, Interstate and Foreign Commerce.

For reasons outlined below, I think the bill is extremely sound and would materially assist this State in coping with significant social problems.

There is urgent need in my State for the improvement of present nursing home services and for the construction of new nursing homes. The California State plan for the construction of hospitals and nursing homes in 1961–62 shows an additional nursing-home-bed need of 10,023. Existing beds number 45,339 with total long-term-care-bed need estimated at 55,362.

The California State Department of Public Health licenses approximately 700 nursing homes with more than 17,000 beds. Approximately 30 percent of the total beds are in nursing homes of 25 beds or less, and 8 percent of the total beds are in homes of 10 beds or less.

There is need for the development and coordination of all health facilities to provide comprehensive health services to meet ever-growing community demands. We are quite anxious to secure expansion of existing nursing homes and the replacement of many small units.

Additional Federal financial assistance would, I believe, encourage local communities to provide more adequate facilities and promote coordination between general hospitals and specialized long-term care facilities. Improvement in quality of care would be enhanced through the development of facilities that can provide services for rehabilitation, outpatient, home care, and similar programs.

Although an impressive amount of good, solid demonstration work has been

done with the modest Federal funds ($300,000 annually) presently available, much broader and more comprehensive development of many public health programs would be undertaken if additional funds are made available.

California is deeply interested in developing new patterns of community health services. With the additional Federal financial assistance H.R. 4998 would provide, the State department of public health would be able to extend its present system of aiding community projects to establish new and better ways of caring for patients with chronic illness.

These funds also would enable California to step up its demonstration programs of early disease detection, medical rehabilitation, and home care, including visiting nurse type of service.

And, finally, the provision of the bill which removes the ceiling on hospital administrative research grants to include other medical facilities would be extremely beneficial to my State in its endeavor to provide and encourage broader community health service facilities.

Sincerely,

EDMUND G. BROWN, *Governor.*

STATE OF CONNECTICUT,
EXECUTIVE CHAMBERS,
Hartford, May 17, 1961.

Hon. OREN HARRIS,
House of Representatives, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: Thank you for the opportunity to comment on H.R. 4998 now pending before your committee.

Connecticut is interested in improving home care and nursing home programs, and is prepared to take advantage of the assistance offered in the bill under consideration.

My budget for the 1961–63 biennium, now pending before the Connecticut General Assembly, recommends funds to enable the State health department to expand community health services and facilities.

The department has prepared a plan to utilize the additional $49,000 in Federal grants for community services which the adoption of H.R. 4998 would make available in Connecticut. These funds would be used to train personnel in home care programs, to hold statewide consultation on the improvement of community home care programs, to gather information and evaluate results of existing home care programs and to provide grants-in-aid for the establishment and improvement of local home care services. Such grants would be made to visiting nurse associations, local health departments and other organizations, and would be used also for the operation of community health information and referral centers to aid patients in obtaining health services.

I hope the foregoing will be helpful to your committee in its consideration of H.R. 4998.

Sincerely,

JOHN DEMPSEY, *Governor.*

STATE OF DELAWARE,
EXECUTIVE DEPARTMENT,
Dover, June 1, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRISS This is in reply to your letter concerning H.R. 4998, which is before the Interstate and Foreign Commerce Committee for action. As far as Delaware is concerned the possibilities for better community health services and facilities, particularly for the aged and the chronically ill, have not been fully explored.

Over the past several years this State has maintained a program of hospital inpatient care for the aged in a State institution. No provisions are made for outpatient services except in outpatient clinics in the general hospitals of the city of Wilmington. A study of inpatient care in all general hospitals for the calendar year 1959 indicated that of all patients 65 years of age and older admitted, 16 percent were unable to pay hospitalization costs. Community health services, including outpatient service, to meet the needs of the aged and chronically ill would be especially valuable. Community health services of all is especially urgent.

The three questions contained on the last page of your letter are answered from the point of view of the advisory committee of the division of the aged of this State.

1. There is a need for community home health services and for provision for more adequate nursing homes, and also the improvement of the quality of existing ones. The magnitude of this need has not been measured.

2. Additional Federal assistance to this State should help stimulate—

(*a*) Studies of wheat is needed.

(*b*) Programs to meet these needs.

3. Whether Delaware could utilize available Federal funds in the 1961 fiscal year is questionable. The financial condition of the State is such that further new services are unlikely to be favorably considered.

To the best of my knowledge there has been no attempt on the part of any group, including the aged, to expand beyond the study phase any of the health services provided for in your bill.

Cordially yours,

F. EARL MCGINNES,
Administrative Assistant.

STATE OF FLORIDA,
OFFICE OF THE GOVERNOR,
Tallahassee, June 2, 1961.

Re H.R. 4998.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: I appreciate very much your letter of May 10, 1961, together with a copy of H.R. 4998. Members of my staff have studied this proposed legislation in relation to our State health needs, discussed it with our State health department and have advised me concerning the need for it, and its effect and impact upon our people. Careful consideration has been given to our need for more community health services, to ways and means of stimulating these services, and to our ability at this time to use additional Federal funds if available.

Florida's public health programs, including every one of the 67 health departments, have given major attention to the old-line activities of preventable diseases, epidemic diseases, sanitation, and maternal and child health services. Our health authorities are now expected to interest themselves in the health problems of the aged, in the various chronic disease problems and in the effective use and application of the knowledge and findings of public health research.

Hospital facilities, the construction of which has been stimulated by the Hill-Burton Act, contribute greatly in providing for intensive, short-term care for the acutely ill. We believe, however, that many hospital patients could be, and ought to be, cared for in a nursing home, and, also, many need only care at home with added services that are provided by a home-nursing service. It is believed that a substantial number of those in nursing homes could be cared for at home if conditions were favorable. Florida's county health departments, in cooperation with the State board of health are working diligently toward upgrading the standards of existing nursing homes. They are trying to assure that all proposed conversion of existing structures, as well as new construction, are planned to meet optimum, rather than minimum standards for licensure. They place particular emphasis upon fire protection, safe building construction, sanitation, and good nursing care. At present over 9,000 licensed nursing home beds exist in the State. There is a need for double this number and, equally important, a need for greater skilled services in nursing homes.

While hospital and nursing homes are needed for those with chronic illnesses and disabilities of the aged, there is also need for assistance to be directed toward making it possible for suitable continuing care to be provided in the familiar environment of the home. Some nursing service at present is provided in the home as an established part of every county health department, but it is very inadequate with respect to bedside nursing care. The approximately 550 public health nurses employed devote a major portion of their time to the needs of mothers and children and services related to control of communicable diseases. One of the additional community health service needs of foremost importance is to extend such services to include bedside nursing care as needed by the ill and disabled at home. Substantial additions to local nursing staffs

will be necessary if home nursing needs are to be satisfied and particularly in rural and less populous areas.

I believe that without question, Federal assistance to Florida would stimulate programs designed to meet the key provisions of H.R. 4998. Our past experience in the use of Federal grants for construction of hospitals and health centers, for the promotion and development of local health services, venereal disease control, heart disease control, cancer diagnosis and detection, water pollution, maternal and child health programs, and others illustrate the stimulation that could be expected.

If this legislation passes, I am sure that our State board of health will develop a plan for using the additional Federal funds to provide better care to our thousands of aged and chronically ill citizens. Even now, our State has recognized these needs and has systematically proceeded with a plan to develop, as part of its regular State and local public health services, programs to better care for this segment of our population. Greater State and local funds have continually been used for these types of services to the limit of our resources; and there would be no difficulty in matching Federal funds. At the present time Federal funds constitute less than 10 percent of our health departments' (State and local) budgets. This figure not only indicates our ability to match, but the minimum nature of Federal participation in the present program.

I share with you and your committee the desire to properly assess the needs for greater community health services and provide these together to the best of our ability. I hope that this bill will be endorsed by Congress and the purposes of this legislation activated by appropriate Federal funds.

Sincerely,

FARRIS BRYANT, *Governor.*

STATE OF GEORGIA,
EXECUTIVE DEPARTMENT,
Atlanta, May 12, 1961.

Hon. OREN HARRIS,
Congress of the United States,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: Thank you for your letter of May 10 concerning H.R. 4998 now pending before your distinguished committee.

I am today referring your letter to the Honorable John H. Venable, director of the department of public health, for his information and further reply.

With kindest personal regards, I am,

Sincerely,

S. ERNEST VANDIVER, *Governor.*

STATE OF HAWAII,
EXECUTIVE CHAMBERS,
Honolulu, May 16, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: This is to acknowledge receipt of your letter of May 10, 1961, requesting the views of the State of Hawaii on H.R. 4998, which would assist States and local communities in making available more and better health services and facilities, particularly for the aged and chronically ill.

Both I and Dr. Richard K. C. Lee, State director of health, have gone on record in favor of this measure. However, in order to provide specific answers to the questions raised in your letter, I am referring your letter to the State department of health for followup action.

As soon as I receive the department's report on this matter, I will write you further concerning our views on this proposal and providing the information you have requested.

Sincerely,

WILLIAM F. QUINN,
Governor of Hawaii.

STATE OF HAWAII,
EXECUTIVE CHAMBERS,
Honolulu, May 22, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, House Office Building, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: This is in further response to your letter of May 10, 1961, relating to H.R. 4998. I referred your letter to the State department of health, and have now received the department's analysis of and report on this measure. I am enclosing a copy of this report for your information and use.

In reply to the three specific questions raised in your letter, I wish to provide the following information and comments:

1. There is a very real need in Hawaii to expand and improve community home health services and nursing homes. The magnitude of this problem has not yet been fully determined, but the department of health has been surveying the situation here for the past several months and finds a very great need for improvement in this field. I am enclosing herewith a report of May 8, 1961, on this subject by Dr. Sumner Price, chief of the hospitals and medical facilities branch, entitled "Nursing and Care Home Situation in Hawaii, 1961."

2. It is our belief that additional Federal financial assistance would help to stimulate programs designed to meet the needs for nursing homes and community home health services. Hawaii has greatly benefited from the Hill-Burton hospital construction program, to the point now that we can say that our needs in this field are rapidly being met and will soon be almost entirely taken care of. Undoubtedly, Federal funds for nursing homes and community home health services would have a similar effect in this field. However, inasmuch as we in the State government intend to move in this area anyway, the major effect would be to accelerate our efforts rather than to cause us to initiate something entirely new.

3. If H.R. 4998 is enacted into law, I am highly confident that matching funds would be made available to establish and expand community health services and facilities. Certainly we in the State administration would take all steps possible to insure maximum participation in such a vitally important health program, and I feel sure the legislature would do likewise.

In closing, I wish to thank you again for the opportunity you have provided the State of Hawaii to express its views on H.R. 4998. We fully support this measure, and believe it will provide the means for making a great advance in the field of public health in an area of very severe need. If we can be of further assistance to you on this matter, please let me know.

Sincerely,

WILLIAM F. QUINN,
Governor of Hawaii.

NURSING AND CARE HOME SITUATION IN HAWAII, 1961

Most of our senior citizens would be better left in their own homes, or in low-rent housing developments, or in apartments than in institutions unless incapacitation has developed and they have become dependent on others for assistance. Even then it is possible that development of a good public health or other visiting nurse program could often delay the need for institutionalization and produce a good care program. As long as congeniality exists in their home, institutionalization of the aged should be avoided unless there are obvious hazards to their health or welfare.

There is, however, a need for the development of good institutions for the long-term care of physically and mentally impaired adults regardless of age. Good nursing homes are scarce and even the best seldom offer a full range of services required by the needs of their patients. Staffing is frequently inadequate and, where adequate in number, the orientation is more like that of the tender loving care of the general hospital, which has a tendency to keep the patient in bed rather than encourage him to participate in an active social or rehabilitative program. Medical care including restorative services are frequently deficient, in part, because of poor planning and inadequate space for the development of a suitable activity program, and, in part, because of lack of leadership and a failure to recognize that attention to bodily comforts is not enough, that the soul needs nourishment too and should not be left entirely to the Bible, the devil, or entirely to self-development or deterioration.

This deficiency is not peculiar to Hawaii. For example, Kansas reports:

1. Many of the buildings are not structurally suitable.

2. Although most patients need it, 88 percent are not provided with skilled nursing care or supervision. Medical care is inadequate, especially for those unable to pay for a private physician, with 60 percent or more of the patients whose care is paid for by public assistance.

3. Patients are isolated in little groups with few recreational facilities, to say nothing of physical therapy or occupational therapy.

4. An organized system is needed for determining rehabilitation needs and potentials of patients prior to, on admission, or during their stay in nursing homes.

5. There is a shortage of nursing homes which provide good care at prices that can be paid by most older persons or their families.

6. If good care for the aged is to be provided it seems clear the public must see the need and provide support for more nonprofit homes, private and governmental, and these should be organized along regional lines and integrated with general and special hospitals and home care programs.

In other words, their final plea is for a progressive care program where hospitalization may be had for acute care with transfer to nursing home, care home, or own home facility as the need might indicate.

In Missouri the situation may be summarized as identical with that of Kansas.

In Michigan "the typical facility is not regarded as the place to provide post-hospital convalescent care or continuous nursing care when a patient can be discharged from a general hopsital." With exceptions the same may be said for Hawaii, and probably the Nation as a whole, in spite of President Kennedy's proposed program of 180 days of aftercare in a nursing home for the aged under the social security program. The country as a whole is not ready for such a program, although it is evident that either the program or some modification of it will be adopted in the near future with few of the required tools available to implement it. Social planning and legislative action in this case will be way ahead of community progress.

For the great majority of these patients, who will be assigned to nursing or care homes, it will be their permanent home as well as a care-providing facility. Yet, most of the facilities presently available lack arrangements for patient mobility, privacy, and social activities. As a generalization, and for Hawaii, the larger the institution the less progressive the program, due in part perhaps to improperly oriented management. The smaller homes and institutions, where there is more personal touch, are presently doing a better job than the larger facilities and in some instances at less cost in dollars. There is no special attribute attached to a large facility unless there is leadership in management. Overinstitutionalization can be a very impersonal and horrible thing in the area of patient care.

The Hospitals and Medical Facilities Branch of the Department of Health is presently the agency delegated the responsibility for licensing hospitals, nursing homes, and care homes for the aged, infirm, disabled, mentally ill, and mentally retarded.

The program of licensing of nursing and care home facilities includes not only inspection of the facility but patient care as well. Patient care and nutrition are more important than minor variations in facility structure, yet safety standards must be maintained and waivers or code variations should not be granted when they involve hazardous conditions to safety and health. Some latitude of discretion must be granted, however, where the hazards are not great, especially in the initial phases of licensing and in development of a new program where so many of the existing facilities are substandard.

Inspection of all facilities, annually, is made by the Hospitals and Medical Facilities Branch of the Department of Health. The team consists of representatives of—

(1) Hospitals and medical facilities.
(2) Public health nursing.
(3) Nutrition.
(4) Sanitation.
(5) Building department (C. & C. of Honolulu).
(6) Fire marshal.
(7) Department of Social Services.

Four of the seven agencies involved in the inspections lie within the Department of Health. With the exception of the regulations of the fire marshal, Building Department, and those of the Department of Social Services in placing

clients and payment for same, the health and care regulatory protection lies within the responsibility of the agencies of the Department of Health—which is as it should be.

During the legislative session, several accusations were made that the regulations sponsored by the hospitals and medical facilities branch were so strict and rigid that there was interference with the development of adequate nursing and care homes. There was a strong gesture during the early part of the legislative session to take the licensing of care homes away from the Department of Health and place this function elsewhere. As all of you probably know, the regulations sponsored by the hospitals and medical facilities branch are, for practical purposes, those of the various branches of the Department of Health, plus those of the fire marshal and the Building Department. Mere transference of the function of licensing to another agency would not make it possible to circumvent the regulations nor lessen the need for same. However, since the Department of Health is the agency responsible for setting up the regulations, inspection, and licensing, we must not administer these in an unreasonable fashion so as to bring undue criticism on the Department because of unreasonable rigidities. Such obstinacy could delay progress in the development of an acceptable program and make it difficult for the agency responsible for finding care homes. Firmness in objective, tempered with a little tolerance and understanding of the problems involved, could go far in hastening the accomplishment of our goals.

It is interesting to note that the nursing home and care situation on the various islands shows no uniformity, and there is little to indicate that uniformity is necessarily desirable. However, it is my impression the island of Kauai has probably accomplished more than any of the other islands, and Oahu has probably accomplished the least.

On Kauai, there are 18 homes with a census varying from 1 to a maximum of 12. Three of these could be subject to severe criticism insofar as patient care is concerned, and several others have deficiencies in other standards—either building or sanitation—which are in need of immediate attention. However, through proper coordination, the team is developing a system of care homes which is presently the best in the State.

Public health nurses were sent to the rehabilitation center on Oahu for a period of 2 weeks' orientation in rehabilitation techniques. As a result, through visits and through conferences they have established an overall program to where most of the bedridden patients are presently ambulatory or semiambulatory. Emphasis has been placed on having the patient clothed during the daytime and out of bed as much of the day as proves practical. Some of these small homes have attached pulleys to the limbs of trees and installed simple devices so that patients may exercise an arm or a leg, as the case may be. Others have installed parallel bars for walking exercises for the stroke cases; also vises to hold coconuts preparatory to sawing—combining physical therapy exercise and occupational therapy—in making coconut dishes or buttons. Others have used safety swings suspended from trees. These are the things even a small home can have with minimum of expense. The public health nurse has trained the administrator of the home in techniques and has made periodic visits to check on progress and need for revision of exercises. Television, radio, and victrola records are available in most of the homes and several are branching out into other activities such as gardening, animal care, and the like. Certainly, these homes are far superior to a large institution where there is no activity program at all, where overinstitutionalization has occurred and the end of the road has been reached, much as it has in many mainland old folks' homes.

On Maui, they have Hale Makua which is the old Malulani Hospital. As a facility, it is totally unacceptable, but when it comes to patient care the essentials and the standards are high. They have a good rehabilitation program underway although other activities in the social area are deficient.

Maui also has developing a chronic care unit for mental patients and another unit for general chronic care at Kula. Their program is young and incompletely developed. At the time of inspection, it seemed to be geared along lines for TB patients, or toward bed care and enforced rest. Advice was given that considerable reorientation of the program was indicated to meet modern standards of progress in care and total care for the aged or disabled. It is understood considerable progress has been made in reorienting the program.

The situation on Molokai and Lanai has not been explored.

On Hawaii, the Olaa Geriatrics Center is doing a reasonably good job in patient care but the facility needs to be replaced and it is understood that plans for replacement are developing. One care home has been inspected by members

of the Hospitals and Medical Facilities Branch, and several other homes apparently exist but have not been inspected. There is a strong move to reopen old Memorial Hospital as a care home under the name of Rainbow Falls Home. The facility is of questionable structure and some misgivings are held as to the necessity and desirability of its conversion, lest it become just another old folks' home. It seems, however, sufficient pressure has been brought upon the fire marshal to where he may grant a variance which may permit its conversion. The board should inquire as to their personal legal responsibility in case of fire or other disaster, as the result of their request for a variance, and make sure they are adequately covered by liability insurance.

On Oahu, the situation varies from good to tragic. We have some of the worst facilities imaginable, both from the viewpoint of patient care and facility and a few of the best available. Generally speaking, there is an enormous amount of lethargy and indifference as to inadequacy of some of the homes because—where else is there to go?

In another institution, the only food served at lunch was a dab of jelly between two slices of bread, and coffee. In still another, patients are routinely dressed in pajamas so that when transfer to another institution occurred, the patients were robbed of their pajamas and for practical purposes, they were delivered in their birthday suits as the sum total of their worldly possessions after variable but long periods of institutionalization.

These have been cited as examples of overinstitutionalization and be they private, county, or State organizations, they are to be deplored, and corrective steps must be taken. The problem is almost overwhelming because, where else can these patients go? Governmentally controlled or governmentally owned institutions require immediate attention. In some of these institutions, the property is owned by the State, but leased or loaned to supposed nonprofit organizations.

In some instances the rate of pay received is greater for bed care than for rehabilitative ambulatory care, so the patients are kept in bed.

There are 33 nursing and care institutions and homes on Oahu. At least five of these show marked deficiencies in patient care, seven have totally unacceptable facilities and none have a satisfactory activity program. Two are known to have unsatisfactory nutritional programs, and several others are questionable.

There is reason for great concern lest any more of these unsuitable facilities be created without adequate financing to do the kind of job which should be done. These aged, infirm, or disabled persons are entitled to protection from the State as to safety against fire and defects in sanitation, but even more important, they are entitled to adequate nursing care and medical attention, something in the way of social activities program, and an effort toward rehabilitation whenever it is practical. There is no hospital, nursing home, or care home in the State, at the moment, which has a totally acceptable program for chronic care. It is the goal of the Hospitals and Medical Facilities Branch to gradually develop an adequate care program for the future.

Just how will this be accomplished? The answer to that question is undetermined at the moment. It would seem the best way to approach this immediately might be to take a lesson from Kauai and (1) develop more acceptable small nursing care homes to get these people out of these large institutions until such time as satisfactory standards can be met and new construction be developed, (2) add to the Hospitals and Medical Facilities Branch a consultant in occupational therapy who will hold workshops on the various islands and communities to train these small care home administrators in diversional occupational and simple physical therapy rehabilitation techniques, (3) work in close affiliation with the Honolulu Rehabilitation Center in a pilot study of hospital and nursing home situations, (4) strive to obtain greater interest of the public health nurses in the nursing home and care home situation, (5) plan for development of a visiting nurse team for home care either with or without fee for service, (6) improve medical supervision, (7) strive to educate all the personnel involved that good patient care does not necessarily involve bed care, and (8) work with the Department of Social Services in developing more and better care homes. Finally, the objective should be to develop a good progressive care and activities program for all types of patients, regardless of their age. The object is to improve the immediate situation by replacement.

Whether or not the small care home is the final answer is debatable, and contrary to the mainland trend, but such a solution, even though temporary, seems to offer better promise than permitting larger institutions of questionable nature to develop. In such a program, some variances in some of the regulations may

have to be requested if they are not unduly hazardous. It should be easier to close a small care home at the appropriate time than to close a larger institution. The team workload will be increased, but it is hoped the net result will be a marked improvement in patient care throughout the State of Hawaii. One of the functions of the Hospitals and Medical Facilities Branch is to provide a segment of the leadership, assist in determining the goals, obtain coordination, and assist in implementation of a good program through regulation and certification to the public that minimum standards have been met.

To provide safe and decent housing is not enough. Our goal should be to insure a healthy, meaningful, and independent life for the aged, infirm, and disabled at the earliest practicable date.

SUMNER PRICE, M.D.,
Chief, Hospitals and Medical Facilities Branch.

DEPARTMENT OF HEALTH,
STATE OF HAWAII,
Honolulu, May 18, 1961.

To: Hon. WILLIAM F. QUINN, Governor of Hawaii.
From: RICHARD K. C. LEE, M.D., director of health.
Subject: Letter from Congress of United States, Committee on Interstate and Foreign Commerce, by Representative Oren Harris on H.R. 4998 or S. 1071.

Attached for your review is our proposed draft for your reply to Representative Oren Harris regarding H.R. 4998 or S. 1071.

The proposed Federal legislation pertains to community health services and facilities as follows:

1. Community health service grants to States which would provide additional grant-in-aid funds on a 50-percent matching basis to be used in extending and improving the quality, scope, and availability of community health services to the aged and chronically ill outside the hospital. Such services could be for the improvement of services and operations of nursing homes, technical and consultation assistance to nursing home operators, establishment and improvement of home health care services, establishment of community health and referral centers, and establishment of outpatient diagnostic services. Tentative annual allocation to Hawaii would be $26,100.

2. Special project grants would authorize appropriation of funds to public and nonprofit agencies to conduct studies, demonstrations, and experiments and development of new or improved methods of care outside the hospital, particularly for the chronically ill or aged. Grants are apparently total.

In contrast to No. 1, above, which are designed primarily to provide services, the project grants are designed primarily to develop know-how.

3. Nursing home construction grants would increase the appropriation for grants for the construction of nursing homes under the existing Hill-Burton program. Hawaii's allotment would be doubled, from $50,000 to $100,000, under this proposal. Matching funds for construction are supplied by the sponsor.

4. Hospital research grants: Present legislation provides up to a ceiling of $1,200,000 annual appropriation for this purpose. This proposed legislation would delete the ceiling and authorization would be made to include grants for the construction of experimental or demonstration hospitals or other medical facilities and for the acquisition of experimental or demonstration equipment for such. Federal participation limited to 66⅔ percent.

DISCUSSION

Proposed projects for consideration in Hawaii under (1) could be, but are not, limited to the following:

(*a*) Development of a home-care program in conjunction with general hospital outpatient departments. A skeleton program of educational nature already exists in these institutions, but they will always be limited in scope as long as tied to the limited number of students available and the need for close academic supervision required. However, by the addition of nursing staff to these existing departments, the coverage could be expanded and broadened to provide an overall chronic home-care program which would not only include licensed home-care units but individual home care. The hospital would provide medical supervision and the department of health administrative supervision and personnel.

