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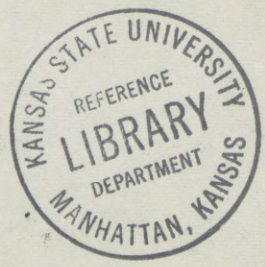
HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON
LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
EIGHTY-SEVENTH CONGRESS
FIRST SESSION

ON
S. 1071, H.R. 4998, and S. 719

BILLS TO ASSIST IN EXPANDING AND IMPROVING COMMUNITY HEALTH FACILITIES AND SERVICES, AND FOR OTHER PURPOSES

AUGUST 3 AND 4, 1961

Printed for the use of the Committee on Labor and Public Welfare



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COMMUNITY HEALTH FACILITIES AND SERVICES

HEARINGS

BEFORE THE

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OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE

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ROBERT W. BARCLAY, *Professional Staff Member*



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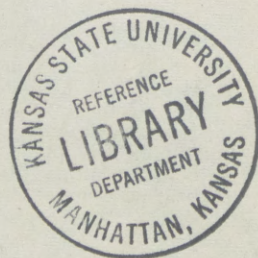
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COMMUNITY HEALTH FACILITIES AND SERVICES

THURSDAY, AUGUST 3, 1961

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 4230, New Senate Office Building, Senator Lister Hill (chairman) presiding.

Present: Senators Hill (presiding), Yarborough, Williams, Pell, and Javits.

Also present: Senator Smith of Massachusetts, a member of the committee.

Committee staff members present: Stewart E. McClure, chief clerk; John S. Forsythe, general counsel; Robert W. Barclay, professional staff member of the subcommittee; and John D. Stringer, minority associate counsel.

The CHAIRMAN. The subcommittee will kindly come to order.

The Subcommittee on Health is meeting this morning to consider S. 1071, which I introduced on February 24, 1961, and H.R. 4998, which was passed by the House of Representatives on July 25 last and referred to the Committee on Labor and Public Welfare.

S. 1071 is the proposed Community Health Services and Facilities Act of 1961, which is a part of the President's health program. It would authorize:

(1) Additional formula grants-in-aid, on a matching basis, to States to stimulate the development of public health programs in communities to assist in meeting the health needs of the aged and chronically ill;

(2) Project grants to public and nonprofit agencies to conduct studies and demonstrations designed to develop new or improved methods of providing health services outside the hospital, particularly for chronically ill or aged persons;

(3) An increase from \$10 million to \$20 million in the authorization of the Hill-Burton program for appropriations for Federal assistance in the construction of public and other nonprofit nursing homes; and

(4) The elimination of the authorization on appropriations for hospital research and the addition of authority to include grants for the construction and equipping of experimental or demonstration hospitals and other medical facilities.

S. 1071, I may say, is identical to H.R. 4998 as introduced in the House. As it passed the House, however, H.R. 4998 provided for a 5-year authorization and a ceiling on appropriations for the formula

grants-in-aid and project grants. In addition, the House-passed bill would—

(1) Increase the authorization for grants-in-aid to schools of public health from \$1 million to \$2,500,000;

(2) Increase the authorization for demonstrations, training of State and local public health personnel, and the detailing of Public Health Service personnel to assist the States from \$3 million to \$5 million;

(3) Repeal as of July 1, 1963, a provision of the Public Health Service Act authorizing, without any matching requirements, outright grants for the construction of health research facilities; and

(4) Extend for an additional year at its present level, the health research facilities program which authorizes Federal assistance on a matching basis for the construction of health research facilities.

(S. 1071, H.R. 4998, and S. 719 and departmental reports follow:)

[S. 1071, 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 purpose 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 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.

"(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 66 $\frac{2}{3}$ 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."

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

AN ACT 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) Subsection (c) of section 314 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 is authorized to be appropriated for each of the first five fiscal years ending after June 30, 1961, the sum of \$50,000,000 for each such fiscal year".

(b) The second sentence of such subsection is amended (1) by striking out "\$3,000,000" and inserting in lieu thereof "\$5,000,000", and (2) by striking out "\$1,000,000" and inserting in lieu thereof "\$2,500,000".

(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 of the first five fiscal years ending after June 30, 1961, the sum of \$10,000,000 for each such fiscal year, 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 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. Nothing in this Act shall preclude a State or community from establishing and collecting fees for personal health services which may be provided through programs financed from funds under this section when collection of such fees is authorized or required by State or local law.

"(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. 3. (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. 4. (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 66 $\frac{2}{3}$ 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.

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."

(d) Effective July 1, 1963, the parenthetical phrase in the first sentence of section 433 (a) of such Act which reads "(including grants-in-aid for drawing plans, erection of buildings, and acquisition of land therefor)" is repealed.

(e) Section 704 of the Public Health Service Act is hereby amended by striking out "five" and inserting "six".

(f) Section 705(a) of the Public Health Service Act is hereby amended by striking out "1961" and inserting "1962".

Passed the House of Representatives July 25, 1961.

Attest:

RALPH R. ROBERTS,
Clerk.

[S. 719, 87th Cong., 1st sess.]

A BILL To improve the public health through revising, consolidating, and improving the hospital and other medical facilities provisions of the Public Health Service Act, authorizing grants for construction of medical, dental, osteopathic, and public health teaching facilities, providing for Federal guaranty of loans for construction of group practice medical or dental-care facilities, 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 "Health Facilities and Training Act of 1961".

TITLE I—REVISION OF TITLE VI OF PUBLIC HEALTH SERVICE ACT

Sec. 101. Title VI of the Public Health Service Act (42 U.S.C., ch. 6A, subch. IV) is amended to read as follows:

"TITLE VI—ASSISTANCE FOR CONSTRUCTION OF HOSPITALS AND OTHER MEDICAL FACILITIES

"DECLARATION OF PURPOSE

"SEC. 601. The purpose of this title is—

"(a) to assist the several States in carrying out of their programs for the construction of such public or other nonprofit hospitals and other medical facilities as may be necessary, in conjunction with existing facilities, for furnishing adequate hospital, clinic, or similar services to all their people;

"(b) to stimulate the development of new or improved types of physical facilities for medical, diagnostic, preventive, treatment, or rehabilitative services; and

"(c) to promote research, experiments, and demonstrations relating to the effective development and utilization of hospital, clinic, or similar services, facilities, and resources, and to promote the coordination of such research, experiments, and demonstrations and the useful application of their results.

"AUTHORIZATION OF APPROPRIATIONS FOR CONSTRUCTION GRANTS

"SEC. 602. In order to assist the States in carrying out the purposes of section 601 (a), there are authorized to be appropriated for the fiscal year ending June 30, 1962, and for each of the two succeeding fiscal years—

"(a) \$150,000,000 for grants for the construction of public or other nonprofit hospitals and public health centers;

"(b) \$40,000,000 for grants for the construction of public or other nonprofit facilities for long-term care;

"(c) \$10,000,000 for grants for the construction of public or other non-profit diagnostic or treatment centers; and

"(d) \$10,000,000 for grants for the construction of public or other non-profit rehabilitation facilities.

"STATE ALLOTMENTS

"SEC. 603. (a) Each State shall be entitled for each fiscal year to an allotment of a sum bearing the same ratio to the sums appropriated for such year pursuant to paragraphs (a), (b), (c), and (d), respectively, of section 602 as the product of—

"(1) the population of such State, and

"(2) the square of its allotment percentage,

bears to the sum of the corresponding products for all of the States. Any amount allotted to a State (other than the Virgin Islands and Guam) under the preceding sentence for any fiscal year which is less than—

"(A) \$400,000, in the case of an allotment for the purposes of paragraph (a) of section 602,

"(B) \$200,000, in the case of an allotment for the purposes of paragraph (b) of such section, or

"(C) \$50,000, in the case of an allotment for the purposes of paragraph (c) or (d) of such section,

shall be increased to that amount, the total of the increases thereby required being derived by proportionately reducing the allotment for the purposes of such paragraph to each of the remaining States under the preceding sentence, but with such adjustments as may be necessary to prevent the allotment of any of such remaining States for the purposes of such paragraph from being thereby reduced to less than that amount.

"(b) For the purposes of this title—

"(1) The 'allotment percentage' for any State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States, except that (A) the allotment percentage shall in no case be more than 75 per centum or less than $33\frac{1}{3}$ per centum, and (B) the allotment percentage for Puerto Rico, Guam, and the Virgin Islands shall be 75 per centum

"(2) The allotment percentages shall be determined by the Surgeon General between July 1 and September 30 of each even-numbered year, on the basis of the average of the per capita incomes of each of the States and of the United States for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce, and the States shall be notified promptly thereof. Such determination shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such determination.

"(3) The population of the several States shall be determined on the basis of the latest figures certified by the Department of Commerce.

"(4) As used in paragraphs (1) and (2), the 'United States' means the fifty States and the District of Columbia.

"(c) Any sum allotted to a State for a fiscal year under this section and remaining unobligated at the end of such year shall remain available to such State, for the purpose for which made, for the next fiscal year (and for such year only), in addition to the sums allotted to such State for such purpose for such next fiscal year.

"MAXIMUM NUMBER OF BEDS FOR PURPOSES OF FEDERAL AID

"SEC. 604. The Surgeon General shall not approve under section 606 in any fiscal year any application for a project to provide additional beds for inpatient care if the number of beds to be provided by such project, when added to the number of beds to be provided by such project, when added to the number of existing beds (included in the State plan as in effect for such fiscal year) and the number of additional beds to be provided by projects therefore approved under this title for the State, will exceed the total prescribed by regulations approved for various types of facilities. Such regulations may provide for increasing such total of beds by the number of beds which were determined for a State to be in excess in any area of such State and were eliminated, pursuant to section 622 (a) of this Act as in effect prior to July 1, 1961, for purposes of the first plan of

such State approved under section 623 of this Act as in effect prior to July 1, 1961; and shall provide that beds for tuberculosis patients which are included in any project for a general or mental hospital which is approved under this title after June 30, 1961, shall, for purposes of the maximums established by such regulations, be deemed to be general hospital beds or beds for mental patients, as the case may be.

“STATE PLANS

“SEC. 605. (a) Any State desiring to participate in this title may submit a State plan. Such plan must—

“(1) designate a single State agency as the sole agency for the administration of the plan, or designate such agency as the sole agency for supervising the administration of the plan;

“(2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) will have authority to carry out such plan in conformity with this title;

“(3) provide for the designation of a State advisory council which shall include representatives of nongovernmental organizations or groups, and of public agencies, concerned with the operation, construction, or utilization of hospital or other facilities for diagnosis, prevention, or treatment of illness or disease, or for provision of rehabilitation services, and representatives of consumers familiar with the need therefor in urban or rural areas, to consult with the State agency in carrying out the plan, and provide, if such council does not include any representatives of nongovernmental organizations or groups, or State agencies, concerned with rehabilitation, for consultation with organizations, groups, and State agencies so concerned;

“(4) set forth, on the basis of a statewide inventory of existing facilities and a survey of need and, except to the extent provided by or pursuant to regulations, on the basis of community, area, or regional plans—

“(A) the number of general hospital beds, mental hospital beds, and long-term care beds needed to provide adequate facilities for inpatient care for people residing in the State, as determined by the State agency in accordance with criteria established in regulations, and a plan for the distribution of such beds in service areas (as defined in regulations) throughout the State;

“(B) the public health centers needed to provide adequate public health services for people residing in the State, as determined by the State agency in accordance with criteria established in regulations, and a plan for the distribution of such centers throughout the State;

“(C) the diagnostic or treatment centers needed to provide at least minimum diagnostic or treatment services to ambulatory patients residing in the State, as determined by the State agency in accordance with criteria established in regulations, and a plan for distribution of such centers throughout the State;

“(D) the rehabilitation facilities needed to assure reasonable access to rehabilitation services for disabled persons residing in the State, as determined by the State agency in accordance with criteria established in regulations, and a plan for distribution of such facilities throughout the State;

“(E) effective July 1, 1962, the extent to which existing hospitals and public health centers in the State are in need of modernization, as determined by the State agency in accordance with criteria established in regulations;

“(5) set forth a construction program which conforms to the provisions set forth pursuant to paragraph (4) and which provides for such needed hospital or long-term care facilities, public health center, diagnostic or treatment centers, and rehabilitation facilities, and for such needed modernization of hospitals and public health centers;

“(6) (A) set forth, with respect to each of such types of medical facilities, the relative need, determined in accordance with regulations, for projects for facilities of that type, with special consideration for facilities serving rural communities or serving areas with relatively small financial resources and, in the case of rehabilitation facilities, with special consideration for facilities operated in connection with a university teaching hospital which will provide an integrated program of medical, psychological, social, and vocational evaluation and services under competent supervision, except

that, on or after July 1, 1962, a State plan may, at the option of the State, provide for a division of the State's allotment for purposes of paragraph (a) of section 602 between projects for modernization of hospitals and public health centers for which an exceptional need (determined in accordance with regulations) exists, and other projects for which the allotment is available, and, in such case, such plan shall set forth separately the relative need for such modernization projects and the relative need for such other projects, but shall provide that no modernization project shall be approved under section 606 prior to approval thereunder of any of such other projects for the construction of a hospital which is in an area having no acceptable hospital beds, and which has adequate financial support and would otherwise meet the requirements of section 606(a), and (B) provide for the construction, insofar as financial resources available therefor and for maintenance and operation make possible, in the order of the relative need so set forth in accordance with clause (A);

"(7) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of facilities providing inpatient care which receive Federal aid under this title and, effective July 1, 1963, provide for enforcement of such standards;

"(8) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as the Surgeon General prescribes by regulations;

"(9) provide for affording to every applicant for a construction project an opportunity for a hearing before the State agency;

"(10) provide that the State agency will make such reports, in such form and containing such information, including copies of the State plan in revised form, as the Surgeon General may from time to time reasonably require, and give the Surgeon General, upon demand, access to the records upon which such information is based; and

"(11) provide that the State agency will from time to time review its program set forth in accordance with paragraphs (5) and (6) and submit to the Surgeon General appropriate revisions thereof, at such times as he may prescribe, and any other modifications thereof which the State agency considers necessary.

"(b) The Surgeon General shall approve any State plan and any modification thereof which complies with the provisions of subsection (a). If any such plan or modification thereof shall have been disapproved by the Surgeon General for failure to comply with subsection (a), the Federal Hospital Council shall, upon request of the State agency, afford it an opportunity for hearing. If such Council determines that the plan or modification complies with the provisions of such subsection, the Surgeon General shall thereupon approve such plan or modification. No change in a State plan shall be required within two years after initial approval thereof, or within two years after any change thereafter required therein, by reason of any change in regulations, except with the consent of the State or in accordance with further action by the Congress.

"APPROVAL OF PROJECTS FOR CONSTRUCTION

"Sec. 606. (a) For each construction project pursuant to a State plan approved under this title and for which funds are requested from an allotment under section 603, there shall be submitted to the Surgeon General through the State agency, in accordance with regulations, an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the project, the application may be filed by one or more of such agencies. Such application, in addition to setting forth a description of the site for such project and plans and specifications therefor, in accordance with regulations prescribing general standards of construction and equipment, shall include reasonable assurance that—

"(1) title to such site is or will be vested in one or more of the agencies filing the application or in a public or other nonprofit agency which is to operate the facility on completion of the project;

"(2) adequate financial support will be available for the completion of the project and for maintenance and operation of the facility when the project is completed;

"(3) the rates of pay for laborers and mechanics engaged in construction of the project will be not less than the prevailing local wage rates for similar work as determined in accordance with Public Law 403 of the Seventy-fourth Congress, approved August 30, 1935, as amended (40 U.S.C. 276a to 276a-5, inclusive);

"(4) in the construction of the project the applicant will comply with such regulations as may be prescribed with respect to use of competitive bidding (as defined in such regulations) in letting contracts for construction and to use of bonding, insurance, and other measures designed to assure completion of the project;

"(5) the facility will, when the project is completed, provide community service without discrimination on account of race, creed, or color; and

"(6) in the operation of the facility, if the project is for construction of a facility providing inpatient care, there will be compliance with applicable State standards of operation and maintenance.

"(b) The Surgeon General shall approve such application if—

"(1) the State agency has certified the Federal share of the project to the Surgeon General;

"(2) sufficient funds to pay the Federal share of the cost of construction of such project are available from the applicable allotment of the State;

"(3) the project is approved and recommended by the State agency; and

"(4) the Surgeon General finds that the application meets the requirements of subsection (a), is in conformity with the State plan, is entitled to priority in accordance with provisions included in the State plan pursuant to section 605(a)(6), over other projects in the State for which grants may be made from such allotment (or from the appropriate division of such allotment in the case of a State which has divided, pursuant to section 605(a)(6)(A), its allotment for purposes of paragraph (a) of section 602), and its approval is not prohibited by section 604.

The Surgeon General may approve such an application for a project for construction of a rehabilitation facility only if it is also approved by the Secretary of Health, Education, and Welfare. The Surgeon General may approve an application for a project for the construction of a diagnostic or treatment center only if—

"(A) the applicant is (i) a State, political subdivision, or public agency or (ii) a corporation or association which owns and operates a nonprofit hospital, or

"(B) the center is primarily for the diagnosis, or diagnosis and treatment, of mentally ill persons and, in the case of a nonprofit diagnostic or treatment center, the ownership or control of the corporation or association which will own and operate such center is sufficiently broad in the judgment of the Surgeon General to assure communitywide interest in the operation of such center, or

"(C) there is no hospital, and no hospital is, under the construction program for the State, to be constructed, in the area to be served by the center (which area shall be determined in accordance with regulations), the center is for provision of general diagnostic, or general diagnostic and treatment, services, and, in the case of a nonprofit diagnostic or treatment center, the ownership or control of the corporation or association which will own and operate such center is sufficiently broad in the judgment of the Surgeon General to assure communitywide interest in the operation of such center.

"(c) No application shall be disapproved until the Surgeon General has afforded the State agency an opportunity for a hearing.

"(d) Amendment of any approved application shall be subject to approval in the same manner as an original application.

"PAYMENTS FOR CONSTRUCTION

"Sec. 607. (a) Upon certification to the Surgeon General by the State agency, based upon inspection by it, that work has been performed upon a project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment is due to the applicant, such installment shall be paid to the State, from the applicable allotment of such State, except that (1) if the State is not authorized by law to make payments to the applicant, the payment shall be made directly to the applicant, (2) if the Surgeon General, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to section 608, payment may, after he has given the State agency notice of opportunity for

hearing pursuant to such section, be withheld, in whole or in part, pending corrective action or action based on such hearing, and (3) the total of payments under this subsection with respect to such project may not exceed an amount equal to the Federal share of the cost of construction of such project.

"(b) In case an amendment to an approved application is approved as provided in section 606 or the estimated cost of a project is revised upward, any additional payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

"WITHHOLDING OF PAYMENTS

"Sec. 608. Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the State agency designated as provided in section 605 (a) (1), finds—

"(a) that the State agency is not complying substantially with the provisions required by section 605 to be included in its State plan; or

"(b) that any assurance required to be given in an application filed under section 606 is not being or cannot be carried out; or

"(c) that there is a substantial failure to carry out plans and specifications approved by the Surgeon General under section 606; or

"(d) that adequate State funds are not being provided annually for the direct administration of the State plan,

the Surgeon General may forthwith notify the State agency that—

"(e) no further payments will be made to the State under this title, or

"(f) no further payments will be made from the allotments of such State from appropriations under any paragraph or paragraphs of section 602, or for any project or projects, designated by the Surgeon General as being affected by the action or inaction referred to in paragraph (a), (b), (c), or (d) of this section,

as the Surgeon General may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments may be withheld, in whole or in part, until there is no longer any failure to comply (or carry out the assurance or plans and specifications or provide adequate State funds, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

"JUDICIAL REVIEW

"Sec. 609. (a) If the Surgeon General refuses to approve any application for a project submitted under section 606 or section 619, the State agency through which such application was submitted, or if any State is dissatisfied with his action under section 608, such State may appeal to the United States court of appeals for the circuit in which such State is located by filing with such court a notice of appeal. The jurisdiction of the court shall attach upon the filing of such notice. A copy of the notice of appeal shall be forthwith transmitted by the clerk of the court to the Surgeon General, or any officer designated by him for that purpose. The Surgeon General shall thereupon file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code.

"(b) The findings of fact by the Surgeon General, unless substantially contrary to the weight of the evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Surgeon General to take further evidence, and the Surgeon General may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive unless substantially contrary to the weight of the evidence.

"(c) The court shall have jurisdiction to affirm the action of the Surgeon General or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

"RECOVERY

"Sec. 610. If any facility with respect to which funds have been paid under section 607 shall, at any time within twenty years after the completion of construction—

"(a) be sold or transferred to any person, agency, or organization (1) which is not qualified to file an application under section 606, or (2) which

is not approved as a transferee by the State agency designated pursuant to section 605, or its successor, or

“(b) cease to be a public health center or a public or other nonprofit hospital, diagnostic or treatment center, facility for long-term care, or rehabilitation facility,

the United States shall be entitled to recover from either the transferor or the transferee (or, in the case of a facility which has ceased to be public or nonprofit, from the owners thereof) an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the facility is located) of so much of the facility as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction of such project or projects. Such right of recovery shall not constitute a lien upon said facility prior to judgment.

“ADJUSTMENT OF ALLOTMENTS WITHIN A STATE

“Sec. 611. Upon the request of any State that a specified portion of any allotment of such State for the purposes of paragraph (a), (b), or (c) of section 602 be added to another allotment of such State for the purposes of another paragraph of such section (other than paragraph (a)), and upon simultaneous certification to the Surgeon General by the State agency in such State to the effect that—

“(a) it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approvable applications for such portion, or

“(b) in the case of a request to transfer a portion of an allotment made for purposes of paragraph (a) of section 602, use of such portion as requested by such State agency will better carry out the purposes of this title, the Surgeon General shall promptly adjust the allotments of such State in accordance with such request and shall notify the State agency, and thereafter the allotments as so adjusted shall be deemed the State's allotments for the purposes of such paragraphs.

“TRANSFER OF ALLOTMENTS TO ANOTHER STATE

“Sec. 612. In accordance with regulations, any State may file with the Surgeon General a request that a specified portion of an allotment to it for purposes of any paragraph of section 602 be added to an allotment of another State for purposes of the same or another paragraph of such section in order to meet a portion of the Federal share of the cost of construction of a project in such other State. If it is found by the Surgeon General (or, in the case of a rehabilitation facility, by the Surgeon General and the Secretary) that construction of the facility with respect to which the request is made would meet needs of the State making the request and that use of the specified portion of such State's allotment as requested by it would assist in carrying out the purposes of this title, such portion of such State's allotment shall be added to the specified allotment of the other State, to be used in accordance with such request. No portion of an allotment for purposes of paragraph (d) of section 602 may be transferred under this section to an allotment for purposes of a different paragraph of section 602; and an allotment for purposes of paragraph (a) of section 602 may be increased by transfer under this section only from an allotment for purposes of such paragraph.

“REGULATIONS

“Sec. 613. All regulations under this title shall be made only after consultation with the Federal Hospital Council.

“FEDERAL HOSPITAL COUNCIL AND ADVISORY COMMITTEES

“Sec. 614. (a) In administering this title, the Surgeon General shall consult with a Federal Hospital Council consisting of the Surgeon General, who shall serve as Chairman ex officio, and eight members appointed by the Secretary of Health, Education, and Welfare. Four of the eight appointed members shall be persons who are outstanding in matters relating to the provision of hospital, clinic, or similar services, three of whom shall be authorities in mat-

ters relating to the operation of hospitals or other types of medical service facilities, and the other four members shall be appointed to represent the consumers of such services and shall be familiar with the need for such services in urban or rural areas.

"(b) Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. An appointed member shall not be eligible to serve continuously for more than two terms (whether beginning before or after enactment of this section) but shall be eligible for reappointment if he has not served immediately preceding his reappointment.

"(c) The Council shall meet as frequently as the Surgeon General deems necessary, but not less than once each year. Upon request by three or more members, it shall be the duty of the Surgeon General to call a meeting of the Council.

"(d) The Surgeon General is authorized to appoint such special advisory or technical committees as he finds useful in carrying out the purposes of this title.

"(e) Appointed Council members and members of advisory or technical committees, while serving on business of the Council or their respective committees, shall receive compensation at rates fixed by the Secretary of Health, Education, and Welfare, but not exceeding \$50 per day, and, while so serving away from their places of residence, they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law (5 U.S.C. 73b-2) for persons in the Government service employed intermittently.

"CONFERENCE OF STATE AGENCIES

"SEC. 615. Whenever in his opinion the purposes of this title would be promoted by a conference, the Surgeon General may invite representatives of as many State agencies, designated in accordance with section 605, to confer as he deems necessary or proper. A conference of the representatives of all such State agencies shall be called annually by the Surgeon General. Upon the application of five or more of such State agencies, it shall be the duty of the Surgeon General to call a conference of representatives of all State agencies joining in the request.

"STATE CONTROL OF OPERATIONS

"SEC. 616. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility with respect to which any funds have been or may be expended under this title.

"RESEARCH, EXPERIMENTS, AND DEMONSTRATIONS IN UTILIZATION OF MEDICAL FACILITIES

"SEC. 617. (a) The Surgeon General is authorized to conduct research, experiments, and demonstrations relating to the effective development or utilization of the services, facilities, and resources of hospitals or other medical facilities and, after consultation with the Federal Hospital Council, to make grants-in-aid to States, political subdivisions, universities, hospitals, and other public or private nonprofit institutions or organizations for projects for the conduct of research, experiments, or demonstrations relating to the development, utilization, or coordination of the services, facilities, or 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. Any grant for any such project made from an appropriation under this section for any fiscal year may include such amounts for carrying out such project during succeeding years as the Surgeon General may determine; and any such grant may be made in such installments, and in advance or otherwise, as the Surgeon General may determine. 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 66 $\frac{2}{3}$ per centum of the cost of such project. The provisions of subsection (a) (3) of section 606

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. There are hereby authorized to be appropriated for each fiscal year for carrying out this section such amounts as the Congress may determine. The Surgeon General shall submit to the Secretary for transmission to the Congress, not later than January 1, 1964, a report on the administration of this section; and the Secretary shall include in such report his recommendations, if any, for amendment of this section.

“(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 refusing 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.

“GRANTS FOR PLANNING COORDINATED MEDICAL FACILITIES SYSTEM

“Sec. 618. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1962, and for each of the two succeeding fiscal years such sums as the Congress may determine to enable the Surgeon General to make grants to public or other nonprofit agencies and organizations to cover part of the costs of projects for developing comprehensive regional, metropolitan area, or other local area plans for coordination of hospitals and other medical facilities and services provided by such facilities, including grants to State agencies, designated in accordance with section 605, to cover part of their costs of projects for the acquisition and provision of basic data for and the provision of other technical assistance to the public or other nonprofit agencies and organizations in developing such plans.

“(b) A grant pursuant to subsection (a)—

“(1) may be made only for a project for which an application has been submitted or approved by the appropriate State agency or agencies designated in accordance with section 605;

“(2) may not exceed 66 $\frac{2}{3}$ per centum of the cost of the project with respect to which it is made; and

“(3) shall be made on such terms and conditions and in such installments, and in advance or otherwise, as the Surgeon General may determine.

“LOANS FOR CONSTRUCTION OF HOSPITALS AND OTHER MEDICAL FACILITIES

“Sec. 619. (a) In order further to assist the States in carrying out the purposes of this title, the Surgeon General is authorized to make a loan of funds to the applicant for any project for construction which meets all of the conditions specified for a grant under this title.

“(b) Except as provided in this section, an application for a loan with respect to any project under this title shall be submitted, and shall be approved by the Surgeon General, in accordance with the same procedures and subject to the same limitations and conditions as would be applicable to the making of a grant under this title for such project. Any such application may be approved in any fiscal year only if sufficient funds are available from the allotment for the type of facility involved. All loans under this section shall be paid directly to the applicant.

“(c) (1) The amount of a loan under this title shall not exceed an amount equal to the Federal share of the estimated cost of construction of the project. Where a loan and a grant are made under this title with respect to the same project, the aggregate amount of such loan and such grant shall not exceed an amount equal to the Federal share of the estimated cost of construction of the

project. Each loan shall bear interest at the rate arrived at by adding one-quarter of 1 per centum per annum to the rate which the Secretary of the Treasury determines to be equal to the current average yield on all outstanding marketable obligations of the United States as of the last day of the month preceding the date the application for the loan is approved and by adjusting the result so obtained to the nearest one-eighth of 1 per centum. Each loan made under this title shall mature not more than forty years after the date on which such loan is made, except that nothing in this Act shall prohibit the payment of all or part of the loan at any time prior to the maturity date. In addition to the terms and conditions provided for, each loan under this title shall be made subject to such terms, conditions, and covenants relating to repayment of principal, payment of interest, and other matters as may be agreed upon by the applicant and the Surgeon General.

"(2) The Surgeon General may enter into agreements modifying any of the terms and conditions of a loan made under this title whenever he determines such action is necessary to protect the financial interest of the United States.

"(3) If, at any time before a loan for a project has been repaid in full, any of the events specified in clause (a) or clause (b) of section 610 occurs with respect to such project, the unpaid balance of the loan shall become immediately due and payable by the applicant, and any transferee of the facility shall be liable to the United States for such repayment.

"(d) Any loan under this title shall be made out of the allotment from which a grant for the project concerned would be made. Payments of interest and repayments of principal on loans under this title shall be deposited in the Treasury as miscellaneous receipts.

"DEFINITIONS

"SEC. 620. For the purposes of this title—

"(a) The term 'State' includes Puerto Rico, Guam, the Virgin Islands, and the District of Columbia.

"(b) The term 'Federal share' with respect to any project means the proportion of the cost of construction of such project to be paid by the Federal Government, determined as follows:

"(1) With respect to hospitals and public health centers for which grants are made from appropriations under paragraph (a) of section 602, the Federal share shall be whichever of the following the State elects:

"(A) the share determined by the State agency in accordance with standards, included in the State plan, which provide equitably for variations between projects on the basis of objective criteria related to the economic status of areas and, if the State so elects, such other factor or factors as may be appropriate and be permitted by regulations, except that such standards may not provide for a Federal share of more than 66 $\frac{2}{3}$ per centum or less than 33 $\frac{1}{3}$ per centum, or

"(B) the amount (not less than 33 $\frac{1}{3}$ per centum and not more than either 66 $\frac{2}{3}$ per centum or the State's allotment percentage, whichever is lower) established by the State agency for all projects in the State;

"(2) With respect to all other facilities, the Federal share shall be whichever of the following the State elects:

"(A) the share determined by the State agency in accordance with the standards, included in the State plan, and meeting the requirements set forth in subparagraph (A) of paragraph (1),

"(B) the amount (not less than 33 $\frac{1}{3}$ per centum and not more than either 66 $\frac{2}{3}$ per centum or the State's allotment percentage, whichever is lower) established by the State agency for all projects in the State, or

"(C) 50 per centum of the cost of construction of the project.

The State agency shall, prior to the approval by it, under the State plan approved under this title, of the first project in the State during any fiscal year, give written notification to the Surgeon General of the Federal share which it has elected pursuant to paragraph (1), and the Federal share which it has elected pursuant to paragraph (2), of this subsection for projects in such State to be approved by the Surgeon General during such fiscal year, and such Federal share or shares for projects in such State approved by the Surgeon General during such fiscal year shall not be changed after approval of such first project by the State.

