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EXTENSION AND REVISION OF HILL-BURTON HOSPITAL CONSTRUCTION PROGRAM

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HEARINGS

BEFORE THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH CONGRESS

SECOND SESSION

ON

H.R. 10041

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

MARCH 9, 10, 11, 12, AND 24, 1964

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EXTENSION AND REVISION OF HILL-BURTON HOSPITAL CONSTRUCTION PROGRAM

MONDAY, MARCH 9, 1964

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

The committee met at 10 a.m., pursuant to call, in room 1334, Longworth Building, Hon. Oren Harris (chairman of the committee) presiding.

The CHAIRMAN. The committee will come to order.

At the outset let me say I am glad to have so many members of the committee able to be with us at the beginning of hearings on the extension and revision of the hospital contruction program. This is a Monday morning and it is sometimes difficult to get our colleagues to attend because of other demands on their time and hearings of other committees.

In the second place, let me say I know every member of this committee joins me in extending a cordial and hearty welcome to the new member of our clan, our colleague from Texas, Mr. Pickle. I think it is well known that Mr. Pickle not only makes a very desirable and welcome addition to this committee, but I think I can say without fear of contradiction that he is the only Member in all the history of the Congress who was sworn in at 7 o'clock on Christmas Eve as a Member of the House of Representatives.

Also, I should point out that he is the Congressman representing the district of the President of the United States, so, Jake, we are glad to have you. We look forward to working with you and having you work with us carrying out the many responsibilities that we have on this committee.

Mr. PICKLE. Thank you, Mr. Chairman.

The CHAIRMAN. Today we have for consideration the bill H.R. 10041. This is a proposed revision and extension of the Hospital Construction Act, which will expire on June 30 of this year. This bill comes to us for the purpose of improving the public health program by revising, consolidating, and improving the provisions of the Public Health Service Act relating to hospitals and other medical facilities.

This program, commonly known as the Hill-Burton program, has been a part of our laws since 1946. It also covers nursing homes, rehabilitation centers, and other categories of health facilities included in the Public Health Service Act. That Act has from time to time been improved and strengthened by the Congress after hearings and considerations of this committee.

I introduced H.R. 10041 recently. The purpose of the bill is to carry out the recommendations of the President in his recent health message. I think that during the course of the hearings today and this week we will develop fully the need and the imperative necessity for the extension of this program as a part of the overall public health service program to provide for the health needs of our people.

As indicated earlier, this proposal would extend what is commonly referred to as the Hill-Burton program for an additional 5 years. It proposes to eliminate some provisions that are thought to be obsolete. It provides specifically earmarked funds for modernization of existing facilities, and establishes a new program of mortgage insurance for hospitals and other health facilities. This program comes to the Congress, as I indicated, in carrying out the President's message through the Department of Health, Education, and Welfare.

I think I might save the Secretary the embarrassment of relating for the record just what occurred, but the bill presently before us is not in toto, word for word, the bill that was sent up. There were certain objectionable provisions, among which was one having to do with the so-called modernization provision, and I will say in all frankness the chairman of the Senate committee across the way was not wholly in accord with that program. After certain discussions some modification was made in the bill that I introduced over here, trying to meet some of these serious objections, but, as I understand, the bill introduced on the other side was somewhat different from the one I introduced here. We will have to let the committee work its will after we develop all the facts and hear the Secretary and his recommendations regarding such problems. There have been these changes from what was originally recommended when the specific language was sent up, but the purpose of the entire program is to carry out the recommendations of the President and to extend this program over another period of 5 years.

The bill and the usual reports will be included at this point in the record.

(H.R. 10041 and reports follow:)

[H.R. 10041, 88th Cong., 2d 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

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 "Hospital and Medical Facilities Amendments of 1964".

SEC. 2. Part B of title III of the Public Health Service Act (42 U.S.C. 243, et seq.) is amended by inserting at the end thereof the following new section:

"SPECIAL PROJECT GRANTS FOR ASSISTING IN THE AREAWIDE PLANNING OF HEALTH AND RELATED FACILITIES

"SEC. 318. (a) There are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1965, and $10,000,000 for each of the next four fiscal years to enable the Surgeon General to make grants to public or nonprofit private agencies and organizations to cover part of the costs of projects for developing (and from time to time revising) and supervising and assisting in the carrying out of comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health facilities, and facilities related thereto, and services provided by such facilities.

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

"(1) may be made only for a project for which an application has been approved by the appropriate State agency or agencies designated in accordance with section 604(a)(1);

"(2) may not exceed 66⅔ per centum of the cost of the project with respect to which it is made, except that the Surgeon General may, during the first three years of a project, make a grant to an agency or organization of a larger percentage of the cost of such project if he determines that such larger percentage is necessary to effectuate the purposes of this section; 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."

SEC. 3. (a) 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 AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

"DECLARATION OF PURPOSE

"SEC. 600. The purpose of this title is—

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

"(b) to further assist in the construction and modernization of nonprofit private community hospitals and other medical facilities and proprietary nursing homes through the provision of mortgage insurance;

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

"(d) 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.

"PART A—GRANTS AND LOANS FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

"AUTHORIZATION OF APPROPRIATIONS FOR CONSTRUCTION GRANTS

"SEC. 601. In order to assist the States in carrying out the purposes of section 600, there are authorized to be appropriated—

"(a) for the fiscal year ending June 30, 1965, and each of the next four fiscal years—

"(1) $70,000,000 for grants for the construction of public or other nonprofit facilities for long-term care;

"(2) $20,000,000 for grants for the construction of public or other nonprofit diagnostic or treatment centers;

"(3) $10,000,000 for grants for the construction of public or other nonprofit rehabilitation facilities;

"(b) for grants for the construction of public or other nonprofit hospitals and public health centers and for grants for modernization of such facilities and the facilities referred to in paragraph (a), $150,000,000 for the fiscal year ending June 30, 1965, $160,000,000 for the fiscal year ending June 30, 1966, $170,000,000 for the fiscal year ending June 30, 1967, and $180,000,000 each for the next two fiscal years.

"STATE ALLOTMENTS

"SEC. 602. (a)(1) Each State shall be entitled for each fiscal year to an allotment bearing the same ratio to the sums appropriated for such year pursuant to subparagraphs (1), (2), and (3), respectively, of section 601(a), and to an allotment bearing the same ratio to the new hospital portion of the sums appropriated for such year pursuant to section 601(b), as the product of—

"(A) the population of such State, and

"(B) the square of its allotment percentage,

bears to the sum of the corresponding products for all of the States. As used in this paragraph, the new hospital portion of sums appropriated pursuant to section 601(b) (which portion shall be available for grants for the construction of public or other nonprofit hospitals and public health centers) is 100 per centum of such sums in the case of the fiscal year ending June 30, 1965, seven-eighths thereof in the case of the first fiscal year thereafter, twenty-seven thirty-fourths thereof in the case of the second fiscal year thereafter, thirteen-eighteenths thereof in the case of the third fiscal year thereafter, twenty-five thirty-sixths thereof in the case of the fourth fiscal year thereafter.

"(2) For each fiscal year beginning after June 30, 1965, the Surgeon General shall, in accordance with regulations, make allotments from the remainder of the sums appropriated pursuant to section 601(b) (which portion shall be available for grants for modernization of facilities referred to in paragraphs (a) and (b) of section 601) on the basis of the population, the extent of the need for modernization of the facilities referred to in paragraphs (a) and (b) of section 601, and the financial need of the respective States.