(*b*) Well oldster clinics for maintenance of health could be developed through provision of nursing personnel for semiannual physical examination, and treat-

ment if necessary, in conjunction with existing outpatient services in hospitals.

(c) Development of an information center, probably in conjunction with one of the hospitals, or the department of health, to aid both patients and professional personnel in securing available health services.

(d) Add consultant personnel to the hospitals and medical facilities branch of the department of health for the purpose of conducting an educational and training program for the nursing home, care home, and boarding home in developing both a rehabilitation program and an adequate daily living activities program.

(e) Provide another psychiatrist (M.D. rehabilitation expert) who would be of service as consultant to all physicians of the State as well as hospitals and nursing homes.

(f) Assistance in training of staff to extend and improve the quality and scope of health services in this program.

Under (2), special project grants, if facilities were available—

(g) A day care center of activities for the aged could be developed on an educational, activity, and diversional therapy basis. Any such project might have a research component developed as to those techniques most suitable for home care and nursing care programs.

(h) Development of a halfway house for alcoholics with an activity program is needed in the community.

(i) Development of both day and/or night care center for followup of psychiatric patients for part-time care could be considered.

To expedite matters, may we request that three copies of your final reply to Representative Harris be forwarded us so that we may submit copies to Dr. Ray Kaiser, chief, chronic disease program, regional office of the Public Health Service.

RICHARD K. C. LEE, M.D.

STATE OF IDAHO,
OFFICE OF THE GOVERNOR,
Boise, May 29, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: In response to your letter of May 10, I would first like to reply to your specific questions in the order in which they were stated.

1. We feel that there is a definite need in Idaho for more community home health services, for the construction of more skilled nursing homes, and for improving the quality of existing nursing homes. In support of this statement I might mention, first, that there is only one county in Idaho which now has a program organized to provide home nursing services. In spite of the fact that this county has had an organized visiting nurse service since 1947, no new home nursing services have been developed in other counties within the past 14 years. Even in this single county the ratio of public health nurses providing this service is only 1 to approximately 8,000 population. Further, the latest revisions of the Idaho hospital and medical facilities construction plan contains the information that there are at present in this State a total of 1,637 existing beds in nursing homes, with 898 of these being classified as unsuitable, according to our State's standards. The State plan allows for a total of almost 2,000 nursing home beds being needed in the State. Of the 51 existing nursing homes, only 31 are currently fully licensed by the State department of health. Eighteen of the 44 counties in Idaho have no nursing home facilities.

2. I do consider that additional Federal financial assistance to Idaho would help stimulate programs to meet these needs. Certainly, the history of the various Federal grants and aid in the public health field indicates that the State and local communities have met the challenges inspired by the Federal grants to develop many of the present ongoing public health programs.

3. If H.R. 4998 is enacted, the State is prepared to utilize available funds in accordance with an agreed-upon plan and predicated upon the usual matching requirements for State and local funds. Several counties and local communities have already expressed considerable interest in the organization and establishment of additional community health services and facilities. This is particularly true in those counties which are already provided with basic public health services.

An additional item of interest is that over half of Idaho's 44 counties now have the services of a full-time organized local health department and local

public health nursing services are available to approximately 75 percent of the State's total population.

I trust that the above information will be helpful to you and that the committee will take prompt and favorable action on this bill.

Sincerely yours,

ROBERT E. SMYLIE, *Governor.*

STATE OF ILLINOIS,
OFFICE OF THE GOVERNOR,
Springfield, May 25, 1961.

Hon. OREN HARRIS,
Congressman from Arkansas,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: This is in reply to your letter relative to H.R. 4998. Illinois has a definite need of this legislation so that further developments of community health services will be possible and that more nursing homes can be built. Every year we have had more requests for construction grants for modern nursing homes than the Federal allocation could cover on a reduced percentage basis. Increasing the amount available to this purpose would greatly hasten the day when all nursing homes in Illinois will, at least, be fire-resistive.

This legislation would enable us to plan an orderly expansion to provide geographic coverage of the State and to strengthen facilities and services in all areas. By a combination of direct State service; regional office coverage; local health departments operating under agreed standards of performance; and informational service in every county not covered by the above facilities, public health in Illinois could be brought up to date.

Within the proposed budget of the Illinois Department of Public Health and the local funds expended through local health departments, Illinois could meet the matching requirements for this additional Federal grant as well as the grants anticipated from regular Federal appropriations.

I certainly hope favorable action is taken on this bill.

Sincerely,

OTTO KERNER, *Governor.*

STATE OF INDIANA,
OFFICE OF THE GOVERNOR,
Indianapolis, May 15, 1961.

Hon. OREN HARRIS,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: Replying to your letter of May 10 concerning H.R. 4998, I would answer your questions generally as follows:

1. Yes, there is definitely a growing need for good nursing homes in Indiana. Our State board of health has made great progress in upgrading the quality of the privately owned homes which are operating for profit through our licensing program, but probably the major difficulty arises from the fact that most of these homes are remodeled old residences. This frequently creates fire and sanitary hazards that are quite serious, and the department has a continual struggle on its hands in policing these homes and insisting that they employ qualified personnel. I do not mean to imply that the private operators as a group are not cooperating to a very great extent, because the department has received the cooperation of their State association in this matter.

2. Federal legislation to encourage the construction of new, specially designed facilities for the aged would be indeed helpful. Perhaps mortgage insurance permitting low interest loans to private operators would be one means of meeting the problem. Another might be to encourage public bodies in the construction of facilities with a program similar to the Hill-Burton Act.

3. If a bill is enacted by Congress making funds available on a matching basis, I am sure it would be utilized by governmental agencies in Indiana. The extent is unknown at this time since it would depend largely upon budgets established by local units and appropriations authorized by our legislature.

I appreciate that the above is quite general, but I have not attempted to furnish detailed information due to your request for a prompt reply.

Sincerely,

MATTHEW E. WELSH.

STATE OF IOWA,
OFFICE OF THE GOVERNOR,
Des Moines, June 8, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: Iowa now ranks No. 1 in the Nation in the percentage of persons over 65 years of age. This is a somewhat dubious honor which was recently won from the State of New Hampshire. The percentage of persons over age 65 in Iowa is 11.4 percent, which, if applied to the 1960 census, would indicate approximately 316,430 persons are over age 65.

We know that all persons 65 years of age or over do not need medical care or hospitalization, but statistics prove that persons over 65 used hospitals and medical facilities at twice the rate of any other age group. The exact ratio of hospital and nursing home beds needed to serve this population is not known, but every indication would point to the fact that the need is in the neighborhood of 10 percent of the persons over age 65. If applied to Iowa, this would place the need for nursing home and custodial care beds around 31,000 beds.

Through the nursing and custodial home licensing program, the department of public health can presently account for around 23,000 beds in licensed nursing homes, custodial homes, county homes, and similar institutions. We know that there are some institutions operating without licenses which would account for a few more occupied beds. However, in the light of these facilities, there remains a very great demand for additional facilities.

An indication of the demand for additional facilities can be seen in recent legislation enacted by the 59th general assembly which authorizes cities and counties operating hospitals to build and operate nursing home facilities. The increased Federal funds made available under H.R. 4998 would enable the department to assist more communities to build the nursing home facilities now authorized by the State statutes.

In the light of the above facts, it is fair to answer your first question by stating that there is a very great need for more community health services, construction of skilled nursing homes, and programs to improve the quality of existing nursing homes in Iowa. It is also fair to assume that the availability of Federal matching grants would tend to stimulate programs to meet the needs.

As we interpret H.R. 4998, it would not require any appropriation of State funds to administer the program in Iowa and the lack of any State appropriations would not prevent local communities from participating in the several programs provided by the act. Local communities would need to provide matching funds for construction of new facilities or operation of community health services to improve quality of nursing home service or home-care programs.

One of the problems in the area of medical care is the ever-increasing cost of institutional care. The obvious answer to this problem would be to provide the medical care in the home and attempt to keep the patient out of the institutions as long as possible. For the lack of a better name, this type program is referred to as home care. These programs are just getting started in some Iowa communities through the Visiting Nurse Association and similar organizations and could be expanded materially through H.R. 4998.

The machinery for the administration of construction grants for nursing home facilities and preventative medical care programs is presently set up in the State department of health. Although the programs provided by H.R. 4998 would increase the burden on existing State health department divisions, it is our opinion that the responsibility for the administration of these programs should rest with the health department rather than some other State agency.

In conclusion, it is my considered opinion that the programs provided by H.R. 4998 are greatly needed and that the State of Iowa would benefit materially if the bill were enacted. I would heartily recommend favorable consideration of the legislation.

Sincerely yours,

NORMAN A. ERBE, *Governor.*

EXECUTIVE OFFICE,
STATE OF KANSAS,
Topeka, May 25, 1961.

Mr. OREN HARRIS,
Congress of the United States, House of Representatives, Committee on Interstate and Foreign Commerce, House Office Building, Washington, D.C.

DEAR MR. HARRIS: In reply to your letter received May 15.

I am sending a copy of your letter to James Bibb, budget department, for his attention.

Sincerely,

JOHN ANDERSON, Jr., *Governor.*

STATE OF KENTUCKY,
OFFICE OF THE GOVERNOR,
Frankfort, Ky., May 29, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: In reply to your letter of May 10, 1961, concerning action on the bill, H.R. 4998, I want to assure you that I am extremely interested in the objectives of this legislation.

The entire question of community home health services, construction of more skilled nursing homes, and improving the quality of existing nursing homes is a real concern to the citizens of the Commonwealth of Kentucky.

The economic and geographical characteristics of this State have contributed to the inadequate distribution of these types of health facilities. Based upon an established population and area formula, a survey of our nursing home needs in Kentucky indicates that the 1,675 beds now available represent 18.7 percent of the total State requirements in this program. While we have been moving ahead with community home health services, particularly with respect to chronic disease and the aging, our program is yet very limited. The use of health department nurses, as visitors from the health department giving service to the chronically diseased in their home under the supervision of a family physician, has been extended to 16 or 18 of the State's 120 counties. This will give you some idea of the extent to which we have been able to meet some of the objectives of this proposed legislation.

It is my belief that the availability of additional Federal financial assistance to the State and its communities would have a significant effect in stimulating programs designed to meet the need of better community home health services and the construction and improvement of nursing homes.

If this bill is enacted, I will bring it to the attention of the general assembly of this State, and encourage any necessary legislation to place the Commonwealth in a position to cooperate in the establishment and expansion of community health services and facilities.

Sincerely,

BERT T. COMBS.

STATE OF MAINE,
OFFICE OF THE GOVERNOR,
Augusta, June 13, 1961.

Hon. OREN HARRIS,
House of Representatives, Congress of the United States, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I have discussed H.R. 4998 with our health and welfare people, and with others who might be expected to have interests in the kinds of problems which may well be solved by this proposal. I find that these people see in H.R. 4998 the possibilities of approaching solutions to some of our major existing problems and some of the important health and welfare problems which we can see facing us in the very near future. We also see in the provisions of this bill the means by which some of these problems may be minimized or prevented in the future.

In general, I should like to express a whole-hearted endorsement of the major provisions in this document.

To answer your questions specifically:

(1) The construction of modern, properly designed, and properly operated nursing homes is one our most important medical care needs, and second to this need is the necessity for improving the quality of services in existing nursing homes.

(2) I am quite certain that Federal financial assistance would provide an essential stimulus to meeting these needs.

(3) I am reasonably certain thStartea

(3) I am reasonably certain that our State would make every effort to utilize available Federal funds by providing State and local funds as needed. I feel that the degree of utilization of funds under this bill can be predicted on the basis of the degree to which Hill-Burton funds have already been used in this State. In our hospital construction program we have used all Federal funds available to us and could undoubtedly have used more had they been available.

Sincerely yours,

JOHN H. REED, *Governor.*

EXECUTIVE DEPARTMENT,
Annapolis, Md., May 25, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I have discussed at length your recent letter concerning H.R. 4998 with Dr. Perry F. Prather, director of the Maryland State Department of Health.

I believe that Maryland should strongly support this bill which provides matching funds for the improvement of community health services for the aged and other persons. While all of the provisions of this bill will help in the development of Maryland's health services, it should be especially valuable in respect to the following:

Inpatient program: By helping to finance nursing home and home care services unnecessary hospitalization will be minimized and money will be saved in the health department's inpatient program (1962 appropriation, $8.7 million).

Nursing home construction: The construction of nonprofit and public nursing homes will be facilitated by the larger Federal appropriations provided under this bill. In the construction plan in Maryland, through recently enacted bond bill, more State funds are available than Federal. Some building projects may be retarded through the exhaustion of Federal funds and the limitation that State funds, in the absence of Federal, can be used only to the extent of 50 percent of the cost.

Community health services: One of the most important health needs in the State is that of local services for the chronically ill patient who remains at home. These consist of nursing, physical and occupational therapy, homemakers, meals-on-wheels, and various other components of organized home care. They are developing slowly in Maryland because of financial limitations. Federal matching money will cover part of the cost and serve as an incentive to local jurisdictions to develop services.

I do hope that the above information will prove helpful to you and the members of your committee.

With kindest personal regards, I am

Sincerely yours,

J. MILLARD TAWES, *Governor.*

THE COMMONWEALTH OF MASSACHUSETTS,
EXECUTIVE DEPARTMENT,
Boston, June 2, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: I wish to express my support for the substance of H.R. 4998. I believe that the proposed legislation recognizes an important problem relative to chronic diseases and medical care for the aged; the lack of such services as those of visiting nurses and other skilled workers who could provide care in the home, and the need for additional nursing homes

as well as the improvement of existing ones. Such programs could well help to reduce or modify the spiraling welfare costs of medical care which represent such heavy expenditures in State government. More importantly, I believe that home care would be a more comforting alternative than institutionalization to many elder citizens afflicted with serious health problems.

Relative to your specific questions:

(1) There is a serious need in Massachusetts for more community home health services. Home care programs scarcely exist except for some developed in the Boston area for teaching purposes. While visiting nurse services do provide a thin coverage throughout the State, these are largely supported by voluntary charitable contributions. Relative to nursing homes, more are needed (particularly of the nonprofit variety), and much could be done to help improve the quality of many of those already in existence.

(2) Additional Federal financial assistance could greatly stimulate programs designed to meet these needs, both on the State and on the community level.

(3) If the proposed legislation were enacted, sufficient State money appears to be available to match the Federal allocation. Such funds could be used in part to encourage local communities to develop their own programs.

I hope these comments will prove helpful to you in your attempt to secure this important program of assistance in the area of medical care for our aging.

Sincerely,

JOHN A. VOLPE, *Governor.*

STATE OF MICHIGAN,
OFFICE OF THE GOVERNOR,
Lansing, May 22, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Buiding, Washington, D.C.

DEAR CONGRESSMAN HARRIS: Michigan needs the expanded funds contemplated in H.R. 4998 for community health services and facilities for the chronically ill and aged. Present programs and appropriations make only a small dent in the vast need for upgrading the institutional and home care of an estimated 217,000 disabled and chronically ill people in Michigan.

Today we see many old folks needlessly disabled and bedfast. We see old folks who could be at home stored away in nursing homes for the rest of their lives. We see spiraling institutional costs and a premium placed on warehouse care. We see chronically ill patients holding down costly hospital beds which are needed for those with acute sickness. We see our chronically ill and disabled citizens cared for in outmoded facilities which have trouble meeting health and fire safety standards and which are providing little more than sanitary storage.

Present day knowledge gives us the tools to improve these situations. For the most part we are doing all we can on a State and community level to help meet these problems. We are anxious to expand our efforts, but we need more funds to do so. Increased Federal assistance would spur forward our State and community programs, accelerate progress, and be returned many times over in savings of health, lives, and institutional costs in the years ahead.

H.R. 4998 authorizes additional appropriations for programs of services to long-term patients and for construction of skilled nursing homes. The provisions of this bill would provide for an expansion and extension of our present efforts.

Improving the quality of existing long-term care facilities: Michigan has 20,377 beds in licensed nursing homes, county facilities, and other long-term-care units. There are an additional 3,352 beds in licensed homes for the aged and county infirmaries. Despite a vigorous program of progressive improvement over the past 5 years, many of the 448 licensed nursing homes are having trouble meeting minimum standards. This is indicated in the fact that as standards gradually have been raised, the number of nursing homes with provisional licenses increased from 27 in 1958 to 81 at present. Most homes do not use modern techniques in restorative medicine and rehabilitation which can help many patients return to a reasonable degree of self-help and lift some back on their feet. Increased Federal funds would reinforce and expand important training and rehabilitation work to help nursing home facilities and the patients in them. Expanding such assistance now is imperative if we are to reduce the costs and misery of older people vegetating their last years away at high expense to us all.

Increased Federal funds for Michigan could mean—

Expansion of the present pilot rehabilitation evaluation project to demonstrate rehabilitation potential and modern treatment methods.

Increased State consultant services to provide nutrition, sanitation, nursing, physical therapy, and medical consultation for improvement of the care of the long-term patient.

Continuation of 10 projects to train nurse aids employed by nursing home, and establishment of training programs in 2 additional areas. Establishment of up to three field training centers.

Development of short course and inservice training for administrators, nursing care supervisors, food service, and maintenance personnel of nursing homes and other long-term-care facilities.

A demonstration and study project in the care of the senile patient using nursing, psychiatric, diversional therapy, and medical evaluation services.

Providing home nursing and home care services: The broadening of benefits to old age assistance recipients has helped to expand home nursing services. Local agencies covering some 42 of Michigan's 83 counties now have agreements to provide home nursing for old age recipients. However, only 23 of Michigan's counties have a home nursing service which is more comprehensive in scope. In other areas, many persons who need service must do without, and often are hospitalized at high expense or remain unnecessarily in nursing homes. A few communities have developed homemaker services and other aspects of a comprehensive home care program. Increased Federal funds would help expand home nursing services and other home care services, particularly in rural and suburban areas, so that more chronically ill persons could be adequately cared for at home.

Increased Federal funds for Michigan could mean—

Development of 10 home nursing programs in rural and suburban areas now lacking this service.

Continued sponsorship of nine home nursing homemaker projects, and establishment of three additional programs.

A demonstration home care project, under local health department auspices, including the services of a part time medical coordinator, nursing care, physical and occupational therapy, homemaker services, medical social service, records management and contractual arrangements for X-ray and laboratory.

Constructing additional facilities: Additional construction of the long-term care facilities is badly needed, to provide skilled nursing home services in those areas of the State which have no facilities at all and to replace existing buildings which are not fire-resistive and which cannot meet present day standards for space, comfort, and program. Less than half of existing beds for long-term care are in adequately constructed facilities. While 43 percent of Michigan's population lives in areas of the State which have a reasonably adequate supply of acute care beds, less than 4 percent of Michigan's population lives in areas with a reasonably adequate supply of long-term-care beds. Thirteen percent of the population lives in the 36 counties of the State which either have no skilled nursing home beds at all or none in fire-resistive structures.

Under the Hill-Burton program, since 1954 Federal funds have assisted in the construction of 9 nursing home projects with 706 beds. Although skilled nursing home projects can be granted up to 50 percent of construction cost, because of the limited funds available, only rarely has it been possible to provide anywhere near this amount. Grants have ranged from $150,000 to $379,000, and have represented the following percentages of total construction cost: 10, 17, 26, 27, 37, 45, 49.

At present 20 counties or general hospitals have indicated interest in developing long-term-care facilities. This represents a potential of more than 1,000 beds at an estimated cost of $6 to $8 million. While these projects could doubtless carry over a 2-year period, they still represent a greater volume of construction than can be assisted with present funds. With the current allocation, it is possible only to help a small number of projects in the areas of greatest need.

Increased Federal funds could mean—

Helping 1 to 3 additional badly needed projects.

Providing a more substantial portion of construction costs and thus enabling the poorer areas of the State to get under construction to provide these essential facilities.

Prevention: Even though the provisions in H.R. 4998 focus primarily upon nursing home and home care needs, this effort could be expected to stimulate added impetus in programs to find disease in its earliest stages and to get patients under treatment in time. Examples here are public testing programs for diabetes, glaucoma, and cervical cancer, which even in beginning stages have proved of immense worth in finding these serious conditions before irreparable harm has been done.

To sum up, specifically in answer to your questions, Representative Harris, we in Michigan say:

(1) The need to expand and improve home nursing and nursing home services and to construct additional long-term-care facilities is acute.

(2) The proposed additional Federal assistance would stimulate worthwhile efforts to meet these needs now.

(3) Government in Michigan can be counted on to the limit of our ability to use the added resources as a foundation for effective and economical programs.

Enclosed is added documentation, which might be of interest. I am taking the liberty of sharing this report with Michigan Representatives and Senators so they may know of our real interest in H.R. 4998 and our hope that it will receive favorable consideration.

Thank you, again, for giving us this opportunity to make known our views and needs.

With warmest personal regards.

Sincerely yours,

JOHN B. SWAINSON, *Governor.*

MICHIGAN DEPARTMENT OF HEALTH, DIVISION OF HOSPITAL AND MEDICAL FACILITIES, MAY 1961

Comparison of need for acute care beds and long-term care beds, Michigan, 1961

Percent of estimated need met [1]	Number of areas	Population		Number of additional beds needed
		Total	Percent	
0 percent:				
Acute care beds	2	38,782	.5	148
Long-term care beds	36	1,013,971	13.0	2,730
11 to 33 percent:				
Acute care beds	1	71,794	1.0	161
Long-term care beds	9	807,881	10.0	1,409
34 to 50 percent:				
Acute care beds	2	38,966	.5	77
Long-term care beds	8	1,194,822	15.0	1,236
51 to 75 percent:				
Acute care beds	14	4,331,880	55.0	5,649
Long-term care beds	18	4,511,394	58.0	3,077
76 to 99 percent:				
Acute care beds	28	1,848,327	24.0	1,348
Long-term care beds	1	36,932	.5	20
100 percent:				
Acute care beds	24	1,470,749	19.0	----------
Long-term care beds	11	243,000	3.0	----------
Total:				
Acute care beds	[2] 71	[3] 7,808,000	100.0	7,383
Long-term care beds	[4] 83			8,472

[1] Need for acute care beds estimated according to 1,300 days of care per 1,000 population and occupancy factor, or roughly 4.1 beds per 1,000. Need for long-term care beds estimated according to a conservative ratio of 2 beds per 1,000 population.

[2] Hospital service areas.

[3] Population of hospital service areas includes 23,100 outstate population, excludes 30,502 population living in border counties and going out of State for care.

[4] Counties.

STATE OF MINNESOTA,
EXECUTIVE OFFICE,
St. Paul, May 24, 1961.

Hon. OREN HARRIS,
Representative from Arkansas,
House Office Building, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: This is in reply to your letter of May 10.

We asked Dr. Robert N. Barr, secretary and executive officer of the Minnesota Department of Health, to furnish the information you requested.

We understand that this has been done.

Cordially yours,

ELMER L. ANDERSEN, *Governor.*

STATE OF MINNESOTA,
DEPARTMENT OF HEALTH,
Minneapolis, May 16, 1961.

Re H.R. 4998.

Hon. OREN HARRIS,
Representative in Congress,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR SIR: The Honorable Elmer L. Andersen, Governor of Minnesota, has requested that I answer your letter of May 10, 1961, relative to H.R. 4998, which is now being considered by the House Committee on Interstate and Foreign Commerce.

Minnesota has for several years actively supported within its available resources programs and activities as provided in H.R. 4998. I can assure you that Governor Andersen, the Minnesota State Board of Health, and other official and voluntary health and welfare agencies and organizations in Minnesota will lend every support to this legislation and to expanded services and activities on a cooperative Federal, State, and local basis as provided for by its provisions. The following gives background development of services and details as to how such matching funds can be used in Minnesota.

Minnesota has a long and rather outstanding history in its activities in the fields of health and welfare, and the problems of the aged have received serious and specific consideration. It was one of the first States to develop a statewide tuberculosis-control program, which in 1913 included funds to assist counties in building multicounty sanatoria and in caring for the tuberculosis patients. Such funds were on a matching basis, the State providing approximately one-half of the cost of care and one-half the cost of construction of local sanatoria. Today a number of these sanatoria have been converted into nursing homes for the care of the aged and chronically ill.

Some 15 years ago the State initiated unlimited medical, hospital, and nursing-home care for the aged as a part of its program in social security under the category of old-age assistance (OAA) and subsequently provided like services for all other categorical aid programs, except aid to the disabled. Today there are approximately 355,000 persons in Minnesota who are 65 years of age and over. Approximately 46,500 of these are on old-age assistance and 24,500 are receiving some form of medical care under that program. Of these, a substantial number receive benefits under old-age insurance or through other individual resources and are also on old-age assistance because the individual's resources are not sufficient to care for the normal living needs as well as his medical services. The total medical cost of this program in Minnesota for old-age assistance recipients today is almost $20 million.

The 1957 legislature also provided for specific activities in the field of aging and for the employment of a full-time person to coordinate the activities in this field at State and local levels. The State also, under the direction of the present incumbent, Mr. Bernard E. Nash, has developed a Governor's Citizens Council on Aging—which preceded the White House Conference for a period of approximately 3 years. This resulted in real interest and planning on the part of all people in Minnesota in this increasing problem.