"(c) The term 'hospital' includes any general, mental, or other type of hospital, and related facilities, such as laboratories, outpatient departments, nurses' home and training facilities, and central service facilities, operated in connection with hospitals, but does not include any hospital furnishing primarily domiciliary care, any hospital primarily for the care and treatment of tuberculosis patients, or (except for purposes of subsections (d), (f), and (g)) any hospital primarily for the care and treatment of chronic disease patients.

"(d) The term 'facility for long-term care' means a facility providing inpatient care for convalescent or chronic disease patients who require skilled nursing care and related medical services—

"(1) which is a hospital or is operated in connection with a hospital, or

"(2) in which such nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State,

but does not include any facility primarily for the care and treatment of mentally ill or tuberculous patients and does not include, except for the portion thereof, if any, which is for the provision primarily of medical and nursing care, any other facility which furnishes primarily domiciliary care.

"(e) The term 'public health center' means a publicly owned facility for the provision of public health services, including related publicly owned facilities, such as laboratories, clinics, and administrative offices, operated in connection with such a facility.

"(f) The term 'diagnostic or treatment center' means a facility for the diagnosis and treatment of ambulatory patients—

"(1) which is operated in connection with a hospital, or

"(2) in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the State or, in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the State.

"(g) The term 'rehabilitation facility' means a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of—

"(1) medical evaluation and services, and

"(2) psychological, social, or vocational evaluation and services, under competent professional supervision, and in the case of which—

"(3) the major portion of the required evaluation and services is furnished within the facility; and

"(4) either (A) the facility is operated in connection with a hospital, or (B) all medical and related health services are prescribed by, or are under the general direction of, persons licensed to practice medicine or surgery in the State.

"(h) The term 'nonprofit', as related to any facility, means a facility which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

"(i) The term 'construction' includes the construction of new buildings, modernization and expansion of existing buildings, and initial equipment of any such buildings (including transportation facilities) and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of any such existing buildings, and including architects' fees, but excluding the cost of off-site improvements and, except with respect to public health centers, the cost of the acquisition of land.

"(j) The term 'modernization' includes alteration, major repair (to the extent permitted in regulations), remodeling, replacement, and renovation.

"(k) The term 'cost of construction' means the amount found by the Surgeon General to be necessary for the construction of a project.

"(l) The term 'title', when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Surgeon General finds sufficient to assure, for a period of not less than fifty years, undisturbed use and possession for the purposes of construction and operation of the project."

Sec. 102. The amendment made by section 101 shall become effective July 1, 1961, except that—

(a) all applications approved by the Surgeon General under title VI of the Public Health Service Act prior to July 1, 1961, shall be governed by the provisions thereof in effect prior to July 1, 1961;

(b) allotment percentages promulgated by the Surgeon General under such title VI during 1960 shall continue to be effective for purposes of such title as amended by this Act for the fiscal year beginning July 1, 1961, and the fiscal year beginning July 1, 1962;

(c) the terms of members of the Federal Hospital Council who are serving on such Council on June 30, 1961, shall expire on the date they would have expired had this Act not been enacted.

TITLE II—GRANTS FOR MEDICAL, DENTAL, OSTEOPATHIC, AND PUBLIC HEALTH TEACHING FACILITIES CONSTRUCTION

SEC. 201. The heading of title VII of the Public Health Service Act (42 U.S.C. chap. 6A) is amended by adding after the word "RESEARCH" the words "AND TEACHING", by inserting immediately below such heading the words "PART A—GRANTS FOR CONSTRUCTION OF HEALTH RESEARCH FACILITIES", and by changing the words "this title" wherever they appear in such title to read "this part".

SEC. 202. Such title is further amended by adding at the end thereof the following:

"PART B—GRANTS TO SCHOOLS OF MEDICINE, DENTISTRY, OSTEOPATHY, AND PUBLIC HEALTH FOR CONSTRUCTION OF TEACHING FACILITIES

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 720. There are hereby authorized to be appropriated for each fiscal year in the period beginning July 1, 1961 and ending June 30, 1966, (1) such sums as the Congress may determine for making grants to assist in the construction of teaching facilities for the training of physicians, and professional public health personnel, and (2) such sums as the Congress may determine for making grants to assist in the construction of teaching facilities for the training of dentists, except that the aggregate amounts appropriated pursuant to clause (1) and clause (2) of this section may not exceed \$75,000,000 and \$25,000,000, respectively.

"APPROVAL OF APPLICATIONS

"SEC. 721. (a) No application for a grant under this part may be approved unless it is submitted to the Surgeon General prior to July 1, 1965.

"(b) To be eligible to apply for a grant to assist in the construction of any facility under this part, the applicant must be (1) a public or other nonprofit school of medicine, dentistry, osteopathy, or public health and (2) accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education, except that a new school which (by reason of no, or an insufficient, period of operation) is not, at the time of application for a grant to construct a facility under this part, eligible for accreditation by such a recognized body or bodies, shall be deemed accredited for purposes of this part if the Commissioner of Education finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will, upon completion of such facility, meet the accreditation standards of such body or bodies.

"(c) A grant under this part may be made only if the application therefor is approved by the Surgeon General upon his determination that—

"(1) the applicant meets the eligibility conditions set forth in subsection (b);

"(2) the application contains or is supported by reasonable assurances that (A) for not less than ten years after completion of construction, the facility will be used for the purposes of the teaching for which it is to be constructed, (B) sufficient funds will be available to meet the non-Federal share of the cost of constructing the facility, and (C) sufficient funds will be available, when construction is completed, for effective use of the facility for the teaching for which it is being constructed;

"(3) the application is for aid in the construction of a new school of medicine, dentistry, osteopathy, or public health, or construction which will expand the training capacity of an existing such school;

"(4) the application does not request aid in the construction of a facility which is a hospital, diagnostic or treatment center, rehabilitation facility, or nursing home, as defined in subsections (e), (l), (n), and (o), respectively, of section 631; and

"(5) the application contains or is supported by adequate assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on the construction of the facility will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5). The Secretary of Labor shall have, with respect to the labor standards specified in this paragraph, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 64 Stat. 1267), and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 376c).

Before approving or disapproving an application under this part, the Surgeon General shall secure the advice of the National Advisory Council on Medical Teaching Facilities established by section 725 (hereinafter in this part referred to as the 'Council').

"(d) In considering applications for grants, the Council and the Surgeon General shall take into account—

"(1) the relative effectiveness of the proposed facilities in expanding the capacity for the training of first-year students of medicine, dentistry, or osteopathy, for the training of professional public health personnel, and in promoting an equitable geographical distribution of opportunities for such training (giving due consideration to population, available physicians, dentists, or professional public health personnel, and available resources in various areas of the Nation for training such persons); and

"(2) in the case of an applicant in a State which has in existence a State planning agency, or which participates in a regional or other interstate planning agency, described in section 728, the relationship of the application to the construction or training program which is being developed by such agency with respect to such State and, if such agency has reviewed such application, any comment thereon submitted by such agency.

"AMOUNT OF GRANT; PAYMENTS

"SEC. 722. (a) The Surgeon General, after receiving the advice of the Council, shall determine the amount of any grant to be made to assist in construction for which an application has been approved under this part; except that in no event may such amount exceed 50 per centum of so much of the cost of such construction as the Surgeon General determines to be reasonably necessary to increase the applicant's capacity for training physicians, dentists, or professional public health personnel.

"(b) Upon approval of any application for a grant under this part, the Surgeon General shall reserve, from any appropriation available therefor, the amount of such grant as determined under subsection (a); the amount so reserved may be paid in advance or by way of reimbursement, and in such installments consistent with construction progress, as the Surgeon General may determine. The Surgeon General's reservation of any amount under this section may be amended by him, either upon approval of an amendment of the application or upon revision of the estimated cost of construction of the facility.

"(c) In determining the amount of any grant under this part, there shall be excluded from the cost of construction an amount equal to the sum of (1) the amount of any other Federal grant which the applicant has obtained, or is assured of obtaining, with respect to the construction which is to be financed in part by grants authorized under this part, and (2) the amount of any non-Federal funds required to be expended as a condition of such other Federal grant.

"RECAPTURE OF PAYMENTS

"SEC. 723. If, within ten years after completion of any construction for which funds have been paid under this part—

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

"(b) the facility shall cease to be used for the teaching purposes for which it was constructed, unless the Surgeon General determines, in accordance with regulations, 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 the 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.

“DEFINITIONS

“SEC. 724. As used in this part—

“(1) the terms ‘construction’ and ‘cost of construction’ include (A) the construction of new buildings, the expansion of existing buildings, and remodeling or alteration of existing buildings if an integral and essential part of expansion of the same or a different building, including architects’ fees, but not including the cost of acquisition of land or off-site improvements, and (B) initial equipment of new buildings and of the expanded, remodeled, or altered part of existing buildings;

“(2) the term ‘nonprofit school’ means a school owned and operated by one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and

“(3) the terms ‘school of medicine,’ ‘school of dentistry,’ ‘school of osteopathy,’ and ‘school of public health’ mean a school which provides training leading, respectively, to a degree of doctor of medicine, a degree of doctor of dentistry or an equivalent degree, a degree of doctor of osteopathy, and a graduate degree in public health.

“NATIONAL ADVISORY COUNCIL ON MEDICAL TEACHING FACILITIES

“SEC. 725. (a) There is hereby established in the Public Health Service a National Advisory Council on Medical Teaching Facilities, consisting of the Surgeon General of the Public Health Service, who shall be Chairman, and the Commissioner of Education, both of whom shall be ex officio members, and twelve members appointed by the Secretary without regard to the civil service laws. Four of the appointed members shall be selected from the general public and eight shall be selected from among leading authorities in the fields of higher education, at least four of whom are particularly concerned with training in medicine, dentistry, osteopathy, or the public health professions. In selecting persons for appointment to the Council, consideration shall be given to such factors, among others, as (1) experience in the planning, constructing, financing, or administration of schools of medicine, dentistry, or osteopathy, or postgraduate schools of public health, and (2) familiarity with the needs for teaching facilities in all areas of the Nation.

“(b) The Council shall advise and assist the Surgeon General in the preparation of general regulations and with respect to policy matters arising in the administration of this part, and in the review of applications under this part.

“(c) The Surgeon General is authorized to use the services of any member or members of the Council in connection with matters related to the administration of this part, for such periods, in addition to conference periods, as he may determine. The Surgeon General shall, in addition, make appropriate provision for consultation between and coordination of the work of the Council and the National Advisory Council on Health Research Facilities and the Federal Hospital Council with respect to matters bearing on the purposes and administration of this part.

“(d) Appointed members of the Council, while attending conferences or meetings of the Council or while otherwise serving at the request of the Surgeon General, shall be entitled to receive compensation at a rate to be fixed by the Secretary but not exceeding \$50 per diem, including travel time, and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law (5 U.S.C. 73b-2) for persons in the Government service employed intermittently.

“NONINTERFERENCE WITH ADMINISTRATION OF INSTITUTIONS

“SEC. 726. Except as otherwise specifically provided in this part, nothing contained in this part shall be construed as authorizing any department, agency, officer, or employee of the United States to exercise any direction, supervision, or control over, or impose any requirement or condition with respect to, the personnel, curriculum, methods of instruction, or administration of any institution.

"REGULATIONS

"SEC. 727. (a) The Surgeon General, after consultation with the Council and with the approval of the Secretary, shall prescribe general regulations for this part covering the eligibility of institutions, the order of priority in approving applications, the terms and conditions for approving applications, and determinations of the amounts of grants.

"(b) The Surgeon General is authorized to make, with the approval of the Secretary, such other regulations as he finds necessary to carry out the provisions of this part.

"TECHNICAL ASSISTANCE

"SEC. 728. In carrying out the purposes of this part, and to further the development of State, and joint or coordinated regional or other interstate, planning or programs for relieving shortages of training capacity and opportunities for training in the fields of medicine, dentistry, osteopathy, and public health, through constructing such facilities, promoting effective use of teaching facilities, providing adequate financial support for schools, or otherwise, the Surgeon General is authorized to provide, to State or interstate planning agencies established for any of such purposes, technical assistance and consultative services and, in the case of such interstate agencies, financial assistance for projects for the planning of such programs."

TITLE III—GUARANTEE OF LOANS FOR CONSTRUCTION OF GROUP PRACTICE MEDICAL OR DENTAL FACILITIES

GUARANTEE CONTRACTS

SEC. 301. (a) The Surgeon General of the Public Health Service (hereinafter in this title referred to as the "Surgeon General") may enter into a contract, to be known as a debt service guarantee contract, pursuant to which the Surgeon General may guarantee the payment of the principal of and interest on the bonds of any private group practice agency or organization if the bonds are to be issued and sold in financing the construction cost of group practice medical or dental care facilities in any State and are to be repaid over a period of not more than thirty years. The debt service guarantee contract shall obligate the Surgeon General, so long as such bonds are outstanding, to pay to a trustee or other designated depository under an indenture securing the bonds, such amounts which, when added to the moneys available from the revenues or funds pledged by such agency or organization as security for the bonds (including all reserve funds therefor), may be needed to make the payments due on the bonds. The aggregate principal amount of such guaranteed bonds outstanding at any one time shall not exceed the amounts authorized for this purpose in appropriation Acts and in no case more than \$30,000,000. No new debt service guarantee contract may be entered into after June 30, 1966.

ESTABLISHMENT OF FUND

SEC. 302. (a) There is hereby established for the purposes of this title a guarantee fund (hereinafter in this title referred to as the "fund").

(b) All fees received in connection with guarantees issued under this title, all funds borrowed from the Secretary of the Treasury pursuant to section 304, all earnings on the assets of the fund, all appropriations for carrying out functions under this title, and all other receipts of the Surgeon General in connection with the performance of his functions under this title shall be deposited in the fund. All payments to trustees or other designated depositories under section 301, repayments to the Secretary of the Treasury of appropriations, and of sums borrowed from him pursuant to section 304 and interest thereon, and all administrative expenses and any other expenses of the Surgeon General in connection with the performance of his functions under this title shall be paid from the fund. Moneys in the fund may be invested in bonds or other obligations of the United States, or in bonds or other obligations guaranteed as to principal and interest thereby, or in obligations which are lawful investments for fiduciary, trust, or public funds, the investment or deposit of which is under the authority and control of the United States or any officer or officers thereof. Such obligations may be sold and the proceeds derived therefrom may be reinvested, as herein provided, if deemed advisable by the Surgeon General. Income from such investment or reinvestment shall be deposited in the fund.

FEE FOR GUARANTEE

SEC. 303. The Surgeon General is authorized to charge and collect, as consideration for the Government's guarantees of loans, fees which will in the aggregate cover, insofar as practicable, all administrative and other expenses in carrying out his functions under this title and all losses incurred on such loans. Any such fee may be included in the amount of the bonds guaranteed.

BORROWING AUTHORITY

SEC. 304. To carry out the purposes of this title the Surgeon General is authorized to issue to the Secretary of the Treasury from time to time notes or other obligations for purchase by the Secretary of the Treasury in amounts sufficient, together with any funds in the fund, to meet obligations of the fund including payments of principal and interest on all bonds guaranteed under this title in accordance with debt service guarantee contracts. Such notes or other obligations shall be in such forms and denominations, have such maturities, and be subject to such terms and conditions as may be prescribed by the Surgeon General with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yields on outstanding marketable obligations of the United States having comparable maturities. The Secretary of the Treasury is authorized and directed to purchase any notes and other obligations of the Surgeon General issued under this section and for such purpose is authorized to use as a public-debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, as amended, and the purposes for which securities may be issued under such Act, as amended, are extended to include any purchases of such notes and other obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this section. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public-debt transactions of the United States.

ADMINISTRATION

SEC. 305. (a) In the performance of, and with respect to, the functions, powers, and duties vested in him by this title, the Surgeon General, notwithstanding the provisions of any other law, shall—

(1) prepare annually and submit a budget program as provided for wholly owned Government corporations by the Government Corporation Control Act, as amended; and

(2) maintain an integral set of accounts which shall be audited annually by the General Accounting Office in accordance with the principles and procedures applicable to commercial transactions as provided by the Government Corporation Control Act, as amended, and no other audit shall be required: *Provided*, That such financial transactions of the Surgeon General as the making of debt service guarantee contracts and vouchers approved by the Surgeon General in connection with such financial transactions shall be final and conclusive upon all officers of the Government.

(b) In the performance of, and with respect to, the functions, powers, and duties vested in him by this title, the Surgeon General, notwithstanding the provisions of any other law, may—

(1) prescribe such rules and regulations as may be necessary to carry out the purposes of this section: *Provided*, That the Surgeon General shall consult with the Secretary of the Treasury or his designee before prescribing rules or regulations respecting interest rates and other terms and conditions of bonds which will qualify for debt service guarantee contracts under this title;

(2) delegate to any officer or employee of the Public Health Service any of his powers and duties under this title, except the promulgation of regulations;

(3) sue and be sued: *Provided*, That nothing herein shall be construed to exempt the Surgeon General from the application of section 507(b) or 2679 of title 28, United States Code, or section 367 of the Revised Statutes (5 U.S.C. 316);

(4) foreclose on any property or commence any action to protect or enforce any right conferred upon him by any law, contract, or other agreement,

and bid for and purchase at any foreclosure or any other sale any property in connection with which he has made a debt service guarantee contract pursuant to this title; in the event of any such acquisition, the Surgeon General may, notwithstanding any other provision of law relating to the acquisition, handling, or disposal of real property by the United States, complete, administer, remodel and convert, dispose of, lease and otherwise deal with, such property: *Provided*, That any such acquisition of real property shall not deprive any State or political subdivision thereof of its civil or criminal jurisdiction in and over such property or impair the civil rights under the State or local laws of the inhabitants on such property;

(5) enter into agreements to pay annual sums in lieu of taxes to any State or local taxing authority with respect to any real property so acquired or owned;

(6) sell or exchange at public or private sale, or lease, real or personal property, and sell or exchange any securities or obligations, upon such terms as he may fix;

(7) obtain insurance against loss in connection with property and other assets held;

(8) subject to the specific limitations in this title, consent to the modification, with respect to the rate of interest, time of payment of any installment of principal or interest, security, or any other term of any contract or agreement to which he is a party or which has been transferred to him pursuant to this title; and

(9) include in any contract or instrument made pursuant to this title such other covenants, conditions, or provisions, not inconsistent with law, as he may deem necessary to assure that the purposes of this title will be achieved.

(c) Section 3709 of the Revised Statutes shall not apply to any contract for services or supplies on account of any property acquired pursuant to this title if the amount of such contract does not exceed \$1,000.

DEFINITIONS

SEC. 306. For the purposes of this title:

(1) The term "construction cost" means the cost of the construction of the group practice medical or dental care facilities and the land on which they are located, but including only such equipment as may be permitted in regulations.

(2) The term "bonds" means any bonds, notes, interim certificates, certificates of indebtedness, debentures, or other obligations.

(3) The term "group practice facilities" means facilities for the diagnosis or diagnosis and treatment of ambulatory patients (in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the State or, in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the State) and which is primarily for the provision of health and medical services by a medical group.

(4) The term "medical group" means a partnership or other association of persons licensed to practice medicine or surgery in the State, or of such persons and persons licensed to practice dentistry in the State, who, as their principal professional activity and as a group responsibility, engage or undertake to engage in the coordinated practice of their profession primarily in the group practice facilities, and who (in this connection) share common overhead expenses, records, and substantial portions of the equipment and the professional, technical, and administrative staffs, and which partnership or association is composed of at least such professional personnel and has available at least such equipment and staff as may be provided in regulations.

(5) The term "group practice agency or organization" means—

(A) a private agency or organization undertaking to provide, directly or through arrangements with a medical group, comprehensive medical care, or medical and dental care, which may include hospitalization, to members or subscribers primarily on a group practice prepayment basis;

(B) a private nonprofit agency or organization established for the purpose of improving the availability of medical, or medical and dental, care in the community or having some function or functions related to the provision of such care, which will, through lease or other arrangement, make the group practice facility with respect to which it has requested a guarantee under this section available to a medical group for use by it; or

(C) a medical group.

(6) The term "State" includes the Commonwealth of Puerto Rico, Guam, the Virgin Islands, and the District of Columbia.

AUTHORIZATION OF APPROPRIATION

SEC. 307. There are hereby authorized to be appropriated from time to time such amounts as may be necessary to carry out the purposes of this title: *Provided*, That all such appropriations shall be repaid from the fund to the general fund of the Treasury prior to July 1, 1966.

FEBRUARY 24, 1961.

HON. LYNDON B. JOHNSON,
President of the Senate,
U.S. Senate, Washington, D.C.

DEAR MR. PRESIDENT: 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 describe the two proposals in more detail. I commend this legislation to you.

Sincerely,

JOHN F. KENNEDY.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE.

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 A. RIBICOFF, *Secretary.*

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., May 4, 1961.

Hon. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.

MY DEAR MR. CHAIRMAN: This is in reply to your letter of February 25, 1961, requesting the views of the Bureau of the Budget on S. 1071, 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.

This bill will help expand and improve community facilities and services for the health care of the aged and other persons, will make possible a substantial addition to the number of nursing home facilities to care for long-term patients, and will help relieve the shortages of home health care programs.

The bill was developed by the administration and was transmitted to the Congress by the President by letter dated February 24, 1961. I am authorized to advise you that the enactment of S. 1071 would be in accord with the program of the President.

Sincerely yours,

PHILLIP S. HUGHES,
Assistant Director for Legislative Reference.

The CHAIRMAN. Mr. Jones, we are very happy to have you here this morning, and Surgeon General Terry and Dr. Shannon and Dr. Halde-
man and Dr. Bauer, and all you gentlemen.

We would be glad now to have you proceed in your own way.

**STATEMENT OF BOISFEUILLET JONES, SPECIAL ASSISTANT FOR
HEALTH AND MEDICAL AFFAIRS, DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE**

Mr. JONES. Thank you, Mr. Chairman.

May I say it is a pleasure to appear again before this distinguished committee which has made such valuable contributions to the health of the Nation through its wise legislative actions and recommendations.

We appreciate this opportunity to appear before your committee today in support of the proposed Community Health Services and Facilities Act of 1961 (S. 1071), introduced by your chairman, and H.R. 4998, which was recently passed by the House.

These bills embody the recommendations which President Kennedy made in his special health message to Congress on February 9, 1961, for extending and improving the availability and quality of community health services and facilities primarily for the chronically ill and aged.

You will recall that he said in that message, after discussing the financing of health care for the aged:

The ability to afford adequate health care is to no avail without adequate health facilities. The financial support which will be available under the health insurance program I am recommending will, in itself, stimulate more facilities and services. But our communities need additional help to provide those services where everybody can use them.

In presenting the views of our Department on this important legislation, I shall undertake very briefly to identify and explain the health problems or objectives toward which the several provisions of the legislation are directed. The Surgeon General, Dr. Luther Terry, will explain in highlight terms the principal provisions of the bill as introduced and describe the amendments contained in the House-

passed bill. Following these introductory prepared statements, we shall be happy, with the assistance of members of Dr. Terry's staff, to answer questions your committee may have.

Long-term illness is a major and growing problem in the United States. In 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—excluding those 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.

The health professions and the Nation face a major challenge in devising means of resolving this problem. At the risk of oversimplification, let me define it as a twofold challenge.

First, there is a need for some better means by which the individual costs of health care for older persons can be financed on a prepayment basis. The administration has submitted a legislative proposal to accomplish this objective through an extension of the social security system. This legislation is under consideration by other committees of the Congress.

Second, there is need for expanded and improved community health services for the aged and for other persons with long-term illnesses or health problems. This need exists today; it is becoming more serious every year; and it will become increasingly urgent regardless of what approach is adopted for the payment of individual hospital and related health services.

At the present time facilities and services for providing high-quality comprehensive care outside the hospital are not available in most communities of the United States. For example, community nursing services for the care of patients in their own homes are available in less than 1,000 communities. Less than 30 communities have coordinated home care programs. There is a national shortage of over one-half million nursing home and chronic disease beds in the United States, and the quality and scope of services offered in some nursing homes today is a national disgrace.

Major National, State, and local action is necessary to increase the availability and improve the 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 chronically ill.

The basic purpose of S. 1071 is to provide the national leadership, stimulation, and assistance which will help States and communities to establish new facilities and services, and to extend and improve the scope and quality of services of those now in existence. The means proposed to achieve these ends are not new. They are the familiar devices—matching grants to the States, special project grants, research project grants, and construction grants—which have proved so effective in mobilizing nationwide attacks on other health problems.

Federal stimulatory grants not only permit the exercise of local responsibility and control, but they also assure increased financial support from State and local sources—usually far in excess of the statutory matching requirements.

We believe, however, that there is an immediate and urgent need for directing these tested means of Federal stimulation toward a new program objective, namely, better community health services for the aged and for others with long-term illnesses and disabilities. We therefore recommend and urge early enactment of the proposed Community Health Services and Facilities Act of 1961.

The CHAIRMAN. Thank you, Mr. Jones.

I believe Dr. Terry is going to give us the details. In the meantime, I would like to recognize Senator Javits.

Senator JAVITS. I am very grateful to our chairman. I am under the urgency of presiding at another hearing, and I do wish to make just a very brief statement on this particular measure.

I would like to point out I have also a bill pending, S. 719, and I hope very much that the Chair will allow me to include that bill in these hearings. It is the community facilities bill developed by the previous administration under Secretary Fleming, which I had the honor of sponsoring here in the Senate.

I emphasize that because this is a completely bipartisan effort, Mr. Chairman. I am confident the Chair will have the support of the Republicans, and I know he will have the support of the people in the majority. I think this is important because it does represent a need of action. And with respect to the interests of the people and the country, Mr. Chairman, it does represent an evaluation, both by the previous administration and by this administration, as to the urgent need which is incorporated in the Chair's bill.

I would most respectfully, therefore, Mr. Chairman, request that S. 719 be included as one of the bills bearing on the subject of this hearing.

The CHAIRMAN. We will do that.

Senator JAVITS. Thank you.

I thank my colleague for recognizing me.

The CHAIRMAN. Now, Dr. Terry.

STATEMENT OF DR. LUTHER L. TERRY, SURGEON GENERAL, U.S. PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. JAMES A. SHANNON, DIRECTOR, NATIONAL INSTITUTES OF HEALTH; DR. T. J. BAUER, CHIEF OF THE BUREAU OF STATE SERVICES; AND DR. JACK HALDEMAN, CHIEF OF THE DIVISION OF HOSPITAL AND MEDICAL FACILITIES

Dr. TERRY. Mr. Chairman and members of the subcommittee, the two bills under consideration by your committee today would provide a fourfold approach to the health objectives defined by Mr. Jones in his opening statement:

First, they would authorize matching grants-in-aid to States for extending and improving the quality, scope, and availability of community health services for the aged and chronically ill outside the hospital.

Second, they would initiate a program of 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.

Third, they would increase the appropriation authorization for grants for the construction of nonprofit nursing homes from \$10 million to \$20 million annually.

Fourth, they would authorize additional funds for a broadened program of research and demonstrations to improve the design and use of hospitals and related medical facilities.

Without going into detail, Mr. Chairman, I should like to describe each of these key provisions and to indicate how they relate to the objectives of the bill as a whole. My initial description will be based upon the provisions of S. 1071, since it contains the proposals in the form submitted by the President. Later in my statement I will briefly describe and comment upon the modifications of these provisions incorporated in H.R. 4998, as passed by the House.

Matching grants to States for community health services

S. 1071 would amend subsection 314(c) of the Public Health Service Act to provide a legislative basis under which matching grants may be made to States for extending and improving the quality, scope, and availability of comprehensive community health services. These grant funds would be used by the States and communities to develop and enforce more effective health and safety standards for the operation of nursing homes; to upgrade the scope and quality of health services in nursing homes through technical assistance to nursing home operators in such areas as nursing, rehabilitation, and nutrition services, and through training programs to improve the skills of nursing home personnel; and to establish and expand community home health care programs, including home nursing services, homemaker services, and other types of preventive, early diagnostic, and health care services which can be provided to patients in their own homes.

With such services available, it will be possible to reduce the period of hospitalization required for many patients and provide more adequate and less costly high quality care for patients in their own homes or in skilled nursing homes.

The amendments proposed by S. 1071 to accomplish this purpose would delete the current annual appropriation ceiling 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 specific public health programs.

These amendments would not establish in law a new categorical grant authorization; rather, they would broaden the existing authorization of subsection 314(c), as was done in the passage of the National Mental Health Act.

This approach has the advantage of providing a more flexible basis for meeting emerging and changing public health needs. Under the proposed authority the Congress could earmark funds for specific health services which may warrant special Federal attention without the necessity for enacting new authorizing legislation for each particular need.

Project grants for improving community health services

In addition to the matching grant provisions which I have just discussed, the bill also authorizes a new program of project grants. Whereas the matching grants are allocated among the States on a formula basis, the project grants would be awarded on the basis of project applications which are submitted and approved by the Surgeon General.

There is an urgent need to develop new and better methods of providing health services outside the hospital. To meet this need, S. 1071 would authorize the Surgeon General to make special project grants to public and nonprofit agencies and 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.

The purpose of these project 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. Projects supported from these grants would yield better and more 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 the bill would revise section 651 of the Public Health Service Act to increase the appropriation authorization for construction of nursing homes from \$10 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 the hospital.

Increasing the supply of long-term care beds will not only reduce the deficit in this category; it will also 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 annually. 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.

Hospital and other medical facility research

Section 5 of the bill would remove the statutory ceiling of \$1.2 million on annual expenditures for hospital and medical facility research, and would authorize research 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 expendi-

tures amount to over \$8 billion annually. Greater emphasis must be placed on research, experimentation, and demonstration in all areas of health services and facilities if the physical plant, equipment, and organizational and operational aspects of health facilities are to reach peak efficiency with minimum costs.

This is an especially urgent need in the provision of comprehensive and high quality care for the chronically ill and aged.

The proposed grant authority for construction of experimental and demonstration health facilities is needed to test research findings, and to demonstrate new ideas of health facility design and construction to communities in various parts of the country. Community officials and other sponsors are understandably reluctant to use local funds for experimental and research concepts in the construction of facilities to meet community needs. These circumstances have led to our proposal that Federal 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.

In the case of facilities which are experimental, research, or demonstration facilities in their totality, the grant funds would participate in the total cost of the project. When only a portion of the facility is of an experimental, research, or demonstration nature, Federal participation would, of course, be confined to the cost of that portion of the facility.

House amendments

H.R. 4998, as passed by the House on July 25, retains all of the key provisions I have just reviewed in my description of S. 1071. Several changes were made, however, in the provisions authorizing State matching grants and special project grants for community health services, and some new provisions relating to research facility construction grants were added to the bill. No changes were made in the provisions pertaining to nursing home construction grants, and the only amendment affecting research grants relating to hospitals and other medical care facilities was a relatively minor one pertaining to the recovery provisions.

The principal amendments to the matching grant and special project grant provisions were the incorporation of time and money limitations on the statutory authorizations. In both cases, the House-passed bill is limited to a 5-year authorization, as compared with the continuing authorizations in S. 1071.

In the case of the matching grant authorization, the 5-year time limitation would apply not only to the expanded authorization but also to the existing grant authority, which is now a continuing one. The purpose of these time limitations, as explained in the House committee report—

is not to express an intent on the part of the Congress that these programs be considered temporary programs. The purpose is rather to induce the Congress to review the progress of community health programs inaugurated or expanded under this legislation with a view to determining whether these programs are adequate to achieve the objectives of this legislation and whether they are carried out in an efficient manner.