"(b)(1) The allotment to any State under subsection (a) for any fiscal year which is less than—

"(A) $25,000 for the Virgin Islands, American Samoa, or Guam and $50,000 for any other State, in the case of an allotment for grants for the construction of public or other nonprofit rehabilitation facilities,

"(B) $50,000 for the Virgin Islands, American Samoa, or Guam and $100,000 for any other State in the case of an allotment for grants for the construction of public or other nonprofit diagnostic or treatment centers, or

"(C) $100,000 for the Virgin Islands, American Samoa, or Guam and $200,000 for any other State in the case of an allotment for grants for the construction of public or other nonprofit facilities for long-term care or for the construction of public or other nonprofit hospitals and public health centers, or for the modernization of facilities referred to in paragraph (a) or (b) of section 601,

shall be increased to that amount, the total of the increases thereby required being derived by proportionately reducing the allotment from appropriations under such subparagraph or paragraph to each of the remaining States under subsection (a) of this section, but with such adjustments as may be necessary to prevent the allotment of any of such remaining States from appropriations under such subparagraph or paragraph from being thereby reduced to less than that amount.

"(2) An allotment of the Virgin Islands, American Samoa, or Guam for any fiscal year may be increased as provided in paragraph (1) only to the extent it satisfies the Surgeon General, at such time prior to the beginning of such year as the Surgeon General may designate, that such increase will be used for payments under and in accordance with the provisions of this part.

"(c) For the purposes of this part—

"(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 33⅓ per centum, and (B) the allotment percentage for the Commonwealth of Puerto Rico, Guam, American Samoa, 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) The term 'United States' means (but only for purposes of paragraphs (1) and (2)) the fifty States and the District of Columbia.

"(d)(1) Any sum allocated to a State, other than the Virgin Islands, American Samoa, and Guam 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.

"(2) Any sum allotted to the Virgin Islands, American Samoa, or Guam for a fiscal year under this section and remaining unobligated at the end of such year shall remain available to it, for the purpose for which made, for the next two fiscal years (and for such years only), in addition to the sums allotted to it for such purpose for each of such next two fiscal years.

"(e) (1) Upon the request of any State that—

"(A) a specified portion of any allotment of such State under paragraph (1) of subsection (a), other than an allotment for grants for the construction of public or other nonprofit rehabilitation facilities, be added to another allotment of such State under paragraph (1) or (2) of such subsection, other than an allotment for grants for the construction of public or other nonprofit hospitals and public health centers, or

"(B) a specified portion of an allotment of such State under paragraph (2) of subsection (a) be added to an allotment of such State under paragraph (1) of such subsection,

and upon simultaneous certification to the Surgeon General by the State agency in such State to the effect that—

"(C) 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

"(D) in the case of a request to transfer a portion of an allotment under paragraph (1) of subsection (a) for grants for the construction of public or other nonprofit hospitals and public health centers, use of such portion as requested by such State agency will better carry out the purposes of this title,

the Surgeon General shall promptly (but after application of subsection (b)) adjust the allotments of such State in accordance with such request and shall notify the State agency.

"(2) In addition to the transfer of portions of allotments under paragraph (1), the Surgeon General, upon the request of any State that a specified portion of an allotment of such State under paragraph (2) of subsection (a) be added to an allotment of such State under paragraph (1) of such subsection for grants for the construction of public or other nonprofit hospitals and public health centers and upon simultaneous certification to him by the State agency in such State to the effect that the need for new public or other nonprofit hospitals and public health centers is substantially greater than the need for modernization of facilities referred to in paragraph (a) or (b) of section 601, shall promptly (but after application of subsection (b) of this section) adjust the allotments of such State in accordance with such request and shall notify the State agency; except that not more than the following portions of allotments of a State under paragraph (2) of subsection (a) may be so added (under this paragraph) to allotments of such State under paragraph (1) of such subsection:

"(A) in the case of an allotment under paragraph (2) of subsection (a) for the fiscal year ending June 30, 1966, one-half of such allotment;

"(B) in the case of an allotment thereunder for the fiscal year ending June 30, 1967, three-sevenths of such allotment;

"(C) in the case of an allotment thereunder for the fiscal year ending June 30, 1968, two-fifths of such allotment; and

"(D) in the case of an allotment thereunder for the fiscal year ending June 30, 1969, five-elevenths of such allotment.

"(3) After adjustment of allotments of any State as provided in paragraph (1) or (2) of this subsection, the allotments as so adjusted shall be deemed to be the State's allotments under this section.

"(f) In accordance with regulations, any State may file with the Surgeon General a request that a specified portion of an allotment to it under this part for grants for construction of any type of facility, or for modernization of facilities, be added to the corresponding allotment of another State for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a facility of that type in such other State, or for modernization of a facility in such other State, as the case may be. 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 or modernization 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 corresponding allotment of the other State, to be used for the purpose referred to above.

"GENERAL REGULATIONS

"SEC. 603. The Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health, Education, and Welfare, shall by general regulations prescribe—

"(a) the general manner in which the State agency shall determine the priority of projects based on the relative need of different areas lacking adequate facilities of various types for which assistance is available under this part, giving special consideration—

"(1) in the case of projects for the construction of hospitals, to facilities serving rural communities and areas with relatively small financial resources;

"(2) in the case of projects for the construction of rehabilitation facilities, to 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; and

"(3) in the case of projects for modernization of facilities, to facilities serving densely populated areas;

"(b) general standards of construction and equipment for facilities, of different classes and in different types of location, for which assistance is available under this part;

"(c) criteria for determining needs for general hospital and long-term care beds, and needs for hospitals and other facilities for which aid under this part is available, and for developing plans for the distribution of such beds and facilities;

"(d) criteria for determining the extent to which existing facilities, for which aid under this part is available, are in need of modernization; and

"(e) that the State plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, assurance shall be received by the State from the applicant that (1) the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant; and (2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpont.

"STATE PLANS

"SEC. 604. (a) Any State desiring to participate in this part 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 part;

"(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 for the services provided by such facilities, 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, in accordance with criteria established in regulations prescribed under section 603 and on on the basis of a statewide inventory of existing facilities, a survey of need, and (except to the extent provided by our pursuant to such regulations) community, area, or regional plans,

"(A) the number of general hospital bed and long-term care beds, and the number of types of hospital facilities and facilities for long-term care, needed to provided adequate facilities for inpatient care of people residing in the State, and a plan for the distribution of such beds and facilities in service areas throughout the State;

"(B) the public health centers needed to provide adequate public health services for people residing in the State, and a plan for the distribution of such centers throughout the State;

"(C) the diagnostic or treatment centers needed to provide adequate diagnostic or treatment services to ambulatory patients residing in the State, and a plan for distribution of such centers throughout the State;

"(D) the rehabilitation facilities needed to assure adequate rehabilitation services for disabled persons residing in the State, and a plan for distribution of such facilities throughout the State; and

"(E) effective January 1, 1966, the extent to which existing facilities referred to in section 601 (a) or (b) in the State are in need of modernization;

"(5) set forth a construction and modernization program conforming to the provisions set forth pursuant to paragraph (4) and regulations prescribed under section 603 and providing for construction or modernization of the hospital or long-term care facilities, public health centers, diagnostic or treatment centers, and rehabilitation facilities which are needed, as determined under the provisions so set forth pursuant to paragraph (4);

"(6) set forth, with respect to each of such types of medical facilities, the relative need, determined in accordance with regulations prescribed under section 603, for projects for facilities of that type, and provide for the construction or modernization, insofar as financial resources available therefor and for maintenance and operation make possible, in the order of such relative need;

"(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 aid under this part or part B and, effective July 1, 1966, provide for enforcement of such standards with respect to projects approved by the Surgeon General under this part after June 30, 1964;

"(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 are found by the Surgeon General to be necessary for the proper and efficient operation of the plan;

"(9) provide for affording to every applicant for a construction or modernization 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, as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General may find necessary to assure the correctness and verification of such reports; and

"(11) provide that the State agency will from time to time, but not less often than annually, review its State plan and submit to the Surgeon General any modifications thereof which it 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.