With the passage of the Community Mental Health Service Act of 1957, Minnesota has taken a substantial step toward developing a preventive mental health program and to date has 17 centers each staffed in most instances with one or more psychiatrists, psychologists, and social workers.

The 1947 legislature (ch. 54, Laws of 1947) provided assistance for the development and expansion of county nursing services in the form of a subsidy to

each county which employs a certified public health nurse. At the present time there are 73 of the 87 counties employing 125 nurses. Some 45 percent of the visits to adults, representing 7 percent of the nurses' total time, are directed toward providing home nursing care to the chronically ill and aged. This year the legislature seriously considered increasing and extending this subsidy to assist counties in employing an additional registered nurse or licensed practical nurse for the specific purpose of expanding home nursing services throughout the State. The cities of Minneapolis, St. Paul, and Duluth, and rural Hennepin County have visiting nursing services under voluntary auspices which are providing home nursing care in considerable amounts. Recently the city of St. Cloud added a nurse to its staff, with assistance from the State health department, for this same purpose. In addition, the county nursing services are developing rosters of individuals living within the community who have special training in the fields of nursing, physical and occupational therapy, and other related services, and have secured from these persons the information as to whether or not they would be willing to provide services on a part-time basis.

The Minnesota statutes allow county nursing services to accept payments, for home nursing care from insurance companies, voluntary agencies, the Veterans' Administration, and from persons able to pay, but services may not be denied if the individual is unable to pay. Recent legislation provided that the local welfare board may pay to the county nursing board the cost of providing such service from funds available under the old-age assistance program. For a number of years local welfare boards have paid nurses directly for providing care in the home. Such services are provided in lieu of placing the individual in a hospital or nursing home when it is preferable and desirable that he remain in his own home.

Under the Hill-Burton Act the State has made great strides in the construction of community hospitals, nursing homes, and homes for the aged. Actually, only 11 percent of the monies spent in Minnesota during the past 13 years for such construction have been Hill-Burton funds which, of course, means that the vast majority of both hospitals and related facilities have been built without Federal assistance.

You will be interested in knowing that approximately 70 percent of the beds in nursing homes and homes for the aged provided since 1950 are owned and operated by governmental and nonprofit organizations. The State likewise has experienced a great expansion in the development of comprehensive as well as satellite rehabilitation services throughout the State. Much of this is due to the fact that rehabilitation services were developed in the early years at the Mayo Clinic, later at the University of Minnesota Hospitals, and following this at the Kenny Rehabilitation Institute. Now a substantial number of the larger hospitals are providing rehabilitation services in varying amounts. There are now four complete rehabilitation centers in Minnesota and an additional 102 satellite rehabilitation services throughout the State. In order to keep pace with population growth, obsolescence and overcome present deficiencies, Minnesota must continue to build nursing home beds at the rate of 1,600 per year for the next 10 years. During 1960, there were 1,566 new beds placed in operation and there are 2,017 beds under construction. We believe that the need for community services and home care programs is very great in Minnesota even though beds in hospitals, nursing homes, and related facilities are beginning to approximate our current needs. Community services are important because of their economic factors which will reduce the cost of care of these individuals. It is even more important that individuals whenever possible be assisted to remain in their own homes as long as feasible. We are of the firm opinion that the provision of home nursing care as well as homemakers and other related services in the community, closely integrated with the health programs and with the hospital and nursing home services, will do much to make Minnesota's program one of the outstanding programs in the country.

From the above it is obvious that any assistance as provided under H.R. 4998 in the development of community service is most welcome, and that the increase in Hill-Burton funds for building nursing homes will assist in this program. Minnesota's experience would indicate that Hill-Burton appropriations for nursing home construction could be increased by five or six times the present allotment without sacrificing good planning and construction. A fivefold increase would give Minnesota approximately $1,020,000.

With the assistance of the health departments in the larger cities and with the cooperation of the State hospital, medical, and nursing home associations,

real strides are being made in the improvement of staffing and services in our hospitals and nursing homes. This program needs to be accelerated and expanded.

If H.R. 4998 is enacted, the State will assist counties and cities in developing and expanding home nursing and homemaker services throughout the State, in improving the quality of existing nursing home services and in the training of nurses and other personnel in charge of such homes. The pattern for these programs has already been established, therefore the funds available under H.R. 4998 will give real impetus to the total program in Minnesota.

Your committee has heard testimony, as of May 3, 1961, from representatives of the Rochester Methodist Hospital relative to their research project in the study of hospital construction and its relationship to the efficiency of hospital operation and costs thereto. I also testified before your committee, and such included proposed research programs of the Minnesota Department of Health relative to the study of urban and metropolitan hospital planning and the kinds of information that should be obtained prior to the construction of hospital and related facilities in such communities. Likewise, reference was made to numerous special projects including: the proposal by the Amherst H. Wilder Foundation relative to the development of home services in relation to the rehabilitation center and the Wilder Residences Infirmary, recently completed with the assistance of Hill-Burton funds; and, the request of the Minnesota Department of Public Welfare, under the direction of Mr. Bernard E. Nash, special consultant on aging, to the Public Health Service for assistance in a countywide survey of the aged and infirm individuals in Morrison County.

Your interest in this legislation is appreciated.

Respectfully,

ROBERT N. BARR, M.D.,
Secretary and Executive Officer, Minnesota Department of Health.

Public health nurses in Minnesota (by type of agency), December 1955 and 1960

	Number of agencies		Number of positions		Number of nurses employed	
	1955	1960	1955	1960	1955	1960
Rural:						
County	58	73	119	138	105	124
City	9	8	20	17	18	16
Indian	2	2	2	6	2	5
Total	69	83	141	161	125	145
Board of education	100	121	136	205	130	203
Total rural	169	204	277	366	255	348
Minneapolis:						
Combined nursing service (MNS and Health Department)	1	1	60	56	59	55
Board of education	1	1	54	50	52	50
Total	2	2	114	106	111	105
St. Paul:						
City bureau of health	1	1	23	23	23	23
Family nursing service	1	1	30	31	29	31
Board of education	1	1	42	44	39	38
Total	3	3	95	98	91	92
Duluth:						
Duluth Health Service (VNS and Health Department)	1	1	5	4	5	4
Board of education	1	1	9	11	9	11
Scottish Rite and county welfare department	2	1	3	2	3	2
	4	3	17	17	17	17
Total (1st-class cities)	9	8	226	221	219	214
Total public health nurses employed in State:						
Generalized public health nursing services	244	260	----	----	----	----
Specialized school nursing services	230	302	----	----	----	----
Total	474	562	----	----	----	----
State agencies:						
Minnesota Department of Health	----	----	----	----	16	16
Crippled Children Services, Department of Public Welfare	----	----	----	----	8	7
Total	----	----	----	----	24	23
Total public health nurses employed in agencies in Minnesota	----	----	----	----	498	585

EXECUTIVE OFFICE,
STATE OF MISSOURI,
Jefferson City, May 19, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I am impressed with the intent of H.R. 4998. To my mind, it is the specific kind of legislation which is badly needed by such States as Missouri. For the past few years Congress has devoted considerable attention to the advancement of medical and health knowledge, particularly through research. As a result of markedly increased appropriations, research has made possible a greatly enhanced knowledge of the etiology and therapy of illness. All of us have been impressed, however, by the fact that increased knowledge, per se, is of little value to our citizens if this knowledge cannot be brought to bear directly upon their problems. This is the great value of H.R. 4998. It is through mechanisms such as that established within this bill that in Missouri we may bring a more adequate application of improved medical knowledge to the needs of our citizens.

H.R. 4998 will help us greatly in solving many of our health problems existent in this State. Section 316 relating to special project grants for improving community services is to my mind a particularly important section. The improvement of such services will, we feel, strike directly at the core of our major health problems.

Missouri ranks within the first four States in the Union as to the density of its senior citizen population. One of the great problems, therefore, is the provision of an adequate number of nursing home beds and the development of proper programs for the improvement of nursing home care. Inseparably associated with problems of the aged is the need for home care programs and homemaker programs. It is financially impossible for Missouri to assume this entire burden alone. We, therefore, respectfully urge that every favorable consideration be given by Congress to the passage of H.R. 4998.

I personally am certain that additional Federal financial assistance to the State of Missouri and its communities will help stimulate programs designed to meet the needs outlined above. I am further convinced that if H.R. 4998 is enacted, the State of Missouri will utilize all available funds for the purposes outlined in the bill.

Sincerely,

JOHN M. DALTON,
Governor.

STATE OF NEBRASKA,
Lincoln, June 2, 1961.

In re H.R. 4998.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: The delay occasioned in replying to your letter of May 10 is due to the careful study we have given this vital problem.

It is very difficult to give specific answers to the specific questions which you have proposed. For example, we assume that there is a need for more community home health services since this need is said to be present universally. We have no good way of measuring quantitatively the magnitude of this need in our State. This is a field which is too new in our State for us to be able to assess the need at the present time.

Likewise, we are sure that there is a need for the construction of more skilled nursing homes and for improving the quality of care given in existing nursing homes. This is evidenced by the great increase of activity in this field throughout the State. Again, it is a difficult thing to evaluate quantitatively with any degree of exactness.

In the field of construction of homes for giving skilled nursing care and upgrading existing nursing homes so that they may give skilled nursing care, we know that additional Federal funds would be utilized on a matching basis by local communities. We would be in favor of this aspect of the bill, if we could be assured that the additional funds for nursing home construction would not be secured at the expense of reducing the funds for general hospital construction. There is a continuing need for construction of general hospitals and upgrading our existing general hospitals, and until this need is met we would not like to

see the program discontinued or reduced merely to transfer additional funds to nursing home construction.

If H.R. 4998 is enacted, and if Federal funds are made available on a matching basis for the other programs mentioned in it, it seems almost certain that our State and local communities would not be able to utilize all of the funds. Many of the health services and facilities eligible for Federal aid on a matching basis would be new to our State and its local communities, and it seems highly unlikely that our State and local appropriating bodies would furnish the necessary matching funds to institute these programs in the near future.

I trust the foregoing information will be of use to your committee.

Sincerely,

FRANK B. MORRISON, *Governor.*

THE STATE OF NEVADA,
EXECUTIVE CHAMBER,
Carson City, May 16, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: Thank you for your letter of May 10 in which you enclosed a copy of H.R. 4998, a bill to assist in expanding and improving community facilities and services for the health care of aged and other persons, and for other purposes.

I certainly appreciate your writing me in this regard and as soon as I have had an opportunity to check into the matter further I shall write you answering specifically the questions you raise, and giving you my views on the proposed legislation in relation to the needs of Nevada.

Kind regards.

Sincerely,

GRANT SAWYER, *Governor.*

THE STATE OF NEVADA,
EXECUTIVE CHAMBER,
Carson City, May 22, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: This is in further reply to your letter of May 10, 1961, with reference to H.R. 4998, a bill introduced by you to assist in expanding and improving community facilities and services for the health care of aged and other persons, and for other purposes.

Dr. Daniel J. Hurley, our State health officer, has been following the progress of H.R. 4998 and S. 1071 with much interest, and considerable thought has been given to these bills in relation to our situation here in Nevada.

I am pleased to enclose a copy of a letter which Dr. Hurley has today sent me on this subject. You will note that, in addition to the answers to your questions, Dr. Hurley states he is wholeheartedly in favor of H.R. 4998 and legislation of this type. I heartily concur in his sentiments.

Sincerely,

GRANT SAWYER, *Governor.*

NEVADA STATE DEPARTMENT OF HEALTH,
Carson City, Nev., May 22, 1961.

Hon. GRANT SAWYER,
Governor of Nevada, Carson City, Nev.

DEAR GOVERNOR SAWYER: I have your letter of May 16, 1961, with a copy of a letter from Congressman Oren Harris, chairman of the Committee on Interstate and Foreign Commerce and a copy of H.R. 4998. During the past few weeks, I have received quite a little information concerning H.R. 4996 and S. 1071 introduced by Senator Lister Hill which is identical with Mr. Harris' bill.

The provisions of the bill would assist State and local health departments in obtaining facilities and personnel to locate those needing care among the aged and chronically ill, get them into hospitals for necessary treatment and restorative services, and then from hospitals into nursing homes or private homes with good nursing care plus medical restorative and rehabilitative facilities as necessary.

In an article in the May 7 New York Times, Dr. Howard A. Rusk writes, "Among the more than 1,500 bills that have been presented to Congress during the current session, there was one of extreme importance to the health of all American people that has received little attention and about which there should be no controversy. It is a community health services and facilities legislation introduced by Senator Lister Hill, Democrat, Alabama, and Representative Oren Harris, Democrat, Arkansas." I will enclose a copy of the article.

I would like to also quote from a personal letter received from Dr. Hugh R. Leavell, associate dean of the Harvard School of Public Health. "I have been warned in Washington, that H.R. 4998, which would bring new Federal funds into your State for public health, is doomed to die unless Congressmen receive more expressions of interest from their own States.

"It seems a shame that the opportunity for perhaps the greatest legislative advance in public health since 1935, when assistance to States was first provided, should be lost because Congress feels it is not wanted or needed by the States. We should realize that this bill would increase the level of grants which we have come to think was fixed at the existing level. It would provide new funds for the serious new problems of the aged and chronically ill."

As requested, I will give you my answers to the questions asked by Mr. Harris.

(1) Certainly there is a need in Nevada for more community home health services also for the construction of more skilled nursing homes and for improving the quality of existing nursing homes. In Nevada, there is only one community in which home nursing services are available. In January 1961, a home nursing service was inaugurated in Washoe County. It is a joint undertaking of the Washoe County Medical Society and the Reno-Washoe County Health Department. Referrals are taken only from attending physicians and the patients receiving home nursing care remain under the care of their own physician. This program has received very good support and many favorable comments. Several of the voluntary health agencies have made contributions to this service. The State health department has contributed expert consultative services by our Director of Public Health Nursing and financial support in the form of cancern control demonstration grant.

Funds made available by passage of H.R. 4998 supplying Federal grant funds would allow the improvement and expansion of this service in Reno and very probably stimulate the establishment of a similar service in other Nevada communities. The Federal funds would be on a matching basis. At the present time, there is no money available for the State health department to take advantage of any of these funds because the appropriation for the biennium starting July 1, 1961, does not provide for such matching funds. Even without the aid of H.R. 4998, the State health department plans to aid in the improvement of quality of nursing home care in the State by more frequent and careful inspection of nursing homes by the staff of the division of hospital services and providing services of a physiotherapist on a demonstration and teaching basis to the operators and staffs of the existing nursing homes.

As stated before, I believe other Nevada communities besides Reno would consider establishing a home nursing service if matching funds were available, also, I am certain that more acceptable nursing home beds would be constructed in the State if additional Hill-Burton matching funds were made available. At the present time, Nevada receives $50,000 a year in the amended Hill-Burton program for the aid in the construction of nursing home beds. At the present time, there are two nursing home units under construction as additions to general hospitals. Mr. Donald Baker, director of hospital services, reports that there are at least three and possibly four nursing homes in the planning stage at the present time. The construction of these facilities may be postponed until matching funds are available. The proposed bill would double the amount of the Hill-Burton grant for this category each year, that is, Nevada would receive $100,000 instead of $50,000 and these planned nursing homes would probably be built at an earlier date.

The following figures were supplied by Mr. Baker as an indication of the nursing home needs in the State. Nevada has established a ratio for determining nursing home bed needs as three beds per 1,000 population. At the present time, the State has a total of 475 nursing home beds of which only 321 can be considered as entirely "acceptable". Mr. Baker has estimated that the State needs an additional 495 beds and breaks down the needs as follows:

Reno	120	Carson City	35
Elko	40	Yerington	9
Ely	31	Hawthorne	19
Fallon	21	Las Vegas	220

The fact that at least one-third of the existing nursing home beds are classed as not acceptable is an indication that many of these facilities should be replaced in the near future.

On portion of the third question is rather difficult to answer. Both Mr. Baker and I agree that the additional $50,000 a year to aid in construction of nursing home beds by governmental or nonprofit associations will be matched and used very profitably in the State. In the proposed bill, Nevada would receive $21,000 as its allotment in the grant for community health services for the aged and chronically ill. There probably would be some difficulty during the first 2 years of the program to match the entire amount of the Federal grant with the State and local moneys; however, Reno and Washoe County have funds that they are expending at the present time which could be used for matching and with the reception the home nursing demonstration has received, it is not unlikely that other communities especially Las Vegas could raise private funds with contributions from the voluntary health agencies to establish a visiting home nursing service on a matching basis.

If it can be demonstrated, and I feel certain it can, that long-term stays in county hospitals can be shortened by supplying this service, even the smaller counties may wish to support a visiting home nursing service on a matching basis. In all areas without full-time local health departments, that is, 15 of Nevada's 17 counties, the logical supervision for this type of service would be from the State health department.

From what I have stated before, it must be evident that I am wholeheartedly in favor of this bill and this type of legislation. This is the logical first step in improving care for the aging and for the chronically ll. The provsion of adequate communty home care and improved skilled nursing home care for these two groups may show that more revolutionary and controversial health legislation is not necessary at this time.

Respectfully yours,

DANIEL J. HURLEY, M.D.,
State Health Officer.

STATE OF NEW JERSEY,
OFFICE OF THE GOVERNOR,
Trenton, N.J., May 25, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: New Jersey supports the intent and the methods proposed in H.R. 4998 and urges favorable and prompt action. New Jersey has utilized, with success, the features proposed in the bill, through its own modest, grant-in-aid and State services since 1952. In many respects H.R. 4998 seems patterned after New Jersey's experience. Testimony on New Jersey's experience as a prototype to what might be accomplished nationally by the bill was presented by Dr. Roscoe P. Kandle, commissioner of health of New Jersey before your committee on May 4, 1961.

New Jersey, although in a comparatively favorable position, needs the Federal assistance proposed in this bill. It will, as has been demonstrated through small additional Federal funds to improve care in nursing homes this current fiscal year, go far in supplying the stimulus and key assistance needed right now.

At a time when funds for medical care of the aged and chronically ill are being increased, the facilities for restorative services, home care, nursing home care, and their interrelation are in some instances being retrenched and in almost all cases are markedly inadequate. This results particularly in the failure to get the restorative benefits now so well demonstrated and in overuse and improper use of the scarce, expensive hospital beds, with unwise pressures to build more hospitals rather than building up supporting home-care services.

A clear example is the effectiveness of homemaker services in New Jersey whereby this still modest service was directly responsible last year for the early discharge to their homes of 516 persons and 296 were prevented from having to be placed in an institution. New Jersey is now being asked to train homemakers and homemaker trainees and administrators for the Nation. Federal funds in small amounts can speedily develop such services throughout the Nation.

The lack of nursing homes operated in connection with hospitals, operated by voluntary, nonprofit auspices and integrated into the medical care pattern of physician, hospital, home care, nursing, and convalescent home is a current, major, medical care, administrative issue. Trial and demonstration by a wide

variety of methods of development of far better nursing home care and particularly of ways of having a practical system of supplying care in the patient's home or whatever type institution is best needed at the particular time is a vital issue. H.R. 4998 can do this particular job of stimulation and modest aid at just the right time.

Even in New Jersey with its relatively well-developed medical care facilities there are but four very small, experimental, organized home-care services now. Visiting nurse services are the key to home care and restorative services in the home yet they are inadequate in amount and scope of services and are in fact having to retrench against the heavy pressures of demands for care of the chronically ill. One older urban area has no such services now but small grants-in-aid will enable them to be developed.

If H.R. 4998 provided funds as proposed New Jersey would—

(1) Expand its promotional, supervisory, and educational services to nursing homes.

(2) Develop much needed hospital and nonprofit voluntary agency-related nursing homes.

(3) Greatly expand community restorative services.

(4) Help devise and develop methods of getting the right kind, amount of services in the home, nursing home, chronic disease or acute disease hospital, needed by a patient and his family at the particular time.

(5) Develop significantly further the rehabilitation and restorative services in county chronic disease hospitals to provide care to the community as a whole.

Sincerely,

ROBERT B. MEYNER, *Governor.*

STATE OF NORTH CAROLINA,
GOVERNOR'S OFFICE,
Raleigh, June 15, 1961.

HON. OREN HARRIS,
Chairman of the House Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: This is in response to your letter requesting information regarding the need for community long-term illness, health services, and facilities, as proposed in H.R. 4998. First, I would like to comment on the need for expanding and improving community health facilities and services for persons with long-term illness. In many areas of North Carolina, there are no such services now available beyond that which is furnished by the general practitioner of medicine and the community hospital, if one is available. A very modest beginning has been made in dealing with this problem by providing home nursing service through local health departments. This, however, is not yet an accepted standard practice or one which is possible with the inadequate amount of funds available for county health programs. The State board of health has been able to offer limited consultative services by physicians, nutritionists, physical therapists, and nurses, but the facilities and staff to establish workable programs on a local basis is still a problem of paramount importance and affects most of the counties in North Carolina. It should be pointed out also that less than one-third of the minimum number of nursing home beds are available (according to the best estimates available). North Carolina is in the process of developing more adequate standards for patient care in such facilities, in conjunction with requirements for licensure, and plans to provide more assistance to operators of such institutions. Much can be done by making available to them services of competent professional health specialists in fields such as nutrition, nursing, physical therapy, and sanitation.

If Federal funds were available to assist States in this important aspect of public health, it would permit us to develop services which otherwise would not be possible. It would permit us to establish services for the chronically ill in their own homes by placing key personnel, such as a nurse, a physical therapist, a nutritionist, and other professional workers as indicated, in the local health department. The value of this type of service has been fully demonstrated and proven in one county in North Carolina with Federal assistance made available through the general health grant. To single out one specific example of the benefit of an adequate program of home care, the patient with stroke is representative. Early and adequate care is now known to be highly effective in preventing total physical disability, indigency, and need for constant care. Such services in most instances are welcomed by physicians and patients alike.

In addition to establishing many vitally needed services for care of the patient in his own home, much still needs to be done toward improving the institutional facilities for the posthospital nursing care of the group who cannot be managed at home. While the old style county homes have been gradually diminishing in number in North Carolina, being replaced by adequately staffed and operated nursing homes, there are still 25 such county homes which are in need of this type conversion. Financial assistance is needed to enable counties to develop facilities which are more in keeping with the physical and emotional needs of these patients.

In summary, we believe that this bill will provide the financial aid which is currently not available in North Carolina, and would enable the early development of services and facilities for which there is an urgent need. We, therefore, urge favorable consideration of this bill by your committee.

With best wishes always,

Sincerely,

TERRY SANFORD, *Governor.*

THE STATE OF OHIO,
OFFICE OF THE GOVERNOR,
Columbus, May 12, 1961.

HON. OREN HARRIS,
Member of Congress, House Office Building, Washington, D.C.

DEAR CONGRESSMAN: We will try to supply you with the specific information requested in your letter of May 10.

It will be forwarded to you as quickly as possible.

Sincerely,

MICHAEL V. DI SALLE, *Governor.*

STATE OF OKLAHOMA,
EXECUTIVE CHAMBERS,
Oklahoma City, May 29, 1961.

HON. OREN HARRIS,
Chairman, House Committee on Interstate and Foreign Commerce, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I am pleased to reply to your letter of May 10, regarding the proposed H.R. 4998 to assist the States and local communities in making available more and better community health services and facilities.

In reply to your first question, that is, "Is there a need, and what is the magnitude of the need, in your State for more community home health services, for the construction of more skilled nursing homes, and for improving the quality of existing nursing homes," you are advised that in view of the fact that Oklahoma's present population over 65 years of age is about 1 percent greater than that of the Nation as a whole, Oklahoma has a particular problem in this area. Home health care services in Oklahoma are at present practically nonexistent. Home nursing services are offered by the Oklahoma and Tulsa City-County health departments but here the nursing services are greatly inadequate to meet the need, there being only 1 nurse per 13,000 population (approximately). The usual recommended standard for home nursing service, including public health nursing service, is 1 nurse per 2,500 population.

The development of larger, more physically suitable nursing homes in Oklahoma is progressing at a fairly satisfactory rate; however, the health care services, particularly nursing services in these homes, in most instances, leave much to be desired. This is in part due to the overall shortage of graduate nurses and licensed practical nurses in Oklahoma, and partly due to the fact that nurses returning to work after rearing their families are unfamiliar with the nursing home setting and, therefore, are reluctant to enter this field.

In reply to your second question, that is, "Do you consider that additional Federal financial assistance to your State and its communities would help stimulate programs designed to meet these needs," you are advised that, in my opinion, Federal financial assistance would be helpful and, in many instances, essential in meeting these needs. Oklahoma would use these funds largely in program development, principally through demonstrations on both a concentrated relatively complete program basis in a community (county), and in specific programs, such as nursing supervision for nursing homes and home care nursing services on a statewide basis. There would be considerable emphasis in all instances placed upon the orientation and inservice training of existing health personnel to prepare them to function in these programs.

In answer to your third question, that is, "If this bill is enacted, would your State utilize available Federal funds, and would State and local funds be made available to establish and expand community health services and facilities," you are advised that at the present level of appropriations in Oklahoma, it is doubtful that we could make maximum use of these Federal funds due to the lack of State funds to meet matching requirements.

I hope that the above information is helpful to you and your committee. If we may be of further service, please do not hesitate to call upon us.