In lieu of the removal of the appropriations ceiling in subsection 314(c), as proposed in S. 1071, the House-passed bill would increase

that ceiling from \$30 million to \$50 million annually. The subceiling on direct training and technical assistance activities of the service would be increased from \$3 million to \$5 million annually—in lieu of the open authorization proposed in S. 1071—and the present \$1 million subceiling on training grants to schools of public health would be raised to \$2.5 million.

In the case of the special project grant authorization, the House bill would place a limit of \$10 million on annual appropriations for such grants. The House bill also added new language to make it clear that States and localities could charge fees for services financed in part through Federal grant funds when the collection of such fees is authorized by State or local law.

In addition to these modifying amendments, the House bill includes two amendments pertaining to authorizations for research facility construction grants. The first amendment would repeal the construction grant provisions of section 433(a) of the Public Health Service Act, effective June 30, 1963. The second would extend for an additional year the present time limits on the construction grant program authorized by title VII of the Public Health Service Act.

While S. 1071 contains no comparable provisions, related proposals are contained in another administration bill—S. 1072—on which we have previously testified before this committee.

We would prefer enactment of the original provisions of this legislation, as contained in S. 1071. In general, however, we believe the amended provisions of the House-passed bill represent acceptable and workable modifications of the original proposals.

We are sympathetic with the purpose of the time limitations, as explained in the House committee report, and, as far as the principal program objectives of the bill are concerned, we do not believe the general appropriations ceilings on subsections 314(c) and 316 would be unduly restrictive during the initial stages of program operations.

We are concerned, however, by the amendment providing a \$5 million subceiling, within subsection 314(c), on direct Service activities relating to demonstrations, training, and detail of personnel to the States. Our concern stems from the accounting difficulties involved, rather than from the adequacy of the appropriation ceiling as such. Because appropriations for certain Service activities often contain items which depend in part, but not in whole, on the authority of section 314(c), it is extremely difficult to determine their relationship to this particular statutory subceiling.

Furthermore, since these funds are for activities directly administered by the Service, it seems hardly appropriate to have them subsumed under a general appropriations ceiling on grants-in-aid to the States.

Therefore, we believe that this authority for direct Service activities should be excluded from any appropriation ceilings that may be incorporated in subsection 314(c).

The House amendments pertaining to the health research facilities construction grant provisions of the Public Health Service Act, while not conforming in several key respects to the legislative recommendations which we had made and which are reflected in S. 1072, would be acceptable as an interim measure pending full consideration of this question by the Congress.

We hope, however, that the Congress can take early action to extend and revise the authority for health research facilities construction grants in order that the program can move forward in an accelerated and orderly manner.

In addition there are several relatively minor clarifying amendments to the House-passed version of H.R. 4998 which would be desirable but which do not warrant taking the time of the committee at this point. We would be glad, however, to discuss them with your committee staff at their convenience, and to suggest clarifying language.

Conclusion

This concludes my introductory description and explanation of S. 1071 and H.R. 4998. As Mr. Jones indicated in his opening statement, however, we shall be glad to discuss in greater detail any of the features of the bills that may be of special interest or concern to your committee.

Mr. Chairman, I have with me, as you indicated earlier, Dr. Bauer, who is Chief of our Bureau of State Services, and is intimately involved in the programs with relation to community services and facilities.

And at the extreme end of the table we have Dr. Jack Haldeman, who is head of our Division of Hospital and Medical Facilities, or our Hill-Burton program in the Public Health Service.

I have asked them to come along inasmuch as they are familiar in a great deal more detail with many of the technical aspects of these provisions, and how they would integrate into our existing programs and developing plans. I would like to utilize them as necessary, Mr. Chairman, in order to give your committee the fullest answers we can to questions which might come up.

The CHAIRMAN. Well, gentlemen, we want to thank you.

With reference to your suggestion, we would like to have a memorandum giving us your full, complete opinions as to any clarifying amendments that should be made, and the reasons for those amendments. Give us the full story, if you will.

Dr. TERRY. We shall be happy to do so, sir.

(The letter from Dr. Terry referred to above follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
August 9, 1961.

HON. LISTER HILL,
Chairman, Senate Labor and Public Welfare Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: In my testimony before the Subcommittee on Health on H.R. 4998 and S. 1071, I indicated that we had several clarifying amendments to the House-passed version of H.R. 4998 which we would like to suggest for the committee's consideration. In response to your request, these amendments are described below together with our reasons for suggesting them:

1. On page 2, line 2 of the House-passed version of H.R. 4998 delete the words "for each such fiscal year" and place the quotation marks and period immediately following "\$50,000,000."

This amendment would only delete redundant words and not alter the meaning of the House amendment since the \$50,000,000 appropriation ceiling is previously identified in the sentence as applying to each of 5 fiscal years.

2. On page 2, line 19, insert after the word "authority" the words "or where appropriate, the State mental health authority,".

As the bill now reads, only the State health authority could request that payments of a grant made under any authority of section 314 of the Public Health Service Act be reduced in connection with the detail of a Public Health Service officer or employee to a State. Although the State health authority would be the appropriate State official to make such a request in relation to most of the grants authorized under section 314, this would not always be the case. For example, the State mental health authority would be the appropriate State official to make such a request in connection with the community mental health grants which are made under authority of subsection 314(c).

3. On page 2, line 19, change the first word "to" to "the".

This amendment would correct a typographical error in the House version of the bill.

4. On page 3, line 4, place a period and quotation marks after the word "State" and delete all of 5.

Payments of grants under section 314 are made to the State rather than to the State health or mental health agency.

5. On page 3, lines 13 and 14 delete the words "for each such fiscal year."

The amendment would only delete redundant words since the \$10,000,000 appropriation ceiling is previously identified in the sentence as applying to each of 5 fiscal years.

In addition to these clarifying amendments, I am also attaching a suggested amendment to carry out the recommendations made in my testimony before the committee that the authorization in subsection 314(c)(1) for direct operations of the Public Health Service in conducting demonstrations, providing training, and detailing personnel to the States be excluded from any appropriation ceiling which may be incorporated in subsection 314(c).

Sincerely yours,

LUTHER J. TERRY, *Surgeon General.*

AMENDMENT TO H.R. 4998 (AS PASSED BY THE HOUSE)

On page 1, strike out everything beginning with line 6 and down to and including line 15 on page 2 and insert in lieu thereof:

"SEC. 2. (a) Section 314(c) of the Public Health Service Act is amended to read as follows:

"(e) To enable the Surgeon General to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate public health services, including grants for demonstrations and for training of personnel for State and local health work, there are authorized to be appropriated for each of the first five fiscal years beginning after June 30, 1961, (1) the sum of \$50,000,000, and (2), in addition, such sums as may be necessary to enable the Surgeon General to provide demonstrations and to train personnel for State and local health work and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist States in carrying out the purposes of this subsection. 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. Of the sum appropriated for each fiscal year pursuant to clause (1) of the first sentence of this subsection, there shall be available an amount, not to exceed \$2,500,000, to enable the Surgeon General to make grants-in-aid, under such terms and conditions as may be prescribed by regulations, for provision in public or nonprofit schools of public health accredited by a body or bodies recognized by the Surgeon General, of comprehensive professional training, specialized consultive services, and technical assistance in the fields of public health and in the administration of State and local public health programs, except that in allocating funds made available under this clause among such schools of public health the Surgeon General shall give primary consideration to the number of federally sponsored students attending each such school."

Page 2, line 16, strike out "(d)" and insert in lieu thereof "(b)".

Page 3, line 6, strike out "(e)" and insert in lieu thereof "(c)".

The CHAIRMAN. Now with reference to your community health services, the way you propose to administer it, that really is an ex-

tension of what we generally call general services today, isn't that true, under which the Federal Government makes certain grants to the State, which in the past have largely gone into the field of preventive medicine?

Dr. TERRY. Yes, they are similar. However, these provisions, of course, are directed toward assisting the State and communities in delivering medical care.

The CHAIRMAN. I understand that. But I mean, you are putting this right in with your general services which we have had for many years?

Dr. TERRY. Yes, sir. I think it is quite obvious that one in the practice of medicine cannot segregate preventive measures from therapeutic and other medical care procedures so that they obviously should go hand in hand, Senator Hill.

The CHAIRMAN. I think it might be of interest to the committee at this point to have Dr. Bauer, who is head of the Bureau of State Services, just briefly tell us what we are doing today and what this means in terms of adding the community health facilities to your present operations.

Dr. BAUER. At the present time we have grants for general assistance to the States for the total activities of health, not only in the personal health services, such as communicable disease, and to a lesser extent chronic disease, but also in the environmental health activities. This bill would add, in addition to these services, an opportunity to step up the program within the United States for the improvement and operations of both facilities and services for the chronically ill and the health of the aged.

One type of outpatient service that this program would stimulate and help develop at the local level would be, for example, the improvement of services and operations in nursing homes. There are now 25,000 nursing homes in the country with a patient load of about 500,000. Many of these are nothing but caretaking homes. There are needs for health services within them.

Then, too, our communities need home health services. By home health services I mean such things as home nursing services, homemaker services, and physical therapy and nutritional services in the home. This bill would help the localities develop activities to provide these types of home health services and cut down considerably some of the unnecessary hospitalization of these older people.

It would also give us an opportunity to study this total problem. In view of the fact that our population is increasing, particularly in the aged group, it would give us an opportunity to study what types of community organizations and services are necessary to most efficiently support the physician in his treatment and care of the chronically ill.

The CHAIRMAN. Give us an illustration or two. I happen to sit on the Appropriations Committee, where we handle these funds, but I think it would be well for this committee, and I think that the committee members would be interested, if you would give us an illustration or two of where your general assistance funds are going in the States today.

Dr. BAUER. At the present time our general assistance funds in the States support environmental health activities such as the engineering and sanitary services both at the State and local levels in order to protect our milk supplies, our food supplies, and our water supply.

Then, too, the general assistance funds are used for communicable disease control and for the support of local health department staffs and services.

We also have, in addition to these general assistance funds, special funds in several areas such as venereal disease control and tuberculosis control. But these are emphasis funds. The general assistance funds are actually the backbone funds of Federal assistance to States and localities to carry out their public health responsibilities.

The CHAIRMAN. As I said, largely in the field of preventive medicine.

Dr. BAUER. Yes, I would say these funds are almost exclusively used in the field of preventive medicine.

The CHAIRMAN. Are there any questions by any of the members about these particular funds?

Senator YARBOROUGH. Mr. Chairman, I want to commend the chairman for introducing the bill, and thank Dr. Terry and Mr. Jones for their fine statements.

However, in regard to Dr. Terry's statement, a delegation called on me yesterday to assure me there was no deficit of medical care in my State, that everyone had adequate medical care where they wanted it, and they did not need any more.

The CHAIRMAN. Senator Pell.

Senator PELL. Sir, what would be the proportion of the nonprofit to profit nursing homes? You said there were 25,000 nursing homes in total?

Dr. BAUER. At the present time, from the standpoint of numbers, about 91 percent of the nursing homes are private nursing homes. The percentage of patients, I think, is a little lower because the nonprofit type of nursing homes have a tendency to be larger in bed capacity than the private nursing homes.

The CHAIRMAN. Any other questions?

Senator WILLIAMS. On the nursing home program, how long has this money been available for nursing home construction?

Dr. BAUER. Senator Williams, I believe Dr. Jack Haldeman would be the best one to answer that question, if I could defer to him, please.

Dr. HALDEMAN. 1955 was the first year in which an appropriation was made for assistance in the construction of nonprofit nursing homes.

Senator WILLIAMS. And in the period since 1955, how much money has been made available?

Dr. HALDEMAN. There has been a total of \$46 million made available for nursing homes and \$48.5 million for chronic disease hospitals. And I mention that because they are both long-term care facilities. A total of almost \$95 million has been made available through the Hill-Burton mechanism to assist in the construction of long-term care facilities.

Senator WILLIAMS. Is this a 50-50 matching program?

Dr. HALDEMAN. It is a variable matching. In the States with lower per capita income we might participate up to 66 $\frac{2}{3}$ percent. In the higher income States Federal participation may be as low as 33 $\frac{1}{3}$ percent. Overall, 30 cents in Federal appropriations brings out about \$1 in sponsor contributions.

Senator WILLIAMS. This bill would increase the authorization by \$10 million, is that right?

Dr. HALDEMAN. That is correct. And that, coupled with the present authorization of \$20 million for chronic disease facilities, will provide a total authorization of \$40 million for long-term care facilities.

Senator WILLIAMS. Is there a considerable backlog of applications now pending?

Dr. HALDEMAN. Yes; the total number of applicants far exceeds the amount of available money.

Senator WILLIAMS. I see.

The CHAIRMAN. You might supply for the record at this point, Doctor, and I realize you would not have it with you at this moment but I know it has been prepared because you appeared before our Appropriations Subcommittee with information showing the number of applicants we now have for funds for nursing homes.

Dr. HALDEMAN. I would be very happy to, sir.

The CHAIRMAN. You might also give us the story of how many beds have been provided in nursing homes up to date through the program.

Dr. HALDEMAN. Yes.

The CHAIRMAN. Along with the story of how many applications you now have, many of which cannot be met because the funds are not there to meet all these applications. Isn't that right?

Dr. HALDEMAN. That is correct, sir.

(The information referred to follows:)

The States do not forward to the Public Health Service applications for construction grants under the Hill-Burton program for amounts in excess of their State allotments.

Each year, however, at the request of the Appropriations Committee, the Public Health Service secures information from the State Hill-Burton agencies regarding the number of projects which could be approved and the amount of Federal funds which could be utilized if there were no limitations on the amount of Federal assistance available.

In January 1961 the State agencies reported that there was a backlog of 392 projects involving 21,575 beds for long-term care facilities (nursing home and chronic disease) which could be approved if there were sufficient Federal funds available. These facilities would be constructed at a total cost of \$224,438,000, utilizing Federal funds in the amount of \$97,534,000. Nursing home and chronic disease facilities care for essentially the same kinds of patients, and funds in the two categories are interchangeable.

Total Hill-Burton program for long-term care facilities, as of June 30, 1961

Type of facility	Number of projects	Number of beds provided	Total cost	Federal share
Nursing homes.....	311	16,414	\$181,071,350	\$55,858,553
Chronic disease hospitals.....	190	¹ 17,075	² 168,393,081	² 46,036,033
Total.....	501	33,489	349,464,431	101,894,586

¹ Includes 5,966 chronic disease beds built in other types of hospitals.

² Costs not available for chronic disease beds constructed in other types of hospitals.

Dr. TERRY. Mr. Chairman, may I make an additional statement here?

Senator HILL. Certainly.

Dr. TERRY. I think that even today we recognize that, though we are in a lot better position in relation to hospital beds than we were, for instance, a decade ago, or when the Hill-Burton program was started, there is still an overall shortage of hospital beds.

One of the critical features in this respect, I think, is the fact that we may reasonably expect as our aging population increases that we are going to encounter increasing difficulties in providing sufficient hospital beds unless we can avoid using hospital beds when they are not necessary.

In other words, I think the gist of this whole thing is that several completely objective studies have indicated that a lot of our hospital beds contain patients who really do not need to be in hospitals. These patients could be given adequate medical care in their own homes or in good skilled nursing homes if those facilities and those resources were available in the community.

Well, it is pretty obvious that, if we are going to decrease this demand for hospital beds and if we are going to provide what we need to provide for our population in terms of facilities and resources, we are going to have to develop these community health resources and facilities to take care of patients who can be taken care of with some assistance at home, or who can be taken care of in nursing homes, and spare the load on the hospital demand. I think this is the real crux of this bill, sir.

The CHAIRMAN. That is the reason you are here this morning.

Dr. TERRY. Yes, sir.

The CHAIRMAN. Is there anything that you want to add, Dr. Terry?

Dr. TERRY. I think this pretty well covers it.

The CHAIRMAN. I want to ask Dr. Haldeman a question.

Doctor, as head of the Hospital and Medical Facilities Division of the U.S. Public Health Service, we would be glad to have any comment you might make on this provision here with reference to research experimentation and demonstration in the construction of hospitals.

Dr. HALDEMAN. I would be very glad to comment, Mr. Chairman.

As the Surgeon General mentioned in his testimony, applicants are reluctant to risk capital to develop experimental or new types of facilities, and it is our feeling that relatively small amounts of assistance would encourage hospitals to undertake this very needed activity.

Hospitals, as you know, are big business, probably the fourth largest industry in the country. Yet it is an area wherein there is less research going on than any major industry. Less than one-twentieth of 1 percent of hospital expenditures goes into research as compared to vastly greater amounts in other areas. We are spending over \$700 million a year in medical research, and yet in the country as a whole we are probably spending less than \$3 million on hospital research.

There are a whole group of areas where we would like to see additional hospital research undertaken. There is much discussion among hospital officials at the present time regarding the advantages and disadvantages of circular and double corridor nursing units in relation to conventional nursing units.

Rapid technological innovation in the hospital equipment field and major growth in the number of products appearing on the market in recent years have greatly increased the difficulties of evaluating the worth of individual items of equipment or of determining how they might best be used. A demonstration project could, for example, illustrate the practicability of nuclear radiation as a superior and economic technique for sterilization of hospital materials when used

jointly by several hospitals in the community. Similarly, the advantages of a central automatic data processing computer to simplify recordkeeping and to analyze program statistics and financial information for several hospitals could be demonstrated.

We have been trying to get some universities interested in building a nursing home in conjunction with a university teaching hospital and medical school in order to serve as a center for research in nursing home operation. It would experiment with better methods for providing continuity of service between hospitals and nursing homes and assist in the development of training activities for nursing home operators in the State.

These are just a few of the types of experimental facilities or equipment activities that we would like to see undertaken.

The CHAIRMAN. Well, now, under the bill an applicant who wishes to carry on some of this experimentation and demonstration would make direct application to the U.S. Public Health Service; is that right?

Dr. HALDEMAN. Yes sir; that is correct. The actual process would be quite similar to our present research grant applications, with review by committees and action by the Federal Hospital Council.

The CHAIRMAN. The difficulty now is that you have an authorization of only \$1,200,000 this year, isn't that right?

Dr. HALDEMAN. That is correct, sir.

The CHAIRMAN. And what you propose now is what we call an open end appropriation, there is no limit on it, to be determined by the Congress through the Appropriations Committee each year; is that right?

Dr. HALDEMAN. That is correct, sir.

The CHAIRMAN. Dr. Shannon, do you want to say something about this action? I am going to call on you about the other act. Do you want to add something about hospitals?

Dr. SHANNON. Well, Senator Hill, not specifically, but I would like to comment in general because prior to my Federal service I did have responsibility for running a fairly complex service in a chronic disease hospital. Actually, the first chronic disease hospital in this country was set up in 1939 and 1940 in New York City. And the thing that impressed those of us who worked in that environment in that early day is that there was an attempt to provide all these facilities and all the resources in the chronic hospital that had been found to be necessary in the acute hospital. And as I see chronic hospitals today, I would say they have not changed one bit since the initial opening of the hospital in 1939 and 1940, when it is quite obvious that the problem that faces the staff and the problem that faces the hospital organization, is considerably different than in an acute hospital.

And I would say, on the other hand, until one can demonstrate in a series of situations what the minimal services are that will still deliver first-class care to the patient, it would be quite impossible for municipalities and States to hazard the risk of putting up what currently, in the absence of demonstration, would be considered sub-minimal facilities.

So quite apart from my present position, sir, and extending back to prior experience, I would fortify everything that has been said relative to this need.

The CHAIRMAN. Is there anything else you would like to add, Dr. Haldeman?

Dr. HALDEMAN. No, thank you.

The CHAIRMAN. Any questions, gentlemen?

Senator YARBOROUGH. Mr. Chairman, I did not intend, by merely repeating the statements made in my office by the delegation from my home State yesterday, to indicate any assent thereto. I think this legislation is badly needed in my home State.

I have attended more than one State convention with the nursing home operators of Texas in the past 2 years and discussed with them and heard speakers discuss this problem. I have talked also with local officials in my home city of Austin and with many more in the city of Houston about this problem and have looked at it in a number of counties as I have traveled over my State.

My State is one that rates in average annual pension per person among the older people about 38th, I regret to say, in the Union. And I think that the experience will show that the lower the pension, the higher the number of old age pensioners or welfare recipients who are driven into nursing homes simply because they are not able to sustain themselves in their own homes as would be possible if the pension welfare would be higher.

So I think there is an acute need for this legislation in my State.

The CHAIRMAN. Dr. Terry, you might provide us a breakdown showing the State allotments or funds for the community health services as will be provided in this legislation before us, this bill. Will you do that?

Dr. TERRY. We would be happy to do that, sir.

The CHAIRMAN. Provide that for the record so we will have it. (The breakdown referred to above follows:)

TABLE 1.—*Tentative State allotments for community health services for aged and chronically ill*

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

TABLE 2.—Comparative State allotments for nursing home construction

	Present authoriza- tion	Proposed authoriza- tion	Increase
Total.....	\$10,000,000	\$20,000,000	\$10,000,000
Alabama.....	304,081	608,162	304,081
Alaska.....	50,000	100,000	50,000
Arizona.....	78,394	156,788	78,394
Arkansas.....	182,949	365,898	182,949
California.....	496,049	992,098	496,049
Colorado.....	94,348	188,696	94,348
Connecticut.....	58,389	116,778	58,389
Delaware.....	50,000	100,000	50,000
District of Columbia.....	50,000	100,000	50,000
Florida.....	298,334	596,669	298,335
Georgia.....	335,618	671,236	335,618
Hawaii.....	50,000	100,000	50,000
Idaho.....	50,000	100,000	50,000
Illinois.....	314,785	629,569	314,784
Indiana.....	247,094	494,189	247,095
Iowa.....	166,324	332,647	166,323
Kansas.....	128,855	257,710	128,855
Kentucky.....	261,636	523,271	261,635
Louisiana.....	262,668	525,335	262,668
Maine.....	88,996	177,991	88,995
Maryland.....	133,355	266,710	133,355
Massachusetts.....	199,643	399,286	199,643
Michigan.....	352,302	704,604	352,302
Minnesota.....	203,724	407,448	203,724
Mississippi.....	245,702	491,403	245,701
Missouri.....	232,991	465,983	232,992
Montana.....	50,000	100,000	50,000
Nebraska.....	82,368	164,736	82,368
Nevada.....	50,000	100,000	50,000
New Hampshire.....	50,000	100,000	50,000
New Jersey.....	190,400	380,800	190,400
New Mexico.....	65,781	131,563	65,782
New York.....	477,232	954,464	477,232
North Carolina.....	409,308	818,616	409,308
North Dakota.....	50,890	101,779	50,889
Ohio.....	408,782	817,564	408,782
Oklahoma.....	165,447	330,894	165,447
Oregon.....	94,435	188,871	94,436
Pennsylvania.....	532,310	1,064,619	532,309
Rhode Island.....	50,000	100,000	50,000
South Carolina.....	236,721	473,443	236,722
South Dakota.....	54,425	108,850	54,425
Tennessee.....	309,272	618,544	309,272
Texas.....	605,513	1,211,025	605,512
Utah.....	59,762	119,525	59,763
Vermont.....	50,000	100,000	50,000
Virginia.....	272,622	545,244	272,622
Washington.....	131,232	262,463	131,231
West Virginia.....	143,065	286,131	143,066
Wisconsin.....	213,882	427,764	213,882
Wyoming.....	50,000	100,000	50,000
Guam.....	7,675	15,350	7,675
Puerto Rico.....	268,969	537,939	268,970
Virgin Islands.....	3,672	7,344	3,672

The CHAIRMAN. Senator Pell.

Senator PELL. One further question in connection with the nursing homes. Do you have any statistics available as to the average cost per month per bed and the profit in the private nursing homes?

Dr. TERRY. Yes; we have some figures. Dr. Haldeman has the best information that we have, Senator Pell.

Dr. HALDEMAN. We have recently done a study of the available literature on the subject of cost per resident day. As you might expect, it varies considerably all the way from \$3.50 a day, at the lower end of the scale, up to some very good nursing homes where the cost is actually around \$14 a day.

In general, the public assistance payments in the State, in effect, dictate the amount that can be paid in many of the nursing homes, be-

cause approximately 50 percent of the individual patients in nursing homes are paid for through public assistance payments.

Senator PELL. Thank you.

The CHAIRMAN. I have here, Doctor, key statistics and other facts on community health services and facility legislation compiled, I believe, by the Public Health Service. We might at this point put into the record this page which gives certain facts with reference to our nursing homes:

The number of homes, number of beds, number of skilled nursing homes, the number of beds in skilled nursing homes, the average monthly charge and the average age of patients in these homes.

I think this might be very helpful to the committee. So without objection, we will put that sheet in the record at this point.

(The information referred to follows:)

NURSING HOME FACT SHEET

Number of homes: 25,000.
 Number of beds: 450,000.
 Number of skilled nursing homes: 9,700.
 Number of beds skilled nursing homes: 180,000.
 Percent of homes privately owned: 91.
 Percent of beds: 71.
 Percent of homes publicly owned: 3.
 Percent of beds: 15.
 Average size privately owned nursing homes: 18 beds.
 Average monthly charge: \$150.
 Range of monthly charges: \$55 to \$155.
 Percent of patients supported from public funds: 50.
 Average age of patients: 80.
 Sex ratio of patients: two-thirds women.
 Percent of patients mentally confused at times: over 50.
 Percent of patients incontinent: over 30.
 Percent of patients with circulatory disorder: over 65.
 Types of State licensing agencies: State and territorial health departments, State welfare departments, other State agencies.

The CHAIRMAN. Is there anything you gentlemen would like to add? I am going to ask Dr. Shannon a question in a minute, but is there anything else about these nursing homes or hospitals you would like to add—community health facilities?

Mr. JONES. There is one question I think is appropriate, Mr. Chairman, and that is whether or not research activity in the past has produced results. I think we can anticipate results on the basis of accomplishments, and I cited one illustration, the concept of progressive care in hospitals where patients are divided according to their need for service in the hospital. This is a concept that is now being tested in practical construction of hospitals throughout the Nation.

We can look to other concepts of this sort that will provide better quality of care at less cost, perhaps, or at no more cost as a result of the programs that are envisioned in this particular bill.

The CHAIRMAN. Better care and more economy, is that correct?

Mr. JONES. That is correct.

The CHAIRMAN. With less cost to the individual patient?

Mr. JONES. We hope. It is not assured.

The CHAIRMAN. All right.

Now, Dr. Shannon, as the Director of NIH, you have been responsible for the administration of health research facilities construction

program. Will you address yourself to that program and give us the benefit of your thinking, your observations, your experience and any recommendations you can with reference to the same?

Dr. SHANNON. I would be glad to do so, Senator Hill.

As the committee knows, as I am sure you know, this program is now in the sixth year of two 3-year cycles. The present program consists of a \$30 million authorization for the construction of health research facilities with the provision that Federal versus non-Federal matching shall be no less than 50 percent non-Federal matching.

This program during the course of its operation has had a significant catalytic effect upon the expenditure of private matching funds for construction of research facilities—I do not have the precise figures with me—but this program has brought forth about \$3 private for every \$1 Federal expended. I place that at a conservative level; I know it is below that which actually obtains.

The program was initiated in 1956. It began at a time when, as the result of a general change in the philosophy of the support of medical research in this country, a positive policy for advancement of medical research was accepted by both the executive and the legislative branches of Government. This policy recognized that the stakes and the opportunities were so great that a substantial broadening of the medical research base was required in terms of support of medical research, in the training of scientists, and in the provision of physical facilities within which these scientists could work.

As a result of the operations of this program over this period of time, the NIH appropriation has moved from \$97 million in 1956 to \$560 million last year. This expanded national effort has produced striking advances of great immediate benefit to our citizens which we have presented to the Appropriations Committees year by year.

In addition, we feel that the productivity of the program promises even more striking and more revolutionary changes in the years to come. At the present time, however, despite the development of this broader research base, it is quite obvious to us and to the Department that the current authorization for the construction of research facilities is quite inadequate in terms of the breadth of the program that is being supported today and that looms ahead tomorrow.

However, the present \$30 million limitation is not adequate to do the job that has been requested by the Congress as a reflection of the will of our citizens. It is not adequate to meet the demand for space for support of today's research, nor to provide the space required for training the scientists of tomorrow.

The reason why these comments are particularly pertinent today is that in the broader bill that relates to community services and community health facilities, the House took action in two respects relative to research facilities construction. As Dr. Terry pointed out, they removed the authority to develop nonmatching construction, and they extended the program for construction of health research facilities at the current \$30 million level.

Our reaction to this House action was mixed. In the absence of some action by the Congress this year there would be a lapse of no less than 1 year in this very important program. On the other hand, we

feel that the facts available indicate that an action no less than that suggested or recommended by the administration in Senate bill 1072 is required. This bill raises the authorization to \$50 million and expands the authority for research facilities to encompass the use of these funds for closely related programs of research training.

So that in viewing the House provision, I am delighted that there will be no lapse in the program, but I am distressed that it will continue under the present authorization. This authorization was perfectly adequate in 1957; it is totally unrealistic for 1961 and the years ahead.

I think probably one can summarize by saying that research facilities constitute the most critical need now confronting the support for medical research, that the program to date has been outstandingly successful and we would urge its continuation and extension.

I think in terms of general comments, sir, that might be about all I have to say.

The CHAIRMAN. I think it is important for members of the committee to understand that what we are talking about now is Federal funds for the construction of health research facilities, capital investment so to speak, building the laboratories which carry on this research work.

Under existing law there is an authorization for \$30 million a year, Congress each year has appropriated that \$30 million. In the bill which we passed last night there was a \$30 million appropriation for these health research facilities.

Now the administration has recommended, and it has been embodied within S. 1072, another bill before this committee, that the \$30 million be increased to \$50 million.

Doctor, I wish you would comment on this matter of the matching requirement provision. As the law is now written the matching is 50-50, or \$1 of Federal funds and \$1 of non-Federal funds.

Dr. SHANNON. The problem of matching is one that always warrants careful consideration in any program where the Federal Government accepts only a part of the total cost of a program, but where the absence of the Federal contribution would completely block the development of what might otherwise be considered essential.

Our program in the past may be considered to have been very successful if viewed merely from the standpoint of the number of private dollars that have been brought to bear on the problem in proportion to the number of Federal dollars that have been used.

Without having any pat answer to what the course of the committee action should be, I would point out that the performance under the present 50-50 matching formula has the appearance of having been more successful than it actually has been.

As we view our operation over the past 5 years, several striking facts appear. The first is that there has not been an equal geographic distribution of these funds throughout the United States.

To be more specific, the number of applications we have had from the southeastern United States has scarcely met these applications, rather approvals has scarcely met the needs and capability of the Southeast, as determined in part by the number of institutions, the concentration of scientists, and the amount of research going on in the area.

On the other hand, the number of applications from the Northeast have been very large. And I suspect they represent the largest single block of applications and represent, too, the largest concentration of funds which have in fact been granted.

That area of the country that is along the Mississippi, going out to the Rockies, has had very little in the way of research facilities construction applications, whereas the west coast, particularly the State of Washington, and the State of California, have done very well. The applications in summary reflect the availability of matching funds rather than the need for the scientific competence of the groups involved.

When we looked into this more carefully, city by city and State by State, in order to determine whether it would be possible to use some type of a matching formula comparable to the Hill-Burton, we found that the differences in need as reflected in a shortage of matching funds were perhaps as great within a given city as when comparing one region of the country with another, or one State with another.

Without relating the circumstances in terms of universities, I would like to talk about one city in the northeastern United States where one institution has received substantial sums for research facilities construction because (1) of extraordinary excellence of the staff, and (2) because there was no deficit in matching funds.