"APPROVAL OF PROJECTS FOR CONSTRUCTION OR MODERNIZATION

"SEC. 605. (a) For each project pursuant to a State plan approved under this part, there shall be submitted to the Surgeon General, through the State agency, 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 shall set forth—

"(1) a description of the site for such project;

"(2) plans and specifications therefor, in accordance with regulations prescribed under section 603;

"(3) reasonable assurance that 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;

"(4) reasonable assurance that adequate financial support will be available for the completion of the project and for its maintenance and operation when completed;

"(5) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of construction or modernization on the project will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 27a—276a–5); and 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; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c); and

"(6) a certification by the State agency of the Federal share for the project.

"(b) The Surgeon General shall approve such application if sufficient funds to pay the Federal share of the cost of such project are available from the appropriate allotment to the State, and if the Surgeon General finds (1) that the application contains such reasonable assurance as to title, financial support, and payment of prevailing rates of wages; (2) that the plans and specifications are in accord with the regulations prescribed pursuant to section 603; (3) that the application is in conformity with the State plan approved under section 604 and contains an assurance that in the operation of the project there will be compliance with the applicable requirements of the regulations prescribed under section 603(e), and with State standards for operation and maintenance; and (4) that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to section 603(a). Notwithstanding the preceding sentence, the Surgeon General may approve such an application for a project for construction or modernization of a rehabilitation facility only if it is also approved by the Secretary of Health, Education, and Welfare.

"(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 OR MODERNIZATION

"SEC. 606. (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, or if the State so requests, 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 607, 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 605 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.

"(c)(1) At the request of any State, a portion of any allotment or allotments of such State under this part shall be available to pay one-half (or such smaller share as the State may request) of the expenditures found necessary by the Surgeon General for the proper and efficient administration during such year of the State plan approved under this part; except that not more than 2 per centum of the total of the allotments of such State for a year, or $50,000, whichever is less, shall be available for such purpose for such year. Payments of amounts due under this paragraph may be made in advance or by way of reimbursement, and in such installments, as the Surgeon General may determine.

"(2) Any amount paid under paragraph (1) to any State for any fiscal year shall be paid on condition that there shall be expended from State sources for such year for administration of the State plan approved under this part not less than the total amount expended for such purposes from such sources during the fiscal year ending June 30, 1964.

"WITHHOLDING OF PAYMENTS

"SEC. 607. Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the State agency designated as provided in section 604(a)(1), finds—

(a) that the State agency is not complying substantially with the provisions required by section 604 to be included in its State plan; or

(b) that any assurance required to be given in an application filed under section 605 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 605; 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 part, or

"(f) no further payments will be made from the allotments of such State from appropriations under any one or more subparagraphs or paragraphs of section 601, 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. 608. (a) If the Surgeon General refuses to approve any application for a project submitted under section 605 or section 610, the State agency through which such application was submitted, or if any State is dissatisfied with his action under section 607 such State, may appeal to the United States court of appeals for the circuit in which such State is located, by filing a petition with such court within sixty days after such action. A copy of the petition 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. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Surgeon General or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Surgeon General may modify or set aside his order.

"(b) The findings of the Surgeon General as to the facts, if supported by substantial 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 if supported by substantial evidence.

"(c) The judgment of the court affirming or setting aside, in whole or in part, any action of the Surgeon General shall be final, 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. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Surgeon General's action.

"RECOVERY

"SEC. 609. If any facility with respect to which funds have been paid under section 606 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 605, or (2) which is not approved as a transferee by the State agency designated pursuant to section 604, 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, unless the Surgeon General determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from this obligation.

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 situated) 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 or modernization under such project or projects. Such right of recovery shall not constitute a lien upon said facility prior to judgment.

"LOANS FOR CONSTRUCTION OR MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

"SEC. 610. (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 or modernization which meets all of the conditions specified for a grant under this part.

"(b) Except as provided in this section, an application for a loan with respect to any project under this part 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 part 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 project involved. All loans under this section shall be paid directly to the applicant.

"(c)(1) The amount of a loan under this part shall not exceed an amount equal to the Federal share of the estimated cost of construction or modernization under the project. Where a loan and a grant are made under this part 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 or modernization under 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 part shall mature not more than forty years after the date on which such loan is made, except that

nothing in this part 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 part 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 part 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 609 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 part 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 part shall be deposited in the Treasury as miscellaneous receipts.

"PART B—MORTGAGE INSURANCE FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

"MORTGAGE INSURANCE

"SEC. 621. (a) The Surgeon General, on behalf of the United States, is authorized, upon application made by the mortgagor and the mortgagee pursuant to this part, to insure any mortgage (including advances on such mortgage during construction) against default in the payment of interest on, and the repayment of the principal of, the obligation secured by the mortgage if the mortgage is for the purpose of financing the cost of construction or modernization of a private nonprofit hospital or other medical facility referred to in paragraph (a) or (b) of section 601 or a proprietary nursing home, and meets the conditions provided in, or prescribed pursuant to, this part. The Surgeon General, on behalf of the United States, is also authorized to make commitments, upon such terms as he may prescribe, for the insuring of such mortgages prior to the date of their execution or disbursement thereon.

"(b) No mortgage shall be insured under this part unless—

"(1) the application has been submitted to the Surgeon General through the State agency and has been filed jointly by the mortgagor and the mortgagee, and complies with the requirements of paragraphs (1) to (5), inclusive, of section 605(a);

"(2) the State agency certifies and the Surgeon General finds that there is a need for the project as determined in accordance with the provisions required to be set forth in the State plan under section 604(a)(4);

"(3) the application contains an assurance from the mortgagor that there will be compliance with State standards for operation and maintenance;

"(4) the mortgagor is approved by the Surgeon General as responsible and able to repay the obligation secured by the mortgage, and the mortgagee is approved by the Surgeon General as responsible and able to service the mortgage properly;

"(5) the principal obligation secured by the mortgage (A) has a maturity satisfactory to the Surgeon General but not to exceed forty years, and provides for complete amortization of such principal obligation by periodic payments within such terms as the Surgeon General shall prescribe, and (B) bears interest (exclusive of charges made pursuant to section 623(a)) at a rate not to exceed 5 per centum per annum of the amount of the principal obligation at any time, or not to exceed such rate (not in excess of 6 per centum per annum of such amount) as the Surgeon General finds necessary to meet the mortgage market;

"(6) the mortgage contains an undertaking (in accordance with regulations in force at the time the mortgage is approved for insurance) to the effect that, except as authorized by the Surgeon General and the mortgagee, the property will be used as a hospital or other medical facility until the mortgage has been paid in full or the contract of insurance is otherwise terminated; and

"(7) the mortgagor and the mortgagee certify (1) that they will keep such records relating to the mortgage transaction and indebtedness, to the construction or modernization of the facility covered by the mortgage, and to the use of such facility as a hospital or other medical facility as are prescribed by the Surgeon General at the time of such certification, (2) that they will make such reports as may from time to time be required by the Surgeon General pertaining to such matters, and (3) that the Surgeon General or any authorized officer or employee of the Public Health Service or of any agency or institution employed or utilized by the Surgeon General for that purpose, shall have access to and the right to examine and audit such records.

"(c)(1) In the case of a project for the construction or modernization of a facility (other than a project for a proprietary nursing home) the amount of the principal obligation secured by the mortgage—

"(A) may not exceed 50 per centum of the value of the facility (including other property subject to the mortgage) after completion of the project, as determined by the Surgeon General, and

"(B) may not, when added to the amount of any grant or loan approved for such project under part A or of any other Federal grant or loan which the mortgagor has obtained or is assured of obtaining for such project under any other law of the United States, exceed 75 per centum of the value of the facility (including other property subject to the mortgage) after completion of the project, as determined by the Surgeon General.

"(2) In the case of a project for construction or modernization of a proprietary nursing home, the amount of the principal obligation secured by the mortgage may not exceed 90 per centum of the value of the facility (including other property subject to the mortgage) after completion of the project, as determined by the Surgeon General.

"(d) Any contract of insurance executed by the Surgeon General under this part shall be conclusive evidence of the eligibility of the mortgage for insurance, and the validity of any contract for insurance so executed shall be incontestable in the hands of an approved mortgagee from the date of the execution of such contract, except for fraud or misrepresentation on the part of such approved mortgagee.