Sincerely,

J. HOWARD EDMONDSON, *Governor.*

STATE OF OREGON,
OFFICE OF THE GOVERNOR,
STATE CAPITAL,
Salem, June 13, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: In response to your letter of May 10, 1961, relating to H.R. 4998, I would respond as follows to the queries you pose:

1. Oregon does need more community home health services, construction of additional skilled nursing home beds and upgrading of the quality of existing nursing homes. It is virtually impossible to express the need with any certainty in the base for estimating that need. However, our department of health has estimated the deficiency at 3,800 beds (based on estimated need of 4 beds per 1,000 population). Another measure is that applications totaling over $1 million are expected in connection with the allocation of $97,000 of Hill-Burton matching funds.

2. Additional Federal financial assistance is not needed in Oregon to stimulate program planning.

3. State and local funds are already available to establish and expand community health services and facilities. If Federal funds for these purposes were available, Orgeon would utilize its full share.

It seems to me that the only appropriate parts of H.R. 4998 are those which provide for research and demonstration grants. This is truly a matter of Federal concern and competence. The grants of general financial assistance in meeting local needs are merely a repetition of the pattern of separating political responsibility for the collection and expenditure of public funds that has contributed so effectively to the inflation of governmental budgets at all levels. I cannot support this aspect of H.R. 4998.

Thank you for affording me this opportunity to comment on this proposed legislation.

Sincerely,

MARK O. HATFIELD, *Governor.*

COMMONWEALTH OF PENNSYLVANIA,
GOVERNOR'S OFFICE,
Harrisburg, June 21, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: Thank you for asking me to comment on H.R. 4998.

I feel that this is an important piece of Federal legislation. Pennsylvania would make good use of sections of the bill which (*a*) authorize grants for studies, experiments, and demonstrations looking toward development of new or improved methods of providing health services outside the hospital, particularly for chronically ill or aged persons, (*b*) increase grants for construction of nonprofit nursing homes, and (*c*) add projects for construction of experimental or demonstration hospitals or other medical facilities.

I am supporting this bill because recent studies show that Pennsylvania is only meeting 36.5 percent of the need for beds for skilled nursing home care. This bill will provide funds to increase the number of nursing home beds in Pennsylvania. I urge the support of this legislation because the chronic diseases are one of our most urgent public health problems. Heart disease especially in the aged demands protracted medical care. Arthritis, too, is a

common cause of disability. Some of the patients with these diseases can be treated in the home if nursing services are available.

We recognize the need for home nursing services. Only 15 of our 67 counties have well-staffed and equipped nursing services. Thirty-one have no nursing care services at all and in the other 21 we can only describe these services as sparse. With additional funds we can not only make every effort to provide some service where there is none, but to expand it where it is sparse; and to try to develop new and more efficient methods of providing nursing care for these patients with chronic disease.

These provisions would materially assist Pennsylvania to meet its growing needs in the fields of chronic disease and care of the aged. I urge you to favor this legislation.

With kind regards, I am,

Very truly yours,

DAVID L. LAWRENCE.

COMMONWEALTH OF PUERTO RICO,
OFFICE OF THE GOVERNOR,
La Fortaleza, San Juan, May 15, 1961.

Hon. OREN HARRIS,
House of Representatives, Congress of the United States, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I take pleasure in acknowledging receipt of your letter of May 10 to the Governor, with reference to H.R. 4998, to assist the States and local communities in making available more and better community health services and facilities.

I shall bring your letter to the Governor's attention immediately.

Cordially yours,

HIRAM TORRES RIGUAL,
Special Assistant to the Governor.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS,
EXECUTIVE CHAMBER,
Providence, June 14, 1961.

Hon. OREN HARRIS,
Chairman, House Interstate and Foreign Commerce Committee,
House Office Building, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: The purpose of this correspondence is to respectfully request approval by your committee of H.R. 4998. If enacted, this bill would help immeasurably to spur construction of nursing homes and provide experimentation and demonstration projects in the care of the aged and chronically ill.

There is no doubt in my mind that legislation of this kind is needed urgently in order to alleviate the widespread problem existing in Rhode Island and in the majority of our States with respect to meeting the needs of our aged citizens who are suffering from chronic disabilities which necessitate the requirement of nursing home care.

I will be deeply grateful to you and to the members of the committee if you would look favorably upon this important legislation.

Sincerely yours,

JOHN A. NOTTE, JR., *Governor.*

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS,
EXECUTIVE CHAMBER,
Providence, May 1961.

Hon. OREN HARRIS,
Congress of the United States, House of Representatives, Committee on Interstate and Foreign Commerce, House Office Building, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: Appropriate members of my staff and informed citizens in the community have been watching with considerable interest and with great hope the progress of H.R. 4998. With the rising costs of hospital care we all agree that every effort should be made to provide medical and health services outside the hospital whenever possible. The monetary aspects are not any more important than the humanitarian aspects concerned with treating the patient in his own community and in his own home. Improvement in the qual-

ity and extension of our programs of nursing home care, home medical and health care, community health information referral centers, and outpatient diagnostic services will help solve this problem to a great extent.

It is the opinion of the health department members of my staff that this bill is, perhaps, the most significant advance in public since 1935 when grants-in-aid were first made.

I shall attempt to answer the specific questions you have raised in your letter, but I assure you my answers will not completely indicate the magnitude of the problem.

(1) There is a need, in our State, for more community home health services, for the construction of more nursing homes and for improving the quality of existing nursing homes. We have nursing home care services, but we have just scratched the surface in this area and our great need is for increased funds and staff, so that such service will be available to the many individuals for whom it is not available now. We have, in our State, according to our last survey, some 2,000 nursing home beds, of which some 85 percent are in need of replacement. At least as important as the facility, in our estimation, is the need for the expansion of training programs for the operators and personnel of nursing homes, so that they, by virtue of better training, will be in a position to give the patients in their care much better service than is presently provided. Our efforts in this area have begun, but they would be quickened and enhanced if Federal funds were available.

(2) There is no question in our minds that the availability of additional financial aid to our State, and the communities in our State, would greatly stimulate the programs so badly needed. There is much information available to us which has resulted from basic research. Our problem is to put these research facts into program operation. Increased grants would thus serve to strengthen the basic structure of our public health services and enable them to meet new and more difficult problems such as health care of the aged.

(3) If this bill is enacted, and it is our sincere hope that it will be, our State would utilize to the maximum available Federal funds and we would make every effort at both the State and local level to make available funds to establish and expand community health services and facilities.

It is of interest to note that your bill has the support of the Rhode Island Council of Community Services, Inc., and I would imagine that by this time you have received an indication of that support from them. This organization represents most of the voluntary health and welfare units in our State.

In summary, I might say that it is my belief that we must expand nonhospital health services if we are to make any progress in reducing the high cost of medical care. Even more important, by so doing we will not only save money but provide improved service for the early detection, treatment, and prevention of disease, and provide the service to the patient in a setting that will be more conducive to his recovery. It seems to us that with this bill we have an oppportunity to enter on a new era in the provision of health services to our citizens.

I hope that your legislation will be successful.

Sincerely yours,

JOHN A. NOTTE, Jr., *Governor.*

STATE OF SOUTH CAROLINA,
EXECUTIVE DEPARTMENT,
Columbia, June 2, 1961.

Hon. OREN HARRIS,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I appreciate the opportunity to comment on H.R. 4998. In response to your specifically outlined questions, may I reply:

1. We have found a need exists in the State for the construction of more skilled nursing homes and improving the condition of those already in existence.

2. I can answer with reasonable certainty that the attitude of this State, both intangibly and tangibly, will be stimulated by participation of this act.

3. I am informed reliably by Dr. G. S. T. Peeples that our State will be able to immediately utilize properly funds available under this program. We do definitely have on hand funds for use in connection with this Federal assistance.

Again let me thank you kindly for your thoughtfulness. If there is any other way we can be of assistance in this matter, please let me know.

Sincerely,

ERNEST F. HOLLINGS.

STATE OF SOUTH DAKOTA, OFFICE OF THE GOVERNOR,
Pierre, June 6, 1961.

Hon. OREN HARRIS,
House of Representatives, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: Thank you for your communication requesting my views in relation to the needs of South Dakota, on the proposed legislation originating as H.R. 4998.

In order that you may have a more comprehensive reply to the points posed in your letter of May 10, I am taking the liberty of referral to Mr. Matthew Furze, director of the South Dakota Department of Public Welfare. I feel sure you will have a response from that source in the near future.

Very sincerely,

ARCHIE GUBBRUD, *Governor.*

STATE OF TENNESSEE,
EXECUTIVE CHAMBER,
Nashville, May 17, 1961.

Hon. OREN HARRIS,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: This is to acknowledge your letter of May 10, concerning H.R. 4998, a bill to assist the States and local communities in making available more and better community health services and facilities, particularly for the aged and the chronically ill.

Since this is a matter which would directly affect the department of public health, I am asking Dr. R. H. Hutcheson, commissioner of that department, to review the proposed bill and write you regarding information on the questions outlined in your letter.

Of course, we are most interested in improving and expanding our facilities and services for health care of the aged and other persons in Tennessee, and I appreciate your contacting me regarding this proposed legislation.

Sincerely yours,

BUFORD ELLINGTON.

STATE OF TENNESSEE,
DEPARTMENT OF PUBLIC HEALTH,
Nashville, May 18, 1961.

Hon. OREN HARRIS,
Congress of the United States, House of Representatives,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: Governor Ellington has routed to me a copy of his letter dated May 17, 1961, and addressed to you, with the request that I give you such information as we have and our opinions regarding H.R. 4998.

We appreciate the opportunity that you give us to express our views on the subject contained in this bill. First, let me say that we are for the bill in general. We believe it comes nearer bringing our 1936 social security program, involving the health services, up to date than any bill heretofore proposed on this particular subject. We have only one objection to the bill which will be set forth in the last paragraph of this letter.

You have asked three questions which we shall attempt to answer in the order that they have been asked.

1. There is a need in Tennessee for more community home health services, for the construction of more skilled nursing homes, and for improving the quality of existing nursing homes.

In this same question you asked the magnitude of the need. While this is somewhat difficult to answer, I shall try to do so by pointing out that at the present time we are attempting to reach a ratio of 1 public health nurse to 12,000 population. I think that any student of public health service will tell you that the average community needs 1 public health nurse to 5,000 population. We have constructed under the Hill-Burton hospital construction program five community nonprofit nursing homes. We have two under construction, and one authorized for construction, making a total of eight. We have in Tennessee 95 counties. As I have shown above, eight counties have constructed, are constructing, or plan to construct this type of facility.

Quality is a difficult item to assess in connection with nursing homes because it is usually judged on the basis of the average of similar facilities. In Tennessee we have some excellent nursing homes. We have a number of average, and I am sorry to say, our share of those that are below average. While there

has been a gradual increase in the quality of service produced since the licensing program went into effect in 1947, there is yet much to be desired. In the body of your letter in the fourth paragraph you state that the committee has been told, "that many of the existing nursing homes are not now able to provide the scope and quality of health care necessary to insure maximum early recovery and rehabilitation of patients."

I believe that the statement made to your committee is an understatement because I think that what should have been said is that there are not many who do provide such services. A great majority of the nursing homes in our State make no effort to provide any rehabilitation services, preferring to keep the old people in bed because it is easier to look after them. The situation is improving, but it has been pretty bad.

2. There is no question but that the answer to this question is in the affirmative. Additional Federal financial assistance to our State and its communities would help stimulate programs designed to meet the needs outlined above in No. 1.

3. If your bill is passed, Tennessee will be able to utilize the available Federal funds.

Since part of this deals with our so-called Hill-Burton hospital construction program, I would like to suggest that these funds could be used much more effectively if the hospital authority in each of the States was permitted to transfer funds under certain circumstances between part C and part G.

For example, this year we will have some money left over in the rehabilitation category that we cannot use because no eligible applicant has asked for the money. At the same time we are having to beg our sister State of Virginia to assist us with a project in Bristol, a city on the State line, and while Virginia has agreed to do this, we have in the funds allocated to Tennessee adequate funds to have constructed the project in Bristol that will go back into the Federal Treasury.

I am somewhat concerned over one particular feature of the bill. In section 316, page 3, line 15, you say such sums as the Congress may determine "for grants to States or other public or nonprofit private agencies or organizations * * * ". If the State government is to be responsible for planning a program, then the program should be administered through the official State agency, and I can see no justifiable reason for permitting the Federal agency to bypass the State agency in making grants direct to the cities, counties, nonprofit corporations, including churches, et cetera, which this portion of your section 316, we believe, will do.

I appreciate the opportunity of submitting the above comments.

Sincerely yours,

R. H. HUTCHESON, M.D., *Commissioner.*

STATE OF UTAH,
OFFICE OF THE GOVERNOR,
Salt Lake City, June 12, 1961.

HON. OREN HARRIS,
Congressman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I regret the delay in replying to your letter of May 10. This matter was submitted to the Department of Health and I just now have their reply which expresses in principle my feeling with respect to this problem.

H.R. 4998 and the identical Senate bill 1071, will I believe if made into law, stimulate effective and economic solutions to the problems of private and public medical care. I believe that the provisions with respect to community health services outside of the hospital can, and will, result in community actions both with respect to need and with respect to the proper responsibility of the individual beneficiary. I also believe that the provision for increased construction of nursing homes is essential to reduction of the more costly burden of hospital construction. I believe further that the other provisions which are designed to improve hospital and nonhospital operations are essential to a better applicaiton of public and private resources in my State.

It is recognized that there is a great but incompletely measured need for a community home health service for the construction of more skilled nursing homes and for improving the quality of existing nursing homes.

We, in Utah, not being a wealthy State have fiscal problems which will control in any cooperative undertaking of this kind, but I want to assure you that to the

extent consistent with a sound fiscal policy this State will utilize Federal funds made available to it, and cooperate to the limit of its fiscal capacity in the solution of these very important problems.

Yours sincerely,

GEORGE D. CLYDE, *Governor.*

COMMONWEALTH OF VIRGINIA,
GOVERNOR'S OFFICE,
Richmond, May 18, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: This is in reply to your letter of May 10, concerning Virginia's attitude toward H.R. 4998, to assist the State and local communities in making available more and better community health services and facilities for the aged and the chronically ill. I have studied this bill thoroughly and would like to add my support to the bill by offering the following answers to the questions posed in your letter.

1. Question: Is there a need, and what is the magnitude of the need, in your State for more community home health services, for the construction of more skilled nursing homes, and for improving the quality of existing nursing homes?

Answer: There is great and urgent need to strengthen and expand community home health services in Virginia. As to the need for more skilled nursing homes, I feel there is a need here but the demand does not appear so great, judging from the lack of applications for Hill-Burton funds for the construction of such facilities. Nursing home supervision is already a function of our health department and the basic program has proven effective. However, enlarged local health department staffs and expanded services to nursing homes are indicated.

2. Question: Do you consider that additional Federal financial assistance to your State and its communities would help stimulate programs designed to meet these needs?

Answer: Yes.

3. Question: If this bill is enacted, would your State utilize available Federal funds, and would State and local funds be made available to establish and expand community health services and facilities?

Answer: Yes.

I feel that the overall comprehensive health care of the aged and chronically ill is out of balance. There has been relatively too much emphasis on inpatient care as compared to the all-important home care phase for older citizens and chronically ill. This has led in many instances to waste of the taxpayer's dollar through unnecessary hospitalization or inpatient care because no satisfactory community home services were available. The type of assistance proposed in H.R. 4998 would encourage and enlist the services of the practicing physicians in the care of patients outside of the hospitals and would fit in well with our long-range plan for the care of the aged and chronically ill.

The Commonwealth of Virginia is completely covered by full-time local health departments, and assistance through the State department of health to the localities would enable them to strengthen and expand their services to our older citizens. Virginia at present has sufficient State and local funds to match proposed Federal funds and could initiate such a program immediately.

In conclusion, I would like to state that I feel this is the soundest piece of Federal legislation in this field offered to date.

Sincerely yours,

J. LINDSAY ALMOND, Jr.

STATE OF WASHINGTON,
EXECUTIVE DEPARTMENT,
Olympia, June 8, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I appreciate your interest in wanting to know how we, in the State of Washington, feel about H.R. 4998, and am most happy to take this opportunity to comment on it as requested in your letter of May 10, 1961. First I shall answer the specific questions you posed and then will make some additional comments.

1. The magnitude of need in this State and the effect on and usefulness of Federal funds for more community health services. In the State of Washington, although much thought and energy have been devoted by many highly competent individuals to the problems of the chronically ill and aged, largely because of fiscal problems, community health services rendered to the patient in his own home are relatively few and far between. Although numerically they are not great, we are proud of our forward-looking trail-blazing activities and are happy to enumerate them to you. Visiting nurse services are available in six communities, and one of these (Everett) is currently initiating a homemaker service for certain families receiving public assistance. The King County Hospital (Seattle), whose services are restricted to those on public assistance or those who are medically indigent, has for several years pioneered a home care program (200 cases per year), utilizing University of Washington medical students. This particular project has been especially noteworthy because of its low per diem cost of approximately $1 per patient.

Finally we are particularly proud of the role the State of Washington is playing in changing the attitude of nursing home staffs toward their patients and increasing their competence to stimulate the aged to keep active and happy. For the past 3 years, under the leadership of the State department of health, a project has been sponsored jointly by that department and by the State department of public assistance and the State division of vocational rehabilitation, financed largely through funds from the Federal Office of Vocational Rehabilitation. In this, a team specializing in restorative care, including a physician, public health nurses, physical therapist, and occupational therapist, devotes 8 weeks of concentrated action in each of several selected nursing homes to train the nursing home staff of each to maximize the patient's ability toward self-care and, whenever feasible, to create independence.

Such programs as these illuminate clearly, however, the need to reach the families of these aged before nursing home care is needed and bring about sufficient intelligent preplanning to forestall institutionalization of some and postpone it for many. To professional personnel concerned with this field, the provision of Federal support to community health services which would help keep the aged active and living in their own homes or in those of their nearest and dearest relatives would be most welcome. The alternative: namely, to be confined forever within the walls of an institution and at the same time to be restricted more and more to inactivity until finally bedfast, is not only appalling from a humanitarian point of view but economically most costly. The more so since so much could be prevented.

We feel strongly that a program to provide community home care services is long overdue. The potential of such a program in terms of better care to patients at lower cost is great. However, in view of the limited funds available to the State and local agencies of government, such a program had best be inaugurated through Federal grants. All Federal funds which might reasonably be expected to be made available to implement and maintain such a program could and would be fully utilized in the State of Washington.

2. The magnitude of need and effect on and usefulness of Federal funds for the construction of more skilled nursing homes and beds. This State is in a unique position in that our proprietary nursing home industry long ago assumed major responsibility to provide care to the chronically ill and aged, and that for some time we have had more nursing home beds than hospital beds, i.e., 14,316 to 11,006. Eighty percent and more of these nursing home beds are occupied. Actually, few areas are in need of additional beds. Even our Hill-Burton program, planning for new nursing home beds, shows a total need for only 370 additional beds throughout the entire State.

It is, therefore, very doubtful that we could or would desire to utilize more Federal funds than are currently available for construction of more skilled nursing homes.

3. The magnitude of need and the effect on and usefulness of Federal funds for improving the quality of existing nursing homes. Whether or not additional Federal funds as provided in H.R. 4998 would stimulate the replacement of substandard nursing home beds with adequate ones is difficult to answer. Of our 339 nursing homes, 302 are privately owned and provide 11,862 beds. Thus only 37 nursing homes, as nonprofit or government-owned agencies, would be eligible for Federal funds. The proportion of these whose beds need replacement is so small that the total impact of H.R. 4998 in this respect would be minimal here.

4. Additional observations on H.R. 4998: Your specific questions did not touch on what may be the most important elements of the proposed legislation in terms of insuring the effctiveness of whatever program is undertaken. I refer to the

provisions relating to research grants. The research portions of the bill are, in my opinion, basic to a reasonably rapid achievement of the overall objectives. While a major need exists to work with nursing homes and other medical facilities to develop newer techniques and generally improve the quality of care provided, and it is high time to implement a community health service program, a great deal more knowledge in these fields and its application is necessary before field programs can be developed with an assured degree of effectiveness. Furthermore, training of personnel is also vital. A demonstration nursing home set up as a teaching institution would be another key factor in providing trained staff and improved quality of care in nursing homes. Such a project has long been visualized here by the Washington State Department of Health in cooperation with the University of Washington, and H.R. 4998 might well provide the mechanism whereby this could be brought into existence.

In conclusion, I feel that many provisions of H.R. 4998 have great merit. While the nursing home construction aspects of the bill would have limited application here, the other provisions do reflect needs of this State and, if enacted, the Federal funds provided would be productively utilized to stimulate such programs to meet these needs. Within the limits of my comments, I strongly endorse the principles involved and urge the passage of this type of legislation.

Sincerely yours,

ALBERT H. ROSSELINI, *Governor.*

APPENDIX B

(Information received from health officials and other interested parties (by States).)

ALABAMA

HALEYVILLE, ALA., *May 23, 1961.*

Congressman KENNETH A. ROBERTS,
Fourth Congressional District of Alabama,
Washington, D.C.:

The Alabama Nursing Homes Association recommends that an amendment be added to bill H.R. 4998 to read as follows: That any person or persons that receives all or any part of the money mentioned in this bill be required to take a designated percentage of indigent patients and also someone in authority from the State health department be designated to see that the designated percentage of indigent is taken care of.

EXECUTIVE BOARD OF THE ALABAMA NURSING HOMES ASSOCIATION.

STATE OF ALABAMA,
DEPARTMENT OF PUBLIC HEALTH,
Montgomery May 2, 1961.

Congressman KENNETH A. ROBERTS,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN: It is noted that the House Committee on Interstate and Foreign Commerce will consider H.R. 4998 at hearings during the current week. The Alabama Department of Public Health is very much interested in the contents of this proposed legislation, and would urge your support. The whole problem of care of the aged and chronically ill is a very pressing one. We have gone a long way in Alabama toward improving the caliber of our nursing homes, and the care that they are able to give but we have only made a beginning, and not only is there a great shortage of nursing home beds, but we need to construct modern facilities for the care of this type patient. Equally the care of these people in their own homes must be provided, since only a fraction of them can be accommodated in a nursing home program.

Very sincerely,

D. G. GILL, M.D.,
State Health Officer.

ONEONTA, ALA.

DEAR MR. ROBERTS: I am writing you as a fellow Alabamian and my representative to Congress. This is the main reason that my request is directed to you, in hopes that every consideration will be given to the optometrist to be included in H.R. 4998 before the House Interstate and Foreign Commerce Committee (sec. 5 of this bill). I, as an optometrist, think that in all fairness, optometric services should be included in this bill. I have talked with numerous friends and people associated with health care at the university hospital in Birmingham, and when discussing this matter, could see all the good that could come from the optometrist's services in this type project. We in Alabama need this type of community facility as I am sure is needed in all the States. I wish you would look into this matter and please consider most strongly the support of the optometric amendments.

Thank you very much, sir.

Sincerely,

LARRY GORDON.

P.S.—I would greatly appreciate some type of verification or reply to this letter if possible, sir. I know this is a request that you must receive upon numerous occasions, but it would mean so very much to me that I could make some type of contact with such a high man in office, and know that he was aware of my request. Thanks again.

ARKANSAS

LITTLE ROCK, ARK., *May 1, 1961.*

HON. OREN HARRIS,
U.S. Congress, Fourth District, Arkansas,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: The Arkansas Public Health Association fully supports your efforts for the passage of legislation contained in H.R. 4998. Furthermore, the association considers such legislation construction and necessary for the proper care of the aged and chronically ill citizens of the United States. Your work in the U.S. Congress has the support of your many friends in Arkansas. The Arkansas Public Health Association appreciates the manner in which you represent the State of Arkansas in the U.S. Congress.

Yours very truly,

JAMES H. SHELTON,
President, Arkansas Public Health Association.

CALIFORNIA

UNIVERSITY OF CALIFORNIA,
SCHOOL OF PUBLIC HEALTH,
Berkeley, Calif., April 27, 1961.

HON. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I have just learned that hearings on H.R. 4998, the proposed Community Health Services and Facilities Act of 1961 will be held May 4. Distance and commitments prevent my attendance so I should be very grateful if this letter could be included in the records of the hearings.

It was my privilege to have chaired the section of the 1958 National Conference on Public Health Training concerned with training resources. Public Law 86–720 has been a valuable partial fulfillment of the recommendations of that conference. As additional implementation of those recommendations, may I urge that H.R. 4998, in appropriately amending section 314(c) of the Public Health Service Act, also remove the $1 million ceiling provided in Public Law 86–720 to the accredited schools of public health. Our five State-supported schools are, like the seven privately supported schools, truly national and international as Public Law 86–720 recognizes. However, the recent addition to the number of accredited schools and plans for more, reduce the amount each

school receives. The $1 million limitation is in direct conflict with the efforts to expand the enrollments and breadth of instruction in these schools and one of the specific recommendations of this national conference was to remove this ceiling. The situation in 1961 is much more acute than in 1958.