On the other hand, two other capable medical schools in the same city, have been unable to construct adequate research space primarily because of the lack of matching funds. In one case there were scarcely any matching research facility funds available at all. In the other case the funds that could be obtained were barely enough to satisfy those research needs specifically related to clinical research but not those that relate to the underpinning of the preclinical sciences upon which all advance must rest. So that within a city one sees one university that, because of the wealth available to the alumni body, can make available broad matching funds, and other universities which, by accident of their alumni groups, do not have matching funds so that the staff cannot have the facilities in proportion to their capabilities.

So that in a sort of abstract way, Senator Hill, I would say that in devising a formula for the further development of this program, were it possible to make available to the Research Facilities Construction Council some discretion so that the factor of institutional need, institutional opportunity could be considered in making the grant, and perhaps in the law be concerned with the total overall matching rather than the matching in the specific individual institution that was concerned, I think these provisions would permit our Council and our staff to do a much more effective job, and for the same dollars expended deliver to the Congress a more effective and more useful program.

I would say, however, that the present program with 50-50 matching has in itself had such a large measure of success that by all cost, at the very least, this should be continued and certainly at not less than the departmental proposal. But, if one is striving for formulas that are closer to perfection, that are more suited to satisfy the needs as they exist and as our staff knows them to be, then some considera-

tion should be given to provisions which would enable the Council to determine in the individual case what the matching should be without at the same time interfering with any general provision in relation to overall matching levels for the total funds.

The CHAIRMAN. Well, Dr. Terry, would you like to add anything?

Dr. TERRY. I do not think there is anything that I need to add specifically, Senator.

The CHAIRMAN. Well now, with reference to this provision in the bill as the House voted it, and not in the bill as originally introduced by the administration, with reference to section 433(a) of the Public Health Service Act, surely that section should be maintained in its full integrity for the construction of regional facilities and facilities in the national interest that are going to serve more than any one institution, isn't that right?

Dr. SHANNON. Senator Hill, it would be our feeling, as expressed in the bill submitted, that the authority which is presently contained in section 433(a) might be more rigidly defined and more specifically circumscribed within the law to apply to those facilities that are of regional and national importance as determined by the Surgeon General. It should not be available as separate conflicting authority as it is now since this confuses the issue relative to the regular research facilities construction program.

It was in this light that the Department made the proposal to re-define the purpose for which the authority could be used rather than do away with the authority.

The CHAIRMAN. Would you submit for our consideration some language to carry out the thought you just expressed?

Dr. SHANNON. I believe, sir, that the language proposed by the administration and contained in section 712 of S. 1072 entitled "Construction of Regional Facilities" provides amply for the problems which I have mentioned:

"CONSTRUCTION OF REGIONAL FACILITIES

"Sec. 712. When the Surgeon General finds, in accordance with regulations, that the purposes of this part can best be achieved through the construction of research, or research and related purposes, facilities of particular value or significance for the Nation or a region thereof, and that because of the cost of such facilities or their use as a national or regional resource for research or related purposes a grant pursuant to the preceding provisions of this part does not provide an effective or appropriate means of financing the construction of such facilities, he may construct or make arrangements for constructing, through contracts for paying (including advance or installment payments) part or all of the cost of construction or otherwise, facilities for the conduct of research, or for research and related purposes, in the sciences related to health. The Surgeon General may, where he deems such action appropriate, make arrangements, by contract or otherwise, for the operation of such facilities (for the conduct of such research, or research and related purposes) or may make contributions toward the cost of such operation of facilities of this nature whether or not constructed pursuant to, or with aid provided under, this section. Title to any facility constructed under this section may be transferred by the Surgeon General on behalf of the United States to any public or nonprofit private institution competent to engage in the type of research, or research and related purposes, for which the facility was constructed. Such transfer shall be made subject to the condition that the facility will be operated for the research, or research and related purposes, for which it was constructed and to such other conditions as the Surgeon General deems necessary to carry out the objectives of this part and to protect the interests of the United States."

(g) The parenthetical phrase in the first sentence of section 433(a) of such Act which reads "(including grants-in-aid for drawing plans, erection of buildings, and acquisition of land thereof)" is repealed.

The CHAIRMAN. Are there any questions, gentlemen?

Senator YARBOROUGH. Doctor, I believe you said in 1956 the National Institutes of Health appropriation was ninety-some-odd-million dollars?

Dr. SHANNON. \$97 million, sir.

Senator YARBOROUGH. \$97 million. And how many million in 1960?

Dr. SHANNON. \$560 million, sir.

Senator YARBOROUGH. \$560 million.

Now, Doctor, is part of that used for construction of medical schools rather than direct research?

Dr. SHANNON. No, sir, they have not been used for that purpose. There is at the present moment no legislative authority for Federal assistance to the construction of medical schools. Thirty million dollars of the \$560 million is, of course, used as Federal matching grants for the construction of research facilities.

Senator YARBOROUGH. Is all of this \$560 million used for research?

Dr. SHANNON. No, sir. I can give you some round figures on that. Approximately \$130 million was used for research training.

Senator YARBOROUGH. What was the other used for?

Dr. SHANNON. I would say in the order of magnitude of \$30 million or \$40 million for professional and technical assistance and State control activities. The bulk of the remainder for research either for the direct operation or for the research grant operation.

Senator YARBOROUGH. The remainder would be roughly close to \$400 million, or \$380 million or \$390 million?

Dr. SHANNON. Somewhere, I would say, closer to \$400 million when one takes into account such things as administration, program development, and things of that sort.

Senator YARBOROUGH. How much?

Dr. SHANNON. \$400 million.

Senator YARBOROUGH. What did you term that, Doctor? That is used for what?

Dr. SHANNON. You mean the \$400 million, sir.

Senator YARBOROUGH. \$400 million. What was the terminology that described the use of that part of it?

Dr. SHANNON. That would be for the support of medical research.

Senator YARBOROUGH. Medical research. Now isn't a lot of that used to support medical schools?

Dr. SHANNON. Senator YARBOROUGH, the primary purpose for which these funds are used is in support of medical research. However, some of these funds do indirectly benefit medical schools.

And I would like to explain what I mean. When one man, when one puts in a medical school environment a research team, particularly to pursue—

Senator YARBOROUGH. You understand, Doctor, I am not criticizing the use. We are very short in the medical schools and I am helping to support this bill, to try to increase medical education. But I have had doctors and people interested in this tell me we are not doing enough research because this money that you vote for research, most of it, is supporting the medical schools.

Dr. SHANNON. That is not true, sir.

Senator YARBOROUGH. Are there medical schools where over half of the full expense of running the medical school, the full salaries, are coming from the National Health Institutes?

Dr. SHANNON. Do you mean total expenses sir, or faculty salaries?

Senator YARBOROUGH. Over half of all the salaries paid to teachers in those schools is coming out of this fund?

Dr. SHANNON. If one excepts the hospital, about 25 percent of the full-time faculties of medical schools derive some part of their salary from Federal research and training grants as a consequence of their participation in these programs. Those who derive 50 percent or more of their salary from Federal sources amount to less than 15 percent.

Senator YARBOROUGH. You started to explain something else.

They told me, and I am not criticizing the medical schools or the Department, that this was a fact and we were not getting enough into research.

Mr. JONES. May I speak to the point, Senator Yarborough, as a former administrator of a university, having responsibility for a medical school and its related research activities?

I would like to speak to this particular point. The research grants that are made to institutions competent to carry on medical research are made on request of the institution and then receive review and approval through the processes of the National Institutes of Health. Now the program that is supported by these grants is in fact a research program. The personnel required to be paid from these grants to carry on the work are a part of the academic environment of the institution. Only about half of the extramural research grants from NIH goes to medical schools, and the balance to independent research institutions and to hospitals. When research funds are awarded to a medical school the research staff paid from these funds augments but does not replace the teaching faculty. So that the purpose of these funds is not to support education in respect to teaching of medical students. Rather it is to support and enlarge faculty in order to carry on the purposes of this research program, that is, the effort to find the causes and cures of disease.

Senator YARBOROUGH. I want to make it plain, Doctor, I am not advocating that you cut down on the money going to the medical schools. I just want to be certain that we get enough in here for research, too.

Are there medical schools in the country where over two-thirds of all the salaries paid to the instructors in those medical schools come out of these funds?

Dr. SHANNON. I would say no, sir.

Senator YARBOROUGH. I have been told there are some where more than two-thirds of all the salaries paid all the instructors—

Dr. SHANNON. Not to my knowledge sir. However, I would say that in some departments of medical schools there is in excess of 50 percent of the faculty receiving 50 percent or more of their support from Federal sources based on the extent of their involvement in federally supported research and research training programs.

Dr. TERRY. May I comment on this, Senator Yarborough?

I think this is very important because in general, and specifically, where we have permitted the salary support of individuals from research funds, the criterion which has been used is that the amount of

support is equivalent to the amount of their time spent in pursuit of these NIH supported research activities. Now if they have 10 percent of their time or 5 percent of their time which is available for teaching activities beyond their research activities, it is very obvious they can be quite helpful to the university, to the medical school, in carrying out its teaching program. We do not pay people from research funds to teach who are not doing research. We do feel it is proper, however, for faculty members to engage in research and to receive that portion of their salary from research funds. We are not supporting medical education at this time.

I should like to make myself quite clear here. I think we should support medical education and our bill, S. 1072, which is before this Committee proposing the support of scholarships and part of the cost to the medical schools of their education, in my mind is essential. But I think for persons to speak against it, against this proposal, saying that we are financing medical education from research funds today, just is not true.

Senator YARBOROUGH. Dr. Terry, I made it plain I was not speaking against it.

Dr. TERRY. I was not speaking to you, sir, I was speaking to the people to whom you referred.

Senator YARBOROUGH. I have supported these appropriations, I will support more, and I am supporting this medical education fund. We know that we are not educating enough doctors in this country, we know the lag in medical education. Last year we licensed 8,000 doctors, 6,300 graduates of American institutes and 1,700 emigrants from abroad. Is that correct?

Dr. TERRY. Roughly so, sir, yes.

Senator YARBOROUGH. I want you to know I am supporting that. But, you know, the research institutions claim the medical schools have their hands on research and are holding research down. Have you heard that?

Dr. TERRY. I have heard it, and I think it is ridiculous, sir.

Senator YARBOROUGH. Well, Dr. Terry, I do not agree with you it is entirely ridiculous.

Dr. TERRY. I do, sir.

Senator YARBOROUGH. But this is not a criticism of your department, nor of the appropriation. I think it illustrates a need that we need to do more. I do not think we are doing enough in either education or research. This is not to criticize what has been done, it is just to say we are not doing enough.

Dr. TERRY. Maybe I did not understand your question. You said that medical schools are holding research down?

Senator YARBOROUGH. No, the institutes say under the regulations that the medical schools have too much authority in controlling research. This is very poorly stated. I am sure you know the controversy that I refer to between research institutes and the medical institutions.

Dr. TERRY. Yes, sir, I think I understand the controversy. I do not think there is any simple answer to it.

Senator YARBOROUGH. I did not say there was.

Dr. TERRY. I do not think that qualified research institutions outside of medical schools are being penalized because preference is

being given to medical schools. That is the point I would like to make, sir.

Senator YARBOROUGH. That is the point they make, that education is their primary objective, and it is harder for other institutions to get the support they need and to push research as fast as they need to.

Dr. TERRY. I understand it, but I do not agree with it, sir.

Senator YARBOROUGH. Doctor, you have advisory committees to recommend on these grants?

Dr. TERRY. Yes, sir.

Senator YARBOROUGH. Where do those advisory committees come from geographically?

Dr. SHANNON. The advisory committee membership geographically come from all 48 States on the mainland, and we now have one or two members from Hawaii. They are derived primarily and in very rough proportion to the concentrations of science. In other words, where you have in one geographical area a large concentration of really topflight scientists, then proportionately from that area a larger number of advisers can be expected to be drawn. But in a very purposeful way we attempt to develop in our advisory groups truly broad geographical representation of the Nation, and also distribution within the advisory groups of the various elements of the research community, including industry, private research institutions and educational institutions—educational institutions involving broad university interest and medical school interests. So that these advisory groups, as best we can make them, are truly representative of the cross section of American science.

Senator YARBOROUGH. Have you had any complaints as to certain of these, certain branches of health, that they have been topheavy in certain areas and that the grants made were in direct percentage proportionate to those areas in relation to the number of advisers on those boards from those geographical areas?

Dr. SHANNON. Senator Yarborough, quite the contrary. And this came up for discussion—

Senator YARBOROUGH. All I am asking is, Have they been made to you that way? They have been made to me.

Dr. SHANNON. No, sir, they have not.

Senator YARBOROUGH. They have not. I just want to know if those had come home, if you had those complaints made.

They have not been made to the National Health Institute?

Dr. SHANNON. No. Informally I have heard that some of the individuals from smaller schools have expressed concern that they do not find the extent of representation—that the larger university groups have—in our advisory study sections and council.

Senator YARBOROUGH. I have not had the complaint made to me on the basis of the schools, but geographical distribution of the advisory boards, concentration in a few areas with the grants, they say, going to the areas with the greater representation. It did not relate to any particular school or schools.

Dr. SHANNON. We have really not had direct criticism, Senator Yarborough, and the facts would not support the contention were it made.

Dr. TERRY. Senator Yarborough, may I comment on this, because I was very active in this field in relation to our Council members and the

proposal of persons, for Council membership during my several years of association with the Heart Institute.

I think you can take any one of our Council groups and find a wide geographic distribution of the members of those Councils because a concerted effort is made to get capable people representing various areas throughout the country. Now in certain respects it is a little more difficult to do it with regard to study section. Because, for instance, you do not have lay persons on study sections, they are all professional, technically skilled persons. Because of the need to get the persons who are best qualified to do the sort of study section scientific review, it is difficult to maintain equal geographic distribution.

On the other hand, in terms of the National Advisory Councils, I think that we have evidence of a consideration of geographic factors and a good geographic distribution results which, as Dr. Shannon has said, will coincide with the distribution of scientific and related personnel throughout this country.

Senator YARBOROUGH. Of course, Doctor, if people who had applications for grants were complaining—you realize the reason I ask, whether they have come to your knowledge or not, they might be rather hesitant to complain to the Board who is going to pass upon those grants. It is rather like a lawyer who losses all of his cases in a certain court, though he has reasonable success in other courts. He does not generally complain to the judge. Now human experience proves this.

Dr. SHANNON. Senator Yarborough, I said we have not had direct complaints. However, I believe we have had letters where they would say they wonder whether or not we do have adequate distribution.

Senator YARBOROUGH. Isn't that a pretty blunt way for a scientist to ask? Aren't scientists really rather cautious?

Dr. SHANNON. Senator Yarborough, the scientists I know are much more blunt than almost any other group of people. If they have a conviction, they will come out and say it flatly.

And I think our general answer, when the question is raised, is to just lay the facts on the table. And we have never had the inquiry pursued further.

Now I do know that some of my Institute directors have had very specific and very pertinent complaints that are a bit more difficult to handle on their level which come in relation to specific grants that are acted upon within a specific categorical council. But, nonetheless, the answer is always approached the same way, that these are the facts. And in general, while an individual may be unhappy about not having received a grant, I think that they go away from such discussions fully convinced that within the power of any granting agency those factors of bias which can be removed are removed by the mechanisms which we have set forth.

Senator YARBOROUGH. The complaints made to me have not been about any specific grants from specific areas, but they said the advisers, the councils, come from an area into which they are putting seven-eighths, or eight-ninths of the money.

Dr. SHANNON. This was discussed just yesterday at some length by the House committee headed by Congressman Fountain, who really explored this in depth, and his report pointed out that as far as they

could determine there was no bias, and they were quite surprised to find that although our advisers were drawn more heavily from the larger centers where there was the heaviest concentration of scientists, the percentage of our total grants that went to the small areas not represented by scientists were considerably greater than the proportionate representation on the councils.

So that the facts were quite contrary to what might have been, and obviously was, a criticism that came to Mr. Fountain. Otherwise, he would not have explored this particular aspect of the operation.

So I think this has been explored in depth both by ourselves on an Institute level, and by Congressman Fountain. And it just does not obtain.

Senator YARBOROUGH. I want to say some of my questions arose out of this. I made a talk a few months ago, and I was bragging about the leadership of our distinguished chairman. We have gotten these appropriations up in the space of 4 years from less than \$100 million under his leadership to over a half billion a year. And I had expressed the hope with this much money in research we would make real progress in a hurry on finding out the answers to some of the crippling arthritis or malignancies and other things.

And some people knowledgeable in these affairs came up to me after that and said, "You are not putting that much in research; the majority of that, over half of that money is going into medical education."

They did not object, and I do not object, but this \$350 million, the fact over 50 percent goes to salaries, leads me to believe we ought to put more money into research.

I am not criticizing how this is spent. We probably have to pull this up, and probably some earmarked for research alone.

Dr. SHANNON. Well, sir, the statement that the bulk of this goes into education is just not correct, sir. I mean, these are the blunt facts.

The National Institutes of Health supports research solely on its merits. In the early years, our program followed the private foundation pattern and paid only a tiny fraction of the direct costs incurred by the institution. Along with other Federal agencies, we soon recognized, however, that institutions undertaking research in the national interest are entitled to be reimbursed for the full direct costs involved. These direct costs include salaries for research assistants, technicians, and helpers, for supplies, for travel and so on pertaining to the research being supported. It may also include compensation for that portion of a principal investigator's time devoted to research on an NIH project. If the principal investigator is a faculty member, the time devoted to research cannot be spent twice, it cannot be used simultaneously to instruct medical students. Consequently, we are not supporting medical education when this situation occurs, we are merely paying the legitimate costs of carrying out research in the national interest.

One more point, Senator. Many people consider research as a cost of medical school operations and then raise the question you have raised about support for faculty salaries. Sponsored research is not properly a cost of medical education—it is the cost of research, pure and simple. It is true that many tangible and intangible benefits accrue to medical education in a research environment but research grant funds are never used to cover the costs of medical education.

Senator YARBOROUGH. I am not challenging you, but these were not just laymen off the street, these were medical doctors engaged in both teaching and research, and who studied this pretty closely.

The CHAIRMAN. Mr. Jones, you were vice president in charge of medical affairs, at Emory University, including its medical school, and I would like to have your comments on this matter again.

Mr. JONES. I think it should be clear, Mr. Chairman and members of the committee, that—

The CHAIRMAN. I hope you are going to stay with us. We have some other very distinguished witnesses.

Senator YARBOROUGH. I have an urgent call, Mr. Chairman, as to action being debated on the floor. I regret I must leave. I am very much interested in this subject and I am very strongly in favor of this legislation. I regret very much that I am forced to leave and will not have the privilege of hearing this list of distinguished witnesses we have here.

The CHAIRMAN. Mr. Jones.

Mr. JONES. It should be clear, Mr. Chairman, that the research program as supported through NIH has been tremendously beneficial to the medical educational institutions of the country. Medical education embraces three parts: Teaching, research, and service. To the extent that the research programs of these educational institutions are supported by these grants, and are expanded in the national interest toward an attack on disease—to that extent, the environment of education in the health professions is greatly augmented for all three parts of medical education.

The research part of medical education has been developed extensively during recent years of progress through NIH grants. But the teaching part of medical education has not been aided, except that research people in the teaching environment do have a contribution to make in the community of scholars. Thus, there has been tremendous improvement in our whole educational process in the health professions by virtue of the emphasis on research made possible by NIH grants.

But in no way can this support of research be interpreted as a direct subsidy of medical teaching.

I think we must recognize, too, that much of this money, as Dr. Shannon has pointed out, goes for research training, which is the preparation of competent young scientists for careers in research.

This is an educational function, too. But the purpose, again, and the direct relationship, is with research.

May I add one other comment while I am speaking, Mr. Chairman?

The CHAIRMAN. Surely.

Mr. JONES. I invite attention again to the fact that the administration has proposed and has testified before this committee in support of a continuation of the program of grants for research facilities: construction and for an increase in the authorization of funds for this purpose which we think is essential to support the continuing development of our research potential.

The CHAIRMAN. Dr. Terry.

Dr. TERRY. And of course, Mr. Chairman, as you know at the present time, since June 30, we have not been able to accept applica-

tions for research facilities construction grants for the simple reason that our authorization to accept new applications expired and we are in the terminal year of funds made available on the basis of applications last year. So that this is a vital issue to which the Congress must direct its attention, sir.

The CHAIRMAN. Any other questions, gentlemen?

Dr. Shannon, I believe you have some charts and other data and information that you could provide us on this matter as to the physical health research facilities construction. I should like to arrange for these materials to be submitted for the record.

Dr. SHANNON. We would be glad to.

The CHAIRMAN. Fine.

(The information and charts referred to above follow:)

AUGUST 4, 1961.

Dr. JAMES A. SHANNON,
*Director, National Institutes of Health,
Bethesda, Md.*

My DEAR DR. SHANNON: I particularly appreciated the information which you provided the committee during the course of your testimony relating to S. 1071 and H.R. 4998 in the committee hearings on August 3, 1961.

As you are aware, Dr. I. S. Ravdin, vice president for medical affairs for the University of Pennsylvania and Dr. Paul Gross, professor of chemistry at Duke University, testified concerning that part of H.R. 4998 which relates to the extension of the health research facility construction program (title 7 of the PHS Act). Both Dr. Ravdin and Dr. Gross emphasized the importance of increasing the authorization for Federal appropriations under this program, citing \$100 million as the minimum amount immediately necessary to meet program needs. They also stressed the necessity to provide for variable matching ratios under which Federal funds could be awarded through these grants.

Since you had left the hearing room at the time Dr. Ravdin and Dr. Gross completed their testimony, the committee did not have the opportunity to inquire into your views concerning these two important points made by these distinguished witnesses. Rather than scheduling another meeting for this purpose, therefore, I would appreciate your writing me your full and frank answers to the following questions:

(1) Would Federal appropriations of \$100 million per year for the health research facilities program provide sufficiently for the support of the construction of research facilities and research training facilities?

(2) Would an authorization of \$100 million eliminate the problems that have been encountered in the conduct of this program during the past 5 years?

(3) What important objectives in the development of the Nation's medical research program do you believe could be accomplished through providing authority for a variable matching ratio in the use of Federal funds under this program?

(4) What are the evidences of inadequacies in a program that requires 50-50 matching?

(5) What is your best judgment of the ratios which should be authorized and how would you suggest that such authority for variable matching ratios be exercised in the administration of the program?

I should like, as soon as possible, your frank and full answers to these questions, based on your professional judgment, together with such data as you feel may be needed to convey clearly these matters to the committee.

I should also like your assistance in a further matter in connection with the committee's hearing. You will recall the exchange between Senator Yarborough, Dr. Terry, and yourself concerning the role of research funds provided through NIH in the medical schools of the country. Senator Yarborough, because of the press of Senate business, had to leave the committee hearings before his questions had been completely answered. I believe it would be helpful to the committee and to Senator Yarborough if you could provide for the record a statement setting forth in full detail that information which you believe will clarify completely the questions and problems raised by Senator Yarborough.

I should like to express my great appreciation for your assistance in these matters.

With kindest regards and best wishes, I am,
Very sincerely,

LISTER HILL, *Chairman.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
Bethesda, Md., August 15, 1961.

HON. LISTER HILL,
Chairman, Subcommittee on Labor, Health, Education, and Welfare, Committee on Appropriations, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I am writing to you in response to your request of August 4 asking for full and frank answers bearing upon the extension of the health research facilities program. In particular, you have referred to the testimony of both Dr. I. S. Ravdin and Dr. Paul Gross emphasizing the importance of increasing the authorization for the program and providing for variable matching ratios. The administration, in recommending legislation for the further extension of the health research facilities construction program, provided for several modifications in the present terms of the program to take into account current needs to be met in providing adequate facilities for the Nation's medical research effort. These provisions are included in the bills S. 1072 and H.R. 4999 now before the Congress. The amendments of the current program contained in these bills represent a substantial step toward dealing with the kinds of problems emphasized by Drs. Ravdin and Gross in their testimony.

However, in respect to the questions posed in your letter, I shall try to deal with them in terms of the basic factors affecting the matters to which your queries are directed as follows:

(1) Would Federal appropriations of \$100 million per year for the health research facilities program provide sufficiently for the support of the construction of research and research training facilities?

In considering what level of appropriation authorization would provide sufficiently for the support of the construction of facilities for health research and research training, the critical question is how to balance current expenditures for support of research with capital investment in resources for the future—training of scientific manpower and construction of facilities for research and research training. The health research facilities construction program was enacted in 1956. In that fiscal year NIH research project grants totaled \$40 million, and approximately \$17 million was allocated for the development of research manpower through fellowships and training grants. Thus a program providing \$30 million in matching grants for the construction of research facilities, the physical resources required, was adequate to balance the support of research with the development of the necessary resources in terms of the distribution of effort existing at that time.

Since 1956, however, Federal support for medical research and research training has undergone a major transformation. Last year NIH funds for research grants totaled more than \$316 million, eight times the 1956 level; private support for medical research has doubled in the same period. Also, NIH funds for research training in fiscal year 1961 totaled \$132 million, again eight times the 1956 level. In sharp contrast to these eightfold increases, funds for research facility matching grants have been frozen by statutory limitation to \$30 million a year (table 1).

The change which has taken place can be illustrated in another way. NIH extramural funds in fiscal year 1957, the first year of the research facilities construction program, were distributed 60 percent for research grants, 20 percent for training of research manpower, and 20 percent for facilities construction. In fiscal year 1961 this distribution was 67 percent for research projects and 27 percent for research training but the \$30 million for research facilities works out at only 6 percent of the total (chart I). In short, investment in research facilities has dropped from one-fifth to one-twentieth of NIH extramural funds in this 5-year period. Thus, the present distribution of effort between the support of research and the development of research resources is out of balance and the research facility construction program does not provide a solid physical base for the expansion of research support and the training of research manpower projected in current operating budgets.

The growth of support for medical research has created large demands for suitable space and facilities, only a fraction of which can be met under the current limited program and from wholly non-Federal sources. There has developed a major national deficit in the availability of modern health research facilities coincident with the time a rapidly rising number of highly trained research investigators are embarking upon their careers. Meeting this need for research facilities is now the single most urgent problem affecting the advancement of medical research in this country.

I do not wish to minimize the accomplishments of the health research facilities program. They have been substantial. In the first 5 years of the program, several hundred educational and research institutions received \$150 million in matching grants, making possible the erection of roughly \$600 million worth of research and related facilities. These grants have enabled medical schools, universities, hospitals, and other educational and research institutions in most sections of the country to expand plants to meet the Nation's research needs.

Despite these accomplishments, the swift pace of medical research has, in most instances, resulted in overflow occupancy of current research space and has rendered inadequate research space which seemed ample a short 5 years ago. Experience has demonstrated that most institutions have grossly underestimated their future building needs primarily because the factors influencing future requirements are being generated by national demands for a vigorous research and research training program. The 1960's will witness a 100-percent increase in the numbers receiving predoctoral and postdoctoral research training in the sciences basic to the advancement of health through research. The prospect for the future appears to be one of continued acceleration in the Nation's requirements for research and research training facilities. Therefore, in our current planning for the future, it seems only realistic to provide for a research facility construction program which is in consonance with these changes—both present and prospective. The administration's proposal for an increase from \$30 to \$50 million in the annual appropriation authorization for this program reflects the importance of the substantive changes in the national medical research effort which the research facilities construction program should be designed to meet.

(2) Would an authorization of \$100 million eliminate the problems encountered in the conduct of this program during the past 5 years?

An increase in the authorization to \$100 million per year would alleviate the major problems.

The current authorization has not been sufficient to meet the volume of applications which have been approved by the Health Research Facility Advisory Council in any given fiscal year. As of June 30, 1961, the deadline for the receipt of applications under this program, there was a backlog of \$57.3 million in requests for Federal funds for projects already reviewed and recommended for approval by the Health Research Facilities Council (table 2); \$42.5 million in applications are awaiting review by the Council in its November meeting; and 87 institutions have filed notices of intent totaling \$36 million in funds requested.

The present authorization does not enable the development of an adequate research plant for the Nation. It is recognition of this fact that the administration has recommended an increase in the appropriation authorization for this program to \$50 million as contained within the terms of S. 1072 and H.R. 4999.

The grants awarded under the research facilities construction program include a large number of relatively small awards—under \$100,000 (table 3). More than one-third of the total number of awards made thus far under this program are in this category. Almost half of these were made in the last 2 years. These smaller awards have, for the most part, been for renovation and alteration projects urgently essential for already ongoing research programs or for equipment rather than for new laboratory construction. It would appear that the effect of the present limitation on the funds available for construction in the face of such urgent current needs has been to discourage the purposeful programing of these funds to achieve the maximum in the way of major new, modern research facilities which add substantially to the research plant of the Nation.

This is not to disparage the many needy and worthy projects which have been supported; these have been essential for the ongoing productive research program, though with more adequate funds it would have been more economical to have built modern, new research facilities than to renovate or alter existing space which will be inadequate, or obsolete, in a short period of time.

There is another manner in which this pressure for research space seems apparent. During the past year a number of issues have arisen concerning the

use of research project funds for renovation and alternation of space. The Senate Appropriations Committee expressed its views concerning this problem in its current report on our appropriation. I am personally convinced that the majority of requests for the use of large amounts of project funds for space modification are due to the inability of institutions to meet urgent facility needs under the current limitation of our research construction program. An increased appropriation authorization and broader conditions for the administration of our construction program will do much to eliminate pressure for the use of project funds for general alteration purposes beyond that strictly necessary to provide for the specific research project being supported.

In respect to the next three questions posed in your letter, I believe question 4 seems to be the one that would most logically be answered next.

(4) What are the evidences of inadequacies in a program that requires 50-50 matching?

The problems discussed in relation to the level of appropriation authorization also derive in a fairly large degree from the fixed 50-50 matching ratio of the law as it now stands. Some of the pressure for use of research and training project funds for space modification purposes would appear to be due to the difficulties institutions encounter in providing 50 percent matching to meet urgent research and research training space requirements. In like manner, the tendency toward a high proportion of relatively small projects to be supported under this program, as noted previously, is also linked to the 50-50 matching requirement. Institutional funds are limited and the need to match Federal funds equally under the program forces many institutions to settle for a smaller facility or be content with a major renovation and alteration job which is not an adequate answer to their needs—nor in the broader view a sound national investment.

One manifestation of the problem encountered under the 50-50 matching ratio has been that the distribution of funds geographically and amongst institutions is the random product of the availability of institutional matching funds. The availability of institutional matching funds derives from such factors as endowment status of the institution, wealth of the alumni, fund raising ability, community prestige, attitudes of State legislatures, and other construction needs. Not any of these factors necessarily relate to the substantive merits of an institution's position in respect to the receipt of Federal construction support versus that of any other institution. Such important considerations as institution research capability, opportunity for effective institutional development, needs for balanced development of research facilities geographically, and other objectives important from the national point of view have too little determining influence over the distribution of these funds.

Thus the administration of this program under the required 50-50 matching ratio has meant that the distribution of funds could not be most purposely geared to satisfy the national need.

The ability of an institution to undertake the construction of adequate new laboratories and other facilities has depended more on the other factors than the scientific worth of its research program. As a consequence, the Nation is losing many valuable opportunities to enhance its research capacity by taking full advantage of the scientific potential in many of our financially poor institutions. To some extent this is a regional problem, particularly for universities and hospitals in the South and the rapidly growing areas of the West. The following regional distribution of funds awarded under this program during the past 5 years of its operation reflects in part this problem.