"(e) The failure of the mortgagor to make any payment provided for under the terms of a mortgage insured under this part shall be considered a default under such mortgage. If such default continues for a period of thirty days, the mortgagee shall be entitled to receive the insurance benefits upon conveyance to the Surgeon General of the title to the property with respect to which the mortgage was insured and assignment of all related claims of the mortgagee: *Provided*, That the mortgagee may, in the event of such default, assign to the Surgeon General all rights and interests arising under the mortgage and all related claims and assets, and in such event the insurance benefits shall be reduced by 1 per centum of the unpaid amount of the principal obligation. The insurance benefits shall include the sum of the unpaid principal amount of the loan and the unpaid interest on the loan to the date of default; and, in addition, shall include interest on such sum from the date of default to the date of payment of such benefits, at the rate determined by the Secretary of the Treasury for the purpose of section 622(b) for the fiscal year during which such benefits are paid.

"(f) Nothing in this part shall be construed to preclude any forbearance for the benefit of the mortgagor which may be agreed upon by the parties to the insured mortgage and approved by the Surgeon General, or to preclude forbearance by the Surgeon General in the enforcement of the obligation after payment of the insurance benefits.

"(g) The maximum aggregate amount of insurance liability (contingent or actual) with respect to mortgages insured under this part and outstanding at any one time shall not exceed $250,000,000, increased by annual increments of $500,000,000 on July 1, 1965, and on July 1 of each of the next three years. For the purposes of this subsection, the insurance liability (contingent or actual) with respect to any mortgage insured under this part shall be deemed to be the outstanding principal obligation of the mortgage.

"FINANCING; MEDICAL FACILITIES MORTGAGE INSURANCE FUND

"SEC. 622. (a) (1) There is hereby established a Medical Facilities Mortgage Insurance Fund (hereafter in this subsection called the 'fund') which shall be available without fiscal year limitation to the Surgeon General for carrying out the provisions of this part. In addition to sums transferred to the fund pursuant to paragraph (2) of this subsection, all amounts received by the Surgeon General as premium charges for insurance and as receipts, earnings, or proceeds derived from any mortgage or claim or from any other property acquired by the Surgeon General in connection with his operations under this part, or from the disposal of such mortgage, claim, or other property, and any other moneys, property, or assets derived by the Surgeon General from his operations in connection with this part, shall be deposited in the fund. All expenses pursuant to operations under this part, including sums authorized from year to year in appropriation Acts to be paid from the fund for administrative expenses under this part, shall be paid from the fund. Moneys in the fund not needed for current operations under this part may be invested in obligations of the United States or obligations guaranteed as to principal and interest by the the United States. If at any time the Surgeon General determines that the capital surplus and reserves of the fund exceed the present and any reasonably prospective future requirements of the fund, such excess may be deposited in the Treasury as miscellaneous receipts.

"(2) There are authorized to be appropriated, for transfer from time to time, at the direction of the Surgeon General, to the Medical Facilities Mortgage Insurance Fund, $5,000,000 for the fiscal year ending June 30, 1965, and such sums as may be necessary for each of the next four fiscal years. Any sums appropriated under this subsection shall remain available until expended. No contract for insurance shall be entered into under this part after June 30, 1969, except pursuant to a commitment to insure issued on or before that date.

"(b) Interest shall accrue to the Treasury on outstanding capital transferred to the Medical Facilities Mortgage Insurance Fund from appropriations authorized by subsection (a)(1) of this section and shall, for each fiscal year, be determined on the basis of the average daily amount of such capital outstanding during such year. The rate of such interest shall be determined annually in advance by the Secretary of the Treasury taking into consideration the current average yields to maturity (on the basis of daily closing market bid quotations during the month of June of the preceding fiscal year) on outstanding interest-bearing marketable public debt obligations of the United States having maturities comparable to loans secured by mortgages insured under this part. From time to time and at least at the close of each fiscal year, the Surgeon General shall pay to the Treasury, as miscellaneous receipts, all accrued interest.

"(c) If at any time the moneys in the Medical Facilities Mortgage Insurance Fund are insufficient to make payments in connection with the default of any loan insured under this part, the Surgeon General is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and 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 yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of such notes or other obligations. The Secretary of the Treasury is authorized and directed to purchase any notes and other obligations to be issued hereunder and for such purpose he 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 obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this subsection. 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. Funds borrowed under this subsection shall be deposited in the Medical Facilities Mortgage Insurance Fund and redemption of such notes and obligations shall be made by the Surgeon General from such fund.

PROVISIONS APPLICABLE TO INSURANCE

"SEC. 623. (a) The Surgeon General shall fix premium charges for the insurance of mortgages under this part at rates which in his judgment are adequate to cover expenses and probable losses, but such charges shall not be more than one-half of 1 per centum per annum of the amount of the principal obligation of the mortgage outstanding at any time, without taking into account delinquent payments or prepayments. Such premium charges shall be payable by the mortgagee at such times and in such manner as may be prescribed by the Surgeon General.

"(b) In the performance of, and with respect to, the functions, powers, and duties vested in him by this part, the Surgeon General may—

"(1) prescribe such regulations with the approval of the Secretary, as may be necessary to carry out the purposes of this part;

"(2) sue and be sued in any district court of the United States, and such district courts shall have jurisdiction of civil actions arising under this part without regard to the amount in controversy; but no attachment, injunction, garnishment, or other similar process, mesne or final, shall be issued against the Surgeon General or property under his control, and nothing herein shall be construed to except litigation arising out of activities under this part from the application of sections 507(b) and 2679 of title 28 of the United States Code and of section 367 of the Revised Statutes (5 U.S.C. 316);

"(3) include in any contract for insurance such terms, conditions, and covenants relating to repayment of principal and payment of interest, relating to his obligations and rights and to those of mortgagees and mortgagors in case of default, and relating to other matters as the Surgeon General determines necessary to assure that the purposes of this part will be achieved, and any term, condition, and covenant made pursuant to this clause or any other provision of this part may be modified by the Surgeon General if he determines such modification is necessary to protect the financial interest of the United States;

"(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 accept assignment of, foreclose on, or bid for and purchase at any foreclosure or any other sale, any real or personal property (tangible or intangible) in connection with which he has insured a mortgage pursuant to this part; and, in the event of any such acquisition (and notwithstanding any other provisions of law relating to the acquisition, handling, or disposal of real or personal property by the United States), complete, administer, remodel and convert, sell, exchange, or otherwise dispose of, lease, and otherwise deal with, such property in such manner as he deems appropriate to protect the financial interest of the United States: *Provided*, That no action shall be taken in connection with any such acquisition of real property which would 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) consent to the release of a part or parts of the mortgaged property or project from the lien of any mortgage insured under this part upon such terms and conditions as he may prescribe.

"(c) Notwithstanding the proviso following clause (3) of section 103(a) of the Contract Work Hours Standards Act (Public Law 87-581), the provisions of that Act shall apply to any contract which may require or involve the employment of laborers or mechanics for work financed in whole or in part by loans insured by the Surgeon General under this part.

"ADMINISTRATION

"SEC. 624. With a view to avoiding unnecessary duplication of existing staffs and facilities of the Federal Government, the Surgeon General is authorized to utilize available services and facilities of any agency of the Federal Government in carrying out the provisions of this part, and to pay for such services and

facilities, either in advance or by way of reimbursement, in accordance with an agreement between the Secretary of Health, Education, and Welfare and the head of such agency.

"PART C—GENERAL

"FEDERAL HOSPITAL COUNCIL AND ADVISORY COMMITTEES

"SEC. 641. (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 twelve members appointed by the Secretary of Health Education, and Welfare. Six of the twelve appointed members shall be persons who are outstanding in fields pertaining to medical facility and health activities, and three of these six shall be authorities in matters relating to the operation of hospitals or other medical facilities, one of them shall be an authority in matters relating to the mentally retarded, and one of them shall be an authority in matters relating to mental health, and the other six members shall be appointed to represent the consumers of services provided by such facilities and shall be persons 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 Council is authorized to appoint such special advisory or technical committees as may be useful in carrying out its functions.