Very sincerely,

CHARLES E. SMITH, M.D.,
Dean, School of Public Health,
President, California State Board of Public Health.

STATE OF CALIFORNIA,
DEPARTMENT OF PUBLIC HEALTH,
Berkeley, Calif., May 25, 1961.

Hon. OREN HARRIS,
House Post Office, Washington, D.C.

DEAR MR. HARRIS: You will be pleased to know that the County Supervisors Association of California, representing statewide county government, has indicated its active support of H.R. 4998.

Mr. William R. MacDougall, general counsel and manager, CSAC, has informed us that their Washington representative will be calling on Mr. Moss and Mr. Younger this week and may contact you personally, to urge favorable action on this legislation.

Very sincerely yours,

MALCOLM H. MERRILL, M.D.,
Director of Public Health.

STATE OF CALIFORNIA,
DEPARTMENT OF PUBLIC HEALTH,
Berkeley, Calif., May 22, 1961.

Hon. CLEMENT W. MILLER,
Representative of California,
Washington, D.C.

DEAR MR. MILLER: I wish to bring to your attention further information concerning H.R. 4998, now before the Interstate and Foreign Commerce Committee. The bill would assist the States and local communities in making available more and better community health services and facilities, particularly for the aged and chronically ill.

Public health in California considers the bill the greatest legislative advance in public health since 1935, when assistance to States for health purposes was first provided, and strongly urges it be passed.

To acquaint you with the types of new programs that can be developed with the additional Federal funds H.R. 4998 would provide, I am attaching a review of the California local health demonstration program. It describes projects which the State department of public health has been able to conduct with its limited Federal general health and maternal and child health funds.

Your support of this bill, which would provide immeasurable benefit to the citizens of California, will be most appreciated by public health and by the people it serves.

Very sincerely yours,

MALCOLM H. MERRILL, M.D.,
Director of Public Health.

REVIEW OF THE LOCAL PROJECTS PROGRAM

California State Department of Public Health

In July of 1957, the California State Department of Public Health with the endorsement of the California Conference of Local Health Officers undertook a program of financial support of special projects carried on by local health agencies in the State.

The objectives of the program are to stimulate, encourage, and provide financial support to local health departments in carrying out demonstration and evaluation activities. It is already clear that the projects aid the development of new patterns of health care and the revision and strengthening of traditional public health services.

These projects, now 50 in number, provide a wealth of priceless experience. Among other things, they are demonstrating multiphasic health screening for the early detection of chronic illness, rehabilitation nursing for the disabled and elderly, new ways of nutrition education, how to improve food management in nursing homes, better institutional care of chronically ill and aged, an industrial health survey, home care of the chronically ill, care of unwed mothers, ways to determine the cost of medical care for aged persons on public assistance, a family treatment program for juvenile delinquency, study of prematurity, child health survey, preschool vision tests, coordinated health services for needy children, cytological screening for cancer, and needs for a community meals-on-wheels program.

Project locations include the counties of Modoc, Los Angeles, Santa Clara, San Joaquin, San Mateo, San Francisco, Butte, Yolo, Contra Costa, Santa Cruz, Madera, Imperial, San Bernardino, Shasta, Marin, and Alameda, plus the cities of Berkeley, Los Angeles, Long Beach, and San Jose.

Available for such projects annually in California at present is $330,000 in Federal funds. Obviously, although an impressive amount of good, solid demonstration work has been done with these limited funds, much broader and more comprehensive development of these many public health programs would be undertaken if additional funds were made available.

From the start, participation in the program by local health departments has been on a competitive basis. Support for projects is sought by formal applications and submission of a complete protocol of the proposed project. Each application receives extensive and detailed review by departmental staff and their consultants, and by an advisory committee which has included representatives of the Conference of Local Health Officers, faculties of medical schools, faculties of the schools of public health, and voluntary health organizations.

Strict demand for high quality in the applications has resulted in acceptance of only about one-half of those submitted (a total of 50 approved projects through 1961). The wisdom of requiring high quality of performance is becoming apparent as many projects now reach completion. It is especially encouraging to note that the number of applications acceptable to the staff and advisory committee has increased markedly—to the point, in fact, where available funds are not sufficient for support of accepted proposals.

In addition to the formally approved projects, administrative approval has been given for several smaller projects. In general, this form of support has been made in amounts of $2,000 or less, for the purpose of planning or exploring on a small basis a larger and more definitive project.

For the first 3 years of the program, projects have been limited to an annual expenditure of not more than $50,000 each, and the duration of support has been restricted to 3 years or less, with expectation that the local community will incorporate the desirable newly demonstrated services into regular programs. This has already occurred in several instances. Projects to date have been limited to chronic diseases and aging, maternal and child health, and occupational health.

A considerable number of local health agencies have accepted the challenge and opportunity provided by this mechanism of financial support and have been assisted in taking substantial steps along the way toward gaining new knowledge of public health importance, demonstrating the community application of knowledge available, and evaluating its effects.

Briefly summarized, a description of some of the local projects follows:

DISEASE DETECTION

The Long Beach City Health Department has completed a multiphasic screening project for detecting previously unknown or inadequately treated cases of diabetes, anemia, syphilis, high blood pressure, and overweight.

Multiphasic screening, as one effective means of early detection of chronic disease, has been used successfully many times in California over the past decade. For the first time, however, the Long Beach program built chronic-disease screening into regular health department operations on a demonstration basis. In addition to bringing unknown asymptomatic disease under medical management, other gains were sought from this endeavor—increase and awareness of the importance of regular medical checkups among persons who were screened and knowledge about community attitudes toward illness.

Evaluation of this project brought many significant implications for local health programing. Screening proved its potential for detecting previously

unknown cases of diabetes—especially among persons 40 years of age and over, pointing to the need for continuous casefinding services in the community. Classes of instruction for diabetes in the project helped diabetics gain a clearer understanding about the disease. Further, the project showed the multiphasic casefinding can be successfully carried out and merged with other regular local health department services.

REHABILITATION

A 3-year rehabilitation project, started in San Mateo County, is bringing physical restorative services into nursing homes. This is apparently the first time an organized rehabilitation program has been extended into private nursing homes in California.

The effectiveness of this new pattern of service is being judged by improvement in the health of the individual patient, as well as by the extent to which encouragement and assistance from their families is aroused. The medical community will have an opportunity to observe how organized restorative services in a nursing home help bring about higher levels of independent living among the chronically ill and aging.

In Alameda County, a 3-week course was organized to train nurses in newer rehabilitation techniques. The course was oversubscribed and repeated several times. Nurses who took the course are now effecting substantial improvement in many hospitals for long-term illness in northern California.

HOME CARE

One of the first applications to be approved under the new program was the Modoc County Nursing Service. The project aimed at lessening the burden on hospital facilities by bringing nursing care into homes, and was the first organized attempt in California to provide home nursing in a rural area. Services are being offered to everyone on a basis of medical need regardless of economic status, fees being charged where there is financial ability. Revenue from fees is used to partially sustain the costs of the operation.

Convinced of its practicability and value, the Modoc County Board of Supervisors recently resolved to assume local support for the project—adding an important and permanent new health service for the community.

Another home-care demonstration project has been developed in Los Angeles. Following highly successful home care for postpolio respirator patients, the attending staff of Los Angeles County Hospital and the Welfare Planning Council of Los Angeles are exploring, on a pilot basis, comprehensive home care as one means of meeting the heavy demand for medical services at the county hospital.

The continuous population growth in Los Angeles, as well as the increasing longevity of persons eligible for county medical care, make the problem especially severe in that community.

Patients treated in the home-care program are compared with a similar number of control patients who are receiving the usual hospital services. The age of the patients ranges between 60 and 70 years. Conditions treated in the home include diabetes with complications, cancer, heart disease, strokes, chest diseases, fractures, and burns. A broad scope of service is provided, including round-the-clock physicians' services, skilled nursing, laboratory, portable X-ray, social services, and physical and occupational therapy.

A preliminary review of data collected thus far shows great economic savings for some of the types of patients treated at home, and probably some savings of money for all patients thus cared for. While maintaining high quality care in the home, hospital beds are freed for other persons requiring immediate and intensive hospitalization.

EVALUATION OF OCCUPATIONAL HEALTH SERVICES

An intensive survey was carried out in San Francisco to assess the needs of the community for occupational health services and the resources which are available to meet them. Almost 10,000 occupational illnesses or disabling injuries are reported annually from San Francisco, and about 10 percent of available beds are occupied by patients receiving workmen's compensation benefits. Only about 175 professional persons, including doctors, nurses, safety engineers, and industrial hygienists, are available in the community to meet the need for protection against occupational injury and illness.

FAMILY TREATMENT PROGRAM FOR CONTROL OF DELINQUENCY

The Imperial County Health Department is seeking to provide continuous health supervision and medical care for children and their families who are eligible for county hospital care and services from the county welfare department. One important object is to overcome the usual fragmentation of health and welfare services.

Health supervision is provided in the well-baby clinic, with pediatric medical care as needed. The same pediatrician also supervises the pediatric hospital services at the county hospital for the same group of families, thus providing continuity of services and records.

As a part of this comprehensive family health service, the program proposes to study intensively a group of families with delinquent children. The aim is to determine the effects of a coordinated multidiscipline treatment program focused on the control and prevention of juvenile delinquency. Treatment includes total health and medical care plus social and psychological services for the delinquent and his family.

CONTINUITY OF HOSPITAL AND HOME NURSING

One of the serious and expensive breaks in usual health care of patients with chronic illness is the separation of home service from that of the hospital. In Santa Monica, a local hospital, the health department, the Visiting Nurse Association and physicians are cooperating on a project which places a nurse in the hospital with full-time responsibility for assuring good coordination of nursing service in the home with that in the hospital.

CONNECTICUT

GRACE-NEW HAVEN COMMUNITY HOSPITAL,
New Haven, Conn., May 13, 1961.

Hon. OREN HARRIS,
Chairman, House Interstate and Foreign Commerce Committee, Old House Office Building, Washington, D.C.

DEAR MR. HARRIS: I wish to strongly support and urge an increase in appropriation for research in hospital and medical care facilities, organization, administration, and related subjects.

I was a member of the Federal Hospital Council when the original $1,200,000 was appropriated. In my judgment, this step was one of the most important that has been made in stimulating improvement and development of better hospital and health care facilities in this country.

Prior to this appropriation, any studies or research in this field were almost exclusively the responsibility or the interest of the U.S. Public Health Service. They were doing a magnificent job, but were not tapping the vast resources of the great teaching centers and the universities in this country in this field.

I, frankly, was very dissatisfied with many of the original projects submitted for support from the newly appropriated funds. They were an illustration, however, of the lack of thinking and development of research facilities in this area in this country, and indicated even more clearly the need for stimulus and development in this field.

Over the years the quality of the applications and the type of work has improved steadily and along with this has developed a number of important university and major teaching hospital research centers that are contributing valuable information in this field. When one realizes the billions of dollars that are involved in the operation of hospitals as well as many milions in construction, it is obvious that if any improvement, simplification, or constructive change is to occur, it must come from research and objective study.

There is a growing need for adequate research funds. They cannot and should not all come from the Government. Individual hospitals and universities should share in this task. They are doing so. However, the present amount available through Federal funds for this area is embarrassingly small and totally inadequate. I would hope that it could be increased. I can assure you, that this is one investment that will return to the public in efficiency and economy of operation, the original investment manyfold.

The bill H.R. 4998 also is suggesting amending section 636 so that it will provide opportunity for the construction of experimental or demonstration hospitals as part of other medical facilities or projects. This is another area in which I can speak from experience inasmuch as this hospital and Yale University has been participting in a major research project on function and design

of hospitals for over 5 years. The problems of financing new construction or equipment that can be scientifically tested in an active hospital environment are many. Although we have utilized our engineering and mathematics colleagues and have made certain studies by simulated models which we have studied on computers, we obviously cannot prove anything without having actual experience with experimental equipment and hospitals.

We are very grateful to you for your interest and support in this area, and if there is any way that I can give you additional information or support, I would appreciate hearing from you.

With best wishes.

Sincerely yours,

ALBERT W. SNOKE, M.D.,
Executive Director.

BOARD MEMBERS' ORGANIZATION
OF CONNECTICUT PUBLIC HEALTH NURSING AGENCIES,
New Haven, Conn., May 18, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
Washington, D.C.

DEAR MR. HARRIS: I am writing to you in regard to the community health services and facilities legislation introduced by Senator Lister Hill and you.

As the president of this statewide organization of lay board members of 100 voluntary public health nursing agencies, I wish to go on record for my organization in favor of this bill. Howard A. Rusk, M.D., in the New York Times, made these statements, which express tersely and well our exact views on this matter:

"With the rising costs of hospital care, all medical economists agree that every effort should be made to provide medical and health services outside of the hospital whenever possible. This can be done by improving the quality and extending our national programs (and I would add local programs) of home care, home medical and health care, community health information and referral centers, and outpatient diagnostic services."

Your bill is essential to implement the Kerr-Mills law, in our opinion. We believe that public health nursing is vitally essential in rural communities. Dr. Rusk goes on to say, "In doing so [expanding nonhospital services], we will not only save money but will provide improved services for the early detection, treatment, and prevention of disease."

To quote from a letter which I have recently sent to the Connecticut Legislature for the Board Members' Organization: "In public health nursing agencies, lay board members as well as professionals believe and have demonstrated that patients are happier at home, and respond more positively to care at home once their need for the intensive service of the hospital is passed. Indeed, the need for hospitalization in many instances can be avoided when skilled nursing care is available in the home. Public health nursing agencies (visiting nurse associations) have as a primary goal that of teaching patients and families regarding self-care, as well as bringing into play current knowledge and concepts of rehabilitation so that independence of the individual can be maintained as long as possible."

We feel so strongly about this matter that if there is anything we can do to help, please let us know.

Sincerely,

MARJORIE W. RAMSAY,
Mrs. Robert E. Ramsay, *President.*

STATE OF CONNECTICUT,
STATE DEPARTMENT OF HEALTH,
Hartford, Conn., June 20, 1961.

Re H.R. 4998.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: House Resolution 4998 which you introduced on February 24 is of considerable interest to us here in Connecticut because we have a somewhat higher proportion of elderly people than does the Nation as a whole.

There is a great need for increasing such programs as those for home care and for improving nursing home services and I am therefore glad to know of your interest in furthering legislation such as this which means so much in relation to long-term health care.

Sincerely yours,

FRANKLIN M. FOOTE, M.D.,
Commissioner.

HAWAII

STATE OF HAWAII,
DEPARTMENT OF HEALTH,
Honolulu, May 17, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D.C.

DEAR SIR: On behalf of the health workers of the State of Hawaii, I would like to go on record as supporting H.R. 4998.

Extending and improving the quality, scope, and availability of community health services for the aged and the chronically ill outside of the hospital are most important health services that communities can provide in order to meet the changing needs of this group in our population. The high cost of medical care in general hospitals and the improvement in our knowledge of rehabilitation services are significant reasons for support of this measure. The increasing numbers of the aged and the chronically disabled in our communities require active health department leadership in improving community health services. Hawaii is endeavoring to meet this challenge as it has for the mentally ill and the mentally retarded.

H.R. 4998 will enable this State to extend and improve its services for our older and disabled population. This Federal financial assistance will be helpful in stimulating our programs and we would plan to use these funds to develop home care programs in conjunction with the outpatient departments in homes. We are interested in developing suitable programs and facilities for the long-term patient. The problem of chronic diseases presents many aspects—prevention, medical care in the home, hospital and nursing homes, convalescence and rehabilitation. The objective is to restore the individual as a self-supporting, productive member in the community.

For the reasons stated above, I strongly urge passage of H.R. 4998.

Very truly yours,

RICHARD K. C. LEE, M.D.,
Director of Health.

ILLINOIS

RESOLUTION OF ILLINOIS PUBLIC HEALTH ASSOCIATION

Whereas there are many areas in the State that have no community services for persons with long-term illnesses;

Whereas the development of community services for patients suffering with the long-term illnesses where none exists is a proper function of local full-time and health departments;

Whereas local full-time health departments need subsidies to employ additional staff before community services to patients with long-term illnesses can be provided; and

Whereas several years are required to develop such services before they can be supported primarily by the local community: Therefore be it

Resolved, That the Illinois Public Health Association recommend to the U.S. Public Health Service, the Illinois Representatives and Senators in Congress, and the Illinois State Legislature that action be taken to assure that appropriations will be made over a period of years to assist local full-time health departments in establishing needed community services for patients with long-term illnesses.

KENTUCKY

COMMONWEALTH OF KENTUCKY,
DEPARTMENT OF HEALTH,
Frankfort, Ky., June 16, 1961.

HON. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR MR. HARRIS: Attached is a copy of a letter which was forwarded to Representative John Watts of Kentucky.

It is thought that you would be interested in observing this comment which is typical of numerous Kentucky citizens who have been touched with this program. It is unfortunate that all of them are not really capable of putting into written word the expressions that are stated in this letter.

As you may recall we have been able to demonstrate in Kentucky that the home care program as referred to in H.R. 4998 can be exceedingly successful. If we can be of any further assistance in demonstrating the need for this legislation, we shall be more than glad to comply with any request.

Very truly yours,

RUSSELL E. TEAGUE, M.D.,
Commissioner of Health.

LEXINGTON, KY., *June 12, 1961.*

Representative JOHN C. WATTS,
Washington, D.C.

DEAR SIR: From a child I have loved older people. As I walked through the city to my high school it was touching to me to see old ladies and old gentlemen sitting on their porches; many in their wheelchairs fast approaching inactivity. It was not on any particular street, but on all streets, and on all levels of living standards. There was a need then; and more particularly now since our life expectancy has been raised to a higher age for those people to have care.

I had my mother and father in my home for about 10 years. Mother had a chronic heart ailment; father was confined to his wheelchair for 10 years. Father passed at the age of 92 last November 29, and mother 39 days later on January 7, 1961, at the age of 87.

One of their and my greatest blessings in the care of them was the efficient, attentive care and cooperation between our health nurse and doctor as carried out through the program for home care for older adults as practiced in Scott County and a few adjoining counties here in Kentucky.

Several years ago the hospital expenses were mounting so heavily they were becoming a serious problem. Our doctor advocated this home care program; and incidentally has worked vigorously to have it practiced for he feels as I feel there is a real need for it.

A healthy mind stems from a healthy body, and a satisfactory environment and if we will supply this care to our youth and our aged we will have made real progress in stemming the tide of communism and dissatisfaction.

I wholeheartedly advocate better care of our aged adults. I see constant neglect of them every place I go. Their problem is our problem to help them physically, mentally, and financially. Please give any legislative measure that comes before you your careful consideration and wholehearted support. For example H.R. 4998.

Yours sincerely,

NANCY BEATTY ELAM
Mrs. McKinley Elam.

GREEN COUNTY HEALTH DEPARTMENT,
Greensburg, Ky., May 31, 1961.

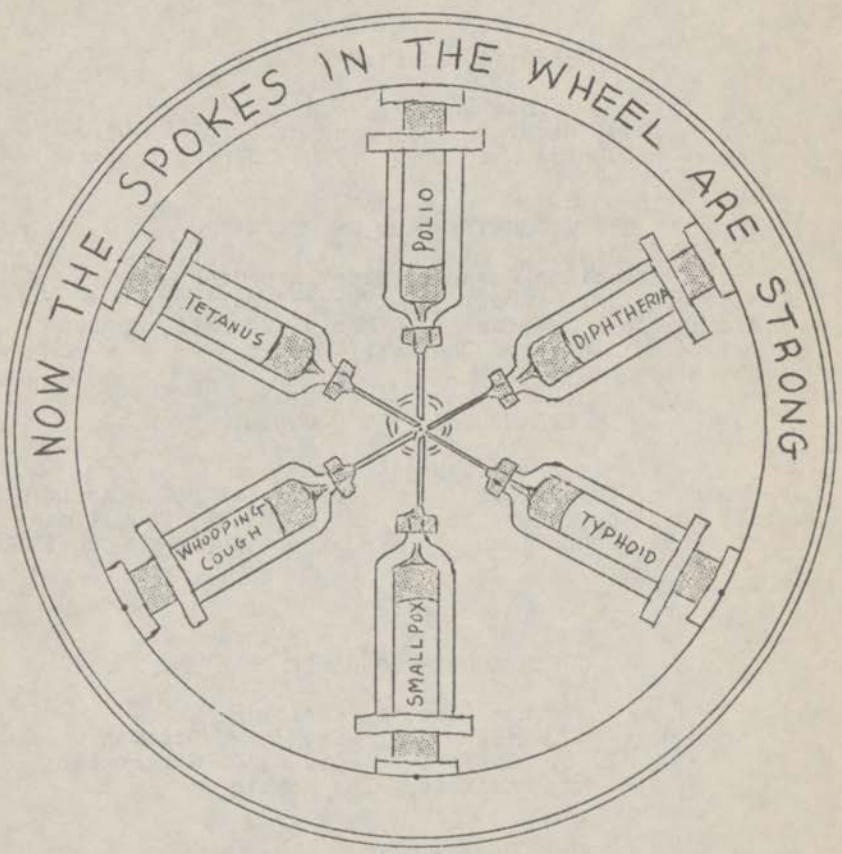
Mr. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
Washington, D.C.

DEAR MR. HARRIS: It has come to my attention that hearings are in progress on bill H.R. 4998; it would seem to me that this piece of legislation would fill a long-needed place in our rural health program. Provided that there is money earmarked for areas that are now destitute of facilities to care for the aged, the chronically ill, and the indigent. You are, I know, aware of statistics, but these are pertinent to our small county. We had 78 people of all ages die in our county last year; 49 of these people were over 65, some of them died in conditions that were as primitive as the conditions that their grandfathers died in. We do not have a single hospital bed in the county, we do not have a single nursing home bed in the county. There is a great need for such a bill as H.R. 4998, provided the money can be sent to the places that actually need it.

Sincerely,

SAM W. MOORE, *Administrative Assistant.*

P.S.—Enclosed is an annual report for the year 1960.