Construction grants awarded, fiscal year 1957-61

Region	Number	Federal funds	
		Amount	Percent
Total.....	785	\$149,987,382	100.0
North Atlantic States.....	265	52,554,598	35.1
Southern States.....	121	29,162,750	19.4
Midwestern States.....	230	35,845,116	23.9
Mountain and Western States.....	169	32,424,918	21.6

(3) What important objectives in the development of the Nation's medical research program do you believe could be accomplished through providing authority for a variable matching ratio in the use of Federal funds under this program?

Variable matching would undoubtedly contribute to overcoming the major problems arising from the present 50-50 matching ratio under the current programs. Most importantly variable matching would permit purposeful consideration of the factors important to program development and overall national needs and objectives in the administration of research construction funds. This would obviate the heavy dependence upon the accidents of institutional finances as the essential criterion in distribution of funds which is implicit in the present program. This kind of matching would provide an opportunity and means for special programing to meet research needs important from the national point of view and the strengthening of the research capability of institutions on a national basis.

A major advantage to be gained by some form of variable matching would be the possibility of encompassing within a single program and a single consistent set of operating guidelines and mechanics the means for dealing with research construction needs. At the present time there is one program administered under title VII of the Public Health Service Act with a specified Federal matching provision and a cognizant Advisory Council and another series of construction actions centered around the language of section 433a of the Public Health Service Act without matching provisions and administered through different advisory councils with varying objectives and points of view. This to me is unsound in terms of public policy and unconscionably difficult administratively.

(5) What is your best judgment of the ratios which should be authorized and how would you suggest that such authority for variable matching ratios be exercised in the administration of the program?

There is no data that will support with certainty any given matching ratio for Federal funds as being most equitable and effective for the purposes of this program. Nor does there appear to be any means to devise a formula for this purpose which on a wholly objective basis can present a requisite balance between institutional needs and the national interest.

Precedents in other Federal construction programs are various and none seem adaptable to the particular problems and needs encountered in a national program for assistance in the construction of health research facilities. It is interesting to note, however, that matching ratios in other Federal programs range from 2 to 1 Federal funds in the Hill-Burton hospital construction program to 9 to 1 as a basis for Federal sharing in highway construction.

However, since you have asked for a personal judgment, I would say that the Hill-Burton pattern of two-thirds Federal as the overall matching limitation on the use of Federal funds provides a realistic basis for this program. Because of the many broad national needs and objectives to be achieved under this program, the capability to match up to a 3-to-1 level would be advantageous in circumstances where such action is clearly necessary and desirable. Institutions which were unable to match at even the 3-to-1 level must be looked upon as basically unstable and there would be a high probability that they would not be able to meet the operating requirements of any facility proposed.

Under this concept, the bulk of the Federal funds made available would be expended somewhere between the 50-50 and 2-to-1 levels of matching. Awards at ratios higher than 2 to 1 would be limited to actions necessary in the achievement of national objectives or the resolution of exceptional institutional circumstances.

The general terms and conditions under which such a program would be administered would entail a special application for Federal funds in excess of 50-50 matching. It would be the staff responsibility of the NIH to obtain complete substantiation of purpose and need to be met, to identify the financial circumstances requiring such an action, and on the basis of this compilation of information to provide a rigorous overall evaluation to the National Advisory Council. Each such action would in addition involve special council review prior to a decision.

In respect to your request for further information concerning the matters raised by Senator Yarborough during the course of the committee hearing, I am attaching a separate statement which I hope will clarify the role of NIH research support in the Nation's medical schools.

I hope the statement made in response to your questions will be helpful to the committee in the course of its deliberation. I should be pleased to provide any further information that you may desire.

With kindest regards, I am,
Sincerely yours,

JAMES A. SHANNON, M.D., *Director.*

TABLE 1.—*Balance between National Institutes of Health expenditures for support of extramural research, training, and construction of health research facilities, 1955-61*

[In millions]

Fiscal years	Total		Support of research		Training of scientific manpower		Construction of health research facilities	
	Amount	Per-cent	Amount	Per-cent	Amount	Per-cent	Amount	Per-cent
1955.....	\$48.7	100	\$35.0	72	\$13.7	28	-----	-----
1956.....	58.0	100	40.6	70	17.4	30	-----	-----
1957.....	160.7	100	97.0	60	33.7	21	\$30	19
1958.....	180.9	100	111.3	61	39.6	22	30	17
1959.....	246.0	100	155.8	63	60.2	25	30	12
1960.....	345.0	100	225.1	65	89.9	26	30	9
1961.....	480.1	100	317.8	66	132.3	28	130	16

¹ Excludes \$5,000,000 nonmatching grants for construction of cancer research facilities.

Source: Resources Analysis Section, Office of Program Planning, NIH, Aug. 9, 1961.

TABLE 2.—*Summary of health research facility program operations, 1957-61 and outlook for 1962*

	Number	Amount (in millions)
<i>1957-61</i>		
Applications received.....	1,254	\$358.2
Grants awarded.....	785	149.9
<i>1962</i>		
On hand, grants recommended by Council for approval and on priority list.....	150	57.3
Funds available ¹	-----	30.0
Backlog at beginning of fiscal year 1962.....	-----	27.3
Applications received as of June 30, 1961, for Council review in November 1961.....	135	42.5
Deficit over funds available ¹	-----	69.8
Plus formal notices of intent to file as of June 30, 1961.....	87	36.0
Total, unmet demand for fiscal year 1962, as of June 30, 1961.....	222	105.8

¹ Assuming that funds for 1962 will be appropriated at current authorized level of \$30,000,000.

Source: Health Research Facilities Branch, DRG. Prepared by Resources Analysis Section, Office of Program Planning, NIH, Aug. 10, 1961.

TABLE 3.—*Distribution of number and percent of awards under Public Law 835 by dollar intervals, fiscal years 1957-61*

Amount of awards	Number of awards	Percent
Total.....	578	100
Under \$50,000.....	192	33
\$50,000 to \$99,999.....	94	16
\$100,000 to \$199,999.....	95	17
\$200,000 to \$499,999.....	105	18
\$500,000 to \$1,000,000.....	52	9
Over \$1,000,000.....	40	7

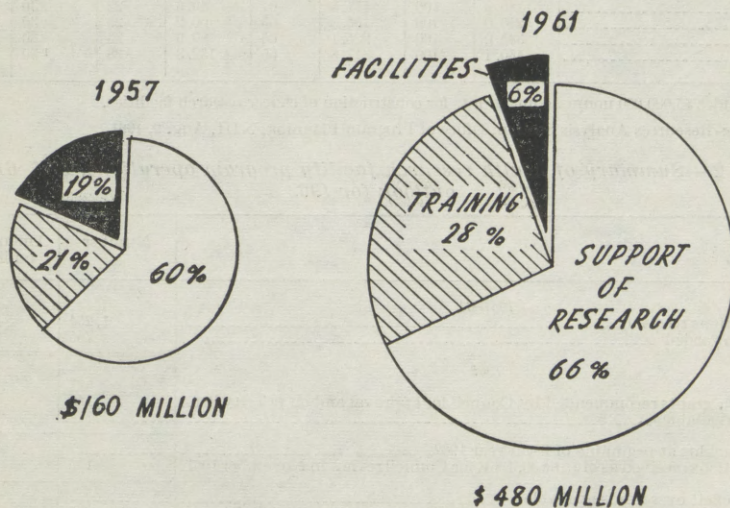
Source: Health Research Facilities Branch, Division of Research Grants. Prepared by Resources Analysis Section, Office of Program Planning, NIH, Aug. 2, 1961.

TABLE 4.—Distribution of number and amount of awards under Public Law 835 by dollar intervals, fiscal years 1957-61

Amount of awards	Number of awards	Percent	Amount of awards	Percent
Total.....	578	100	\$149,410,500	100
Under \$50,000.....	192	33	4,044,313	3
\$50,000 to \$99,999.....	94	16	6,547,235	4
\$100,000 to \$199,999.....	95	17	13,295,877	9
\$200,000 to \$499,999.....	105	18	31,923,271	21
\$500,000 to \$1,000,000.....	52	9	35,331,624	24
Over \$1,000,000.....	40	7	58,268,180	39

Source: Health Research Facilities Branch, Division of Research Grants. Prepared by Resources Analysis Section, Office of Program Planning, NIH, Aug. 2, 1961.

**NIH EXPENDITURES FOR SUPPORT OF RESEARCH,
TRAINING AND CONSTRUCTION OF HEALTH RESEARCH FACILITIES,
1957-1961**



**THE ROLE OF THE NATIONAL INSTITUTES OF HEALTH IN PROVIDING SUPPORT FOR
RESEARCH IN MEDICAL SCHOOLS**

Since 1946, the National Institutes of Health has administered a steadily growing program of extramural research in universities, medical schools, hospitals, research institutes and other research organizations.

Despite this rapid but steady growth, the fundamental principles adopted in 1945-46, when NIH agreed to take over the active contracts of the Office of Science Research and Development's Medical Research Committee, continue to govern extramural research planning and program development. These principles are: (1) Support of the best men and most promising ideas will produce the new knowledge required to combat disease and improve health; (2) the best men will seek support only if NIH gains and holds the respect of the scientific community; (3) support for the best men and ideas is most likely to emerge from open competition based upon scientific merit; (4) the judgment of one's scientific peers provides the wisest and fairest method for evaluating scientific merit, promise, and feasibility; and (5) terms and conditions that assure reasonable stability of support and foster freedom and flexibility for the investigator will facilitate productive inquiry.

At the present time, roughly 80 percent of the NIH research dollar is spent for extramural research. Medical schools receive the largest share of the NIH extramural research dollar. However, the proportion of the total funds for NIH research projects received by medical schools has been declining steadily, from about 60 percent in 1952 to less than 50 percent in 1960; the proportion awarded to universities, hospitals, and research institutes has been rising during this period. All applicants for research project support are on an equal footing; they compete for support on the basis of scientific merit. Their applications are judged by their scientific peers. This is not an infallible system but its integrity is held in high regard throughout the scientific community.

The terms and conditions under which research is supported are the same for all types of institutions. In the early years, our extramural research project program followed the private foundation pattern and paid only a tiny fraction of the direct costs incurred by the institution. Along with other Federal agencies, we soon recognized, however, that institutions undertaking research in the national interest are entitled to be reimbursed for the full direct costs of the research being supported. These direct research costs include salaries for research assistants, technicians, and helpers, for supplies, for travel and so on. It may also include compensation on for that portion of a principal investigator's time devoted to research on an NIH project.

The time devoted to research cannot be spent twice. If the principal investigator is a medical school faculty member, he cannot simultaneously engage in independent research and provide routine instruction to medical students. If a faculty member devotes 50 percent of his time to an NIH-supported research project, that proportion of his salary is a legitimate cost of carrying out research in the national interest. However, NIH research project grant funds cannot be used and are not used to pay the salary for any portion of the investigator's time devoted to teaching or activities other than research. What is true for medical school faculty members is equally true for staff of independent hospitals or scientists employed by research institutes. The time spent by an investigator on sponsored research is converted to a like proportion of the investigator's salary which constitutes a part of the direct cost of the research activity in any research setting.

This is not to say that research does not contribute to education in the medical school setting. It does and mightily. Research helps to attract and retain top-flight faculty; it assures that the medical student will benefit from today's new knowledge as well as yesterday's learning; it exposes medical students to the world of science and the dedicated attack upon the diseases of man through research; it shapes the environment in which interns and residents prepare to assume their full-fledged responsibilities as physicians in our society; it is part of the warp and woof of graduate education and post-doctoral training in the sciences.

Some people consider research as a cost of medical school operations and then equate support for salaries of faculty engaged in research as tantamount to support of medical education. Sponsored research is not properly a part of the cost of medical education—it is the cost of research, pure and simple. It is true, however, that the research environment so created enriches the quality of medical education. We would not have it otherwise.

The CHAIRMAN. There being no further questions, we certainly want to thank you very, very much.

And now, Dr. Ravdin, and Dr. Gross, will you gentlemen come around, please.

STATEMENT OF DR. I. S. RAVDIN, VICE PRESIDENT FOR MEDICAL AFFAIRS, UNIVERSITY OF PENNSYLVANIA

The CHAIRMAN. Dr. Ravdin, I note from your prepared statement you are a professor of surgery, School of Medicine of the University of Pennsylvania; vice president for medical affairs of the University of Pennsylvania; chairman of the clinical panel, Cancer Chemotherapy National Service Center; president of the American College of Surgeons; American Cancer Society director at large and member of its legislative committee.

We might add, too, you have been president of the American Association of Surgeons.

Dr. RAVDIN. American Surgical Association.

The CHAIRMAN. That is the most exclusive association of surgeons in the world. You have only 225 surgeons; isn't that correct?

Dr. RAVDIN. That is correct, sir.

The CHAIRMAN. And also a member of the Southern Surgical Association and many other distinguished honors and recognition of your very outstanding ability and the services you have rendered.

We would be happy to have you proceed in your own way.

And, incidentally, the chairman of the board of regents of the American College of Surgeons. Is that correct?

Dr. RAVDIN. Yes, sir, I have been.

The CHAIRMAN. You have been chairman of the board of regents, American College of Surgeons?

Dr. RAVDIN. Yes, sir; I was for several years.

The CHAIRMAN. For several years.

Dr. RAVDIN. Senator Hill, I am delighted to be back here and testify before you and your committee again, and I shall address my remarks in large part to two aspects of this major problem.

As I have watched the development of the proposals for funds for the Public Health Service, especially those affecting research and development, I have become convinced that, although the Health Research Facilities Act has been of tremendous usefulness to the medical schools and research institutions of this country, those of us who have been close to this total effort must be responsible for calling your attention and your colleagues' to the fact that there should be three specific changes in the health research facilities program.

(1) It is my considered conviction that for the best interests of the health of the Nation the program should be expanded for an additional 5 fiscal years, that is, through fiscal year 1967.

(2) I would hope that you and your colleagues could convince your colleagues that the authorization for appropriations should be increased from \$30 million for each fiscal year, as has been proposed to \$100 million a year, so that over a period of 5 years \$500 million would have been made available for extending and expanding the opportunities which have existed under the health research facilities grants program.

(3) I previously called your attention to the fact that a great many of our great institutions of learning have come to the point where they can no longer receive funds which are given on an equal matching basis. I would hope that it would be possible within the act to provide the circumstances whereby Government might under certain conditions provide 75 or 80 percent of the necessary funds and the receiving institution provide 25 or 20 percent of the funds. In extraordinary circumstances of great urgency it might be reasonable to expect that the Government pay the entire expenses of these programs. And this may well become necessary in the not-too-distant future.

This might be done under conditions where the National Advisory Council on Health Research Facilities recommend a grant in excess of 50 percent of the construction cost and when the Council determines that such an action was necessary to secure an immediate expansion

of research facilities or to improve the quality of research in sciences related to health that would not otherwise be possible.

It should be possible to make additional funds available for construction. Under the conditions it would bring about the circumstances of greatly increasing the number of research workers being trained in the health sciences and thereby facilitating research training in all of the areas of sciences related to health.

I listened with great interest to the discussion that just went on, and I wish to say as an educator that what Mr. Jones said at the end of his discussion was correct. To do really great teaching in medicine you must have great research workers in these institutions. To have great teachers and practitioners you must have them associated with those who are doing research. One cannot drop a cleavage line and say, "This is all pure research and this is all pure teaching." Medicine in this country has reached its present heights in teaching and training as the result of research.

There can be no doubt but that the most productive line of medical effort has come from a clearer understanding of the biological processes which control normal function and the deviation from the normal which comes about as the result of disease.

In my own field of effort spectacular techniques have been devised within recent years for conditions hitherto thought completely unamenable to surgery, and many operations previously considered extremely hazardous have passed out of the hands of master pioneers to become relatively commonplace and increasingly less dangerous.

You have had evidence in hearings you have recently held, when Dr. LeBahey and others presented work that is now being done on men that was thought to be unattainable 10 years ago.

However, these advances have been predicated far less on the ability of the surgeon to perform technical feats than on the ability of the patient to withstand the operative assault. Each of the successful major expansions of surgical science has followed the solution of one of a variety of problems attendant on subjecting the patient to an admitted trauma.

The contemporary surgeon is no more dextrous than his predecessors, but his knowledge of normal physiology and its deviations in the organism with which he is dealing, are vastly superior.

An indication of this tendency to divert attention in large part from the operating amphitheater can be seen in two previous advances to which surgical achievement is most indebted, asepsis and anesthesia.

I have watched closely the development of and the administration of the Health Research Facilities Act. It has, without any doubt, provided a means whereby a small amount of the research facilities so badly needed in this country in relation to health have been made possible.

There have been two difficulties which have faced American medical science since the passage of the act gave the Public Health Service the clear responsibility under the National Institutes of Health of carrying out the conditions of the act.

In the first place, the amount of money available each year has been inadequate and in the second place, the conditions of the act whereby the institution awarded a grant had to provide equal matching funds before the grant became available, has led to the circum-

stance that many of the finest of the medical schools in this country, and the finest of our research institutes find that they have exhausted their own funds.

We need additional research facilities. It is my considered opinion that a hundred million dollars a year could be used wisely in the provision of adequate research facilities for medicine in this country, in the broad sense.

If we are to meet our responsibilities for physicians for a growing America on the one hand, and the conditions necessary for a constant improvement of the health of our people on the other hand, we should within the shortest period of time make available a hundred million dollars a year for the expansion of medical research facilities in this country.

These facilities should not only be doing research to expand knowledge, but they should at the same time realize their full responsibilities in increasing the number of biological and medical research workers in this country. Unless we wisely and earnestly set about providing for the expansion of these facilities, we will soon lose our leadership in these areas.

We must constantly be training an ever-increasing number of talented young men and women who wish to play an important part in the biological and medical research areas. This will necessitate an ever-increasing financial investment in basic and applied research.

If we fail to realize that this is a major national responsibility for strengthening the productive capacity of our medical schools in the areas of medical and biological science, we shall find that in the years to come we will have fallen behind, not only in our contributions to an improvement and better understanding of the matters concerned with the abnormality of function in disease, but we shall have an inadequate number of properly trained teachers and departmental heads, who will be so necessary in training more and more people for practice and research in medicine.

The National Science Foundation, recently in a major policy document, stated:

The investment is large, but the potential returns on the investment are much, much larger.

While this statement applied to science in general, it applies extraordinarily well to the medical and biological sciences.

It is my considered opinion the future health of our Nation depends upon wise action by this Congress at this time.

The CHAIRMAN. Doctor, I have had the privilege of hearing you testify a number of times, and you always bring the most informative and challenging statement, and you have certainly done that this morning.

Let me ask you this question: On this matter of not requiring a 50-50 matching, would you give to the council that makes the awards of these grants certain discretionary power as to what the requirement should be as to matching, or just how would you handle this matter?

Dr. RAVDIN. I would give such authority of recommendation to the council as the final discretionary power is that of the Surgeon General under the law under which he conducts his office. But surely these advisory councils are set up, I think, with great wisdom. They represent wide segments of the country. They represent labor, and they represent the people in medical science and in medical practice.

These are dedicated individuals, as I have seen them, and I would give them the discretionary power of making specific recommendations in this regard to the Surgeon General.

The CHAIRMAN. And you speak now from your own experience because I know you have served on these councils.

Dr. RAVDIN. I have served on two of them, sir.

The CHAIRMAN. You served on two of the councils.

Any questions?

Senator WILLIAMS. I just want to get these figures straight. What do we provide for research?

The CHAIRMAN. Under the existing act—I say existing but it has expired now—there is an authorization for \$30 million of Federal funds for the construction of physical research facilities. Under the law as it was written those funds had to be matched dollar for dollar, one Federal dollar had to be matched by \$1 from the applicant. That act has expired and therefore we must take steps to provide for carrying forward this program of constructing physical research facilities. And the question now is, in passing new legislation, how much are we providing in terms of funds, and how often the act should be in existence, 3 years or 5 years, and also the question as to the matching provision.

Senator WILLIAMS. And the House has already acted—

The CHAIRMAN. The House has acted and set the figure at \$30 million and left the matching provision just as it was in the previous act. The House just extended what was the existing act for a 1-year period of time, which would just mean the \$30 million. But the administration in its bill S. 1072, recommends and provides for a sum of \$50 million.

Any other questions?

Senator PELL?

Senator PELL. No questions.

The CHAIRMAN. Dr. Gross, we are happy to have you here.

STATEMENT OF DR. PAUL GROSS, PRESIDENT-ELECT, AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCES, AND PROFESSOR, DUKE UNIVERSITY

The CHAIRMAN. Dr. Gross, you are president-elect of the American Association for the Advancement of Science and also a distinguished professor at Duke University in North Carolina, and I am sure you have many other accomplishments that you might tell us about, but I am sure you are too modest. However, would you mind adding a few?

Dr. GROSS. I think I will forgo that, Mr. Chairman, except to say I have had considerable experience, as Mr. Jones has, as the administrator of medical and health affairs. I served in this capacity at Duke University as vice president in the educational division for some 10 or 12 years before resigning from that position a year ago to return, I hope, to research.

I must apologize to you and the committee. You will recall the shortness of the notice, and I have not prepared a written statement, which I had hoped would be possible. However, it was not possible for me to do so. So if you will bear with me, I will speak orally.

The CHAIRMAN. You just proceed in any way you see fit, Doctor.

Dr. GROSS. Let me first endorse very strongly the statement which Dr. Ravdin has just made from the standpoint of the urgency of the situation. I would like, however, to approach it somewhat differently.

My contacts in science have been fairly broad, and I think a situation is developing of vital interest to medical research and medical affairs of which the committee and the Congress should be aware. As a Nation we are now engaged scientifically not only in nuclear affairs, as you know, but also in space activities of all kinds. We have a competitive situation in the education of young people and in the research activities of universities which is assuming what may be a serious aspect from the standpoint of attracting the best minds into medical and health research. The day was when we could be assured that the good minds in the undergraduate body would be looking to medical research and a medical career as the thing they wanted to do most. This is not always so today and the reason is that other scientific activities of all kinds have grown, expanded over the years, so that there are opportunities of all sorts, leaving aside any mention of the lucrative rewards for research in industry. There are areas in oceanography, ventures in space research, and challenges in nuclear physics that are highly attractive to a bright, eager, young mind.

Many of these have great glamor associated with them and for the first time in my experience they are reaching a state of development and of achievement which makes them competitive as career opportunities with the very strong and proper urge that young people have had in the past to do good in the health field through medical research, service, and so on. In view of this I feel very strongly that it is absolutely essential to provide the necessary environment and adequate environment.

If one looks at a physics department, for example, in a university he finds a reactor or the glamour tools of electronics. Now, the day was when the glamour of the surgical operation, the various complex activities in the medical schools, stood out in the university complex. It is extremely important, in my judgment, therefore, to provide modern and adequate surroundings and environment for medical teaching and research. And if one goes around to medical schools and research institutes, but particularly to medical schools, one finds they are overcrowded and often obsolete. In my own institution people working on research problems and with research funds are so crowded and short of space that their research is often seriously handicapped. I am sure it is the same with Dr. Ravdin's institution and many other cases. So I believe the provision of adequate research environment and facilities is one of the crucial items in any national effort to improve the health of our people.

The Congress, and your committee, have taken the leadership in providing liberal project research funds, but we are reaching a point now where we cannot find places for the people. If we do not, they will be attracted elsewhere. And I think it is a very vital thing to realize that something has to be done of this sort, and done very quickly. So I want to very heartily endorse the statements that have been made about the need for more adequate support for medical research and teaching facilities, but I want to underline the timing. The timing is very critical and even crucial.

Here is a bright young mathematician and physicist. He can go five or six different ways. I would hope, in the interest of the public in the long run, that he would go toward biophysics, let us say, and

contribute some new ideas such as the great physiologist, A. V. Hill, contributed in the classic development of physiology. So it is extremely important, in my judgment, at this time, that I see a cross section of scientific activity over the country.

Take the engineer, the electronic engineer. He has a great contribution, as Dr. Ravdin pointed out, to make to medical instrumentation, to devices of all sorts that are used in surgical operations that could not have been performed years ago. These are very expensive. I recall the first operation that was carried on at my own university some years ago, which involved exterior circulation of the blood through complex apparatus for oxygenization of the blood. It was very elaborate. It had a special room of its own and cost some \$18,000 for one operation. That was simply to get the new technique started and to test it out.

Now if this type of thing becomes routine in medicine and one does this kind of thing generally, that we used to call exotic and impossible operations, you are going to have to provide for medical facilities analogous to those that the nuclear physicist and the electronic engineer has. Through refined instrumentation, precisely controlled automation, it thus becomes possible to carry out the operations and increasingly complex medical procedures which lie beyond the capabilities of human skill—great as this may be.

So I feel very strongly that the provision of adequate facilities, and their early provision, is very essential. I reemphasize that young people coming in now, as I see them when I go to the science fairs which are subsidized by the Science Foundation, are looking in many directions. It used to be true these were heavily weighted toward health interests on the students' part. One finds a lot of other things coming into the picture nowadays. They are not just thinking in those terms. They are thinking of space; they are thinking of the Mohole operation of boring through the floor of the ocean. They are thinking in all sorts of wide ranges of the very broad spectrum of science that is developing today.

Again if we take a look at the applicants for medical schools, not just those intending to become practicing physicians but those who go on in research and academic medicine, we find they no longer are at the apex of choice of the undergraduate student. One of the reasons is, and an important one, that they do not see in the environment of the medical schools they see, the adequate facilities. They see crowding, they see people working under very poor conditions that are not true of other areas of scientific work today.

So I heartily associate myself with this very important matter of providing funds for adequate facilities.

The final thing I want to say is this, and Dr. Ravdin has stated it better than I can. I believe that the great breakthroughs in medicine and in surgery and in the health field are still to come, and they are going to be based on fundamental biological, biophysical, and biochemical discoveries.

To take one example, there is great interest, and I am sure Dr. Ravdin could cite this better than I, today in Europe, and beginning interest in this country, in the possibility of carrying out certain operations under pressure in a pressure chamber. Well, the reason for this—and I am a chemist—is very simple. If one has an oxygen tension which is higher than the normal oxygen tension in this room,

one does not need as many red corpuscles to perform the same function in the body that you have proceeding with the normal population of red corpuscles now in the body. And there is tremendous interest in this.

An animal experiment has been done in Holland, for example, in which a group of pigs had about 80 to 90 percent of their red corpuscles removed. They were put under higher oxygen tension for 3 or 4 weeks. They survived, happily, and the corpuscles were put back in. This involved equipment and elaborate facilities.

To duplicate the equipment in Holland, I am told by people who have been over there, would cost about \$300,000. My own institution and others I know of are very much interested in this possibility.

I cite these as specific examples. We are not asking to gild the lily with elaborate devices and so forth, but these are necessary things to do if medicine is to advance, not in the conventional way it has been carried out for many years, as Dr. Ravdin stated, but in terms of the many new types of medical procedures that are being carried on throughout the country.

I am familiar, as president of the Oak Ridge Institute, with the use of radioactive tracers. And this has had a profound effect upon medical research in the past decade. It is a new tool of great power for certain types of research.

Well, if one does this one has to have radiochemical laboratories in which one guards against contamination, where a new radiation hazard is now. These are down-to-earth, specific needs, yet any university has difficulty in trying to find the funds to carry out the building and construction costs involved.

I think that is all I need to say, Mr. Chairman.

The CHAIRMAN. You are president of the National Association for the Advancement of Science?

Dr. GROSS. I am president-elect. I will be president next year.

The CHAIRMAN. President-elect. You can speak more authoritatively, then, than the president.

Dr. GROSS. I am sure that is true.

Dr. RAVDIN. I should like to say that Dr. James Eckinhoff of our department of anesthesia, which is a very distinguished one under Dr. Robert Gripps, is going to southern England to work on one aspect of the problem that Professor Gross has just been talking about.

The CHAIRMAN. That is most interesting.

Dr. Ravdin, I believe your University of Pennsylvania, your school, is the oldest medical school in the country, isn't it?

I do not mean by that that you were there when it was founded.

Dr. RAVDIN. It is the oldest medical school, and it will celebrate in 1965, sir, its 200th anniversary, and I hope you will be there.

The CHAIRMAN. Thank you, sir. I hope we will all be there. Any questions?

Senator WILLIAMS. Just one. Isn't it true, Dr. Gross, that even as our population is advancing, the actual number of applicants for medical schools is declining?

Dr. GROSS. This is true in our school, and I believe it is a general phenomenon. I have been told so. In proportion, relatively, the absolute number has.

Senator WILLIAMS. And some of the factors apply here that apply to those going into medical research?

Dr. GROSS. That is right.

Senator WILLIAMS. Just one other brief observation.

From time to time our chairman, who is almost a medical doctor himself, advises us against the dangers of smoking. I see you have been smoking quite a bit.

Dr. GROSS. You have given me opportunity for comment of another sort. I have been asked to help with the whole study of environmental health, which your committee is very much interested in. I think that this very broad scientific and technologic development which I mentioned to which all of us are exposed is going to have to have undergirding it an activity as important perhaps as the medical research we have been talking about, namely, a total study of the environment as this develops technologically and scientifically—radiation, food supplies, air and water pollution. We are going to need information of a basic sort such as Dr. Ravdin mentioned. We do not have this now in any sound or comprehensive way, yet this is extremely important for the future of our people. Until we have it—and this is a personal matter—I still smoke.

Senator WILLIAMS. It occurred to me maybe you were just being a loyal son of North Carolina.

Dr. GROSS. That is also true.

Could I add one other thing, Mr. Chairman?

The CHAIRMAN. Surely; go ahead, Doctor.

Dr. GROSS. This is on the matter of matching of funds—I think there is an important point in relation to this because you have asked questions about it. The report of the Seaborg Committee of the President's Scientific Advisory Committee stresses the need for developing more widely geographically—and Senator Smith raised the same point—centers of scientific activity and centers of medical scientific activity is an important general point.

I know in the Southeast, as I do not have to tell Senator Hill, this is one of our problems, that we develop in this region, and other regions of the country, centers of activity in medical research comparable with those that we have well established in other parts of the country.

If one has to deal with the finances of a university as I did for 10 or 12 years at the university I represent—and Duke University is not one that is on the poor side, let us say, it needs money as all universities do, just as Harvard and Pennsylvania do—I found it very difficult to assess the competitive needs of a new dormitory, of new classrooms, developing work in physics and expansion of research facilities in medicine. One cannot say because an institution has resources that look good and look large that it can easily build and maintain a new medical research wing costing \$3 or \$4 million.

The point I want to make is this, that if you regard the advancement of our medical research as a long-range problem, you could appraise and weigh their relative merits over a 10-year period in the life of the Constitution and the Nation, but my insistence is that this is a short-range problem and it is urgent now.

Therefore, I would heartily endorse a reasonable deviation from 50-50 matching such as the bill indicates. Judgment concerning the merits of individual cases can safely be left to the advisory group which apportions the funds available. I found it very difficult to meet a need when it arose necessarily at the 50-50 matching level, whereas

if this had been allowed one way or the other sometimes, an institution is in a position to do it, and it only needs one-third other times. And those who have handled university finances, their pressures from growing student bodies, growing additional kinds of activities, scientifically, which we did not have at all 20 years ago, realize the great flexibility given by a provision such as in this bill. I strongly urge that this discretion be put in the hands of these councils and of the Surgeon General as the bill indicates.

This seems to me very wise mainly because the time for action is now. If we do not do this I think the whole medical research area is going to suffer very severely as I pointed out earlier.

The CHAIRMAN. Would you agree with Dr. Ravdin as to the amount he recommended?