"(e) Appointed Council members and members of advisory or technical committees, while serving on business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary of Health, Education, and Welfare, but not exceeding $75 per day, including travel time, and, while so serving away from their places of residence, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently.

"CONFERENCE OF STATE AGENCIES

"SEC. 642. 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 604, 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. 643. 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.

"STUDIES AND DEMONSTRATIONS RELATING TO COORDINATED USE OF HOSPITAL FACILITIES

"SEC. 644. (a) The Surgeon General is authorized to conduct research, experiments, and demonstrations relating to the effective development and utilization of 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 and nonprofit private institutions or organizations for projects for the conduct of

research, experiments, or demonstrations relating to the development, utilization, and coordination of services, facilities, and resources of hospitals or other medical facilities, agencies, or institutions, and including the construction of units of hospitals or other medical facilities which involve experimental architectural designs or functional layout, the efficiency or economy of which can be tested and evaluated, or the demonstration thereof, and projects for acquisition of experimental or demonstration equipment for use in connection with hospitals or other medical facilities. Any award for any such project made from an appropriation under this section for any fiscal year may 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. A grant under this section with respect to any project for construction of a facility or for acquisition of equipment (1) may not exceed $500,000, and (2) except where the Surgeon General determines that unusual circumstances make a larger percentage necessary in order to effectuate the purposes of this section, may not exceed 50 per centum of so much of the cost of such facility or such equipment as the Surgeon General determines is reasonably attributable to experimental or demonstration purposes. The provisions of clause (5) of the third sentence of subsection (a) of section 605 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 is authorized to be appropriated not to exceed $10,000,000 for any fiscal year to carry out the provisions 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 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 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.

"DEFINITIONS

"SEC. 645. For the purposes of this title—

"(a) The term 'State' includes the Commonwealth of Puerto Rico, Guam, American Samoa, 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 projects for which grants are made from allotments made from appropriations under paragraph (b) of section 601, 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 66⅔ per centum, or less than 33⅓ per centum, or

"(B) the amount (not less than 33⅓ per centum and not more than either 66⅔ 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 projects for which grants are made from allotments made from appropriations under paragraph (a) of section 601, 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 33⅓ per centum and not more than either 66⅔ 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 part A, 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 general, tuberculosis, and other types of hospitals, and related facilities, such as laboratories, out-patient 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.

"(d) 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.

"(e) The term 'nonprofit' as applied 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 innures, or may lawfully inure, to the benefit of any private shareholder or individual.

"(f) The term 'proprietary nursing home' means a facility which is not nonprofit and which is for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care but who require skilled nursing care and related medical services, and in which such nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to provide such care or services in accordance with the laws of the State where the facility is located.

"(g) The term 'diagnostic or treatment center' means a facility for the diagnosis or 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.

"(h) 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.

"(i) 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 (other than a hospital primarily for the care and treatment of mentally ill or tuberculous patients) 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.

"(j) The term 'construction' includes construction of new buildings, expansion, remodeling, and alteration of existing buildings, and initial equipment of any such buildings (including medical transportation facilities); 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.

"(k) The term 'cost' as applied to construction or modernization means the amount found by the Surgeon General to be necessary for construction and modernization, respectively, under a project, except that such term, as applied to a project for modernization of a facility for which a grant or loan is to be made from an allotment under section 602(a)(2), does not include any amount found by the Surgeon General to be attributable to expansion of the bed capacity of such facility.

"(l) The term 'modernization' includes alteration, major repair (to the extent permitted by regulations), remodeling, replacement, and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

"(m) 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.

"(n) The term 'mortgage' means a first mortgage (1) on real estate, in fee simple, or (2) on 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 secure the mortgage debt and to assure, for a period of not less than fifty years from the date the mortgage is executed, undisturbed use and possession for the purposes of construction and operation of the project. The term 'first mortgage' means such classes of first liens as are commonly given to secure advances (including but not limited to advances during construction) on, or the unpaid purchase price of, real estate, under the laws of the State in which the real estate is located, together with the credit instrument or instruments, if any, secured thereby, and any mortgage may be in the form of one or more trust mortgages or mortgage indentures or deeds of trust, securing notes, bonds, or other credit instruments, and, by the same instrument or by a separate instrument, may create a security interest in initial equipment, whether or not attached to the realty.

"(o) The term 'mortgagee' includes the original lender under a mortgage, and his or its successors and assigns, and includes the holders of credit instruments issued under a trust mortgage or deed of trust pursuant to which such holders act by and through a trustee named therein.

"(p) The term 'mortgagor' includes the original borrower under a mortgage and its successors and assigns."

(b) The amendment made by subsection (a) shall become effective upon the date on enactment of this Act, except that—

(1) all applications approved by the Surgeon General under title VI of the Public Health Service Act prior to such date, and allotments of sums appropriated prior to such date, shall be governed by the provisions of such title VI in effect prior to such date;

(2) allotment percentages promulgated by the Surgeon General under such title VI during 1962 shall continue to be effective for purposes of such title as amended by this Act for the fiscal year ending June 30, 1965;

(3) the terms of members of the Federal Hospital Council who are serving on such Council prior to such date shall expire on the date they would have expired had this Act not been enacted;

(4) no application with respect to a project for modernization of any facility in any State may be approved by the Surgeon General, for purposes of receiving funds from an allotment under section 602(a)(2) of the Public Health Service Act, as amended by this Act, before July 1, 1965, or before

such State has had a State plan approved by the Surgeon General as meeting the requirements of section 604(a)(4)(E) as well as the other requirements of section 604 of such Act as so amended.

(c) No application for insurance with respect to a mortgage on a nursing home under section 232 of the National Housing Act shall be approved by the Federal Housing Commissioner unless such application is filed before the close of the sixth month following the month in which this Act is enacted.

(d)(1) The sixth sentence of paragraph "Seventh" of section 5136 of the Revised Statutes, as amended (12 U.S.C. 24), is amended by inserting after the words "Federal home loan banks," the following: "or obligations which are insured by the Surgeon General of the Public Health Service under title VI of the Public Health Service Act".

(2) The third sentence of the first paragraph of section 24 of the Federal Reserve Act, as amended (12 U.S.C. 371), is amended by inserting after the words "or title V of the Housing Act of 1949, as amended," the following: "or which are insured by the Surgeon General of the Public Health Service pursuant to title VI of the Public Health Service Act,".

(e)(1) Section 35(4) of chapter III of the Act entitled "An Act to regulate the business of life insurance in the District of Columbia", approved June 19, 1934 (48 Stat. 1125), as amended (D.C. Code, 1961 edition, sec. 35–535), is further amended by inserting after the words "the National Housing Act, as amended," the following: "or insured under the provisions of title VI of the Public Health Service Act,".

(2) Section 18(4) of chapter II of the Act entitled "An Act to provide for the regulation of the business of fire, marine, and casualty insurance, and for other purposes", approved October 9, 1940 (54 Stat. 1063), as amended (D.C. Code, 1961 edition, sec. 35–1321), is further amended to read as follows:

"(4) Bonds or notes secured by mortgages or deeds of trust insured by the Federal Housing Administrator, or insured under the provisions of title VI of the Public Health Service Act, or in debentures issued by the Federal Housing Administrator: *Provided*, That the restrictions in subparagraph (3) of this section in regard to the ratio of the loan to the value of the property shall not apply to such insured mortgages or deeds of trust."