GREEN COUNTY HEALTH DEPARTMENT

ANNUAL REPORT

1960

GREEN COUNTY FISCAL COURT

Finis Durrett, Judge
R. P. Judd, Esquire — H. H. Lyle, Esquire
E. F. McCubbins, Esquire — T. J. Gorin, Esquire

GREEN COUNTY BOARD OF EDUCATION

Lucille Guthrie, Superintendent
Tom Sidebottom, Member — Vernard Wallace, Member
Voris Whitlock, Member — Mrs W. C. Bell, Member
Richard Shuffett, Member

GREENSBURG CITY COUNCIL

W. T. Boyd, Mayor
H. H. Durham, Councilman — Udell Kelly, Councilman
Russell Phillips, Councilman — E. J. Milby, Councilman
Robert Upton, Councilman — Garnett Gupton, Councilman

GREEN COUNTY BOARD OF HEALTH

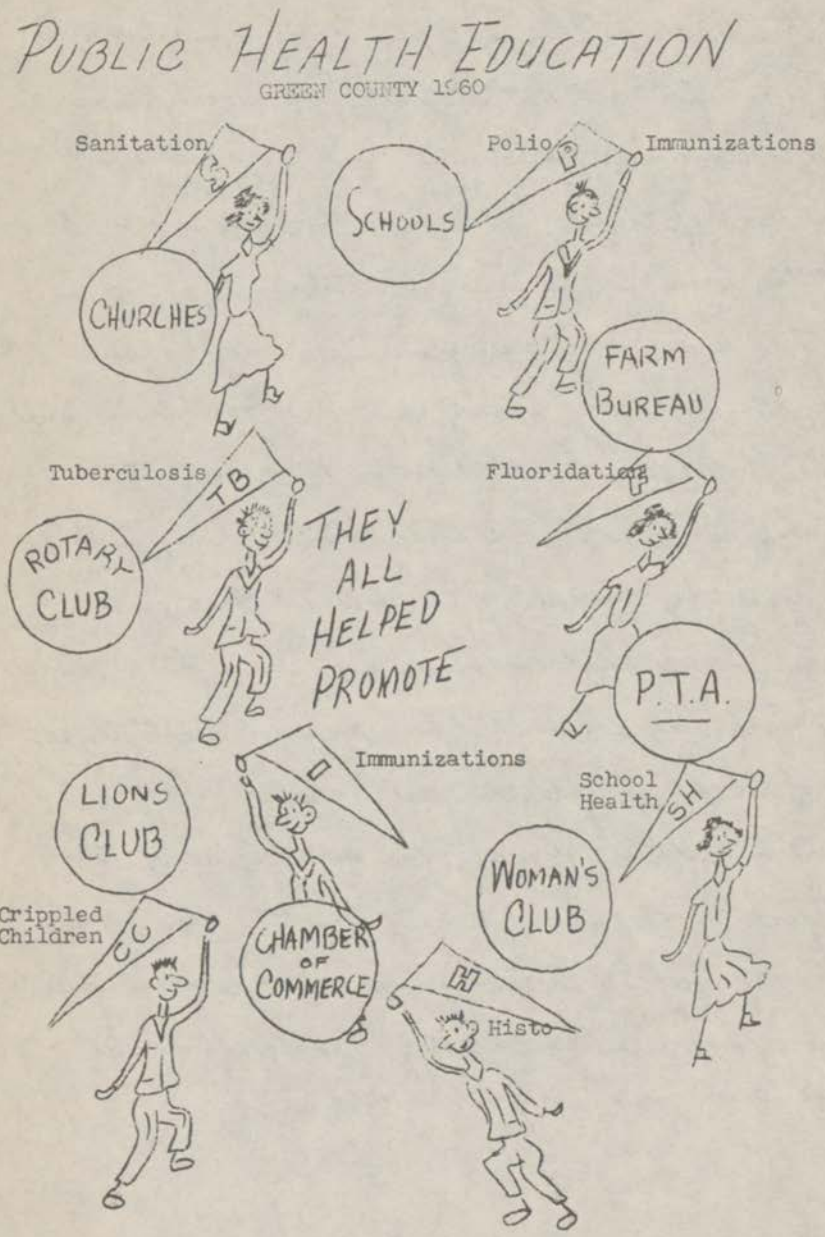
Finis Durrett, Chairman
Dr. J. W. Miller — Dr. J, M, Dishman
Dr. R. L. Shuffett — Dr. R. D. Winchester
Ray Shuffett, Lay Member

GREEN COUNTY HEALTH DEPARTMENT

Joseph R. Griffitt, M. D. Health Officer
Sam W. Moore, Health Administrator
Ruby N. Moore, Public Health Nurse
Charles F. Garnett, Sanitarian
Mell M. Lingle, Clerk

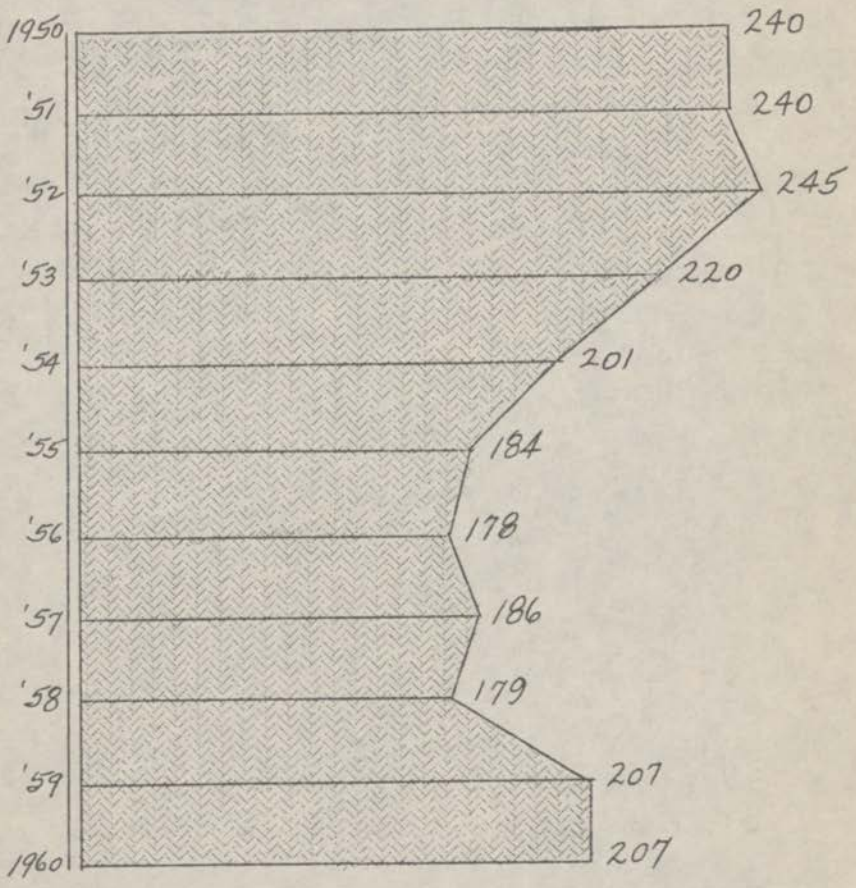
This is the 27th Annual Report of the Green County Health Department. Within it's self there is only those impassionate figures that show the gross effort in terms of hours of labor exerted by the personnel of the Green County Health Department.

The year 1960 by these figures one may measure effort, efficiency, money spent and their gross sum will be what a health department is worth to Green County in dollars and cents. What you can't measure by the sum of the data is the life it saved, those that walk in light may have walked in darkness, those that hear are not deaf, those that walk upright are not Crippled. These intangibles are "we hope" the sum total of the efforts of the Green County Health Department. This we feel is worth more since a man must have some inner satisfaction where God is not the measure of the world.


PUBLIC HEALTH EDUCATION
GREEN COUNTY 1960
Sanitation
CHURCHES
SCHOOLS
Polio
Immunizations
FARM BUREAU
Tuberculosis
TB
ROTARY CLUB
THEY ALL HELPED PROMOTE
Fluoridation
P.T.A.
Immunizations
LIONS CLUB
School Health
SH
WOMAN'S CLUB
Crippled Children
CC
CHAMBER OF COMMERCE
H
Histo

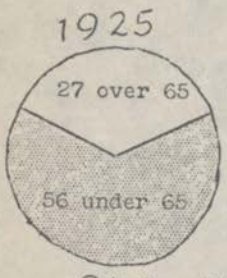
BIRTH RATE GREEN COUNTY 16.8

BIRTH RATE KENTUCKY 24.4

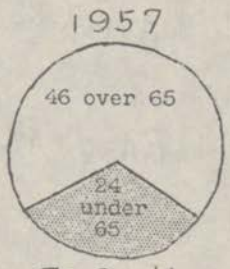


71495 O—61——20

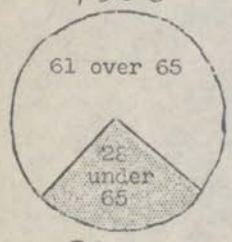
DEATHS OVER AND UNDER 65 YEARS AGE
GREEN COUNTY



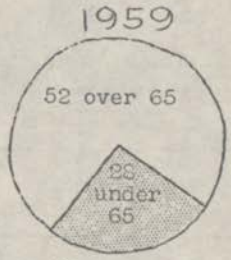
83 Deaths



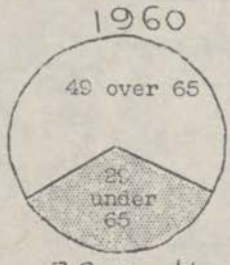
70 Deaths



89 Deaths



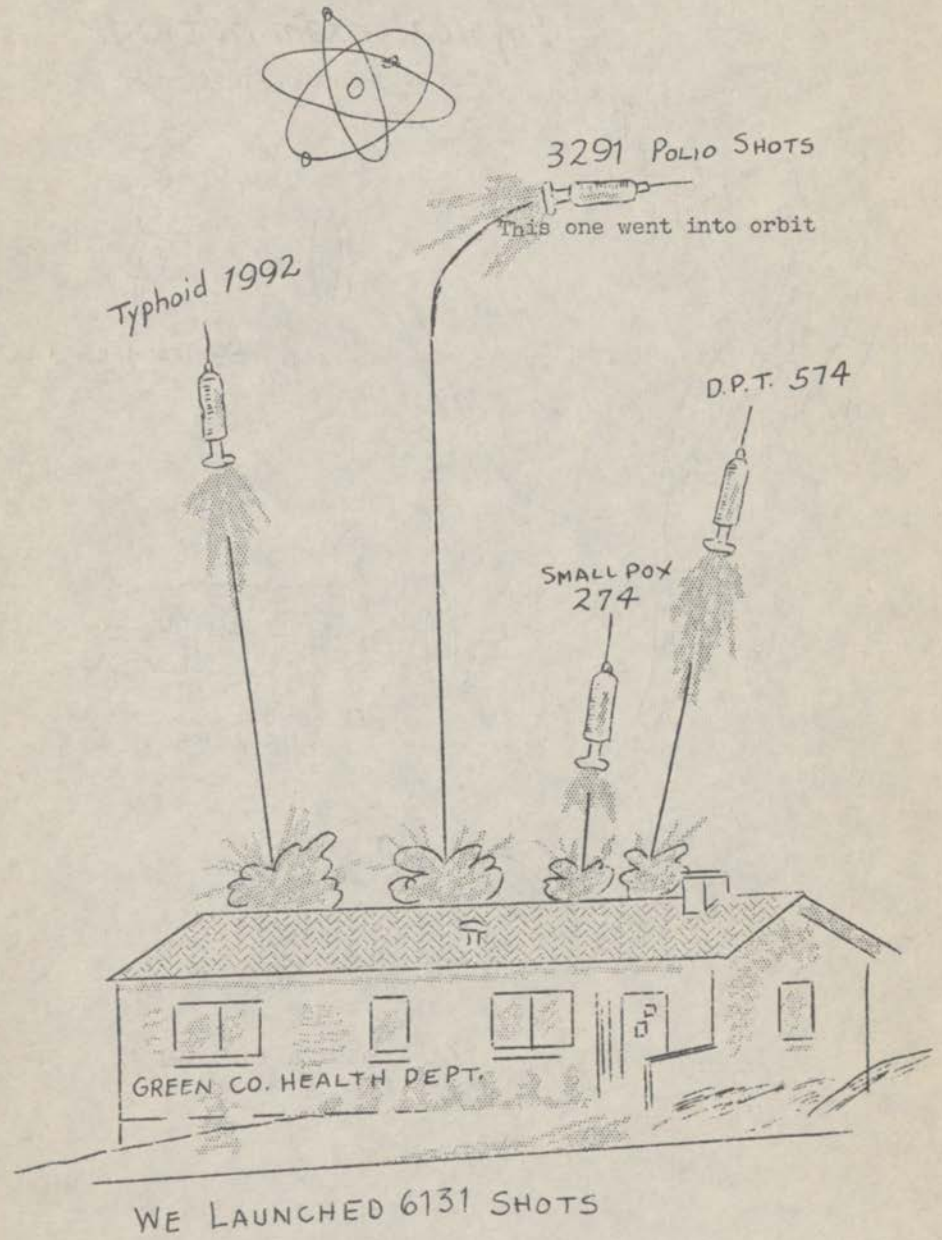
80 Deaths

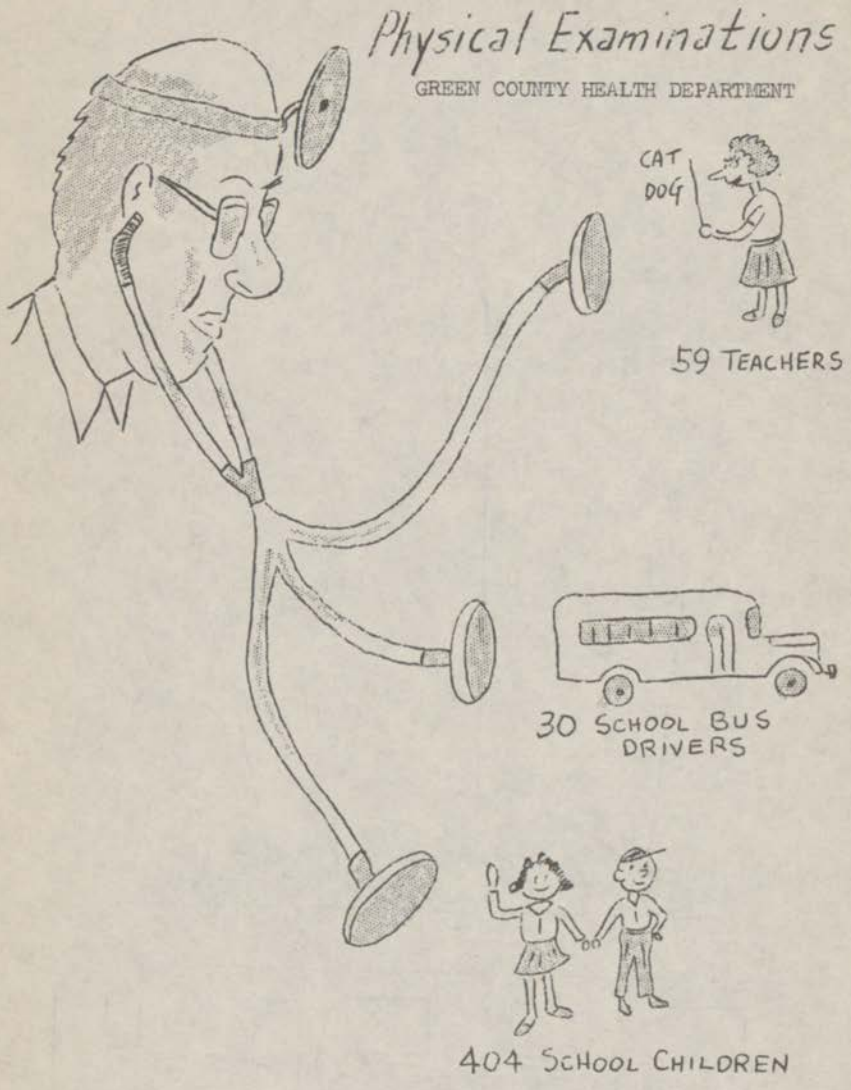


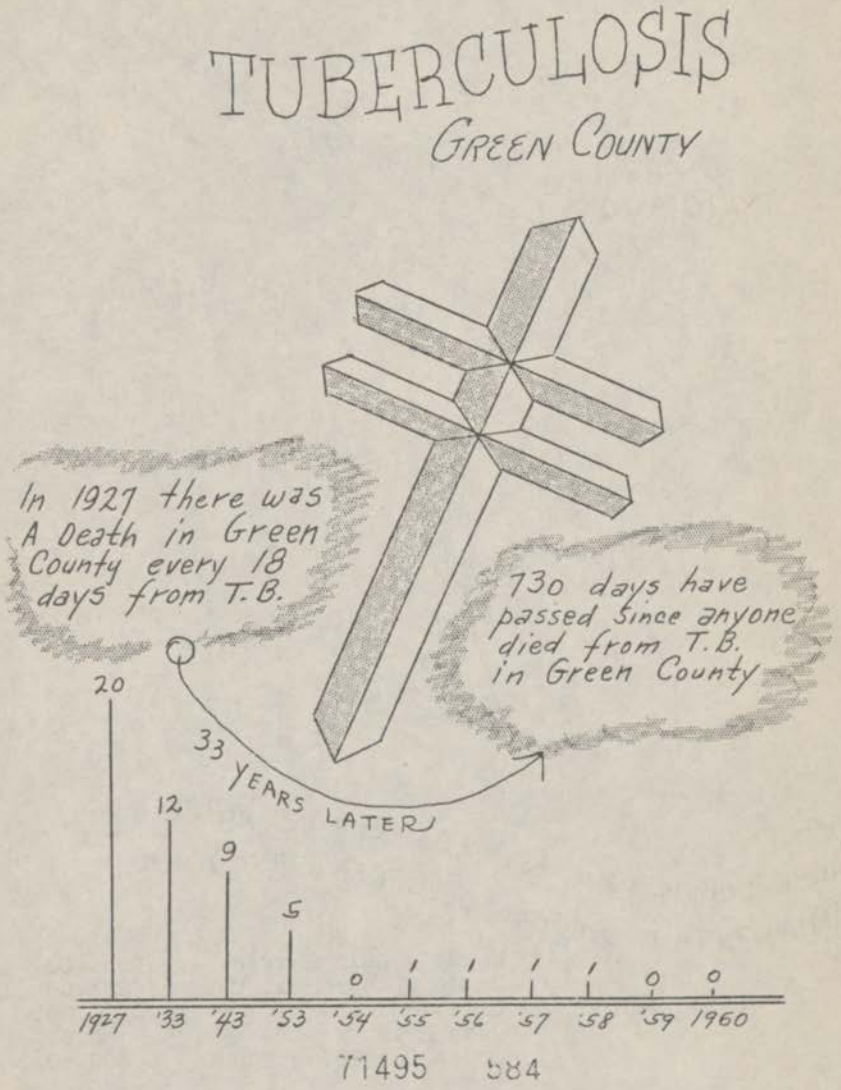
78 Deaths

47 Green Countians died in Green County 1960

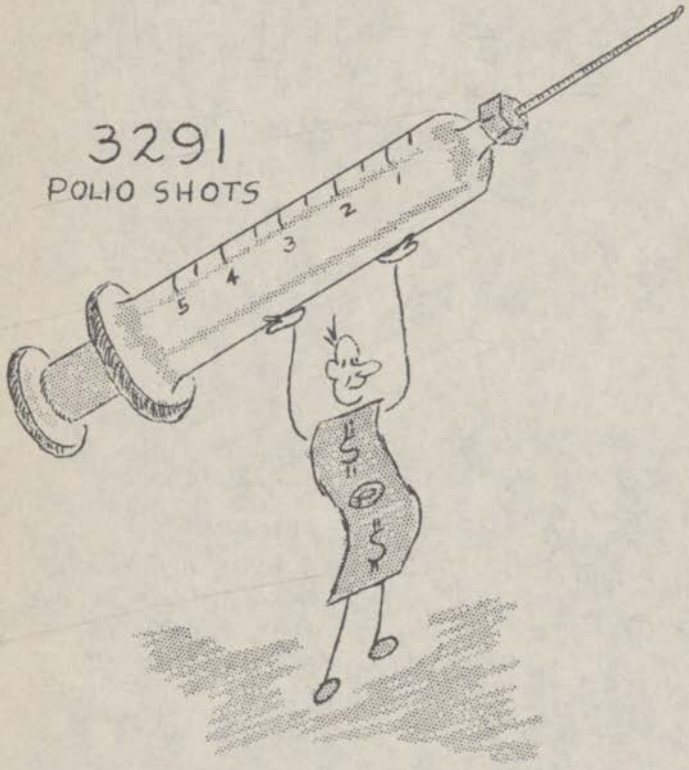
31 Green Countians died outside of Green County 1960


3291 Polio Shots
This one went into orbit
Typhoid 1992
D.P.T. 574
Small Pox
274
GREEN CO. HEALTH DEPT.
We Launched 6131 Shots


Physical Examinations
GREEN COUNTY HEALTH DEPARTMENT
CAT
DOG
59 TEACHERS
30 SCHOOL BUS DRIVERS
404 SCHOOL CHILDREN

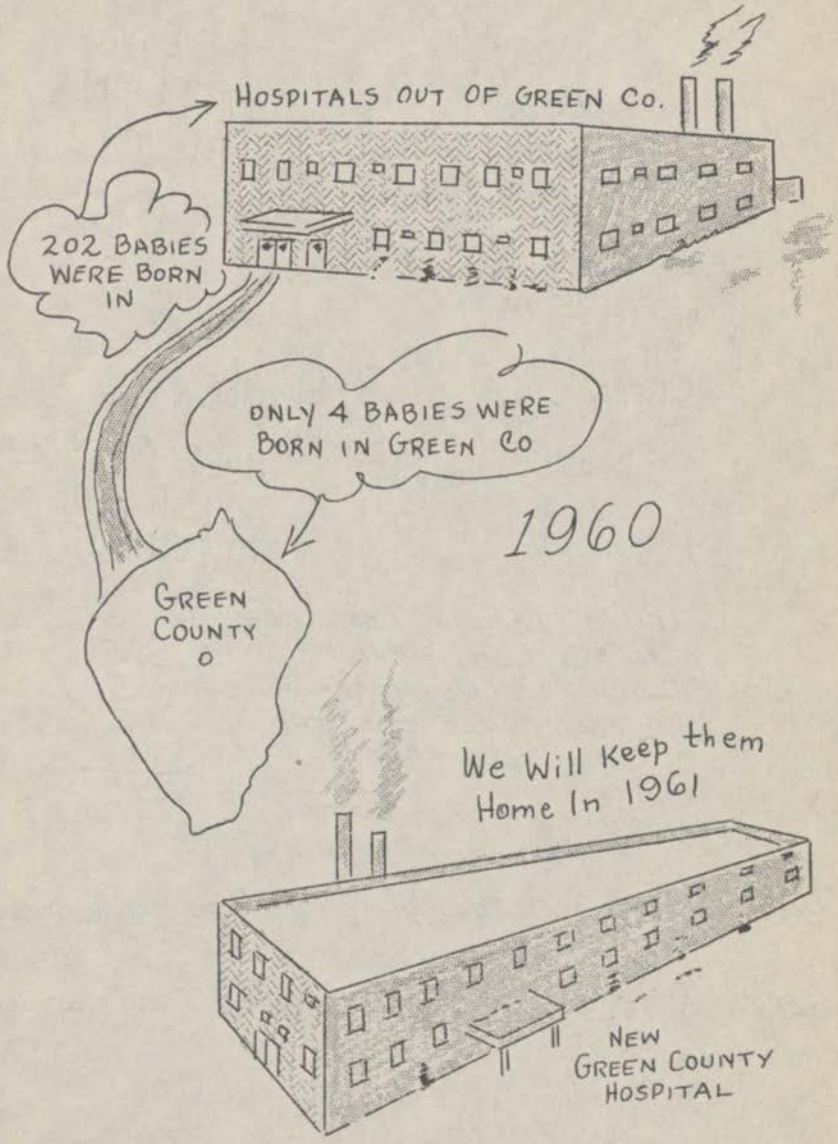

TUBERCULOSIS
GREEN COUNTY
In 1927 there was A death in Green County every 18 days from T.B.
730 days have passed since anyone died from T.B. in Green County
33 YEARS LATER
20
12
9
5
0
1
1
1
1
0
0
1927
'33
'43
'53
'54
'55
'56
'57
'58
'59
1960

71495 584

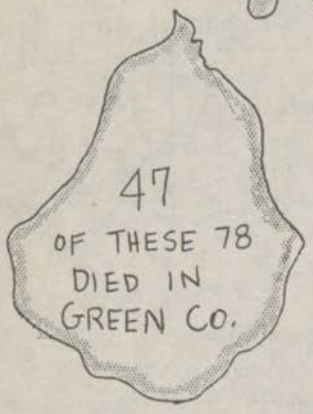


These people paid for the entire POLIO IMMUNIZATION program in GREEN COUNTY 1960

Danny's Acid Service	$350.00
James T Moore Oil Co.	281.00
Olie Larimore	20.00
John Ewing	5.00
Green Co. Polio Fund	500.00


HOSPITALS OUT OF GREEN Co.
202 BABIES WERE BORN IN
ONLY 4 BABIES WERE BORN IN GREEN Co
1960
GREEN COUNTY
We Will Keep them Home In 1961
NEW GREEN COUNTY HOSPITAL

78 GREEN COUNTIANS DIED IN 1960



31 DIED IN HOSPITALS OUTSIDE OF GREEN CO.

ELIZABETHTOWN HOSPITALS	5
GLASGOW HOSPITALS	15
LOUISVILLE HOSPITALS	3
CAMPBELLSVILLE HOSPITAL	2
OTHER HOSPITALS	6
TOTAL	31

DEATH RATE KENTUCKY 9.7 per 1000 population

DEATH RATE GREEN COUNTY 9.8 per 1000 population

ACTIVITIES HIGHLIGHTS OF GREEN CO. HEALTH DEPT.

6131 Immunizations
109 Immunization clinics
817 X-rays by Mobile X-ray Unit
36 Tuberculin Test
404 Health Examinations to children
180 Hearing examinations
102 Visits to schools by nurse
35 Talks by Health Department personnel
1097 Attendance to above
197 Dental examinations to children 5 years and older
21 Children given dental corrections
34 visits from State Health Department personnel
294 Visits or conferences with other individuals
26 Restaurants registered for supervision
128 Inspections and visits to above restaurants
13 Inspections and visits to itinerant restaurants
20 Insoections of schools
25 Inspections to public buildings
22 Investigations of nuisances
15 Nuisances found
13 Nuisances abated
4 Test Run, percolation / dye
89 Water samples to laboratory
222 Conferences with city or county officials
58 Conferences with managers / operators
8 Conferences with State Personnel
39 Conferences with School Personnel
12 Conferences with private citizens
4 Inspections and visits to swimming pool

MARYLAND

BALTIMORE, MD., *May 1, 1961.*

HON. OREN HARRIS,
Chairman, Commmittee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.:

As mayor of Baltimore City I urge your committee to take prompt and favorable action on H.R. 4998 because our studies show great need for expanding and improving community facilities for medical care of the aged, especially in their homes.

J. HAROLD GRADY,
Mayor of Baltimore, Md.

BALTIMORE, MD., *May 6, 1961.*

HON. OREN HARRIS,
Chairman, House Interstate and Foreign Commerce Committee,
U.S. House of Representatives, Washington, D.C.:

I am in favor of H.R. 4998 to assist in expanding and improving community facilities for the health care of aged and other persons in Maryland. There is need to develop additional health and health related services to complement existing public medical care programs. I am thinking especially of the need for trained personnel for a range of out-of-hospital services in the community. I am also in favor of the development of demonstrations of home care programs in different regions of these States.

THOMAS J. S. WAXTER,
Director, State Department of Public Welfare.

HEALTH AND WELFARE COUNCIL OF THE BALTIMORE AREA, INC.,
Baltimore, Md., May 29, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: Please give your strongest support to the community health services and facilities bill, H.R. 4998.