Dr. GROSS. Oh, yes. I do not think there is any question about this. Anyone who has seen the need and seen the crowding and conditions would agree. For the Cancer Council, of which I am a member, I have visited a dozen of these places and seen people are working in back hallways and in improvised huts. You can go down to Florida and see the kind of thing that is going on down there. They are doing the work, but they are doing it under conditions that I think should not have to pertain, and I am not speaking of any gilt-edge facilities of luxurious surroundings.

The CHAIRMAN. Doctor, I wish you would furnish for the record a little more biography of yourself. You spoke about being responsible for the financial operation of the university. I would like to have your status there and everything, if you will do that.

Dr. GROSS. All right, I will send it.

(The information referred to follows:)

BIOGRAPHY OF PAUL MAGNUS GROSS

Born: September 15, 1895, New York City, son of Magnus and Ellen Sullivan Gross.

Married: Gladys Cobb Petersen, August 4, 1918.

Children: Paul M. Gross, Jr., and Beatrix Cobb Gross (Mrs. Robert L. Ramey).

Education:

College of City of New York, B.S., 1916.

Columbia University, M.S., 1917.

Columbia University, Ph. D., 1919.

University of Leipzig, study and research, 1929.

Oxford University, study and research, 1937.

Academic career:

Instructor in chemistry, College of the City of New York, 1916-18.

Assistant professor of chemistry, Trinity College, Durham, 1919-24.

Professor of chemistry, Duke University, 1924 to date, Duke.

Chairman, department of chemistry, 1921-49, Duke University.

Dean, graduate school, 1947-52, Duke University.

Dean of the university, 1952-58, Duke University.

Vice president in the division of education, 1949-60, Duke University.

War records: Second lieutenant, chemical warfare service, World War I, 1918.

Memberships:

Fellow, American Physical Society.

Fellow, New York Academy of Science.

Phi Beta Kappa.

American Chemical Society.

American Association for the Advancement of Science.

Phi Lambda Upsilon.

Sigma XI.

Honors:

- Herty Medal, 1945.
- President's Medal for Merit, 1948.
- Southern Association of Science and Industry Award, 1951.
- Florida Section of American Chemical Society Award, 1952.
- Townsend Harris Medal of City College of New York, 1953.
- Carnegie Corp. Manship Award, 1954.
- Appointed honorary commander, Civil Division, Order of the British Empire (honorary CBE) by Her Majesty Queen Elizabeth II (April 1958).

Further information (current):

- Contributor to scientific journals, publications.
- Member of the board of the National Science Foundation.
- President, Oak Ridge Institute of Nuclear Studies.
- Chairman, Advisory Committee of the Ordnance Corps.
- Member, Picatinny Arsenal Advisory Council.
- Attended General UNESCO Conference in Paris, 1949, as scientific adviser to the U.S. delegation.
- Member of the National Advisory Cancer Council, 1959 to date.
- Adviser to Stern Family Foundation project on Excellence, 1959.
- Trustee of Woodrow Wilson National Fellowship Foundation, 1960 to date.
- Member, Conference on "Excellence," Wesleyan University, 1961.

The CHAIRMAN. Are there any other questions, gentlemen?

Gentlemen, we certainly want to thank you for coming here and being with us this morning and for your very fine statements.

Dr. RAVDIN. Thank you, Senator Hill, for asking us to come back.

The CHAIRMAN. Thank you very much.

Now, Dr. Stebbins.

STATEMENT OF DR. ERNEST L. STEBBINS, VICE PRESIDENT, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH, AND DEAN OF THE SCHOOL OF HYGIENE AND PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD.

The CHAIRMAN. Doctor, we are glad to have you back with us again.

You are vice president of the Association of Schools of Public Health and dean of the School of Hygiene and Public Health, Johns Hopkins University. Is that correct?

Dr. STEBBINS. That is correct, sir.

The CHAIRMAN. Is there anything you want to add?

Dr. STEBBINS. Well, I prejudiced myself, that I was formerly president of the association and I was demoted to vice president.

The CHAIRMAN. In other words, you have the working job now?

Dr. STEBBINS. That is right, sir.

The CHAIRMAN. You may proceed, Doctor.

Dr. STEBBINS. I am speaking for the Association of Schools of Public Health which you I know are aware is a small group of schools, 12 in the United States, that assume the responsibility for the training of public health personnel for the country as a whole, and also many foreign students sent to us under the auspices of the Federal Government.

These schools have really three functions. We carry on basic research programs. We also train research workers, and we also provide training for those who are to apply the results of research, that is, the practicing health officers of the country.

In order to do this most effectively we feel that we must keep in contact with the needs of the various parts of the country, and I think

my own case is typical of that of many of the faculty of the schools of public health.

I was a county health officer in Virginia for a number of years. I was in the New York State Health Department as assistant commissioner for a number of years, and commissioner of health in New York City for 4 years before assuming my present job.

All of this experience has led to the belief that there is urgent need for some mechanism of providing more broadly the benefits of modern medicine which has become so greatly enhanced in recent years.

One of the things that impresses the health officer is that the cost of care has increased tremendously. For example, I can remember when the average cost of a day in a hospital was less than \$10, and now in most of our modern hospitals it is nearer \$40 a day. This means we need to provide, insofar as possible, for this constantly increasing demand for medical service, some means of making it as economical as possible.

We believe that this legislation, S. 1071 and H.R. 4998, would be a major step forward in meeting this need for improved service and more economical service.

Some of the studies that have been carried out recently show that in our general hospitals, not infrequently patients are kept for a considerably longer period than would be required for maximum medical benefit.

This means that either the individual patient or the community pays a much higher cost than would be required if we had adequate home-care programs, nursing homes, convalescent homes and rehabilitation centers.

In my own city and in a number of other cities there have been set up evaluation centers that determine the level of hospital or medical care that a patient needs in order to make the most rapid recovery and be most quickly rehabilitated.

This type of activity will be provided under the proposed legislation more extensively, and would undoubtedly markedly reduce the cost of care of the chronically ill.

As was mentioned by members of the previous groups testifying, the present situation of our nursing homes is a near scandal in many parts of the country. And the proposed legislation would make possible the studies that will provide a plan for improving this situation, and actually build additional nonprofit nursing homes that would meet a very real need.

Now I know the time is short, and I will be very brief, but I would like to mention the need for the personnel to carry out these functions—the studies that are envisioned in the legislation and the development of plans for a coordinated program of care for the chronically ill.

The schools of public health have this as the major responsibility: the training of personnel. Being limited in number, we are all regional schools and we cannot turn to our States or even to regions for the support that we need in order to provide a fine educational program.

For example, in my own school, we have had students from every one of the 50 States. We have had students from 77 different countries. There is no place that we can turn for the kind of support that such a regional school requires other than to the Federal Government.

Another point that I think is important to bring out is that 90 percent of the graduates of the schools of public health go into public service. That is, they go into the U.S. Public Health Service, the preventive medical services of the Army, the Navy, the Air Force, and other Federal services.

Many of them go into the States to serve as health officers of cities, States, and counties. They do not receive large incomes, and therefore as alumni cannot materially contribute to the support of their school.

This was recognized by the Congress in the enactment of the Hill-Rhodes Act of 3 years ago, and this support has been of inestimable value to the schools. It has made it possible for us to expand our programs and to improve our teaching methods.

It was brought out at that time that the students sent to these schools by the Federal Government, federally sponsored students, that the Federal Government paid in tuition just about one-fifth of the cost of training those students. And at that time it was pointed out that there was a deficit to the schools of approximately \$4,000 per student that was sent to them by the Federal Government.

Now this \$1 million in the original Hill-Rhodes Act improved that situation, but it did not completely eliminate the deficit.

The schools are now spending in addition to the tuition they receive for every student the Federal Government sends to them \$3,690 out of school funds to provide an educational opportunity that is needed.

The proposed amendment introduced in the House would increase the ceiling from \$1 million to \$2,500,000. This would be another step toward removing the deficit that the schools have to bear in the training of those students sent to the school by the Federal Government.

In regard to the point made by Dr. Ravdin, this is extremely important to the schools of public health. We have not been able to attract private funds to match the research facilities grants to any considerable extent. We believe that since we are regional schools, and since we are providing education primarily for federally sponsored students, that a ratio of 80 or 85 percent of the cost for research and teaching facilities might well be borne by the Federal Government under this program.

In general I want to say that we strongly support the proposed legislation. We feel it is extremely important to the health of the Nation, and certainly the provision for increased assistance to the schools of public health will go far in making it possible for us to expand and to increase our services.

The CHAIRMAN. Doctor, how many schools of public health are there in the United States today?

Dr. STEBBINS. There are 12 at the present time.

The CHAIRMAN. Twelve. Well, I think it is important for us to remember that just 12 schools of public health must serve the entire population of the United States, serve the population of 50 States.

Most of these States do not have a school of public health. Therefore, your Federal Government really has a direct responsibility if we are going to have these trained public health workers, which we must have to get this job of public health done. Isn't that true?

Dr. STEBBINS. We feel that is extremely important.

Senator WILLIAMS. Mr. Chairman, this committee hopes we will be able to give the schools of public health a new opportunity to render a new service.

This committee has passed out the bill to make public health service programs available to the migratory farm families across the country.

And if that should be enacted, I would judge that this probably would be a new course of study within those schools.

Dr. STEBBINS. We have recognized the health problem of migrant workers as of extreme importance. We have had a number of research projects, trying to determine the best method of meeting the health needs of the migrant laborer. And I think that all of these schools would welcome the opportunity to carry on research and assist in training personnel to meet this need.

The CHAIRMAN. Senator Williams has done a tremendous amount of work and has been most devoted on its behalf. And I am sure he can find cooperation from the public service groups to get the trained workers we must have to make effective the legislation to which he has given so much of his time.

Dr. STEBBINS. I can assure you the schools would welcome the opportunity to be of help.

The CHAIRMAN. Senator Pell?

Senator PELL. Am I correct in the assumption that as to the public health professions, when M.D.'s go into public health schools they are already doctors?

Dr. STEBBINS. Yes; the health officers, the health administrators are M.D.'s, and then they have a year of academic training at least, or 2 years of academic training, and then residency training before they become fully qualified as specialists.

But there are also other public health workers that are trained in some of these schools of public health, particularly public health nurses and public health engineers.

Now in some of these schools the proportion of physicians is high and in others it is low. There is a tendency for specialization among the schools and the training of the different professional groups.

Senator PELL. According to some testimony here a couple of months ago, the point was made that men who had graduated from a public health school, who are also M.D.'s, receive a much lower average income than the average M.D. who does not go into public health, which would seem to me to show a tremendous degree of public service and dedication in this particular field.

Would that be your view?

Dr. STEBBINS. I can assure you that the average salary of the public health worker is far lower than the figure that appeared in public health economics recently of the average income of the practicing physician.

Senator PELL. It seems rather unfortunate, the very fact of taking the extra degree means that they then write themselves out of an additional income.

Dr. STEBBINS. Well, that does not necessarily follow. It is true that salaries are low in public health, but the man who has training in public health may, if he wishes, go in private practice.

He is qualified to practice, but the majority of them do not, they stay in public service. And I do think it indicates a sense of responsibility and dedication on the part of those who work in public health.

Senator PELL. So, in essence, their return is a greater degree of sense of public service and dedication.

Senator WILLIAMS. In that connection, Senator Randolph of this committee said on the floor the other day that Jonas Salk was making \$15,000 a year while Johnnie Mathis was—I do not know how to describe his singing—making \$15,000 a week.

The CHAIRMAN. Any other questions, gentlemen?

If not, Doctor, we certainly want to thank you for your presentation here this morning. You have been most helpful and we deeply appreciate it.

Dr. STEBBINS. Thank you, sir.

The CHAIRMAN. Thank you very, very much.

The subcommittee will now stand in recess until 10 o'clock in the morning.

(Whereupon, at 12:25 p.m., the subcommittee recessed, to reconvene at 10 a.m., Friday, August 4, 1961.)

COMMUNITY HEALTH FACILITIES AND SERVICES

FRIDAY, AUGUST 4, 1961

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10:05 a.m., in room 4332, New Senate Office Building, Senator Lister Hill (chairman) presiding.

Present: Senators Hill, Yarborough, Williams, Pell, and Case.

Committee staff members present: Stewart E. McClure, chief clerk; John S. Forsythe, general counsel; Robert W. Barclay, professional staff member of the subcommittee; and John D. Stringer, minority associate counsel.

The CHAIRMAN. The subcommittee will kindly come to order.

The subcommittee is meeting this morning to continue consideration of the proposed Community Health Services and Facilities Act of 1961 as provided for in S. 1071 and H.R. 4998 and the proposed Health of Citizens and Training Act of 1961 as provided for in S. 719. All three of these measures would authorize further assistance to communities for expansion and extension of health services. The text of these bills, showing the provisions of each, will be included in the public record of these hearings.

Dr. Sowder, will you come around, please, sir?

STATEMENT OF DR. WILSON T. SOWDER, EXECUTIVE BOARD, AMERICAN PUBLIC HEALTH ASSOCIATION

Senator HILL. Doctor, we are glad to have you here. You have been with us before and we are always glad to welcome you back. You represent the American Public Health Association. You are also past president of the State and Territorial Health Officers and you are health officer of the State of Florida.

Dr. SOWDER. Yes, sir.

The CHAIRMAN. Proceed in your own way.

Dr. SOWDER. Senator Hill, I have a statement on file here and I am not going to repeat that statement or any of the contents of it. I would like to supplement it a little bit.

The CHAIRMAN. All right, sir.

Dr. SOWDER. I might say I feel a little bit like carrying coals to Newcastle, trying to tell you anything about a bill of this kind or health subjects in general.

The CHAIRMAN. I am sure there is much you can tell us, Doctor.

Dr. SOWDER. I have listened to you talk to me about health so many times I am a little bit under constraint to be on the other side and talk with you.

The main thing I do want to say to you, though, to you and Senator Pell and the other gentlemen on the committee, is this, that the organizations that I represent are heartily in favor of this bill. We feel that it is a conservative and well thought out approach to very obvious health problems. It is an approach that is not controversial and it is sound. I am speaking particularly on the amendment to section 314(c) and the special project grants.

The other gentlemen in the audience will speak, I am sure, more fully on the others. But these two particular phases of the bill, in the opinion of the people in the Association of State and Territorial Health Offices and the American Public Health Association, will give us the push and the stimulus to do the kind of job, the public health job, in the field of chronic diseases that we think has been done in the past in tuberculosis control and venereal disease control.

We would like to use some of the same techniques that have been used to control those communicable diseases and we think there is a similarity. Of course, in detail, the approach is different. We want to extend beside nursing care. We want to have some visiting of the sick by nurses. In some of the States, we want to set up outpatient clinics while in others we will not.

We in Florida would like to extend our community program for the mentally ill and we have made a start in that direction. The bill, however, is so written that the several States can tailor their approach to suit their own particular legal and administrative setup in the health field, and yet obtain the overall objective which I am sure, Senator, you and the members of your committee want to be uniform, you want the objective to be uniform throughout the country.

Health programs in the States need a great deal of help. In recent years, the support they have gotten has not increased in comparison to the problems, or what is expected of us, rather. The problems themselves have been with us a long time. Of course, the number of aged have been on the increase, particularly in my own State. With the increased products of research, more is expected of everybody in the field of services to the sick. We are well equipped, we think, if provided with the proper financing, to make a major contribution to the care of old people and to the chronically ill.

We like this bill because, too, it gives a certain amount of freedom, it is not categorical. We can help old people, no matter what disease they may have and we can help people that are chronically ill regardless of their age. We can select the particular type of vehicle or machinery or technique that fits the need of our State and local community.

Now, Senator, I know you have a lot of witnesses and I know that you and Senator Pell and Senator Yarborough are well informed as to the content of these bills, and I have filed a written statement for both of the organizations which I represent. If it is all right with you and you do not want me to go into more detail, I will stop there and just offer to try and answer any questions you may have.

The CHAIRMAN. Doctor, you have found your past relations with the Federal Government satisfactory?

Dr. SOWDER. Very satisfactory, yes.

The CHAIRMAN. In other words, these programs which have been carried on now for a number of years have worked out well, haven't they?

Dr. SOWDER. The partnership between the Federal and State Governments in the field of health has worked very well. Of course, it is the one with which I am most familiar. I have worked on the State level, Federal level, county level, and city level and I think it is one of the best examples of Federal-State partnership in action; yes, sir.

The CHAIRMAN. Do you think passage of this bill would make it possible to have better home care and therefore—

Dr. SOWDER. Yes, I do, and it is badly needed. The States are making a beginning, but they need the shot in the arm that this will give.

The CHAIRMAN. You think this will not only help the States, but be quite a stimulant?

Dr. SOWDER. A great stimulant, yes, sir.

The CHAIRMAN. Any questions?

Senator Pell.

Senator PELL. Doctor, would it be correct to say that in your own State, there is a higher percentage of older people than in other States because of people moving down from northern climates to retire, and these people need even greater help in your area?

Dr. SOWDER. Especially in my State; yes. Now, we are beginning to get a greater and greater proportion of older persons.

You know, the States in the South generally have a younger population. Florida is a southern State, but the natural condition there is overbalanced by the immigration of older people, so we have a greater number and are getting an even greater number of older people than the average. In some of our counties, we have a terrific pileup of older people, such as Pinellas County. The last time I checked there, at least 20 percent of the people were over 65.

Senator PELL. Thank you.

Senator YARBOROUGH. Doctor, by the recommendation, there will be an increase in medical service to the chronically ill in their home. You think this might be done at an overall saving to our economy, that it will be cheaper to care for these people at the same level in their homes if they had one, than to move them into a nursing home?

Dr. SOWDER. I think so absolutely, sir. It is true, that no matter what scheme of public health or medical care anyone thinks of, it is expensive, and I think it is an absolute necessity that we seek out the most economical ways of caring for sick people. Furthermore, it is best for the patient, wherever possible, to keep him at home. This is a more economical way and a better way to do it and it should be encouraged, yes, sir.

Senator YARBOROUGH. I am glad to get your opinion, considering your experience, both at State level, city level, and national level, in this problem.

Dr. SOWDER. Thank you.

The CHAIRMAN. Any further questions?

Doctor, we certainly want to thank you for your appearance here this morning and your very important testimony.

Dr. SOWDER. I enjoy the privilege and I appreciate your having invited me, sir.

(The prepared statement of Dr. Sowder follows:)

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION ON S. 1071 AND H.R. 4998 PRESENTED BY WILSON T. SOWDER, M.D.

The American Public Health Association is appreciative of this opportunity to present to this committee this statement in support of S. 1071 and H.R. 4998. We believe this legislation will prove a milestone in this Nation's efforts to better the health of her citizens through a Federal-State action program that will help provide public health services to the aged and others suffering the disabling effects of chronic illness and who are in need of immediate, competent, and effective care. These identical bills, which illustrate the keen insight of their authors into the medical problems facing our Nation, would upon enactment and implementation go far to correct the current imbalance between the search for and acquisition of knowledge and the appropriate, timely, and efficacious application of that knowledge.

While the APHA supports the objectives of this legislation in its entirety, we are particularly anxious to express our support for that portion of the bill which will provide for an increase in health services to the chronically ill at home. That we need to search diligently and extensively for new and better ways to provide care to the chronically ill and aged seems to us to be self-evident. With few exceptions, our hospitals are superbly equipped and dedicated to the care of the acutely ill. This should be considered in no respect an aspersion—we need all the hospitals we now have and more. But this competency is of little solace to the patient who is in need of long-term care for chronic illness.

Equally axiomatic to us is the value of the proposed doubling of grants for the construction of nonprofit nursing homes. In the face of a direly needed one-half million beds in nursing homes and chronic disease units, a Federal contribution toward the construction of slightly under 6,000 nursing home beds per year appears a most conservative venture. Support for this particular facet of our medical care armament is sharpened by our experience which indicates clearly that progressive, productive-to-the-patient care is found almost exclusively in the nonprofit or public nursing homes.

The most significant aspect of this bill, it seems to us, is the stimulatory grants to help provide health care in the homes of the chronically ill and aged. The list of diseases which contribute to this human suffering and economic waste is most ominous. It includes mental and emotional illness, heart diseases, arthritis and rheumatism, diabetes, epilepsy, cancer, cerebral palsy, muscular dystrophy, multiple sclerosis, and blindness. Many of those millions suffering from one or more of these causatives can be effectively cared for at home. Many now occupying hospital beds, beds desperately needed for the care of the acutely ill, could be more beneficially cared for in a good nursing home or in their own homes. While our primary concern is to assure the best therapy at the proper time, in the proper place, it should be pointed out that properly organized care will result too in economic savings, particularly to the patient.

The approach proposed by S. 1071 and H.R. 4998 is, in our opinion, a brilliant combination of simplicity and effectiveness. State and local health departments have for years provided public health services to patients with tuberculosis and venereal diseases, and this is an extension of these services into the area of chronic diseases. The increased grants will make it possible for existing, well-established, and community-accepted health departments to expand their staffs to provide, under the supervision of local physicians, needed care to the chronically ill and aged right in their homes. As an example:

A public health nurse can teach a diabetic to give himself insulin shots, test his own urine, and give instructions in the importance of good skin care to prevent infections. A nutritionist can assist in the preparation of needed special diets.

Or the nurse together with a physical therapist can give proper exercises to a person who has a paralyzed or otherwise crippled limb. Responsible members of the family can be taught how to give these exercises and how to care for the patient, and as the patient improves he can be taught to care for himself.

Or with the availability of a homemaker service, an older person or couple may be able to live their twilight years in the familiar surroundings of their own home rather than being relegated to the new and perhaps unwanted environment of an institution. A homemaker could assist with preparation of wholesome meals and needed household tasks so that important ingredient to human dignity—independence—can be maintained.

Or the public health nurse could go into the home of a person suffering from external cancer to do needed dressings, to teach other family members how to do the dressings, bathe the patient and to otherwise provide needed care and comforting procedures.

We do not mean to infer that this needed new program can be accomplished by existing staffs. Additional trained staff is needed—doctors, dentists, nurses, practical nurses, physical and occupational therapists, homemakers, social workers, nutritionists, and others. To obtain these skills, additional moneys are needed. The proposed Federal increase of \$20 million must be matched by at least an equal amount of State and local funds, and we are convinced that States and local communities will more than do their share. We are not convinced that the increased Federal grants will be adequate for all needs, but we believe that they will provide a good start. We subscribe to the House action which calls for a review of the program by the Congress before termination of the authority in 5 years.

In summary, we wish to urge favorable consideration of S. 1071 and H.R. 4998 because it will initiate the means of truly coordinating our Nation's medical care program so as to use to the optimum the skills and capabilities of medical and paramedical personnel and of medical facilities. It will lend much to the application of newly gained research knowledge, better the use of present medical facilities, and help in finding new and better program methods and more effective medical facility construction techniques. This legislation is, in our opinion, a most significant advance.

Senator HILL. Now, Dr. Buerki.

STATEMENT OF DR. ROBIN C. BUERKI, CHAIRMAN OF THE COUNCIL ON GOVERNMENT RELATIONS OF THE AMERICAN HOSPITAL ASSOCIATION; ACCOMPANIED BY KENNETH WILLIAMSON, ASSOCIATE DIRECTOR, AND DR. VANE HOGE

The CHAIRMAN. Dr. Buerki, we are glad to have you gentlemen here with us this morning.

Dr. Buerki, you are chairman of the Council on Government Relations of the American Hospital Association and also director of the Ford Hospital in Detroit?

Dr. BUERKI. You are correct, sir.

The CHAIRMAN. We will be happy to have you proceed, sir, in your own way.

Dr. BUERKI. Thank you, sir.

My name is Robin C. Buerki. I am executive director of Henry Ford Hospital, Detroit, Mich. I appear before this committee today in my capacity as chairman of the Council on Government Relations of the American Hospital Association, accompanied by Mr. Kenneth Williamson, associate director of the association, and Dr. Vane Hoge, assistant director of the Washington Service Bureau.

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 hospitals admitted more than 23 million patients. Our primary interest—and the reason for the organization of the 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 S. 1071, the Community Health Services 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. I shall discuss the areas touched upon by the bill in which we are interested, and, in addition, comment upon the need we feel exists to make the rehabilitation facilities provided by the Hill-Burton Act more widely available.

1. Section 316, 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 nursing homes is greatly needed. 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 complimentary to that of hospitals.

We should move forward quickly in the construction of nursing home facilities. All 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 do not meet a standard of high quality nursing home care.

Moreover, it is essential that patients be discharged from 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 facilities, demands a rapid turnover of patients and the discharge of many patients suffering with long-term or chronic illnesses. Too many existing nursing homes do not provide care of sufficient quality to permit transfer of patients from acute hospital 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 section 636 of 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 66 $\frac{2}{3}$ 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.

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 avoided undue pressure upon the Surgeon General with respect to individual projects.

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. 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 a various service areas within the hospital. Such construction will facilitate research leading to improvement in the organization and operation of services. Hill-Burton provides for permanent structures.

We believe 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.

We recommend that section 5 be amended so as to permit each State to set aside a certain percentage of its annual allotment for projects designed to permit the construction of experimental or demonstration hospitals or other facilities provided for under the Hill-Burton Act, and for the acquisition of experimental or demonstration equipment.

The State agencies would submit to the Surgeon General applications setting forth a description of the project and providing the same assurances required for all other projects under the act. The Federal share should not exceed $66\frac{2}{3}$ percent of the cost of an approved project, except where the Surgeon General determines that the circumstances require a large percentage.

If, however, the committee does not see fit to alter the bill as suggested above, we would strongly urge that at the very least the bill be amended by placing a specific limit on that portion of research funds which can be spent for construction purposes and, in addition, to require State agency approval of any research construction project under this section.

Section 5 also proposes to remove the present ceiling of \$1.2 million on research funds presently provided for. 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 administrative research funds is long overdue. A growing list of needed research projects must be rejected because funds are not available.

Our recommendation for a 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. 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, however, 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, nevertheless, 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 summary, we are generally in favor of the objectives of the bill and we urge its passage with the following modifications:

First, we recommend an increase from \$20 to \$30 million in the funds available for nonprofit nursing homes.

Second, we believe it would be preferable to amend the bill so as to provide for the establishment of a separate research construction category within the Hill-Burton program and for administration of such funds by State agencies.

At the very least, however, we urge that the bill be amended to provide a ceiling on that portion of research funds available for construction and to require State agency approval of construction projects.

Third, we recommend an amendment which would eliminate the requirement now appearing in part G of title VI of the Hospital Survey and Construction Act that a "rehabilitation facility" encompass all possible aspects of rehabilitation.

I wish to express our appreciation for the opportunity afforded to discuss this legislation with you.

Thank you, sir.

The CHAIRMAN. Well, Doctor, you have certainly brought us a splendid statement.

Anything you would like to add, Mr. Williamson?

Mr. WILLIAMSON. No, thank you, sir.

The CHAIRMAN. Anything from you, Dr. Hoge?

Dr. HOGE. No, sir; thank you.

The CHAIRMAN. Any questions?

Senator PELL. In your role representing American Hospital Association have you had any cause to compare our facilities for the treatment of old people with those outside the United States?

Dr. BUERKI. Repeat that, please. How we are handling compared to—

Senator PELL. How our facilities for older people compare with other technologically advanced countries. Are we behind them or ahead of them?

Dr. BUERKI. It is hard, frankly, to compare apples and oranges, but at the same economic level of the people you will find in Norway, Sweden, Denmark, more thought of the elderly than in this country. Do I make the point?

Senator PELL. But, in general, would you say we are a little behind the other civilized nations?

Dr. BUERKI. Yes; if you consider people at comparable economic levels.

The CHAIRMAN. We certainly want to thank you, Doctor. This was a most informative, interesting, and splendid statement.

Dr. BUERKI. It was a privilege to be here, sir, as always.

The CHAIRMAN. Thank you.

Now, Dr. Butt, Dr. Beahrs, Mr. Mickey.

STATEMENT OF DR. H. R. BUTT, MEDICAL CONSULTANT, ROCHESTER METHODIST HOSPITAL, MAYO CLINIC; ACCOMPANIED BY DR. O. H. BEAHR, SURGEON, AND HAROLD MICKEY, ADMINISTRATOR, ROCHESTER METHODIST HOSPITAL, MAYO CLINIC, ROCHESTER, MINN.

The CHAIRMAN. We welcome you gentlemen here this morning.

Dr. Butt, you are a medical consultant from Rochester Methodist Hospital, Mayo Clinic. I do not have to say where that is. I suppose there is no clinic better known in the world than Mayo Clinic, is there?

Dr. BUTT. I hope not, sir.

The CHAIRMAN. Dr. Behrs, you are a surgeon at the Rochester Methodist Hospital, Mayo Clinic, and Mr. Mickey, you are an administrator, Rochester Methodist Hospital, Mayo Clinic.

Dr. BEAHR. Correct, sir.

Mr. MICKEY. Yes, sir.

The CHAIRMAN. Dr. Butt, you proceed the way you see fit.

Dr. BUTT. Thank you, Senator Hill.

We are here in support of Senate bill 1071 and House bill 4998.

Our story begins about 6 years ago, Senator Hill, when the Methodist Hospital asked the Mayo Clinic if it would appoint a group of physicians to help them in drawing plans for a new hospital which they were considering building. This committee of physicians began to review this problem and review the world literature on hospitals and some very interesting things came out of the study.

One was that there had been very little change in hospital design in the past four or five decades. Most hospitals in the past were built because some architect had an idea or some benefactor wanted it a certain way, or even at the whim of some physician. We found that very little had been done to relate hospital construction and design to patient care.

The second thing noted was that there had been a large number of very good studies on patient care, but very few studies with controls. The data reported was often not factual.

The next thing we found was, to our surprise, that the cost of hospital care in the last two decades had increased something over 300 percent. Also that, of the cost to the patient in the hospital, about 65 percent came from the cost of personnel and, of this 65 percent, about half of it was related to the cost of nursing personnel.

So it became rather obvious that in designing any new hospital we had to think of some way of utilizing more efficiently our personnel and reducing the cost to the patient.

The first thing to find out was what type of patient we had in the hospital. Some research was done in this direction and about 1,100 patients were studied, totaling to about 7,800 patient-days. It was found, as you see in this diagram, that about 20 percent of the patients in so-called stage 1 are individuals in the hospital on any given day who require more than average nursing care, that 60 percent of them require average nursing care, and about 20 percent less than average nursing care.

It was decided that the important group to start on first in any study would be that 20 percent that required more than average nursing care,

because these were the ones who have to pay the most. Special nursing care around the clock is a very substantial drain on any family savings.

A research committee was appointed. Proper statisticians, time and motion people, et cetera, were assembled and with the architects, a new design was decided upon. This unit was built with funds obtained from the Ford Foundation and the Maud Hill Foundation and the research was supported by the Kellogg Foundation.

Well, the design that was developed was essentially very simple. If you slice an orange in half, the center is where the nurses sit and the sections are where the beds are, as you can see in this next diagram. It is rather obvious that the nurses in the center can see the patients and the patients can see the nurses and that the nurses and doctors have little distances to walk.

We have emphasized that in order to get any real factual information (scientific facts), you have to have controls. By that I mean we took a regular rectangular unit such as you see in this chart, with a long corridor with rooms on either side, and compared it with the circular unit and with the same type of patients.

In this unit, as you can see in this next diagram, this is about what the nurse sees—the patient.

In the next chart, you see what the patient sees at all times to comfort him.

Over a period of 3 years these studies went on, the carefully planned, controlled studies. This mass of data has now been published in a monograph by the American Hospital Association in the past year, and I see no need to bother you with the details. Suffice it to say that of the several important things that came up, one, a very obvious one, the nurse likes it. She can still see her patient and does not have to walk so far. This is a diagram showing the long corridor versus the circular unit.