(f) Subsection (a) of section 304 of the Trust Indenture Act of 1939 (15 U.S.C. 77ddd) is amended by striking out the word "or" at the end of subparagraph (8); by striking out the period at the end of subparagraph (9) and inserting in lieu thereof a semicolon and the word "or"; and by adding after subparagraph (9) a new subparagraph as follows:

"(10) any security issued under a mortgage or trust deed indenture as to which a contract of insurance under title VI of the Public Health Service Act is in effect; and any such security shall be deemed to be exempt from the provisions of the Securities Act of 1933 to the same extent as though such security were specifically enumerated in section 3(a)(2), as amended, of the Securities Act of 1933 (15 U.S.C. 77c(a)(2))."

(g) Section 263 of chapter X of the Bankruptcy Act (11 U.S.C. 663) is amended by adding at the end thereof the following: "Nothing contained in this chapter shall be deemed to affect or apply to the creditors of any corporation under a mortgage insured pursuant to title VI of the Public Health Service Act.".

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., March 31, 1964.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request for the views of the Bureau of the Budget on H.R. 10041, 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.

This bill is the same in most major respects as the administration's proposed legislation which was sent to Congress on February 10, 1964. It differs from that proposal in two significant ways, however, by omitting language specifically requiring the availability of the facilities without discrimination on account of

race, creed, or color and by reducing the total authorization requested by the administration for the modernization of existing medical facilities.

H.R. 10041 would eliminate the "separate but equal" provision of the Hill-Burton Act and require that State plans provide for adequate facilities "for all persons residing in the State." The bill also authorizes a requirement that before State approval of any project, assurance must be given that "the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant."

The administration proposal is more specific in this regard in that it expressly provides that the availability is to be "without discrimination on account of race, creed, or color." We recommend inclusion of the language in the administration's proposal because it more clearly expresses the national policy on this matter and because it would remove any basis for the contention that there may be discrimination on account of race, creed, or color, in the availability of such facilities.

The modernization of existing hospitals has been a problem of increasing importance for many years and one which cannot be met adequately under the present Hill-Burton program. Although the greatest requirements are in larger urban areas, the effort to overcome functional obsolescence and to correct fire, safety, or other hazards to patients' health must be made in every hospital and medical facility. Thus even the smaller hospitals in rural areas may require modernization in order to raise the general level of medical care. The total estimated cost of modernization is considerable, with an estimated present backlog of several billion dollars. Moreover, it cannot be looked upon as a one-time requirement to be met over a period of a few years because hospitals which were built at such a rapid rate in the two decades before 1930 will soon add to the volume of obsolescence.

The administration's draft bill included $340 million for 5 years in a special category to begin support of modernization projects in fiscal year 1965. H.R. 10041 contains only $160 million of authorizations for the years 1966 to 1969. Furthermore, it contains authority permitting use of $70 million of that amount for other purposes, so that the most which can be guaranteed for modernization support for the entire Nation over the 4-year period is limited to $90 million. Neither the $90 million nor the maximum of $160 million for that purpose are adequate if a meaningful national effort is to be made.

Since its inception, the Hill-Burton program has made a major contribution in the national effort to raise the level of medical care and to make such care available in every area. Now, with this program due to expire on June 30, 1964, we believe it is highly appropriate to consider needed improvements such as reorientation to meet the modernization needs of existing medical faciilties, the enlargement of the grant authorization for nonprofit nursing homes and other long-term care projects in combination with mortgage insurance for proprietary nursing homes, and the provision of Federal financial support for the encouragement of areawide planning of the diverse types of facilities required for modern medical practice.

The Bureau of the Budget recommends enactment of H.R. 10041, amended to include the nondiscrimination language set forth in the administration's proposal, and the authorization of $340 million specifically for modernization beginning in the fiscal year 1965. The enactment of H.R. 10041, so amended, would be in accord with the program of the President.

Sincerely yours,

PHILLIP S. HUGHES,
Assistant Director for Legislative Reference.

U.S. DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, March 13, 1964.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in further response to your request for our views on H.R. 10041, the Hospital and Medical Facilities Amendments of 1964.

The Department of Labor strongly favors the enactment of legislation to implement recommendations in President Johnson's special health message. However, we believe that the Department of Health, Education, and Welfare can best

advise whether H.R. 10041 would effectively carry out these recommendations.

From the standpoint of our particular responsibilities, we note with approval that the bill contains provisions to protect the labor standards of laborers and mechanics employed on projects authorized by this legislation.

The Bureau of the Budget advises that there is no objection to the submission of this report from the standpoint of the administration's program.

Yours sincerely,

W. WILLARD WIRTZ, *Secretary of Labor.*

HOUSING AND HOME FINANCE AGENCY,
OFFICE OF THE ADMINISTRATOR,
Washington, D.C., March 20, 1964.

Subject: H.R. 10041, 88th Congress (Representative Harris).

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in further reply to your request for the views of this Agency on H.R. 10041, a bill to be cited as the Hospital and Medical Facilities Amendments of 1964.

The Housing Agency is primarily concerned with those provisions of the bill which deal with State and local planning of hospital and other medical facilities and with the proposed program of mortgage insurance for the construction and modernization of such facilities.

The bill would authorize a 5-year program of grants to assist in the development and implementation of comprehensive regional, metropolitan area, or other local plans for health and related facilities and services. These local plans would, except as provided by regulations of the Surgeon General, form a basis for State plans which would set forth the type, location, and priority of needed health facilities. Any construction or modernization project seeking grant assistance would have to be in accord with a State plan.

Public or nonprofit private agencies and organizations would be eligible to receive these planning grants, which could be made for up to 66⅔ percent of the cost of approved projects, except that during the first 3 years of a project up to 100 percent of such cost could be granted under special conditions. The proposal would authorize the appropriation of $5 million for fiscal year 1965 and $10 million for each of the succeeding 4 fiscal years.

This Agency has no objection to the establishment of the proposed new medical facilities planning program. Such a program will help to assure that the construction and renovation assistance provided under the bill is used effectively and efficiently. In this connection we should like to call your attention to the federally assisted comprehensive planning program administered by this Agency under section 701 of the Housing Act of 1954. Comprehensive planning assisted under section 701 deals with general development planning and coordination of State, regional, and local development programs. Over 3,000 acres of under 50,000 population—including over 800 localities of under 2,500 population—have received or are receiving assistance for such planning through their State planning agencies. In addition, over 160 metropolitan areas and urban regions are receiving section 701 assistance in carrying on metropolitan or areawide comprehensive planning.

The proposed medical facilities planning is a specialized type of functional planning which extends substantially beyond the scope of the planning assisted under section 701. However, the medical facilities planning should be closely related to any local comprehensive planning being carried on with regard to such matters as population projections and the location and density of residential and other development; the location of highways, water, sewer, and other public facilities needed for hospitals and other health facilities; and the scheduling and financing of public facilities. In addition, the statewide medical facilities plan developed on the basis of these assisted local plans should be properly coordinated with other statewide development planning. The majority of the States are currently carrying on such planning programs, 24 of them with section 701 assistance. Again, such planning must be closely related to medical facilities planning with regard to such matters as the location and scheduling of other State-sponsored public facilities.

We are pleased to note that the Secretary of Health, Education, and Welfare, in his recent testimony on H.R. 10041 before your committee, explicitly recognized the importance of close coordination with general development planning and stated that the Surgeon General would take steps to assure that health facilities and services are developed accordingly. He also indicated that his Department planned to take all appropriate steps to assure coordination at the Federal level.

The bill would terminate the program of mortgage insurance for proprietary nursing homes administered by this Agency under section 232 of the National Housing Act. The expiration date for this program would be 6 months after enactment of H.R. 10041. The bill would instead authorize the Surgeon General to establish a program of mortgage insurance for the construction or modernization of proprietary nursing homes and private nonprofit hospitals, nursing homes, and other medical facilities. The agency administering the State medical facilities plan would be required to determine, in accordance with the State plan, that there was need for the assisted facility.

The Housing Agency has no objection to these provisions of the bill.