The chief need we see in Baltimore is for precisely the kind of services which this bill would promote. That means out-of-hospital services. We are working to get stronger local financial support for the voluntary health services such as the visiting nurses. But much more is required through a mixture of public and voluntary funds, for homemakers, rehabilitation therapy in the home, information and referral, transportation service, and all those services which are needed to maintain sick and disabled people in their homes.

Several committees of our council, each dealing with a different problem, have come to the same conclusion—that the philosophy of H.R. 4998 is exactly what the situation calls for.

Yours sincerely,

WILLIAM A. MARTIN,
Secretary, Community Problems Committee.

THE BALTIMORE COUNTY PUBLIC HEALTH ASSOCIATION, INC.,
Lutherville, Md., June 16, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: We respectfully request your vigorous support of Federal bill, H.R. 4998, which would permit increasing Federal funds for programs of immediate concern to Maryland residents.

These programs are in the areas of public health services to the aged and chronically ill, including studies and demonstrations to improve out-of-hospital services and facilities, for the construction of nursing homes and for training of personnel and research.

While the Maryland State Department of Health acknowledges progress made in some services for the chronically ill, the development of other services, especially nursing home care and services, have lagged. The Maryland Legislature has supported very well the State's plan for the improvement and development of nursing home services.

The construction of nonprofit and public nursing homes is now facilitated by State grants combined with Federal funds. Presently available Federal money is limited. Therefore, the prospect of additional Federal funds is urgently welcome.

Such funds through H.R. 4998 combined with State and local moneys will go far in developing these urgently needed home care services.

This association will be most appreciative of your cooperation in supporting the passage of this bill.

Sincerely yours,

HELEN P. CORBIN
Mrs. C. Reed Corbin,
Executive Secretary.

STATE OF MARYLAND,
STATE COORDINATING COMMISSION
ON PROBLEMS OF THE AGING,
Baltimore, Md., May 19, 1961.

In re H.R. 4998, community health services and facilities, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I am writing to express the genuine interest of our commission in the above-mentioned bill. The matters covered by this bill are those with reference to which our commission has been much concerned ever since its creation in 1959.

I am certain the commission would wish to be placed on record as favoring a favorable report on this bill by your committee. We hope such action will be taken at an early date.

Sincerely yours,

GERALD MONSMAN, *Executive Director.*

BALTIMORE COUNTY HEALTH DEPARTMENT,
Towson, Md., June 15, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House Office Building, Washington, D.C.

DEAR MR. HARRIS: The Baltimore County Commission on the Aging was organized on April 11, 1961, following appointment of members to the commission by the Honorable Christian H. Kahl, our county executive.

The Baltimore County Commission on the Aging has, through its legislative committee, seriously considered and thoroughly studied all of the provisions of bills H.R. 4998, H.R. 4999, S. 1071, and S. 1072. At its meeting on June 14 a resolution was unanimously adopted to endorse the provisions in these bills and to bring to your attention this action of the entire membership of our commission.

I have been authorized by every member of the commission to support you in your efforts to place these bills before the Congress and to respectfully request that your Committee on Interstate and Foreign Commerce support this legislation. On behalf of the Commission on the Aging in Baltimore County, I am making a similar appeal to the Honorable Samuel N. Friedel and the Honorable Lister Hill.

There is attached to this letter the membership of the Baltimore County Commission on the Aging.

Respectfully yours,

WILLIAM H. F. WARTHEN, M.D., M.P.H.,
Chairman, Commission on the Aging in Baltimore County.

MEMBERSHIP OF THE COMMISSION ON THE AGING IN BALTIMORE COUNTY

Dr. William H. F. Warthen, chairman; deputy State and Baltimore County health officer.

Rev. Robert W. Galloway, vice chairman; president of the Baltimore County Health and Welfare Council.

Mrs. Jacob Blaustein, well known in the metropolitan area for her association with many projects in the fields of philanthropic endeavor.
Mrs. E. Gillet Boyce, past president of the Aged Women's and Aged Men's Home.
Mrs. William H. Chambers, past president of the Baltimore YWCA and an active member of the Baltimore County Health and Welfare Council.
Mr. William J. Culbertson, Maryland State legislative representative of the Brotherhood of Railroad Trainmen.
Mr. Malcolm H. Dill, director of the Office of Planning and Zoning of Baltimore County.
Mr. James F. Everett, president of the Donnelly Advertising Corp. of Maryland.
Mr. David L. B. Fringer, member of the employment service division of the State department of employment security.
Dr. George S. M. Kieffer, distinguished general practitioner of medicine in Baltimore County.
Miss Irene Olson, director of the Baltimore County Welfare Board.
Mrs. Richard W. Opfer, junior league committeewoman.
Dr. Elinor Pancoast, professor emeritus of economics of Goucher College.
Mrs. Robert H. Riley, president of the First District Public Health Association of Baltimore County.
Mr. Walter Rothschild, vice president of the Sun Life Insurance Co. and active in Jewish philanthropy.
Mr. Cecil R. Ryan, secretary of the Baltimore County Health and Welfare Council.
Mr. Harry W. Schwarz, chairman of the Baltimore County Welfare Board.
Dr. Nathan W. Shock, chief of the Department of Gerontology of Baltimore City Hospitals (Eastern Avenue) and an internationally known gerontologist.
Dr. Bryce Smith, distinguished practitioner of dentistry in Baltimore County.
Mr. Hubert I. Snyder, director of the Baltimore County Department of Recreation and Parks.
Mr. Edward G. Stapleton, superintendent of schools of Baltimore County.
Mrs. Clayland A. Williams, director of the Children's Aid and Family Service Society of Baltimore County.

ANNE ARUNDEL COUNTY COMMISSION ON THE AGING,
A COMMITTEE OF THE
ANNE ARUNDEL COUNTY COUNCIL OF COMMUNITY SERVICES,
Annapolis, Md., June 22, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: The Anne Arundel County Commission on the Aging is concerned with the services which are offered by House bill 4998 (S. 1071). We trust you will give them favorable consideration.

Sincerely yours,

MARY P. FAWCETT,
Mrs. Arthur H. Fawcett,
Chairman.

MASSACHUSETTS

THE COMMONWEALTH OF MASSACHUSETTS,
DEPARTMENT OF PUBLIC HEALTH,
Boston, May 2, 1961.

Re H.R. 4998.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

MY DEAR MR. HARRIS: May I respectfully record the Massachusetts Department of Public Health in favor of the above legislation. I feel that this is extremely important legislation necessary to stimulate the development of community facilities in order to deemphasize the need for hospital care and place emphasis on preventive medicine. This country will not be able to deal effectively with the problems of the aged and chronically ill, if we continue to limit our support to hospital care and do not take vigorous steps to provide services and facilities outside the hospital. Many of the great advances in medicine

have been made in the field of prevention, and it is high time that the preventive type services be made available to this group in our population.

I would appreciate it if this letter was made part of the hearing record.

Sincerely yours,

ALFRED L. FRECHETTE, *Commissioner.*

THE COMMONWEALTH OF MASSACHUSETTS,
DEPARTMENT OF PUBLIC HEALTH,
Boston, May 4, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

MY DEAR MR. HARRIS: I should like to amend my recent comments to you in support of H.R. 4998 by expressing the hope that your committee will support proposals that may be introduced to include in this bill provision for the removal of the present $1 million ceiling earmarked by the Hill-Rhodes Act (Public Law 85-544). These funds which are presently inadequate for their purpose will become increasingly so.

The Hill-Rhodes funds, although extremely helpful, presently reimburse the schools for less than one-third of the deficit incurred by the schools in training federally sponsored students. The number of graduate schools in public health is increasing. One has already been accredited and there are others seeking accreditation.

I should like to give my wholehearted support to the efforts of the Association of Schools of Public Health in this regard. I should also appreciate it if this letter will be made part of the hearing record.

Sincerely yours,

ALFRED L. FRECHETTE, *Commissioner.*

NEWTON BOARD OF HEALTH,
Newton, Mass., May 16, 1961.

Representative OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR SIR: I am writing to you both as a private citizen and as a professional public health administrator asking you to exert your influence in support of the community health services and facilities bill (H.R. 4998).

Our health department in Newton and the community as a whole have become increasingly aware of the need for developing better community organization for meeting the needs of older people, the chronically disabled, and their families. We have recently established a home care and geriatrics program, which aims to make better use of the health, social, and personal services available outside of institutions. This has been set up with the support of the Newton Community Council and a financial backing from the Massachusetts Department of Public Health. Our first year of experience has amply confirmed the impression that much more can be done to assist patients and their families to meet the medical care needs in the home setting. One of the ways of making better use of community resources is to employ a coordinate whose function it is to assist the personal physician, the family, and the individual in accepting, procuring, and maintaining ancillary services in the home. With support and avalability of services, many realtives find that they can continue to cope with the problems of chronic disability without resorting to institutionalization—or at least postponing or abbreviating expensive hospital care.

I believe that the enactment of H.R. 4998 will make it possible for communities such as ours and many others to accelerate the developing of programs urgently needed to meet the changing needs of an aging population.

For your information I enclose two statements concerning our program, which may be of interest to you.

Very truly yours,

HARRY T. PHILLIPS, M.D.,
Director of Public Health.

NEWTON HOME CARE AND GERIATRICS PROGRAM, HEALTH DEPARTMENT, NEWTON, MASS.

A demonstration home care and geriatrics program has been established by the Newton Health Department in collaboration with the Newton Community Council and the assistance of the Massachusetts Department of Public Health.

What services will the program provide?

The program will assist the people of Newton by providing information, counseling, and coordinating services in connection with the care of elderly and long-term patients. Professional services of a medical social worker will be available through—

(1) an information and counseling service on medical care problems; and

(2) a home care program in which the medical social worker serves as coordinator.

What is home care program?

A home care program is an organized plan to assist the physician, the patient and the family during that phase of prolonged illness when the patient's needs can best be met in the familiar surroundings of the home. It is a centrally coordinated program which brings to the patient and family the benefits of planned, comprehensive, and continuing care through the organized use of medical, nursing, social, rehabilitative, and other community resources required by the homebound patient. Such a plan extends into the community the kind of coordinated operation that functions in a hospital. The home care program, however, is not a substitute for hospital or nursing home when these facilities are necessary for medical or nursing reasons; nor would it be recommended when unfavorable conditions in a particular situation make it impossible for the patient to be cared for at home.

What advantages does a home care program offer?

In the reports of various successful programs, the following advantages have been described:

1. It provides the family physician with a single source from which he can obtain a comprehensive array of nursing, social, and rehabilitative services, individualized and coordinated for the particular needs of the homebound patient and the management of his care.

2. It speeds recovery of those patients to whom the family environment has a therapeutic effect.

3. It bridges the gap in medical care for those patients too ill to visit an outpatient clinic, but who do not need inpatient facilities.

4. It shortens the length of stay of hospital patients and reduces the necessity for readmission of discharged patients by providing better follow-up care at home.

5. It meets the needs of a growing number of chronically ill and/or aged patients who do not require hospital care and for whom a more suitable place for care is lacking.

6. Although the objective of home care is not primarily the saving of expense, many programs emphasize the fact that the care of the patient in the home is a saving of public and private funds.

Who is eligible for home care service?

Any Newton resident with prolonged disability, regardless of his financial status provided that: (*a*) his personal physician considers medical care at home preferable for any reason; (*b*) there is someone in the home willing and able to assist with his care; and (*c*) more than one service is needed.

What agencies will cooperate with the program?

In addition to private physicians and dentists, available participants who give direct services include such agencies as the Visiting Nurse Association, Family Service Bureau, Red Cross, Newton-Wellesley Hospital, Newton Welfare Department and Newton Health Department. Where needed services are not available, it will be the responsibility of the coordinator to procure resources for specific needs. Inquiring families, able to pay for needed services which they do not realize are available to them, will be helped by the coordinator to select and make use of those which the community now offers.

Who will make the plan for the patient?

The physician in charge of the case will discuss the referral with the coordinator who will then explore the needs and resources of the patient and his family and their readiness to participate. A conference will be arranged for an evaluating and planning group made up of the patient's doctor, the program staff and representatives of all agencies whose services are required. The plan of care will be the result of group decision based on the doctor's recommendations. Conferences will be held periodically to evaluate the patient's progress and to consider his eventual discharge. The purpose of such conferences is to facilitate communication among those serving the patient.

Who will pay for the services?

Direct services will be paid for by the patient or his family if he is financially able to do so, just as at present. For those receiving assistance from the Department of Public Welfare, the department provides payment for various specified items of medical care as stated in the medical care plan of the Massachusetts Department of Public Welfare. When families are unable to pay for recommended services, the coordinator will be responsible for helping them obtain financial assistance from public or private sources.

The cost of administering the program is being borne by the Massachusetts Department of Public Health during the demonstration period.

How are referrals made?

Referrals to the home care and geriatrics program may be made by anyone in the community. Approval of the attending physician is essential before acceptance by the home care program. Referrals should be addressed to Mrs. Lucile Palmer, coordinator, home care and geriatrics program, City Hall, Newton—Bigelow 4–4700, Extension 247.

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH, INC.,
Boston, Mass., June 1, 1961.

Re H.R. 4998.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I trust that the activity of the deans of the 12 schools of public health in behalf of H.R. 4998 has been reflected in a much greater expression of interest in the bill throughout the country than was evident at the time of the committee hearings. We have alerted all 50 State health officers and many local health officers in key cities and districts to the importance of H.R. 4998 and have urged them to invite it to the attention of various groups and community leaders in their respective areas. As a result of our early communications with them, the State health officers were prepared to assist their Governors in replying to your inquiry of May 10, 1961.

We have also been in direct touch with influential citizens and organizations outside the health professions and, to them, have described H.R. 4998 as "perhaps the greatest legislative advance in public health since 1935 (when assistance to the States for public health was first provided)." We have stressed the fact that the bill would make possible an increase in the level of the grants which we may have come to think was fixed at the existing level, and would authorize new funds to meet the serious new problems of the aged and the chronically ill. The response in the form of letters to the committee members and to other members of the Congress constitutes real evidence that enactment of H.R. 4998 is needed and wanted in the States and communities throughout the country.

Although our recent efforts have been in behalf of the measure as a whole, because we believe in it deeply as public health people, our public health school leaders do hope very much that your committee will report it out with added provision for removal of the present ceiling on the Hill-Rhodes formula grants for comprehensive public health training. You will recall testimony suggesting this action on the grounds that:

(1) Comprehensively trained public health professionals will be needed to plan, organize and administer the community health services and facilities envisioned in H.R. 4998.

(2) The 12 schools of public health are the only source of such comprehensively trained people, who are in short supply.

(3) The present $1 million ceiling of the Hill-Rhodes Act (Public Law 85–544) reimburses the schools for less than one-third of the deficit incurred by the schools in training federally sponsored students.

(4) Two of the three ceilings in section 314(c) would be removed by the bill as introduced; it would be consistent and appropriate to remove the third, which is the Hill-Rhodes ceiling.

We have been advised that the Department of Health, Education, and Welfare would not object to the removal of the Hill-Rhodes ceiling as part of H.R. 4998. You may already have received informal advice to this effect from the Department. If not, I am sure an inquiry from you on this point would elicit favorable reply from the Department. I am sending a copy of this letter to Dr. Wilbur J. Cohen, Assistant Secretary for Legislation.

Please call on my colleagues and me in the schools of public health if we may provide further information or assistance. We are grateful indeed for your interest and leadership.

Sincerely,

HUGH R. LEAVELL, M.D., Dr. P.H.,
President.

THE MASSACHUSETTS ASSOCIATION FOR MENTAL HEALTH, INC.,
Boston, Mass., June 19, 1961.

Representative OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: I strongly urge the passage of H.R. 4998 and hope you will give it your support.

Sincerely yours,

EDWARD LICHTENSTEIN,
Director of Public Relations.

THE COMMONWEALTH OF MASSACHUSETTS,
SENATE,
Boston, June 19, 1961

Congressman OREN HARRIS,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: When I was in Washington June 14, I called at your office to tell you of my interest in H.R. 4998, expanding and improving community facilities and services. I talked with Mr. Williamson, clerk of your Committee on Interstate and Foreign Commerce and he suggested I write a letter setting forth the reasons I am supporting H.R. 4998 and said that it might be made a part of the record. I appreciate his courtesy very much and am glad of this opportunity as I could not attend the hearings on your bill because the Massachusetts Legislature was in session at the time.

My interest in public health covers many years of work in this field. I have served on the Board of Health of the town of Needham since 1927 and was reelected in March for another 3-year term. Also I am president of the Needham Community Council and we have a homemakers committee, senior citizens committee and help the handicapped committee. I have been a member of the committee on public health since 1939, which was my first term in the house of representatives.

I am keenly interested, therefore, in H.R. 4998 which will give much needed assistance to health programs and facilities at the community level. We find a constant demand for homemakers in Needham (a town of 28,000 population) very difficult to fulfill. There is special need of a health center in Needham which could be affiliated with our hospital. This health center could have rehabilitation and workshop facilities, rooms for a much needed mental health clinic, and here could be the board of health office, now located in the basement of the town hall which is very inadequate. Our well-child conference could be in the health center also. On the second floor of this health center some rooms could

be provided for convalescent patients. This would release beds in the hospital for care of the seriously ill cases and would reduce the cost for the convalescent patients.

I am convinced that health programs at the community level must be improved in order to achieve better health for all people. This is the announced objective of H.R. 4998 and so I want to assure you it has my wholehearted support. As the need is urgent I hope it will be possible for your committee to expedite favorable action.

I saw my very good friend Congressman Hastings Keith on June 14 and told him of my interest. I am glad he is a member of your committee as he assured me of his approval of H.R. 4998.

Very sincerely,

LESLIE B. CUTLER,
Senator, Norfolk and Middlesex District.

MICHIGAN

COMMUNITY HEALTH ASSOCIATION,
Detroit, Mich., May 29, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: From the point of view of an organization like the Community Health Association of Detroit, a new group health plan tackling fundamental problems of health services for all segments of the community here, certain of the legislative proposals now before the Senate Committee on Labor and Public Welfare are of great importance. Let me deal briefly with each of these in turn.

The significance of H.R. 4998, the community health services and facilities bill, is clear to all organizations such as ours that are looking at the total health needs of the community and trying desperately to work out patterns or to stimulate action by others that will lead to the availability of health services of high quality, furnished on an economical basis, for all citizens. Sound developments for the aged and chronically ill and necessary studies and demonstrations in the utilization and provision of health services at the local level cannot be accomplished through voluntary, self-supporting efforts alone but must have help and backing from the Federal Government. We wish to express our strong support for H.R. 4998.

We believe that H.R. 4999, the health professions educational assistance bill, is equally important. The increasing shortages of medical, dental, and related personnel are quite evident to those of us engaged in health service programs. The pinch will be felt increasingly by the American people and there is real danger of deterioration in the quality of health care over future years at a time when we should be attaining constantly rising standards of care. It is perfectly clear that aid to the schools for the health professions must go beyond construction aid into special aid for worthy students and help, whether direct or indirect, toward faculty salaries and the operating costs of these schools.

As a problem combining in its operation the concept of group medical practice and prepayment, with comprehensive care being made available to all those selecting our program, we are particularly interested in H.R. 5887, the health services facilities bill. I can speak from personal experience in saying that it is extremely difficult for consumer-sponsored medical care plans to obtain adequate and fair financing for essential facilities through usual channels. It is ironic that profitmaking enterprises of all kinds receive active assistance in various ways from the Federal Government and yet no such assistance has been available to nonprofit, community-based plans of comprehensive care. H.R. 5887 has our strong endorsement, and we would urge that early hearings be scheduled to deal with this vitally important piece of legislation.

Yours sincerely,

F. D. MOTT, M.D., *Executive Director.*

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NEBRASKA

LINCOLN, NEBR., *May 4, 1961.*

Representative OREN HARRIS,
Chairman, House Committee on Interstate and Foreign Commerce,
Washington, D.C.:

Urge support for H.R. 4998. Grants sorely needed for Nebraska 350 nursing homes. Needed for construction purposes and for extending wide range of home care services and hospital research to develop methods for rehabilitation and other aspects of care of aging and chronically ill.

RUBY MCARTHUR, *R.N.,*
Chairman Legislative Committee, Nebraska,
States Nursing Association.

NEVADA

LAS VEGAS, NEV., *May 24, 1961.*

Congressman OREN HARRIS,
Interstate and Foreign Commerce Committee,
Washington, D.C.:

Urge H.R. 4998 be given "do pass" recommendation by your committee. Population expansion creating serious health problems. Only visiting nurse in Nevada paid for by Nevada TB & Health Association. Only four public health nurses in Clark County with population of 132,000 with 7,000 more persons added to county since 1960 census. Great need for beds for aged and chronically ill and hospital expansion.

JOHN PETER LEE,
Chairman, Clark County TB & Health Association.

NEW JERSEY

NEW JERSEY PUBLIC HEALTH ASSOCIATION,
Trenton, N.J., June 19, 1961.

Congressman KENNETH A. ROBERTS,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROBERTS: After a very careful review of H.R. 4998 known as the community health services and facilities bill, the New Jersey Public Health Association composed of over 700 lay and professional people interested in public health, have unanimously endorsed the purposes of this measure through the action of the executive board, May 26, 1961.

The home-rule philosophy is very strong in New Jersey. We have 570 municipalities and each municipality is charged with the basic responsibility for the enforcement of the health laws as promulgated by public health council through the State sanitation code. The State sanitation code is the minimum requirement, and each municipality has the legal right to add to or make more stringent these requirements. In over 400 of these municipalities, there is no full-time licensed and qualified personnel. Therefore, the enforcement of the health laws falls upon the tax assessor or some other municipal official who has a basic job other than health law enforcement.

In order to bring some order into this chaotic situation, the New Jersey State Department of Health must, through grants-in-aid, persuade these municipalities to combine into larger units so as to make the population base large enough for the organization of an effective health unit. New Jersey now has more population per square mile than any State in the Union. Our seashores daily present sewage disposal problems and other environmental sanitation problems of real magnitude that cannot be solved within the framework of each individual municipality.

When eastern equine encephalitis hit New Jersey, we were not prepared to cope with it because of the patchwork pattern of health services. The recent outbreak of infectious hepatitis, traced to the eating of clams from polluted waters, is another example of how diseases, directly traceable to inadequate local health units, can affect a whole State.

Your earnest consideration of this measure will help preserve the famous shores of New Jersey for the whole Nation to use, and make it possible for the State department of health to voluntarily raise standards through a greatly expanded grant-in-aid program. We trust that you will vote affirmatively when the matter comes before the whole committee and support it on the floor when it comes to House action.

Very truly yours,

WALDO R. MCNUTT, L.L. B., M.P.H.,
Chairman, Legislative Committee.

NEW MEXICO

ALBUQUERQUE, N. MEX., *May 4, 1961.*

Representative KENNETH A. ROBERTS,
Chairman, Subcommittee on Health and Safety,
U.S. House of Representatives, Washington, D.C.:

The New Mexico Nurses' Association urges favorable consideration of H.R. 4998. This proposed legislation will provide funds for needed home-nursing services for the aged and incapacitated. Your support will be appreciated.

BEATRICE C. MARTIN,
Executive Secretary, New Mexico Nurses' Association.

NEW YORK

MONTEFIORE HOSPITAL,
New York, N.Y., May 26, 1961.

Representative OREN HARRIS,
Chairman, House Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: We here at the hospital have a great interest in your bill, H.R. 4998.

It would be very helpful to us if you could indicate to me your evaluation of the progress of this bill in your committee, and, if possible, could you send me a copy of the bill, plus any transcript of committee hearings, if and when it becomes available?

Respectfully yours,

H. LUKASHOK, *Assistant Director.*

NEW YORK, N.Y., *May 24, 1961.*

Representative OREN HARRIS,
House of Representatives, Washington, D.C.:

I strongly support H.R. 4998, the community health services and facilities bill introduced by you in the House and Senate respectively, and urge that your committee act favorably upon this legislation. It is desperately needed in New York City as well as in other communities throughout the United States. We are now carrying a staggering burden in attempting to provide adequate preventive and restorative services for the increasing numbers of aged and chronically ill persons in our communities.

Unless we can develop and test out new methods for caring for these persons such as home care services, homemaker services, physical therapy, and high-quality nursing home care, we will be short both on the quantity and the quality of care needed by thousands of citizens.

While this legislation will not provide the facilities or underwrite the costs of the total amount of care that is needed, it would provide some funds, and the initiative and the leadership which will enable us to experiment with improved ways of creating and organizing health services outside of the hospital so that we could begin to cope with this enormous problem in a more efficient and up-to-date manner.

Every objective of this proposed legislation represents an item we in New York City are trying to accomplish with meager resources, or it is one we have wanted to undertake. All too often we have been unable to start worthwhile demonstration projects because we could not find the limited funds required. On the basis of our experience, we know it is possible to develop such projects which will lead to practical programs.

Today, there are many chronically ill patients for whom in-hospital care is not what is required. Hospital care is far too expensive an item to be used needlessly. This legislation will help to bring the benefits of modern medical knowledge to all our people at a cost that they and their communities can afford.

Sincerely,

ROBERT F. WAGNER,
Mayor, City of New York.