The CHAIRMAN. There you get the contrast.

Dr. BUTT. Yes, sir.

Here is some of the data—I will show only this one chart of data. In the circular unit, you see the nurse only walked, in a time and motion study, about 3.8 miles as against 5.2 miles in the rectangular unit. This is not very much, but this is one shift. If you multiply this by 3 and multiply that by 365, you see something about the amount of time wasted in just walking.

Not only did the nurses and doctors and patients like it, but the relatives liked it. They felt that their loved one was under surveillance at all times.

Equally surprising to us was the cost factor, and in Rochester, Minn., to have three nurses, private duty nurses, around the clock, it would cost \$54 a day. This is in addition to your room cost. This figure is about the same in most cities, probably higher in some. We found in this unit we could give the same care for \$13.88; and you see in this chart that this is a saving of about \$40 a day for people who require this more than average care. This is not something we imagine, this is something that is being passed on to patients in this experimental unit even today.

Senator HILL. That is a very considerable savings.

Dr. BUTT. Yes, sir. When this data was collected, it became rather obvious to us that these results were more important than just to

Rochester, Minn. This appeared to be important to those considering building hospitals throughout our country. It was also very obvious that, in order to study the stages 2 and 3, you would need a total hospital, not only to carry out research but in order to assay the value of automation in the handling of histories, the specific handling of drugs, linen, food, and all the ancillary things needed in the care of patients. It was obvious that you would need an entire plant such as is shown in this figure, with four units connected with a center, where the ancillary facilities are, and again, in the same research type of construction, you would need a rectangular unit so that you could do control work so that the data you finally obtained would be worthwhile.

We feel strongly that this work should be done; that it has to be done somewhere. We find that the hospital—shall I call it business or industry—is about the third largest industry in our country. A tremendous amount of money is spent in hospital construction, but very little has been spent in relating hospital design and function to patient care.

It was rather obvious to us that with our increasing aged population, increasing hospital costs, the shortage in nursing and physician personnel, that anything you can do to help solve these problems is important to carry out.

Furthermore, it would seem that if any civilian or military emergency took place, making more efficient use of this personnel is most important.

Senator, we would like to thank you for the privilege of being here. If any of you have any questions, we will be happy to try to answer them.

The CHAIRMAN. Is there anything Dr. Beahrs or Mr. Mickey would like to add?

Dr. BEAHRs. I would like to emphasize one point that Dr. Butt has made, and that is the importance, really, of evaluating hospital functions in a total building rather than trying to carry out limited experiments in parts of buildings or separately. I think if we are to understand the overall hospital picture, it is necessary that these studies be carried out in a total modern hospital.

The CHAIRMAN. Is there anything you would like to add, Mr. Mickey?

Mr. MICKEY. I would like to mention three things. One, in the 6 years we have been carrying on these studies, we are aware that our present research has only scratched the surface in the study of hospital design and function.

We have realized in the last year or two, as we have given consideration to the receiving, processing, and distribution of such things as drugs, food, and supplies, that there are comparable savings in these areas.

If we are thinking now of hospitals in civil defense, and even in the possible war effort, we need to consider more efficient utilization of personnel.

Second, may I please refer to Dr. Buerki's presentation in which he indicated that it might be desirable that a research construction category be established under State agency control. May we bring to your attention that under the Hill-Burton program there are certain

urban hospitals that cannot participate as the program is now established—ours being one. We happen to have a small community of 40,000 people. We have more beds than the State plan calls for; therefore, we cannot be included in the Hill-Burton program as now defined.

I think there might be other hospitals in the country that are in a similar position as ours who can carry on research such as we have done, and we encourage this activity.

Thirdly, I would like to say that there is a great deal of interest in the research and studies that we have done, and we verify this by the fact that we have had many visitors from all over this country and other countries trying to learn of the things that we have done. It is a pleasure to pass this information on to them.

The CHAIRMAN. Any questions, Senator Williams?

Senator WILLIAMS. No.

The CHAIRMAN. I want to strongly commend you gentlemen at the Mayo Clinic for the studies you have made. It is certainly very fine to have the benefit of your studies and research and experiments carried on. I am sure that would be beneficial to the whole people of the United States.

I want to thank you very, very much for your testimony here this morning. It was most interesting and, may I say, not only informative, but challenging, most challenging. We are grateful to you.

Dr. BUTT. Thank you, Senator.

(The prepared statement of Dr. Butt and charts referred to previously follow:)

STATEMENT SUBMITTED FOR THE ROCHESTER METHODIST HOSPITAL, MAYO CLINIC

Mr. Chairman and members of the committee, the following statement is prepared for presentation at the public hearing of S. 1071, 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 the 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 hospital? 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.

¹ Sturdavant, Madelyne, "Comparisons of Intensive Nursing Service in a Circular and a Rectangular Unit," American Hospital Association, 1960.

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.

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.

Hospital survey, summary, Dec. 5-11, 1955—Distribution by hospital service

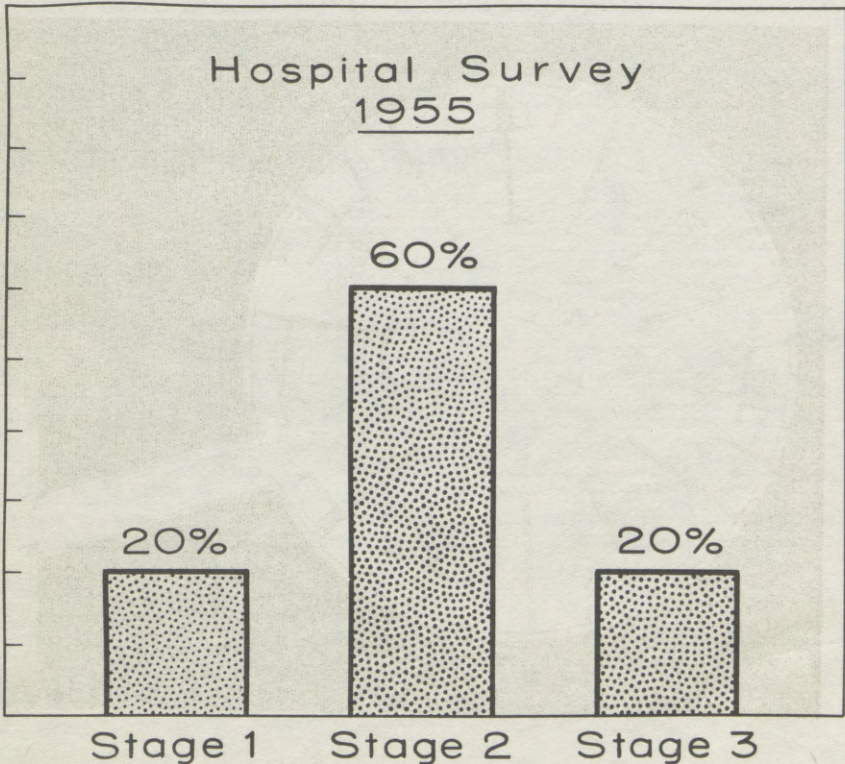
	Total patient-days	Type of hospital care (percent)		
		Constant	Normal	Convalescent
Surgical.....	4,507	22.1	58.9	19.0
General.....	1,873	24.8	47.5	27.7
Neurologic.....	640	39.2	47.0	13.8
Orthopedic.....	957	12.7	76.2	11.1
Urology.....	362	16.3	68.5	15.2
Plastic.....	303	12.9	75.2	11.9
Ophthalmology.....	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-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

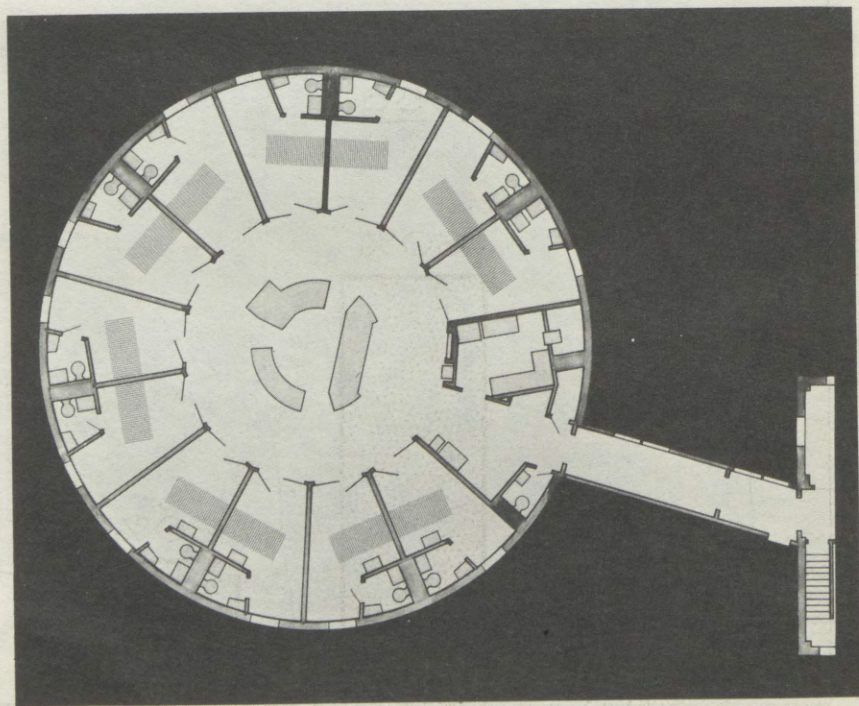
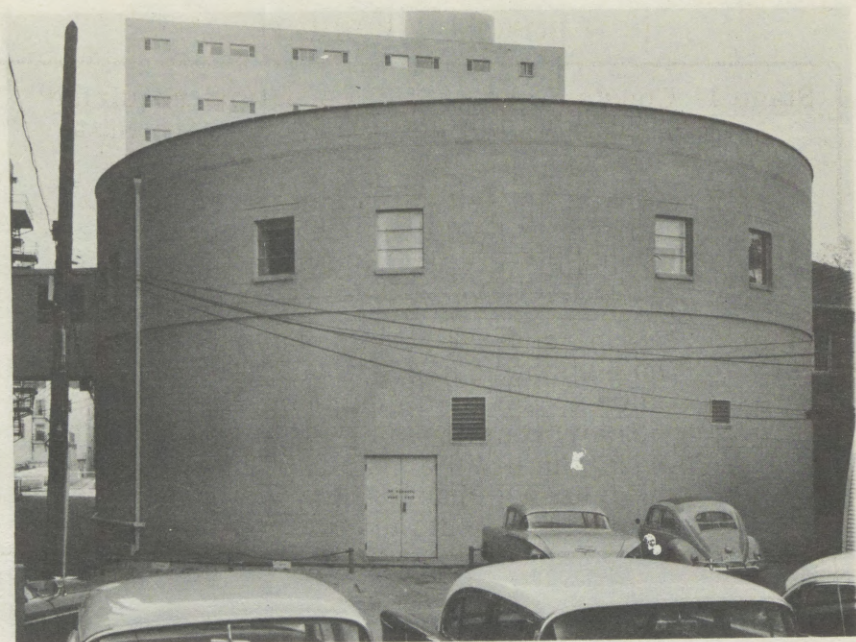
HOSPITAL SURVEY

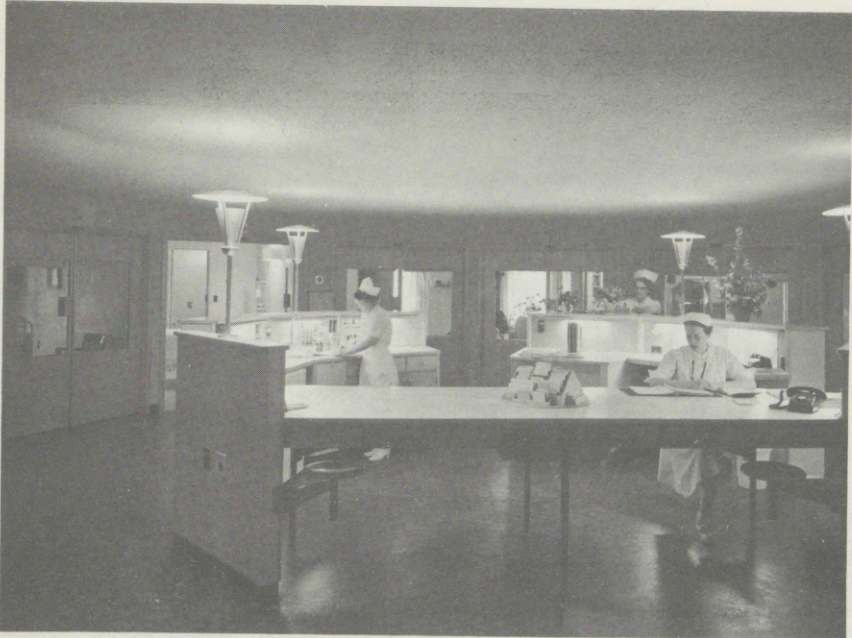
Stage 1. Constant observation: A patient requiring observation, medication or treatment at intervals of 1 hour or less

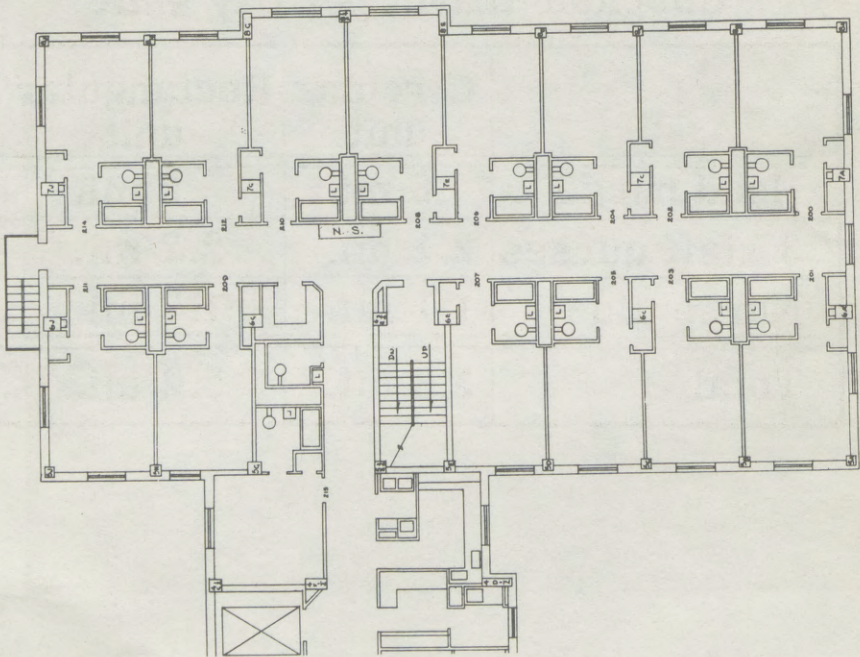
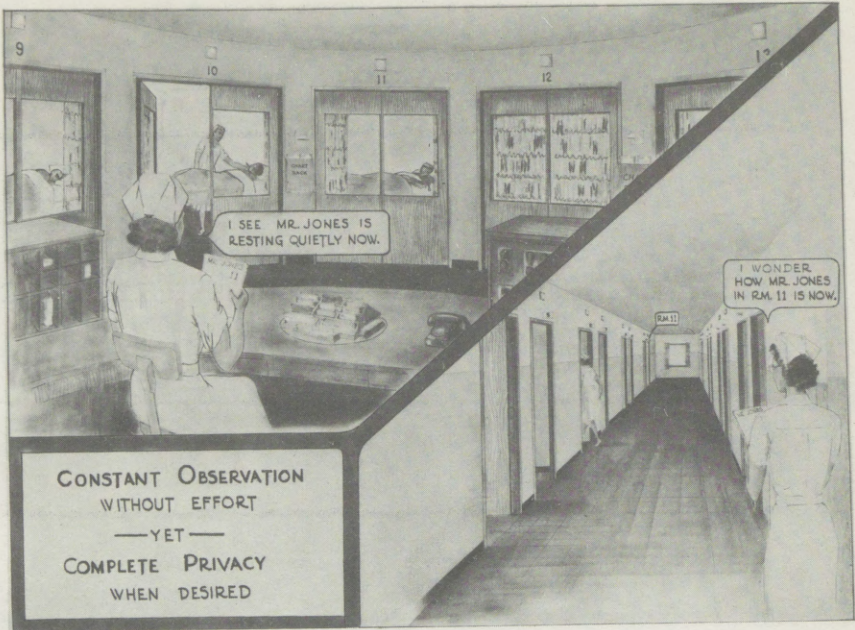
Stage 2. Normal nursing observation and care: Patients who do not need constant observation but are not able to move into the convalescent section

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









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

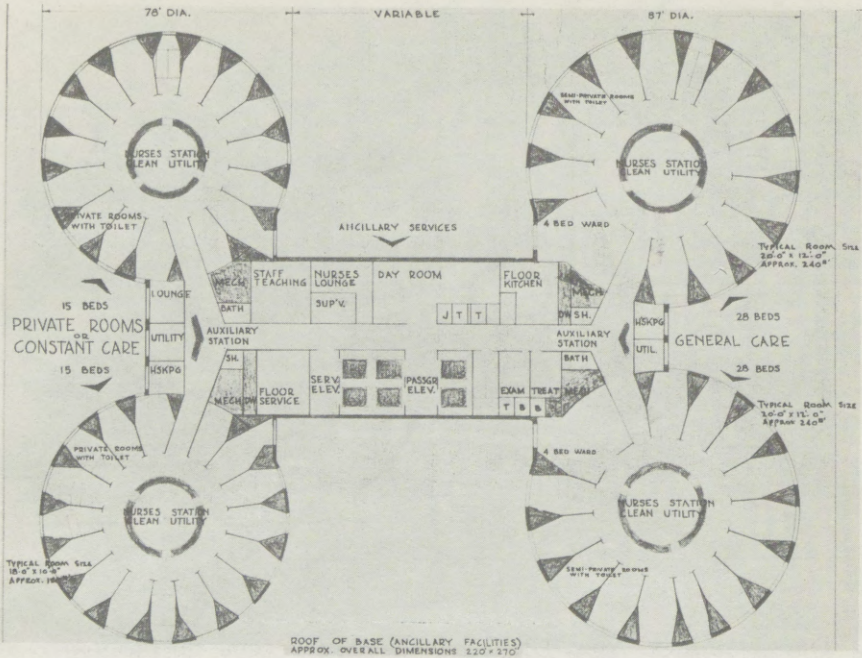
Type of Nursing Care Required

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

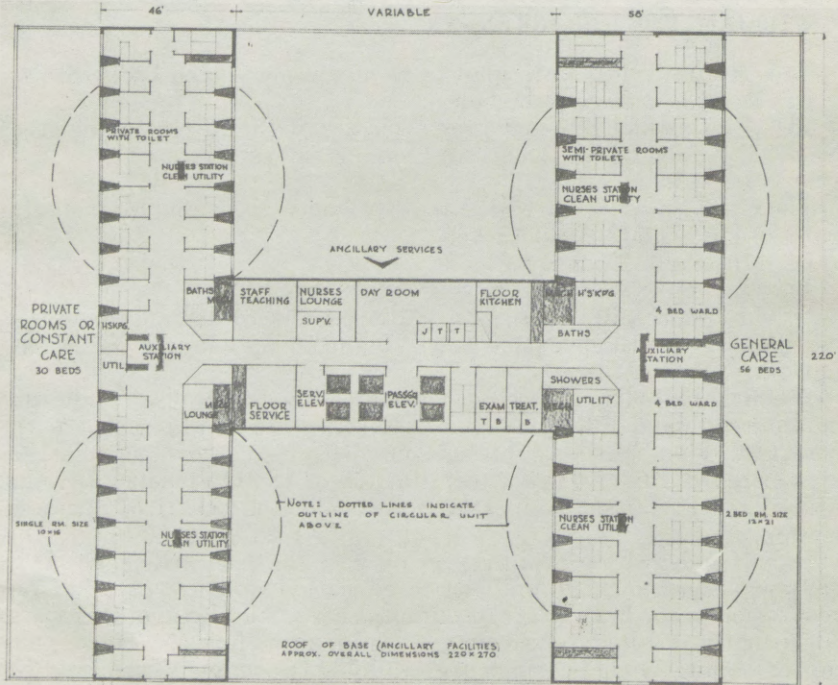
500 Bed Hospital; 80% Occupancy
(1955 Stage Distribution)

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

RESEARCH IN
HOSPITAL FUNCTION AND DESIGN



86 BED RECTANGULAR CONTROL FLOOR PLAN
500 BED "CLOVER-LEAF PLAN" HOSPITAL

RESEARCH IN
HOSPITAL FUNCTION AND DESIGN



The CHAIRMAN. Now, Dr. Eugene McCrary, come up please, sir.

**STATEMENT OF V. EUGENE McCRARY, O.D., ON BEHALF OF THE
AMERICAN OPTOMETRIC ASSOCIATION, ACCOMPANIED BY
WILLIAM P. MacCRACKEN, JR.**

The CHAIRMAN. We are glad to have you gentlemen back with us.

Dr. McCRARY. Nice to be here.

The CHAIRMAN. Dr. McCrary, you are with the Department of National Affairs of the American Optometric Association?

Dr. McCRARY. Yes, sir.

The CHAIRMAN. We are glad to have you with us and your distinguished lawyer, Mr. MacCracken.

Dr. McCRARY. Thank you, sir.

The CHAIRMAN. Proceed in your own way, sir.

Dr. McCRARY. Mr. Chairman and members of the subcommittee, my name is V. Eugene McCrary. I am an optometrist practicing in College Park, Md.

When H.R. 4998 was being considered by the House Committee on Interstate and Foreign Commerce, I appeared and testified at the hearing. That same day this subcommittee held hearings on S. 1072 at which Dr. Henry Hofstetter, director of the Optometry Division of Indiana University, appeared and testified on behalf of our association.

I shall endeavor to avoid repeating here the facts which Dr. Hofstetter presented about optometric education and the place of our profession in the health care of our citizens, I will also avoid, as far as consistently possible, repeating my testimony before the House committee because their hearings are available to you gentlemen and the allotted time is in short supply.

Since my appearance last May, the American Optometric Association did me the honor of electing me to the board of trustees and I am now the trustee consultant to its department of national affairs.

In beginning may I call your attention to the fact that neither bill as introduced contained any section numbered 4. Originally our suggested amendments pertained to section 5 of the bills as introduced, which is section 4 of the bill as it was passed by the House. From now on my remarks will be addressed to section 4 as I presume that if S. 1071 is reported out, what is now section 5 of that bill will be renumbered as section 4.

As a result of the information submitted last May to the House committee, they included in their report the following paragraph to which I want to call particular attention and concerning which I would like the privilege of commenting. The paragraph is at the top of page 7 of the report and reads as follows:

The term "medical" is descriptive of the type of facility, in addition to hospitals, with respect to which research and demonstration relating to services, facilities, and resources could be conducted. It is intended to place a limitation on the kind of facility regarding which research or demonstration is authorized but it is not intended to have any limiting effect on the kinds of professional services provided in such facilities. In this context, the term "medical" is more clearly synonymous with "health."

I would also like to call your attention to the remarks of Chairman Harris addressed to me. They appear on pages 217 to 219, both inclusive. Permit me to quote just two of his sentences:

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.

I would also like to call your attention to the letter which the Surgeon General of the Public Health Service wrote to Congressman Harris, which appears on page 82 of the House hearings, and to Mr. MacCracken's letter written on behalf of the American Optometric Association which appears on page 244.

The quoted paragraph from the House committee report, in the light of Surgeon General Terry's letter and Chairman Harris' comments, would indicate that it was the intention of the House committee that section 4 of the bill should be interpreted so as to include nonprofit optometric clinics, such as the one now operating in New York City and described in some detail in my former testimony before the House committee, and also the clinics maintained by the schools and colleges of optometry, all of which are organized on a nonprofit basis. However, the word "medical," when used as an adjective in any legislation or regulation, is always construed to exclude optometrists and optometric facilities.

Chairman Harris' remarks indicate that if the committee adopted our suggested amendment; namely, in section 4, strike out the word "medical" each time it appears therein and insert in lieu thereof the word "health," it might be construed so broadly as to encompass some activities which are frequently referred to as health fads.

Certainly that was not our intention and therefore, Mr. Chairman and members of the committee I would like to suggest that instead of

striking out the word "medical" you strike out the word "or" each time it appears in front of the word "other" and that after the words "medical facilities" insert each time the words "or optometric clinics."

It has been our experience that unless optometry is expressly included in legislation passed by Congress, optometrists are consistently excluded and discriminated against. Our most recent experience had to do with making optometric services available on an outpatient basis to veterans.

When Congress passed the bill creating the Medical Department in the Veterans' Administration in 1946, the language was broad enough to permit the utilization of optometrists both in the veterans facilities and on an outpatient basis, but it was not until the 86th Congress passed the bill sponsored by Congressman Teague, of Texas, chairman of the Veterans' Affairs Committee of the House, that optometric services were made available to veterans on an outpatient basis.

The resolutions of the American Medical Association prohibit physicians from conferring on a professional basis with optometrists and from teaching in optometry schools. To be sure, in many places, and particularly in small communities, these resolutions are honored in their breach but, nevertheless, they do give rise to friction between the two professions, which is detrimental to the vision care of the public.

It required congressional action, taken notwithstanding strong opposition from the American Medical Association, to secure commissions for optometrists in the Armed Forces following World War II and also to make the optometric services available to the beneficiaries of title X, aid to the blind program, of the social security law.

Based on these experiences I am sure you gentlemen can understand that we are fully justified in our belief that unless optometric clinics are expressly included, none of the Federal funds that may be made available as the result of the passage of the bills now under consideration will be made available to nonprofit optometric clinics.

While the word "aged" is not defined in these bills, in most legislation it refers to those citizens who have passed their 65th birthday, every one of whom has some visual problems which require medical or surgical attention. In those cases which do require medication or surgery, optometrists are required by law and do, in fact, refer their patients to medical practitioners.

In a paper which was presented to the medical section of the Public Health Association in 1960 entitled "Optometrists' Role in Health" it shows that some 800,000 patients are referred annually by optometrists to medical and other health care practitioners. In the clinic of the Optometric Center of New York last year there were some 600 referrals for other health care out of approximately 6,000 patients.

Good vision will do more to give an older person an opportunity to be self-sustaining and to get the maximum possible enjoyment out of life than any other form of his human faculties.

Our association has two committees which deal particularly with this subject: One is the committee on vision care of the aging and the other is the committee on aid to the partially blind. Our profes-

sion was well represented and took an active part in the organization and functioning of the White House Conference on the Aging held in January of this year. This Conference recommended that the disciplines of optometry, ophthalmology, nursing, and social service join together in a united effort to preserve and rehabilitate the sight of the aging.

It is in the public interest that some of the funds which will be appropriated as a result of the enactment of this legislation shall be available to those States which desire to use them to expand and improve nonprofit optometric clinics engaged in providing for the aging members of their populations the best possible visual care through the services of duly licensed optometrists.

We all believe in freedom of choice and States rights. We contend that the State should have the right to use matching funds to give their elder citizens the freedom to choose the services afforded by an optometric clinic if they so desire. There is nothing in our suggested amendments that would curtail the rights of States in determining why type of clinics they would assist financially, nor compel their aged citizens to accept optometric services. On the other hand, if our amendments are not included in the bill, the States will be denied this right and their citizens this freedom of choice.

Mr. Chairman, since I still have a few minutes left in the time which was allotted to me, I would like to respectfully request the privilege of presenting an addition to my written statement.

The CHAIRMAN. Go right ahead.

Dr. McCrARY. One of the fundamental cornerstones on which our great American democracy is built is the preservation of the rights of the minority. There are minority professions in the health care field just as there are racial minorities and religious minorities in our country. The legislative, executive, and judicial branches of our Federal Government are keenly aware of discriminatory actions which tend to suppress the rights of the minority and are generally quick in alleviating discriminatory practices. We are all cognizant of the fact that might does not necessarily make right.

Optometry is a minority profession in the health care field. There are approximately 18,000 to 20,000 optometrists in active practice in the United States today, compared with over 200,000 physicians. Optometry is fulfilling a vital role in maintaining and raising the high level of visual skills demanded by today's complex society. Adequate vision has never been more important to our national defense, economy, and health than it is today. How important, then, is vision?

Think for a moment of the visual tasks of the radar operator on the DEW line guarding our defense perimeter, of pilots flying at twice the speed of sound, of the control console operator at a rocket launching pad, of the factory worker fabricating ever smaller and more sophisticated components for machines and electronic equipment, of the driver out with his family cruising down the turnpikes at speeds of 60 to 70 miles an hour, of the student struggling to acquire an education when the primary channel for the acquisition of knowledge is through his visual senses, of the scientist and legislator who must daily digest reams of material from the printed page. These examples can go on and on penetrating every strata of American life, pinpointing the importance of vision.

However, today we are here concerned primarily with the problems of aging and how best to meet them. Nothing is more certain in the aging process than the eventual appearance of a visual problem.

The Better Vision Institute states that at the age of 60, the incidence of visual problems is over 90 percent. An uncorrected visual problem will tend to considerably restrict the activities and enjoyment of aging individuals. Adequate vision and adequate vision care for young and old alike have never been more important in maintaining America's strength than it is today.

It has been estimated that optometrists perform 75 percent of the eye examinations in the United States. Optometry stands in the forefront of professions serving the visual needs of the American public. Optometry is genuinely concerned about the role it will play in many of the federally sponsored health care and health facility programs which are coming before Congress with increasing frequency.

We have had, as I stated earlier, great difficulty in making optometric services available to recipients of various forms of Federal aid. Unless optometric services are specifically provided for in this bill now before the subcommittee, we fear a repetition of our past experiences, wherein we are excluded from participation by administrative directive promulgated by those who interpret the bills.

Regardless of Congress good intentions, the word "medical" is interpreted generally to mean doctors of medicine and the words "medical facility" to mean an establishment under medical control. This, we submit, leaves no place for optometry to participate.

We feel very strongly that there is a wrong here which needs a righting, the protection of the right of optometry, a minority health profession, to participate in federally sponsored and subsidized health programs.

That concludes my statement, sir.

The CHAIRMAN. Any questions, Senator Williams?

Senator WILLIAMS. I am a little bit unclear on the profession you speak for and its relationship to others who are concerned with problems of the eyes and vision.

Dr. McCrary. Yes, sir.

Senator WILLIAMS. Is there an ophthalmologists' association, too?

Dr. McCrary. There is within organized medicine. There is a section on ophthalmology within the structure of the American Medical Association.

Senator WILLIAMS. Does the optometric association discuss policies such as your statement here today with the ophthalmologists? Do you communicate?

Dr. McCrary. I might say, Senator, that there is a considerable lack of intercommunication because of frictions which exist due to policies adopted by the American Medical Association. We feel very strongly that the establishment of good intercommunication between these two professions which deal with the vision care of the American public is definitely in the best interest of the public and that we should work together for the public welfare, this is a relationship which should exist, but unfortunately, this does not exist at the moment.

One of the principal reasons, probably, is a resolution which has been adopted by the house of delegates of the American Medical As-

sociation, which states that it is unethical for a doctor of medicine to confer with an optometrist.

Senator WILLIAMS. How many ophthalmologists are there?

Dr. McCrary. I do not know specifically, but I would estimate about 3,500 to 4,000.

Senator WILLIAMS. I have no further questions.

The CHAIRMAN. Any questions, Senator Case?

Senator CASE. No.