The Bureau of the Budget has advised that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

ROBERT C. WEAVER, *Administrator.*

DEPARTMENT OF THE INTERIOR,
OFFICE OF THE SECRETARY,
Washington, D.C., March 10, 1964.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. HARRIS: Your committee has requested our comments on H.R. 10041, 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.

In view of the fact that the program authorized by this bill is the primary responsibility of the Secretary of Health, Education, and Welfare, our comments will be restricted to those areas of primary interest to this Department.

Section 602 of the bill provides for allotments among the States, including the Virgin Islands, Guam, and American Samoa, of the sums authorized by section 601 of the bill for each of the types of facilities mentioned. The allotments of the Virgin Islands, American Samoa, and Guam for any fiscal year are increased up to one-half of the minimums applicable to the individual States, but only to the extent these territories satisfy the Surgeon General, prior to the allotment date, that the allotment will be obligated for the purposes of section 601 within the availability period. The minimum allotments for the individual States are $50,000 for grants for the construction of rehabilitation facilities; $100,000 for the construction of diagnostic or treatment centers; and $200,000 for the construction of facilities for long-term care, construction of hospitals and public health centers, and modernization of facilities referred to in section 601. In the case of the States no showing must be made that the increased allotments can be obligated within the availability period.

Finally, the sums allotted under section 602 of the bill to the territories for a fiscal year remain available for the next 2 fiscal years in addition to the sums allotted for each of such 2 fiscal years.

The Virgin Islands, consisting of St. Thomas, St. John, and St. Croix, have developed into one of the major tourist areas of the world. This has resulted in providing an extraordinarily large amount of hospital and medical care to persons who are not residents of any of these islands. During 1962, the Knud Hansen Memorial Hospital, which is the only hospital on St. Thomas, provided inpatient services to nonresidents which represented 34.3 percent of the total number of patient-days in the hospital. At this same hospital, during the period between January and November 1962, 44 percent of the admissions for obstetric care were nonresidents. In December the figure was 46 percent. Thus, more than one-third of the care at this hospital alone is not covered by the provision of the Hill-Burton Act.

When referring to nonresidents, we mean persons who have been in the Virgin Islands for 2 months or less. The number of such visitors during the fiscal year ending June 30, 1962, totaled nearly 291,000. In 1960, the Census Bureau placed the total resident population of the three islands at 32,099. The 1963 estimate is 35,540 which roughly amounts to 157.5 general hospital beds in the Virgin in the Virgin Islands, including St. Croix which is 40 miles by sea from St. Thomas.

Under existing law, the funds for the construction of hospitals and related facilities, diagnostic or treatment centers, chronic disease hospitals, nursing homes, and rehabilitation facilities allotted throughout the United States for fiscal year 1963 totaled $170 million. The share for the Virgin Islands was $65,105. At present, it appears that all of the Virgin Islands' share for fiscal year 1963 will revert to the Treasury. In fiscal year 1962, the Virgin Islands received $77,915 and all of this money reverted to the Treasury at the end of 2 fiscal years.

Existing law, and this bill, do not permit flexibility in these areas to take into consideration the large nonresident tourist population. In many cases the amount of Federal grants are too small to be of any practical use. This is especially true where new construction is involved. Because of this, the provisions of this bill relating to the availability of allotments for a total of 3 fiscal years in addition to the sums allotted for two of those fiscal years will be extremely helpful, as will the minimum allotments.

The Bureau of the Budget has advised that there is no objection to the presentation of this report from the standpoint of the administrations' program.

Sincerely yours,

JOHN A. CARVER, Jr.,
Acting Secretary of the Interior.

DEPARTMENT OF JUSTICE,
OFFICE OF THE DEPUTY ATTORNEY GENERAL,
Washington, D.C., March 10, 1964.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request for the views of the Department of Justice on H.R. 10041, 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.

Section 622(f) of the Public Health Service Act (42 U.S.C. 291e(f)) provides that the Surgeon General shall by general regulation prescribe, among other things, that State plans with respect to the construction of hospitals and other facilities shall provide for adequate hospital facilities without discrimination on account of race, creed, or color. It also provides that the Surgeon General's regulations may require that before approval of any application for a hospital or addition to a hospital is recommended by a State agency, assurance shall be received by the State from the applicant that the facility will be made available to all persons residing in the territorial area of the applicant without discrimination on account of race, creed, or color; an exception shall be made in cases where separate hospital facilities are provided for separate population groups if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group. Section 623 of the act (42 U.S.C. 291f(a)(4)) similarly provides that a State plan must, among other things, set forth a hospital construction program which meets the Surgeon General's requirements as to lack of discrimination on account of race, creed, or color.

In reenacting title VI of the Public Health Service Act in amended form, H.R. 10041 would eliminate completely the above-mentioned antidiscrimination references. It is the view of the Department of Justice that with the exception of the separate-but-equal provision in section 622, which the Court of Appeals for the Fourth Circuit declared unconstitutional in *Simkins* v. *Cone Memorial Hospital*, 323 F. 2d 959, certiorari denied — U.S. —, March 2, 1964, the antidiscrimination provisions should be expressly retained.

Apart from the recommendation made above, the Department of Justice defers to the Department of Health, Education, and Welfare and others more directly

concerned with this legislation with respect to the question of whether it should be enacted.

The Bureau of the Budget has advised that there is no objection to the submission of this report from the standpoint of the administration's program.

Sincerely yours,

NICHOLAS DEB. KATZENBACH,
Deputy Attorney General.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, March 16, 1964.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

DEAR MR. CHAIRMAN: By letter dated February 27, 1964, acknowledged February 28, you requested our comments on H.R. 10041. The stated purpose of this measure is to improve the public health through revising, consolidating, and improving the hosptial and other medical facilities provisions of the Public Health Service Act.

In previous reports to you, particularly in our report, B–143181, April 7, 1961, on H.R. 2414, 87th Congress, we have commented on bills containing provisions which are similar to most of the provisions here discussed. The comments contained in those reports which in part are repeated here, together with additional comments, reflect our views on H.R. 10041.

The improvement of the health and medical services and programs of the Public Health Service are matters of policy primarily for determination by the Congress, and, therefore, we have no recommendations to make concerning the merits of H.R. 10041. However, in the event favorable consideration is to be given the bill we offer the following comments for consideration:

We would like to point out that while subsection 603(e)(1) specifies that a State may, before approval of an application, require that applicants assure that the facility contemplated shall be made available to all persons residing in the territorial area, the State plans provided for in section 604 are to reflect the number of persons living within the State who will be serviced by the new construction or modernization. It could result that while community facilities near State lines will be expected to service out-of-State persons, the State plan which will include such facilities will be based upon the number of persons actually residing within the State. Your committee may want to consider amendatory language to resolve this problem.

Subsection 604(a)(10) affords the Surgeon General access to State records concerned with the implementation of State plans required by the anticipated program. Similarly, subsection 621(b)(7)(3) affords the Surgeon General the right to examine records attendant to mortgage insurance for the construction and modernization of hospitals and other medical facilities. No provision is made to authorize the General Accounting Office to have access to those records for the purpose of examination and audit. We recommend that the bill include a provision to the effect that the Comptroller General, or his duly authorized representatives, shall have access, for the purpose of examination and audit, to any records pertaining to activities under title VI of the Public Health Service Act, 42 U.S.C. 291.

Subsection 606(c) of H.R. 10041 would authorize the Surgeon General to approve the restricted use of Federal allotments by the States to pay expenditures for administration. Federal allotments to States on other Federal-State programs generally have not been made available for administrative expenses of the States. We seriously doubt the advisability of Federal participation in such costs.

Subsections 609 (a) and (b) set forth conditions that will result in recovery of Federal funds contributed toward the cost of the construction of medical facilities projects. The basis for recovery of Federal funds as stated in the proposed legislation is:

"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 situated) *of so much of the facility as constituted an approved project or projects*, as the amount of Federal participation bore to the cost of the construction under such project or projects." (Emphasis supplied.)