HEALTH INSURANCE PLAN OF GREATER NEW YORK,
New York, N.Y., May 22, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I am writing this letter in support of H.R. 4998 and H.R. 5887. HIP is a volnutary nonprofit health insurance plan operating under the insurance laws of the State of New York.

Our plan covers 618,000 enrolled persons who receive medical care from 32 medical groups in the five boroughs of New York City, Nassau and Suffolk Counties, and Hudson County. Because HIP is one of the many rapidly growing prepaid group practice plans in many parts of this country that deliver medical care services instead of cash reimbursement, its ability to fulfill its purpose depends upon the availability of adequate facilities and equipment.

The need for financial aid beyond those currently accessible to prepaid group plans in the support and construction of health facilities is well illustrated by recent HIP experience. When HIP began some 14 years ago, its founders contemplated that existing community hospitals would be used by HIP for inpatient care. HIP today still relies upon community hospitals, but in recent years it has become increasingly evident that these arrangements are unsatisfactory and constitute an ever-present threat to the survival of the program.

The growth of HIP and the growing scarcity of beds in certain New York neighborhoods form the background for this situation. In the foreground is the fear of medical society leadership that prepaid group practice threatens the fee-for-service solo practice system of medical care which they favor. Their desire to impede the growth of plans like HIP is, therefore, made easier as hospital beds become scarce. It is now difficult (and in some cases impossible) for a doctor affiliated with HIP to obtain hospital admitting privileges. The situation, therefore, varies from critical (where HIP doctors cannot gain admittance to a good hospital) to unsatisfactory (where only inferior facilities in proprietary hospitals are available).

Even if the situation should somewhat ease, and beds were to become available in increasing numbers to individual doctors in our medical groups, this would still be far from an adequate solution. Group practice cannot achieve its maximum benefit to patients unless all of the doctors in a group can hospitalize in one facility. Only under these conditions can the medical group work most effectively as a coordinated team.

We have sought to achieve this desirable objective in various ways. We have explored the possibility of purchasing an existing proprietary hospital, converting it into a nonprofit voluntary hospital, and then making its beds available to all of the doctors in one or more of our medical groups. We have analyzed the economics of several such opportunities and were satisfied that the resulting hospital organization could be run under nonprofit auspices, could maintain satisfactory medical standards, and would not show a deficit.

We also know of nonprofit voluntary hospitals in other communities which are adequate in every respect, and which would be willing to admit all the doctors of one or more of our medical groups but are precluded from doing this because of the shortage of beds. In these cases, financial assistance to the hospital to provide for new beds would solve our problem.

In still another case, where the community desperately needs new hospital facilities, we have engaged hospital experts to prepare plans for a combined hospital-group-practice unit. Again, we were satisfied that we could supply medical care of high quality and with substantial economies by building such a facility if only we could find the necessary money.

In our search for financial resources, we have explored the following approaches, with the results as indicated:

(1) Foundations: We have approached a dozen or more foundations in an effort to interest them in the support of a hospital designed to demonstrate the advantages of combining inpatient facilities with a group practice outpatient unit. No foundation was willing to make a grant for this purpose. The reasons given were various, among others, the reluctance to become engaged in an obligation which might continue beyond the initial construction period, the belief that such activities were beyond the proper scope of charitable foundations, and the concern in some instances of current interpretations of certain sections of the Internal Revenue Code.

(2) Community funds: Fund drives for a community hospital are usually initiated either by the community chest for the entire community or by a religious organization with emotional access to members of the church. It is difficult, and we were advised that in our case it would be almost impossible, to go to the community to build a hospital primarily for persons enrolled in a prepaid insurance plan.

(3) Subscriber population: In some communities a prepaid group practice plan has raised substantial moneys from their own subscriber population. This is particularly true where the group practice plan has its roots in a cooperative movement. In HIP, however, the bulk of our subscribers are members of an employer group (such as employees of the city of New York) or a union welfare fund. In such instances, the individual members feel less involved in the affairs of the plan than do individual subscribers to a cooperative movement.

(4) Union welfare funds: Trustees of several union welfare funds in the New York City area have indicated an interest in investing part of their portfolios in a community hospital, but they would have to be assured of the stability of this investment and would need guarantees that the interest and amortization would be met. A small amount of equity money could accomplish this, and could, through the leverage of a relatively small guarantee, obtain substantial financial backing. But once again we were blocked because of our inability to obtain either equity money for this purpose or someone to guarantee the loan.

(5) Commercial loans: Banks and other lending institutions are unwilling to provide funds for the entire cost of any such project, and even when their resources are made available for a substantial part of the project, the commercial rates of interest and amortization schedules are so high that the resulting costs of operating the facility are prohibitive.

(6) Financing by participating physicians: Proprietary hospitals in an area of bed shortages are sufficiently profitable so that it is comparatively easy to obtain financial backing from participating physicians of a group practice organization. In one instance, such financial backing has been instrumental in providing much needed beds for HIP patients. We are convinced, however, that this source of money is not desirable in the long run. No matter how high the integrity of the participating doctors, such a financial arrangement creates a conflict of interest between keeping the hospital solvent and profitable, and operating the program at as low a cost as possible in the interest of the subscribers.

I hope that this recital of recent efforts on the part of one prepaid group practice plan to obtain financial support will reinforce the arguments you have already received in favor of this legislation. We hope that you will put this legislation high up on the list of priorities of your committee. In this time of medical crisis, we know of no way which the Government could adopt to spend more wisely, to get results more quickly, and to foster a pattern of medical care best designed to meet the problem.

Please be assured that we are anxious to serve your committee in any way we can that will help you in your deliberations.

Sincerely,

DONALD B. STRAUS.

VISITING NURSE SERVICE OF NEW YORK,
New York, N.Y., May 17, 1961.

Hon. OREN HARRIS,
House of Representatives, Washington, D.C.

MY DEAR SIR: Although it has never been the policy of this organization to express official approval or disapproval of proposed legislation, my associates on the board of directors of the Visiting Nurse Service of New York, and I, are deeply interested in H.R. 4998 entitled "Community Health Services and Facilities Act of 1961," and I feel compelled to express to you our approval of the bill.

We who are interested in finding the best ways and means of delivering good medical care are not in agreement as to how this can best be done. I think we are fortunate that professional, trained people from a variety of sciences frequently supported by Government, are devoting themselves to this problem. As a result I am sure that there will be developed in time a system that will be most beneficial and most economical for the people of this country.

Although there are those who feel that hospital-centered medical programs provide the greatest opportunity for advance in the science and practice of medicine, they are well aware that greater knowledge and improved techniques result in correspondingly higher costs. This is perhaps unavoidable.

Fortunately, many aged and chronically ill (frequently medically indigent) do not require the very expensive hospital care which is available, and their needs can best be served by a variety of extramural outpatient services, including properly supervised, high quality nursing homes and visiting nurse services.

We, therefore, support unequivocably the bill which you and Senator Lister Hill, of Alabama, have placed before the Congress, and wish to express our gratitude to you for your work in this connection, and the hope that your efforts will meet with success.

Respectfully,

EDMUND A. ROSENTHAL, *President.*

CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK, INC.,
New York, N.Y., May 25, 1961.

Hon. OREN HARRIS,
House of Representatives, House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: Although the Citizens' Committee for Children's health section and board of directors has not taken an official stand on the community health services and facilities bill, House Resolution 4998, Senate 1071, which you have introduced, Mrs. Alt, the chairman of our health section, and Mr. Isaacs, the chairman of our legislative section, have unofficially sent out the enclosed memorandum and summary to our members. I hope that you will be hearing from some of them in response to this memorandum.

It would be helpful to me to have 10 copies of the bill and to know which committee it is before in the House. Could the bills possibly be sent to me by return mail?

It would also be helpful for us to have available any other explanatory material which you may have.

Thank you very much.

Cordially,

BETTY BERNSTEIN, *Assistant to the Director.*

CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK, INC.,
May 25, 1961.

To: Interested CCC members, particularly members of the health section.
From: Mrs. Edith Alt, Hon Stanley M. Isaacs.

We are writing this letter in our personal capacity to you, as a person who is a member of the CCC and vitally interested in expanding the knowledge and methods in children's health services. The letter is taking this unofficial form

because neither the health section nor the board of CCC had the opportunity to pass on this matter. We hope that after reading the summary attached, you agree with us that this is a landmark in forward-looking health legislation. We hope you will write to your own Representative in Congress,[1] to Representative Oren Harris, and any other Congressman you may know.

This bill introduced in the U.S. Congress by Congressman Harris and Senator Hill deals with community health services and facilities.

If this bill is enacted into law, it will provide funds for improving some of the community health services in which we are much interested, e.g., homemaker services, bedside nursing, new nursing techniques, and more visiting nurse service, as well as increasing outpatient diagnostic clinics. Item two, providing for the development of research, experiments, and demonstrations in other areas will aid us significantly in this metropolitan area in finding better methods to develop children's health facilities.

If you would like further information on the bill, please call Miss Betty Bernstein at the CCC office.

MAY 17, 1961.

COMMUNITY HEALTH SERVICES AND FACILITIES BILL—H.R. 4998, INTRODUCED BY CONGRESSMAN OREN HARRIS; S. 1071, INTRODUCED BY SENATOR LISTER HILL

SUMMARY

This bill deals with the organization and provision of health services for the aged and chronically ill, particularly outside the hospital and in the community, including homemaker services, home nursing, information and referral services, improved nursing home services and outpatient department services.

It would amend the Public Health Service Act to remove the ceiling on Federal health grants to States and to provide Federal funds for research and demonstrations in the above fields, in order to spur localities to invent and test out improved methods of dealing with chronic illness.

The main provisions of the bill are as follows:

1. Special project grants for improving community health services

Grants would be made available to State or other public or nonprofit private agencies or organizations for studies, experiments, and demonstrations looking toward the development of new or improved methods of providing health services outside the hospital, particularly for chronically ill or aged persons.

Activities could include beside nursing, homemaker services, physical therapy services, and other procedures to guarantee high quality of care. New nursing techniques, the development of more visiting nurse services and the increase in the number and quality of outpatient diagnostic clinics and health information and referral services also could be provided.

2. Research, experiments, and demonstration in utilization of medical facilities

These grants are designed primarily to develop new knowledge and techniques in the area of disability of the aged, in contrast to the community health grants which are designed primarily to provide service.

The major purpose of grants under this title would be the development of more effective organizational patterns for the provision of hospital and other services, community planning and coordination of hospital and medical facilities and services; the improvement of the efficacy of health and hospital services and of the architectural design of hospital and medical facilities.

3. Increase in grants for construction of nonprofit nursing homes

These grants for the construction of public and nonprofit nursing homes would aim to make the nursing home a real part of the community health chain. The annual Hill-Burton appropriations for nursing homes would be increased from $10 to $20 million.

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[1] In case you don't know the name of your own Congressman, you may obtain this information from the League of Women Voters, ORegon 9–3730.

STATUS

Hearings have been completed on H.R. 4998.

It is not yet known if the Senate will hold hearings.

Representative Harris urges pressure on all Representatives in order to help him get the bill out of committee and passed in the House. He reports apathy. The opposition is from those who are generally against Federal grants to the States.

NORTH CAROLINA

FORSYTH COUNTY HEALTH DEPARTMENT,
Winston-Salem, N.C., June 22, 1961.

Hon. OREN HARRIS,
Chairman of the House Committee on Interstate Foreign Commerce, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: For many years I have been interested in finding ways and means in which a community can provide better medical and nursing care for the chronically ill in an economical and practical manner. H.R. 4998, in my opinion, will do very much to help communities develop such a program. Providing a degree of financial assistance and working through already existing agencies would seem to be the most practical approach.

I think this bill would be of great help to our communities, and I hope that you will support it.

Sincerely yours,

FRED G. PEGG, M.D., *Health Director.*

THE DISTRICT HEALTH DEPARTMENT,
ORANGE-PERSON-CASWELL-CHATHAM-LEE COUNTIES,
Chapel Hill, N.C., June 23, 1961.

Hon. OREN HARRIS,
Chairman of the House Committee on Interstate Foreign Commerce, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: I respectfully ask that you and your fellow Congressmen give favorable approval to H.R. bill 4998. This bill which you and your committee are now considering is termed the Community Health Services and Facilities Act of 1961 (H.R. 4998; S. 1071). The enactment of the above bill would permit the State of North Carolina and its 100 counties to develop services for persons with long-term illnesses. This bill would provide an incentive to the individual counties for establishing and maintaining programs similar to that we have operated in Person County, N.C.

The District Health Department developed the first rural home care program to be established in the United States. This project was supported by local, State, and Federal moneys. This project has proved its value and demonstrated the fact that people can be cared for in their homes without their being separated from the family, removed from the community and placed in expensive hospital beds in distant areas. It is the practical approach to a problem most of us are faced with.

The Community Health Services and Facilities Act would provide incentive and partially support a much needed program in the rural areas of our State.

Sincerely,

O. DAVID GARVIN, M.D., M.P.H.

P.S.—I enclose a brochure of the project development. I will be glad to forward you a copy of the final appraisal of this project if you are interested.

O.D.G.

NORTH DAKOTA

NORTH DAKOTA STATE DEPARTMENT OF HEALTH,
Bismarck, May 2, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.

DEAR SIR: Your committee is presently considering H.R. 4998. This proposed legislation is an amendment to several sections of the Public Health Service Act and one addition. Generally the proposals provide: Increased Federal aid to States for public health facilities, services, and training. More specifically these changes would remove the $30 million ceiling for annual assistance to States and also remove the $3 million ceiling on the portion now earmarked for public health training in the States.

In addition to these changes we hope that Congress will see fit to remove also the $1 million ceiling on the portion now earmarked for Hill-Rhodes grants to schools of public health.

The benefits derived from these changes would be a real asset to public health in our State and the Nation. For this reason I strongly endorse H.R. 4998 and request that my letter be included in the hearing record.

Sincerely yours,

W. VAN HEUVELEN,
Executive Officer.

SOUTHWESTERN DISTRICT HEALTH UNIT,
Dickinson, N. Dak., May 16, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.

DEAR SIR: Your committee is presently considering H.R. 4998. This proposed legislation is an amendment to several sections of the Public Health Service Act and one addition. Generally the proposals provide: Increased Federal aid to States for public health facilities, services, and training. More specifically, these changes would remove the $30 million ceiling for annual assistance to States and also remove the $3 million ceiling on the portion now earmarked for public health training in the States.

In addition to these changes, we hope that Congress will see fit to remove also the $1 million ceiling on the portion now earmarked for Hill-Rhodes grants to schools of public health.

The benefits derived from these changes would be a real asset to public health in our State and the Nation. For this reason, I strongly endorse H.R. 4998 and request that my letter be included in the hearing record.

Sincerely yours,

M. S. BYRNE,
Chairman, Board of Health, Southwestern District Health Unit.

THE FIRST DISTRICT HEALTH UNIT,
Minot, N. Dak., May 17, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: I am writing you regarding H.R. 4998 which is being considered by your committee.

This proposed legislation is an amendment to several sections of the Public Health Service Act and would provide for increased assistance to States for public health facilities, services, and training by removing the $30 million ceiling for annual assistance to States and also remove the $3 million ceiling on public health training funds.

The benefits derived from this proposed legislation would permit better local public health services and facilities in the rural areas where it is needed and where the financing of such programs without outside assistance is difficult.

For the reasons outlined we strongly endorse H.R. 4998 and urge it be given every support possible.

Very truly yours,

A. L. BAVONE,
Director, First District Health Unit.

OHIO

COLUMBUS, OHIO, *May 2, 1961.*

KENNETH A. ROBERTS,
House of Representatives, Washington, D.C.:

Urge your support of H.R. 4998 introduced by Representative Harris to assist expanding and improving community facilities and service for health care of aged and others.

DOROTHY A. CORNELIUS,
Executive Director, the Ohio State Nurses Association.

OREGON

STATE OF OREGON,
OREGON STATE BOARD OF HEALTH,
Portland, May 1, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D.C.

DEAR REPRESENTATIVE HARRIS: This letter is to indicate our support for H.R. 4998, with a request that this letter be included in the record of the hearing on the bill.

Studies made by the Western Interstate Commission on Higher Education indicate that professional schools in the West are not currently training sufficient health manpower to replace the losses by death, let alone the anticipated needs due to population increases and expanding health needs for the geriatric age group of the population.

Furthermore, these studies show that an actual increase in training facilities, as well as student scholarships to help keep these schools operating at full capacity, will be required if we are to begin to meet the health manpower needs of the West during the next decade.

It is believed that the enactment of Federal legislation such as H.R. 4998 is essential to the solution of the health manpower problem in the West.

Very truly yours,

RICHARD H. WILCOX, M.D.,
State Health Officer.

PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA,
DEPARTMENT OF HEALTH,
Harrisburg, May 3, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: We have studied your bill, H.R. 4998, and we believe that when it is passed it will permit us to take an important step forward in the field of public health.

Pennsylvania faces an increasingly serious problem in meeting the health needs of the aged and chronically ill. This bill will offer considerable assistance to us in meeting these needs. Although we have many nursing homes throughout the Commonwealth, there is an ever-increasing demand for additional beds. It has been our plan for some time to develop greater community health services to care for the geriatric patient outside the hospital and nursing home, but we have not been able to implement effectively such a plan. H.R. 4998 would help us expand and improve community facilities and services.

We wish to endorse strongly new section 316 authorizing special project grants to study new or improved methods for providing these health services outside the hospital. It is our feeling that this type of study and experimentation is necessary before we can overcome the great problems facing us in the care of the chronically ill and aged persons.

We wish to endorse the amendment to increase the grants for the construction of nonprofit nursing homes from $10 to $20 million.

The amendments to section 636 of the Public Health Service Act which will permit research, experiments, and demonstrations in the utilization of medical facilities of all kinds also has our support.

Since it will not be possible for me personally to appear before the committee in behalf of H.R. 4998, I would respectfully request that this letter be included in the hearing record.

Sincerely yours,

C. L. WILBAR, Jr., M.D.,
Secretary of Health.

PENNSYLVANIA PUBLIC HEALTH ASSOCIATION,
Harrisburg, Pa., May 3, 1961.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: As president of the Pennsylvania Public Health Association, I wish to put our organization on record as strongly in favor of H.R. 4998 which proposes Federal grants to assist in establishing community health services and facilities. The welfare and efficient health care of the aged and chronically ill is an increasingly important and acute public health problem in Pennsylvania and other States. The problem of healthful and appropriate facilities for their care constitutes an immediate problem but it is, at the same time, equally urgent that appropriate field investigation and research be supported in order that we may develop the most efficient programs for the care of the aged and the chronic ill and the best types of facilities in which to care for them, to include appropriate programs of home care, facilities for domiciliary care of groups, nursing homes, and appropriate hospital care for the more seriously ill when and where indicated. Until these researches are done and there is opportunity to develop programs and facilities based on the results, we shall continue to be faced with a critical problem and fail to provide adequately for increasing numbers of our population in the older age groups.

We would, therefore, like to urge passage of this important and much needed legislation so that health workers throughout the Nation may more adequately meet their responsibilities for the aged and chronically ill.

Sincerely yours,

TOM F. WHAYNE, M.D., *President.*

RHODE ISLAND

PROVIDENCE R.I., *May 5, 1961.*

Congressman OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.:

Do all you can to get bill H.R. 4998 through committee and House of Representatives. Findings and experience of the information and referral service operated within the Rhode Island Council of Community Services demonstrate the need of such services in Rhode Island as defined in H.R. 4998. Thank you, kindness personal regards.

MARY C. MULVEY,
Administrator, Division of Aging, State of Rhode Island.
JOHN P. CRONIN,
Chairman, Advisory Committee.
MEMBERS OF ADVISORY COMMITTEE.

PROVIDENCE R.I., *May 5, 1961.*

Representative OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.:

Urge your most vigorous efforts in getting through committee and House, H.R. 4998, community facilities and services on health care of aging, finding of our information and referral service for chronically ill and aging, document Rhode Island need for this legislation.

ELMER R. SHIPPEE,
President, Rhode Island Council of Community Services, Inc.

SOUTH DAKOTA

STATE DEPARTMENT OF PUBLIC WELFARE,
Pierre, S. Dak., June 16, 1961.

Hon. OREN HARRIS,
House of Representatives,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN HARRIS: The Governor has requested that we reply to your request for comments on H.R. 4998. This department administers the old-age assistance, aid to the blind, and aid to the disabled programs, so we are aware of the problems of the aged and disabled, particularly those who are without resources and who do not have relatives able and willing to care for them. Workers in our county offices are frequently distressed by aged or disabled persons living alone who are unwilling to leave their homes. Actually if they were willing to move into a congregate care facility it would be difficult to find an opening and much more expensive to care for them. Besides they are happier in familiar surroundings.

Many times the availability of services such as are contemplated by H.R. 4998 would mean the difference between a person's remaining in comparative comfort and safety in his own home, which is what he wants to do, and his either being in an unsafe and unhealthy condition or being forced into an expensive nursing home situation.

Recently (September 1960) we made a survey of old-age assistance recipients. Out of 8,729 recipients, 3,192 lived alone and 759 couples lived by themselves. This means a total of 4,710 or more than half of all recipients are living where they are dependent on their own abilities for all of the demands of living. This becomes even more significant when you note that 3,112, or two-thirds of these recipients, are more than 80 years old.

A little over 10 prcent were reported as definitely needing some care from others, from help in getting around outside the home to a very few reported as bedfast. Various methods are used now to secure this care and to give the needed lift with heavy tasks to the many others. In a few cases, a person is hired by the day to come in. In some communities a person has been found who gives the help needed in a number of cases on an informal homemaker basis. Neighbors look in on them and help sporadically. Sometimes youngsters are hired to do the yard work and run errands. Occasionally someone is paid to look in on a person two or three times a day just to see that he is all right. This is to say we recognize a definite need for community services for persons living in their own homes.

We also recommend that whatever community services are provided should be on a communitywide basis, available to those who can pay for them as well as for those dependent on community resources. Today with the number of persons receiving OASDI benefits there are more than ever numbers of persons not receiving public assistance but not in a much better position to secure extra services than are recipients. Even those with considerable financial resources have the same needs for these services which they cannot procure unless there are organized community services from which they can purchase the service they need.

Most skilled nursing homes now in the State have waiting lists and fill a bed as soon as it is vacated. There are many more applications from areas where nursing homes are needed in order to provide nursing home care near the patient's home than can be approved for Hill-Burton funds each year. Much is needed to be done to encourage such rehabilitation measures as physical therapy and occupational therapy.

The growth of community sponsored, high standard nursing homes since the provision of Hill-Burton funds for their construction, not only among those using the Hill-Burton funds but also those carrying their own financing, demonstrates the effectiveness of Federal financial assistance in stimulating community action. The response might not be as great for the kind of programs contemplated here, as they do not provide the same visible accomplishment as a building. Also in South Dakota there are only 8 cities of 10,000 or more and the development of these services in smaller communities may present more difficulties.

The State department of health can give you more precise information on these latter points, so I am forwarding your letter on to them for their additional comment.

Very truly yours,

MATTHEW FURZE,
State Director.
FERN L. CHAMBERLAIN,
Chief, Research and Statistics.

TEXAS

NEDERLAND, TEX., *April 18, 1961.*

KENNETH A. ROBERTS,
House of Representatives,
House Office Building,
Washington, D.C.

DEAR MR. ROBERTS: One of the greatest needs in our country today is competent assistants and doctors' nurses to help the doctor keep up with his ever-increasing patient load, and still do good prophylactic medical care.

While hospitals do need more nurses, it is also true that the doctor is seeing more and more patients in his office, and because of the increased number of medical procedures which are now carried out without hospitalization, his need for specially trained and competent doctors' nurses is ever increasing.

I should like to call your attention, as chairman of the committee on health and safety, to the following objectives of the American Association of DN's, a nonprofit association;

1. It attempts to establish the unique need for and position of the DN as the doctor's Girl Friday, whose training differs from, and is less extensive than for those doing hospital nursing.

2. It is instrumental in setting standards of training for DN's and in raising their level up to the standards established.

3. It brings about recognition of this special type of ancillary medical personnel and encourages young people to enter this field, possibly as a stepping-stone to full professional nursing.

4. It encourages doctors' nurses presently employed, to continue to study and improve themselves for the important part in the medical profession they so ably serve.

I should like to ask that consideration be given American Association of DN's request that any Federal aid to education proposals should include provision for furthering the education of this important group of ancillary medical personnel.

Sincerely,

MRS. WILLIE D. DEESE.

WEST VIRGINIA

CHARLESTON, W. VA., *May 15, 1961.*

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.:

The people of West Virginia desperately in need of health services which would be provided by enactment of H.R. 4998, the community health services and facilities bill. I strongly endorse this bill and urge your committee's support.

N. H. DYER, M.D.,
State Director of Health.

CHARLESTON, W. VA., *May 16, 1961.*

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.:

The executive council of the West Virginia Public Health Association in session on May 9 introduced a resolution stating that the people of West Virginia are desperately in need of health services which would be provided by enactment of H.R. 4908, the community health servicing and facilities bill. We strongly endorse this bill and urge your support.

B. S. BRAKE, M.D.,
President,
KATHERINE L. BROWN,
Executive Secretary, West Virginia Public Health Association.

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