The CHAIRMAN. Any questions, Senator Pell?

Senator PELL. No, sir.

The CHAIRMAN. Anything you would like to add, Mr. MacCracken?

Mr. MACCRACKEN. I would like to add this fact, that Senator Williams wanted to know about the intercommunication between the professions. The lack of that is due entirely to the medical profession. The optometrists have tried and tried to bring it about; wherever they have been forced by Government action to work together, they have gotten along very well. For example, in the armed services, the Surgeon Generals of the Army, Navy, and Air Force all speak very highly of the work that is being done by the 350-odd commissioned optometrists who are now serving in the armed services on active duty and they get along with the ophthalmologists all right. Of course, in civil life, there are a lot of optometrists and ophthalmologists who do work closely together, but it is in violation of the resolution of the house of delegates of the AMA.

I think that Dr. McCrary pointed out that it is honored in its breach in many places. But in other places, though, that it is not honored in its breach, it is enforced to the detriment of the public. They are the ones who really suffer when they do not work together. The only way to make them do it is for Congress to say so in so many words. Then they do.

The CHAIRMAN. We want to thank you gentlemen for your appearance here this morning. You have certainly made your views clear to us and you may be assured that we will consider carefully what you have said.

Dr. McCrary. Thank you.

The CHAIRMAN. Thank you.

Dr. Rubin.

STATEMENT OF DR. ABE RUBIN, SECRETARY AND EDITOR, AMERICAN PODIATRY ASSOCIATION

The CHAIRMAN. Dr. Rubin, you are secretary and editor of the American Podiatry Association?

Dr. RUBIN. Yes, sir.

The CHAIRMAN. We are very glad to have you here. Please proceed in your own way.

Dr. RUBIN. Thank you, sir.

Honorable Chairman and members of the committee, I am Dr. Abe Rubin, secretary and editor of the American Podiatry Association, known from 1912 to 1958 as the National Association of Chiropodists.

Podiatrists are particularly interested in S. 1071 and H.R. 4998 because the basic philosophy of our practice is to keep our patients

on their feet and out of bed, whether this bed be at home, in a hospital, or other institutions. Walter C. Alvarez, M.D., in an editorial "The Value of Foot Care"—a copy of which is appended hereto and we would appreciate it if it would be put in the record.

The CHAIRMAN. We will be glad to put that in the record following your remarks, sir.

Dr. RUBIN. Thank you, sir.

Walter C. Alvarez, M.D., in an editorial, "The Value of Foot Care"—copy appended—in the May 1961 issue of "Geriatrics" says:

With good foot care, patients who might otherwise become or remain bedridden are kept ambulatory. And this is important because in 1950 the cost of a bedridden patient was \$4.03 a day, while that of an ambulatory patient was only \$1.78 a day.

The saving is much greater today.

Incidentally, Dr. Alvarez' editorial was prompted by a special issue of our journal, December 1960, devoted to the care of the feet of the aged in preparation for the White House Conference on Aging. He was citing some work done by Dr. Tarara, one of the podiatrists at the Mayo Clinic and work by Dr. Liss in homes for the aged in California.

More than 40 percent of our patients are over 60 years of age. The percentage is considerably higher in the foot clinics associated with our teaching institutions. I was director of such a clinic before coming to my present position a few years ago. Out of almost 50,000 annual patient visits, two-thirds were by persons over 65 years of age. From a recent independent survey, published October 1960 in the "Journal of the American Podiatry Association" we know that 31.2 percent of the over 8,000 podiatrists serve nursing homes and 28.8 percent serve homes for the aged.

Podiatric care can keep a patient moving about. It is well known that good foot hygiene and care conserves the limbs of diabetics and others with circulatory diseases; in fact, our association is cooperating with the Chronic Disease Section of the Public Health Service in the development of health education information for these individuals.

Because foot problems are rarely listed as the cause of death, too frequently the importance of good foot health is overlooked. All people must be able to move about and, particularly, the chronically ill and aged persons. If poor foot health makes them homebound, very significant medical, social, psychological, and economic problems occur. These individuals become family and public charges.

But more important, as you gentlemen said in Public Law 85-908 providing for the 1961 White House Conference on Aging, these people cannot utilize all of their —

skills and interests, and find social contacts which will make the gift of added years of life a period of reward and satisfaction and avoid * * * unnecessary social costs of premature deterioration and disability.

Podiatry service, facilities, and institutions provide a health service which reduces significantly the number of individuals who would otherwise be hospitalized. With the project grants and the support of research, experiments, and demonstrations envisioned by the legislation under consideration, additional new and improved methods will be developed and present possibilities extended. We believe that the contributions of our facilities and institutions in this connection can

be of such significance that you may wish to specify them by name in the proposed legislation.

I might add here, sir, that we frequently have—perhaps not as often as the optometrists do, but we frequently run into this problem of medical facility being interpreted to mean only those controlled by medicine. However, our people do serve on hospital staffs, the doctor of medicine may associate with us and he does teach in our institutions.

Thank you for the opportunity to appear before you and advise you of our support for this legislation. It would be a privilege to attempt to answer any of your questions.

(The editorial referred to follows:)

[Reprinted from *Geriatrics*, vol. 16, May 1961]

THE VALUE OF FOOT CARE TO THE AGED

In the past, I have commented on the great benefits that old persons can get from expert foot care. They need such care more than do the young. Obviously, they need it when they are suffering from narrowing of the leg arteries, particularly when they have diabetes. Many persons in these situations can be kept from getting gangrene of a foot or a leg by the care of a good podiatrist. As Dr. Edward L. Tarara of the Mayo Clinic recently noted, there is great danger of infection in the poorly nourished tissues of the feet of the aged. Any bruise, abrasion, or cut should occasion alarm.

Often because of the comparative insensitivity of the tissues of the aged, the old person does not become properly concerned when something starts to go wrong with his feet. As a result, gangrene may develop.

Some time ago, when I visited a large and well-run home, I was much interested to hear that the best-loved man in the place was the podiatrist, who added so much to the comfort of the old people. By keeping their feet in good condition, he enabled them to get about.

As we physicians all know, poorly chosen shoes have caused most of the trouble with the feet of civilized men. Because, until just a few years ago, women kept trying to wear shoes too small for them, many today are suffering from bunions and corns. Today, it is good to see that most girls wear soft heel-less shoes.

The December 1960 number of the *Journal of the American Podiatry Association* contains a symposium on the care of the feet of the aged. Besides the articles by Dr. Tarara and others, there is one by Dr. Leo N. Liss of San Francisco who tells of the fine Laguna Honda Old Peoples' Home which houses some 1,600 patients. Forty percent of them are able to be up and about. Some time ago, a podiatry clinic was organized to take care of the feet of these old people, and in 1955, four podiatric externs were given room, board, and laundry at the home, in return for their giving 10 hours a week each for the care of the patients.

The results have been most satisfying, and in 1959, 3,239 patients were taken care of. With the good foot care, patients who might otherwise become or remain bedridden are kept ambulatory. And this is important because in 1950, the cost of a bedridden patient was \$4.03 a day, while that of an ambulatory patient was only \$1.78 a day. Obviously, the wise administrator of a home for the aged will see to it that his people's feet are given proper care.

WALTER C. ALVAREZ, M.D.

The CHAIRMAN. Any questions, Senator Pell?

Senator PELL. No questions.

The CHAIRMAN. Any questions, Senator Case.

Senator CASE. No.

The CHAIRMAN. Doctor, we want to thank you very, very much and you may be sure we will carefully consider all you have said to us here this morning and we will read with much interest the insertion by Dr. Alvarez.

Dr. RUBIN. Thank you, sir.

The CHAIRMAN. Now, Mr. Andrew Biemiller.

STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS; ACCOMPANIED BY MISS LISBETH BAMBERGER, ASSISTANT DIRECTOR OF THE DEPARTMENT OF SOCIAL SECURITY OF THE AFL-CIO

The CHAIRMAN. Good morning, Mr. Biemiller, glad to have you with us, sir. You come to us as director of the Department of Legislation of the AFL-CIO?

Mr. BIEMILLER. Yes, sir.

The CHAIRMAN. Please proceed in your own way.

Mr. BIEMILLER. Mr. Chairman, my name is Andrew J. Biemiller. I am director of the Department of Legislation of the AFL-CIO, and I am here to present the views of the AFL-CIO on S. 1071 and H.R. 4998, the proposed Community Health Services and Facilities Act of 1961. I am accompanied by Miss Lisbeth Bamberger, assistant director of the Department of Social Security of the AFL-CIO.

Let me first compliment you, Mr. Chairman, on your promptness in calling these hearings so soon after passage of H.R. 4998 by the House of Representatives. This action is consistent with your efforts over past years which have produced so much progress in the field of health facilities while other fields of social legislation have lagged behind.

May I also add to that that we are very pleased that you retained in the appropriation bill the full amount of money for the Hill-Burton Act, which we think is an important point, as you well know.

The CHAIRMAN. Thank you, sir.

Mr. BIEMILLER. We appear today as representatives of a large group of Americans who are the potential beneficiaries of this legislation. Many of the witnesses who will testify on this bill are representatives of public and professional health agencies and institutions whose particular talents and training qualify them to advocate this legislation from a professional standpoint.

We appear as representatives of the consumers of health care, those millions whose futures may be brighter and more secure through proper action by the Federal Government to bring to the people those services and facilities which our Nation knows how to provide and for which it has the financial ability to provide.

Mr. Chairman, the proposed Community Health Services and Facilities Act would help to fill a major gap in health care for the chronically ill and the aged. In recent years research into the health needs of these groups has proceeded dramatically, opening up broad new vistas in techniques, services, and new kinds of facilities for improved care. These new developments hold the promise of happier, more fully useful lives for countless victims of chronic disease.

Furthermore, we may rightly expect greater achievements in the future. As health research expands, and as one discovery triggers a new line of inquiry leading to even greater accomplishments, more and more potential benefits will be available to help these forgotten people.

But merely developing new techniques and services will not bring them to those who need them most. Despite our new knowledge, and despite the increased skills of physicians, nurses and other profes-

sional personnel, countless thousands of older people are being denied proper care simply because the needed facilities do not exist, or the necessary services are not adequately organized.

S. 1071 would go far toward bringing adequate care to many who have in the past been neglected and deprived. It would encourage an accelerated program of construction of nonprofit nursing homes, and it would encourage development of new services which would help in rehabilitation and care. We can expect that a primary accomplishment of this legislation would be to return many older people to their own homes where they could be self-sustaining except for needed home nursing care, thus relieving some of the existing pressure on hospital and nursing home capacity.

In connection with the long-recognized shortage of nursing home beds, and organized health services for the chronically ill, I would refer this committee to the views of 31 State Governors who wrote to the House Committee on Interstate and Foreign Commerce regarding H.R. 4998. Without exception, these Governors indicated that a substantial need exists for more and better skilled nursing homes and home health services in their States. With only one exception, these Governors stated that Federal assistance was a needed, and often an essential, prerequisite for the development of more adequate services and facilities.

Passage of S. 1071 could not hope to fill all the needs of our States and local communities. But this is a beginning, and a beginning which should be made promptly.

Mr. Chairman, there are three other programs which this Congress should enact to meet its responsibilities in the health field.

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 these 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 cannot do the whole job; they must be supplemented by legislation as in financing health care of the aged. This is why we are 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 have appeared before your committee in support of this legislation, and hope to see favorable action on it 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. It will do so most effectively if it is amended to include the provisions of S. 1158, the proposed Health Service Facilities Act, to which I will refer again later.

The Senate Subcommittee on the Aging 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. 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.

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 S. 1071 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 wholly 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, at the local level, on the organization and quality of services. This is a matter not only 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 cannot 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 in 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?

A recent article in the Saturday Evening Post described 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 the bill before you. 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.

Earlier this week Dr. Benedict Duffy, chairman of the department of preventive medicine at the Seton Hall College of Medicine, told the House Ways and Means Committee how—

The lost legions of older patients who have assumed total dependent status can be observed lingering without hope in the dark corners of countless chronic hospitals and nursing homes. These are the people who need help and not when it is too little and too late.

With the stimulation of the Federal grants in S. 1071, 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 by the proposed legislation. I said earlier that a well-rounded program of Federal support for community health facilities should include long-term Federal loans to nonprofit-prepaid groups practice plans, as provided in S. 1158, introduced by Senator Humphrey.

It is widely agreed that more effective use of funds spent on medical care can be expected to result from a substantial expansion in the availability of comprehensive direct service health plans with the high quality of medical care that can be provided by doctors practicing in groups. One of the major obstacles to the widespread development of such plans is the difficulty of obtaining necessary physical facilities.

The proper physical facilities are essential to the economic operation of these plans, to the rendering of high quality care and to the recruitment of highly qualified medical and related personnel.

S. 1158 would simply provide the greatly needed financial assistance for the building of facilities to community groups developing direct service comprehensive health plans.

As Senator Humphrey put it in introducing this bill earlier this session—

*** if a group of people in a community where health facilities are inadequate get together and form a voluntary health plan organization and are prepared to assume the financial responsibility for working out their own problem—they should be able to receive low-interest, long-term loans from the Federal Government to enable them to finance the facilities which their community requires.

I urge this committee to consider most seriously the addition of S. 1158 to the legislation it will report to the Senate. It would provide a most important supplement to S. 1071.

Mr. Chairman, we urge this committee to speed the community health facilities and services bill to final passage. The Senate and the Congress can rise to no greater challenge, nor merit more abundant gratitude, than to bring to afflicted Americans the health care which can lift from their shoulders the burdens of pain, dependency, loneliness and despair.

The CHAIRMAN. Anything you would like to add, Miss Bamberger?

Miss BAMBERGER. No, thank you, sir.

The CHAIRMAN. Any questions of the witness?

Senator WILLIAMS. I just want to commend Mr. Biemiller and his associate for the high quality of their statement this morning.

Senator CASE. I may say this is not at all unusual. This is the kind of thing we expect.

Mr. BIEMILLER. I want to thank the Senators.

The CHAIRMAN. When Andy comes, he always comes well prepared with an informative and interesting statement.

Any questions, Senator Pell?

Senator PELL. In your international work with the AFL-CIO, have you had occasion to compare the facilities for the treatment of older people in our country with the treatment of older people of the technologically advanced people of the countries of Western Europe?

Mr. BIEMILLER. I would not say we have made an exhaustive study. We are very familiar, for example, with what is going on in Sweden where we think there is at the present moment, a better—

Senator PELL. Would you say the treatment is more advanced and in general, better, for old people in Western European countries than it is in our own?

Mr. BIEMILLER. I would refer that to Miss Bamberger, who is more familiar with this than I am.

Miss BAMBERGER. I did spend some time in Sweden trying to learn something about their arrangements for both financing and provision of medical care. As a result of what I saw there, I would strongly endorse what Dr. Buerki said earlier today, that the arrangements that they have made for the care of older people are far advanced compared to those we have here in this country. But I think there is no question that we have the potential to catch up with what Sweden and some of the other Scandinavian countries have done. I think the legislation before you would speed us toward that goal.

Senator PELL. But as things stand now, we are second best in this field?

Miss BAMBERGER. I think that is true.

Senator PELL. Thank you.

The CHAIRMAN. Any further questions?

If not, we certainly want to thank you for this very splendid presentation and thank you for your presence, too, Miss Bamberger. We appreciate it very much.

Thank you, sir.

Mr. BIEMILLER. Thank you, sir.

The CHAIRMAN. The subcommittee will now stand in recess.

(Whereupon, at 11:25 a.m., the subcommittee recessed subject to the call of the Chair.)

APPENDIX

U.S. SENATE,
COMMITTEE ON GOVERNMENT OPERATIONS,
SUBCOMMITTEE ON REORGANIZATION AND INTERNATIONAL ORGANIZATIONS,
August 8, 1961.

Hon. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I should like to convey my full support on the presentations which have been made by official and nongovernmental health authorities on behalf of H.R. 4998, the Community Health Services and Facilities Act of 1961, and its Senate version, S. 1071.

Messages which I have received from my State convey unqualified endorsement of the objectives of this farsighted legislation.

These messages stress that the Nation cannot begin too soon to realize the goals set forth by President Kennedy in his special health message of February 9, 1961, including those before your committee at this time—extension and improvement of the availability and quality of community health services and facilities primarily for the chronically ill and aged.

Each and every part of this legislation is necessary and timely:

Matching grants-in-aid to States for extending and improving the quality, scope, and availability of community health services for the aged and chronically ill outside the hospital;

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;

Increase in the appropriation authorization for grants for the construction of nonprofit nursing homes from \$10 million to \$20 million annually;

Additional funds for a broadened program of research and demonstrations to improve the design and use of hospitals and related medical facilities.

Minnesota, I am proud to say, has been a pioneer in serving the chronically ill—the old, as well as younger and middle-aged citizens.

The eloquent comments by the executive officer of our State department of health, Dr. Robert Barr, underline (a) the desire of my State to continue to do its utmost but (b) its need—along with other States—for reasonable assistance by the Federal Government for more nursing homes and beds, as well as attainment of other goals.

I should like in particular to convey my fullest support of the observations presented by the Rochester Methodist Hospital and the Mayo Clinic through the testimony of Mr. Harold E. Mickey, on behalf of adequate authorization of future hospital research. It has been my pleasure to be in close contact with Minnesota authorities on this great research vista for improved hospital service. I cannot too strongly support their presentation.

The possible dividends from such expanded research are at present beyond calculation. The present statutory ceiling of only \$1.2 million on annual expenditures for hospital and medical facility research is disproportionately low in relation to the awesome need and opportunity.

As chairman of the Subcommittee on Reorganization and International Organizations of the Committee on Government Operations, it has been my privilege to conduct a Governmentwide study of research efforts.

In this study, I have noted that the field of hospital research is one of the most promising, yet, at present, most modestly supported in relation to its human and fiscal significance—in all the vast array of \$9 billion annually expended for Federal research, development, testing, and evaluation.

Similarly, our subcommittee has received impressive evidence on the unmet needs of the 6 million senior citizens who are limited in their daily activities as

a result of chronic health problems. Expanded out-of-hospital facilities and services are imperatively necessary for these Americans. In addition, the chronically ill in other age groups require a network of grassroots facilities if their needs are to be efficiently, economically and satisfactorily met.

Finally, may I say that your committee has won a deserved reputation in the eyes of the American medical community and in related healing arts as an outstanding leader in serving American health. I feel confident that your early and favorable action on the Community Health Facilities and Services Act of 1961 will add further to your well-deserved laurels.

I would appreciate if this letter could be printed within your hearing volume.

Kindest wishes.

Sincerely,

HUBERT H. HUMPHREY,
Subcommittee Chairman.

U.S. SENATE,
COMMITTEE ON INTERIOR AND INSULAR AFFAIRS,
August 7, 1961.

Senator LISTER HILL,
*Chairman, Senate Labor and Public Welfare Committee,
Senate Office Building, Washington, D.C.*

DEAR SENATOR HILL: I support H.R. 4998 and so does Montana's chief health officer, Dr. C. D. Carlyle Thompson, whose enclosed August 4 letter please make part of the hearing record along with mine.

Very truly yours,

LEE METCALF.

STATE OF MONTANA,
STATE BOARD OF HEALTH,
Helena, Mont., August 4, 1961.

HON. LEE METCALF,
U.S. Senator, Senate Office Building, Washington, D.C.

DEAR SENATOR METCALF: Now that H.R. 4998 has passed the House and I understand is in the process of being heard in the Senate, I wanted to advise you of what I consider the importance of this bill to Montana.

I have already indicated to you the Hill-Burton needs in Montana so the importance of the bill which increases the funds for nursing home construction is already known to you. The bill in this way, and its other provisions, would simply help us extend activities already in progress but inadequate to meet the problems of the State. We would use the increased funds for nursing home construction as well as for improving out-of-hospital patient care.

This, we are already attempting to do with the \$10,000 allotment primarily through improving patient care in nursing homes and improving home nursing services of the visiting nurse type. The Montana State Board of Health recently has revised its rules and regulations pertaining to nursing homes in order to improve the care in these homes.

In one local area we are developing a home nursing care program. For general educational programs in the nursing homes in the State we have employed a nurse to give full time to this activity. If H.R. 4998 becomes law and additional funds are available, they could and would be used in Montana for the purposes intended.

Any support you can give this legislation would certainly be appreciated.

Sincerely yours,

G. D. CARLYLE THOMPSON, M.D.,
Executive Officer.

AMERICAN DENTAL ASSOCIATION,
Washington, D.C., August 4, 1961.

HON. LISTER HILL,
*Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: 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 for 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 techniques 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 techniques making it possible to provide dental care to afflicted children, slow progress is being made in transferring such techniques 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 S. 917, which also is pending before this committee. S. 917 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 S. 917.

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,

MATTHEW BESDINE, D.D.S.,
Chairman, Council on Legislation.

UNITED STATES CONFERENCE OF MAYORS,
Washington, D.C., August 10, 1961.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: On behalf of the United States Conference of Mayors, I am writing to urge early approval of legislation now pending before the Subcommittee on Health to promote improved health services and facilities. At

its 1961 annual conference, the United States Conference of Mayors approved a resolution supporting this legislation. The full text of this resolution, adopted on June 14, 1961, is attached hereto. I request that this resolution be made a part of the record of the hearings on this subject.

Very truly yours,

HARRY R. BETTERS, *Executive Director.*

RESOLUTION ADOPTED BY THE 1961 ANNUAL CONFERENCE OF THE UNITED STATES
CONFERENCE OF MAYORS, WASHINGTON, D.C., JUNE 14, 1961

HEALTH SERVICES AND FACILITIES

Whereas long-term illness is a major and growing problem in the United States, particularly affecting the aged and chronically ill in the population who are concentrated in our urban centers;

Whereas millions of the aged and chronically ill, at some stages of their illnesses, could be cared for more effectively and economically in nursing homes or in their own residences if community facilities and services were available to provide such care;

Whereas there is a shortage of over one-half million skilled nursing home beds in the United States and most of the existing nursing homes provide only limited health services for their patients and, in many instances, provide these services in unsafe and unsanitary facilities with poorly trained personnel;

Whereas there is a serious shortage of community programs through which patients may receive nursing services, homemaker services, and physical and occupational therapy services in their own homes; and

Whereas there is an urgent need to develop new and better methods of hospital construction and operation and of providing health services outside the hospital: Now, therefore, be it

Resolved by the United States Conference of Mayors, That the Congress be, and is hereby urged to (1) amend the Hill-Burton hospital and medical facilities legislation to at least double the present annual Federal appropriation of \$10 million to assist in the construction of public and nonprofit skilled nursing homes; (2) enact legislation to make Federal grants of at least \$25 million annually available to States and communities to assist in the establishment and operation of community home health care programs and in the improvement of the quality of health care in nursing homes; (3) authorize special project grants to State and local public agencies and to nonprofit organizations for the purpose of conducting studies, experiments, and demonstrations to develop new or improved methods of providing health services outside the hospital particularly for chronically ill or aged persons; and (4) authorize increased appropriations for research activities related to the hospital facilities, resources, and services, including authorization to assist in the construction of experimentally designed and demonstration facilities.

STATEMENT BY DR. HUNTINGTON WILLIAMS, PRESIDENT OF THE UNITED STATES
CONFERENCE OF CITY HEALTH OFFICERS AND COMMISSIONER OF HEALTH OF
BALTIMORE CITY, RELATIVE TO S. 1071 AND H.R. 4998

The United States Conference of City Health Officers is an organization established during recent years representing the health departments of the larger cities and some of the smaller cities in this country. It was organized with the assistance of the United States Conference of Mayors.

I submit this statement to you as president of the United States Conference of City Health Officers with the hope that your committee will act favorably and promptly on S. 1071.

It is my opportunity to present the feeling of many local communities, big and little cities, and city-county units whose health departments will be affected favorably if S. 1071 is reported favorably and enacted.

The city health officers, and I have been in charge of the Baltimore City Health Department since October 1, 1931, are faced with the fact that the elderly in this country are congregating in the cities. It is on the local firing line that the city health department is faced with the fact that hospitals are overcrowded, good nursing homes are small in number and inadequate. The bill before you, if enacted, will make possible the caring for many elderly persons in their homes

where it is most desirable for them to remain, or in improved and more adequate nursing homes.

It is my opinion that there is great need for the expanded and improved community health services for the aged and other persons with long-term illnesses or health problems, and these matters are becoming more serious year by year.

The national leadership provided by S. 1071 will be welcomed by the communities and the result will be a stimulation leading to increased financial support from State and local sources.

May I take the liberty of calling your attention to a more extensive statement which I presented before the House Committee on Interstate and Foreign Commerce on H.R. 4998 which expresses my feelings and that of many city health officers in regard to S. 1071. My statement appears on pages 89 to 97 of the printed hearings on H.R. 4998 entitled "Community Health Services and Facilities Act of 1961."

MISSOURI PUBLIC HEALTH ASSOCIATION,
Jefferson City, Mo., April 19, 1961.

DEAR SENATOR SYMINGTON: I should like to advise you that the members of the Missouri Public Health Association are vitally interested in Senate bill 1071 and H.R. 4998, which are designed to improve the present machinery for providing effective and efficient care for our aged and chronically ill citizens.

We are especially interested in the provisions of the bill which provide community health service grants to States, and provide funds for nursing home construction grants.

I am sure you already know that Missouri has the third largest population of senior citizens of any of the States, and adequate medical care for these people is becoming an increasingly critical problem. Less than half of the counties in Missouri have organized health programs, such as nursing service available for its citizens. Many patients and families can learn to take care of themselves if a public health nurse is available to show them how.

At the present time, the average age of our larger hospitals in Missouri is over 20 years. In most instances it is impossible to expand these outmoded structures, and major rebuilding programs will be necessary in the near future. There are now available only about a third as many long-term beds as we need. An increase in the authorization of nursing home construction grants provided by the bill would raise the current nursing home authorization to \$20 million, and thereby double the construction each year to cut down this urgent deficiency.

These bills are not in any way related to the controversial proposal to provide medical care for the aged through social security. They would, if enacted into legislation, enable State and local health departments to become actively involved immediately in providing medical care programs for the chronically disabled and the aged.

We feel this is a pressing need in our State, and the 500 members of the Missouri Public Health Association will appreciate your continuing support of both Senate bill 1071 and the identical H.R. 4998.

Sincerely yours,

HARRY M. DAWDY, *President.*

THE STATE OF UTAH,
DEPARTMENT OF PUBLIC HEALTH,
Salt Lake City, Utah, July 26, 1961.

HON. FRANK E. MOSS,
*U.S. Senator,
Senate Office Building, Washington, D.C.*

DEAR SENATOR MOSS: We at the Utah State Department of Health are pleased to hear that H.R. 4998 has been reported out of committee and urge your consideration favorable to its passage. Some of the reasons for this point of view follow:

Based upon time-honored, traditional criteria, Utah now has the following additional requirements for medical facilities to meet the needs of today's population: nursing home beds, 918; hospital beds, 1,790.

To meet these needs immediately would require an estimated expenditure of \$27,381,632.

The Bureau of Business and Economic Research reports a Utah 1960 expenditure in private and public funds of \$74 million for medical care, excluding

capital expenditures. The private expenditure is further reported to be 4 percent of expendable income, equal to all private savings in the same period.

With these apparent requirements and the reported expenditure level, it is obvious that we are concerned with one of the largest single economic activity problems of the people of this State. It is reckless and irresponsible to deal with such magnitude by depending on tradition alone. We must consider, in this light, the constructive and progressive atmosphere of any industry of equal weight, which would seek constantly to find more effective and more economic solutions. We must measure the true requirements and erect a cogent plan for meeting them now and in the foreseeable future. To continue, on the basis of outmoded standards, the construction of more and more beds is shortsighted. We cannot afford it.

Experience in numerous other parts of the county has shown two important types of solution. In the first place, it is clear that the nature of the facilities associated with beds in general hospitals, chronic disease hospitals, nursing homes, and at home determines the cost per day for patient care. A typical recent survey in Florida showed that of those then in hospitals, 75 percent needed 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 home care, though two-thirds of this last group would require (at least temporarily) visiting nurse service. If patients were cared for in this manner, enormous savings to them and to privately and publicly funded facilities would result. Additionally, most of the patients would do better in a system of progressive care.

H.R. 4998 proposed four basic approaches to the problem of medical care:

1. Development of home nursing programs and other types of home care health activities;
2. Augmented Hill-Burton funds for construction of public and private nonprofit nursing homes;
3. Demonstration and research grants for development and testing of new and better methods of organizing and providing community health services outside of the hospital; and
4. Increased research directed at improving the quality, efficiency, and economy of hospital operations.

With respect to home nursing and other home care health activities, experience throughout the Nation has shown that these services enable the physician to give adequate care in the home, have been so organized as to provide for payment by the consumer in accordance with his means, and have been so clearly valuable to communities that responsibility for their continuation has been assumed by the communities. Some means for initial organization and development is necessary, however.

With respect to long-term, lower than hospital cost facilities such as nursing homes, the situation of Utah is not very different from the national picture. As of July 1960, there were about 310,000 nursing home beds in the United States, of which only 175,000 were acceptable. At least 260,000 additional beds were needed, according to approved State plans. In general, "acceptable" beds are so classified only on the basis of fire and health hazards, without respect to adequacy and quality. Characteristic major criticisms of the present level of nursing home care are:

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.
9. In a conscientious effort to reimburse nursing homes for the nature of care required by the individual patient, many welfare formulas and private fees make care of the bedfast so much more remunerative that there is no encouragement for rehabilitative effort.

It is, therefore, clear that stimuli are needed for the construction of nursing homes and other long-term care facilities and for better control and management of them.

With respect to development of community health services outside of the hospital, it is manifest that these facilities which represent more effective and less costly solutions must be developed.

With respect to research on quality, efficiency, and economy of hospital operations, there can be no question of need in this area which involves one of the largest expenditure classifications in Utah and in the United States.

Several local health departments are in agreement with us that the advantages offered by H.R. 4998 can and must offer substantial economy by their effect upon private and publicly paid medical care. We urge the passage of this legislation.

Respectfully yours,

JAMES D. WHARTON, M.D.,
Interim Director of Public Health.

PREPARED STATEMENT OF AMERICAN NURSES' ASSOCIATION

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 submit this statement in support of S. 1071 and 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 for which this legislation is designed.

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, show 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 S. 1071 and 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 plants 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 our 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 a 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 north-eastern 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 S. 1071 and 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 percent¹ of employed public health nurses have a bachelor's degree, the U.S. Public Health Service minimum requirement for first level positions.

Senator Hubert Humphrey of Minnesota has introduced a bill (S. 1353) 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, 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 S. 1353 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 there will be less need for an acceleration in the building of nursing homes.

We believe that 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.

¹ "Facts About Nursing," 1960 edition, p. 31.

GROUP HEALTH ASSOCIATION OF AMERICA, INC.,

Chicago, Ill., May 19, 1961.

Senator LISTER HILL,

*Chairman, Senate Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.*

DEAR SENATOR HILL: A few days ago I wrote 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, S. 1071.

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 chronically 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 this committee and, if possible, in the published hearings.

Sincerely yours,

JERRY VOORHIS, *Executive Secretary.*

GROUP HEALTH ASSOCIATION OF AMERICA, INC., CHICAGO, ILL.

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.

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.

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.



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GROUP HEALTH ASSOCIATION OF AMERICA, INC., PORTLAND, OREG.

RESOLUTION NO. 1

Resolved, that the Board of Directors of the Group Health Association of America, Inc., do hereby endorse the following resolution:

That the Board of Directors of the Group Health Association of America, Inc., do hereby endorse the following resolution:

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