It has often been the practice of the Surgeon General to approve projects in terms of a percentage of the estimated cost of the total eligible facility, including equipment, but without identifying the physical components of the approved project. For example, assume the total eligible facility cost is $1 million, the cost approved for Federal participation is $800,000, and the percentage approved for Federal contribution is 50 percent. In this example, the approved project would be designated simply as 50 percent of $800,000. In connection with projects approved on the foregoing basis, we have observed that problems have arisen in some cases in interpreting the meaning of the phrase "so much of the facility as constituted an approved project * * *" because of the absence of an identification of the physical components of the approved project. We believe that such problems are less likely to arise if the bill included language to clarify the term "project," viz, the physical components of the facility comprising the project. We note that the similar provision contained in subsection 644(b) of H.R. 10041 does not include the underscored words "so much of * * * as constituted an approved project or projects."

Section 610 would authorize loans for construction of hospitals and other medical facilities for periods up to 40 years. Repayment of loans with interest is subject to such terms and conditions as may be agreed upon by the applicant and the Surgeon General. We believe the section should contain some indication as to the manner of repayment during the 40-year period, that is to say, whether the repayments shall be in equal or approximately equal annual amounts, or if deferred, the maximum period of time for such deferred repayments.

Subsection 610(c)(2) in authorizing the Surgeon General to modify any of the terms and conditions of a loan to the extent he determines such action is necessary to protect the financial interest of the United States, would appear to vest authority in the Surgeon General to modify the rate of interest determined by the Secretary of the Treasury to be payable on such loans. We suggest that the interest terms of loans should not be modified or revised by the Surgeon General without approval of the Secretary of the Treasury and, therefore, recommend the inclusion of language to so provide or the insertion of the phrase "other than the rate of interest" after the word "conditions" in line 23, page 29.

Section 621(g) of the proposed bill authorizes a maximum aggregate amount of insurance liability with respect to mortgages insured and outstanding at any one time. The bill proposes that the amount be limited to $250 million in the first year and increased by $500 million increments during each of the next 4 fiscal years so that the maximum loan insurance, which may be approved by the Surgeon General, would amount to $2.25 billion during the 5-year period.

This section, when read together with the section 622(c), clearly authorizes the insurance of loans made during the total period through June 30, 1969, in advance of any appropriations being made therefor to cover potential losses under the insurance program. We believe that congressional controls of Federal activities is best exercised through continued annual scrutiny of such activities. In order to retain the usual congressional review and controls over this program, we suggest that section 621(g) be amended so as to provide a stated aggregate of insurance outstanding, such as the initial amount of $250 million stated on line 23, page 35. Then if the insurance program is to be later increased beyond the amount initially authorized, it would require review by the Congress of past experience and reconsideration of future needs, followed by enactment of an increase in the authorized amount of insurance that could be outstanding.

Section 622(c) of the bill would authorize the Surgeon General to issue notes and other obligations to the Secretary of the Treasury for the purpose of financing deficits in the Medical Facilities Mortgage Insurance Fund to be established by section 622(a)(1). While we normally do not favor "back-door" financing, we recognize that there may be some need therefor in programs of this nature where the loan insurance commitments previously have been executed and the loan defaults are greater than were anticipated when the applicable appropriation was made. We suggest, however, that the bill be amended by adding at the end of the new section 622(c) language similar to the following:

"The amount of notes or other obligations issued to the Secretary of the Treasury in each fiscal year shall be disclosed, and an appropriation, which is hereby authorized to be made, requested annually to pay off all notes and other obligations which may be outstanding."

While section 624 authorizes the Surgeon General to utilize available services and facilities of any agency of the Federal Government, with a view toward avoiding unnecessary duplication of existing staffs and facilities of the Federal Government, there is nothing in the bill to prevent the Surgeon General from using personnel and facilities under his control to administer the mortgage insurance program under the proposed part B, title VI, of the Public Health Service Act. In this regard, subsection 645(c) takes away the authority of the Federal Housing Commissioner to approve application for insurance on nursing homes under the law codified at 12 U.S.C. 1715w (supp. IV), 6 months after the passage of H.R. 10041. We suggest that your committee give serious consideration to whether the responsibilities for administering this insurance program should not be vested in any agency presently administering insurance programs rather than creating new authority to set up a similar operation under the Surgeon General.

Other than as set out above, we have no suggestions to make concerning the consideration of H.R. 10041.

Sincerely yours.

JOSEPH CAMPBELL,
Comptroller General of the United States.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 16, 1964.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of February 27, 1964, for a report on H.R. 10041, to improve the public health through revising, consolidating, and improving the hospital and other medical facilities provisions of the Public Health Service Act.

In most major respects this bill is the same as the legislative proposal submitted to the Congress by this Department on February 10 to carry out the recommendations for extension and improvement of the Hill-Burton program in the health messages of Presidents Kennedy and Johnson. Our comments on the differences between our February 10 legislative proposal and H.R. 10041 were included in my testimony before your committee on March 9.

There are enclosed herewith for the convenience of the committe a copy of the draft bill embodying our legislative proposal, a copy of the letter to the Speaker transmitting that bill and the estimates of increased costs, a copy of the detailed section-by-section analysis of that bill, and a copy of my testimony.

For the reasons stated in the Presidential messages, in the letter to the Speaker, and in my testimony, we urge that H.R. 10041 be amended to accord with our draft bill and that, as so amended, it be enacted by the Congress.

Sincerely,

ANTHONY J. CELEBREZZE, *Secretary.*

Enclosures.

(NOTE.—The draft bill mentioned in the above letter was placed in the committee files.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, February 10, 1964.

Hon. JOHN W. MCCORMACK,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: I am enclosing for your consideration a draft of a bill to amend title VI of the Public Health Service Act, usually known as the Hill-Burton program. The proposed Hospital and Medical Facilities Amendments of 1964 would revise, consolidate, improve, and expand the hospital and medical facilities construction grant programs now authorized by title VI of the Public Health Service Act.

This proposal would carry out the recommendations for extension and improvement of the Hill-Burton program in the President's 1964 health message.

The Hill-Burton program—now due to expire on June 30, 1964—has been in operation for more than 16 years. Its provisions now require revision to keep

pace with the changing concepts of health facility planning and operation, to improve the administration of the program, and to extend the life of this highly successful program for an additional 5 years. The new programs which would be authorized are needed to redirect the emphasis of the program and bring about a better balance in the planning, construction, and modernization of health facilities.

The major amendments included in the bill would:

1. Authorize a new program of special project grants to assist public or nonprofit agencies and organizations in the areawide planning of health and related facilities.
2. Authorize a new program of grants for modernization of health facilities and make adjustments in the annual appropriation authorization for construction of hospitals and public health centers.
3. Combine the separate chronic disease hospital and nursing home categories into a single "facility for long-term care" category and increase the annual appropriation ceiling for these facilities.
4. Authorize new programs of Federal mortgage insurance for the purpose of assisting in financing the cost of construction or modernization of (*a*) private nonprofit hospitals, nursing homes, and other medical facilities, and (*b*) nursing homes operated for profit.

PROJECT GRANTS FOR PLANNING OF HEALTH FACILITIES

A new program of special project grants would be authorized to provide assistance in the areawide planning of health facilities and related services. The bill would establish a 5-year grant program beginning July 1, 1964, to assist in the development and implementation of comprehensive regional, metropolitan area, and other local area plans for health and related facilities. Public and nonprofit agencies and organizations would be eligible to receive such grants. The bill would authorize the appropriation of $5 million for the fiscal year ending June 30, 1965, and $10 million for each of the next 4 fiscal years. Applications for grant assistance would be recommended for approval or disapproval by the State agency designated to administer the Hill-Burton program. Grants could not exceed 66⅔ percent of the cost of approved projects after the third year for which a grant has been made for such project.

As health facilities become more numerous and complex, there is a greater need for improved planning of health facilities in communities, areas, regions, and the States. Proper planning insures against the use of public and private resources to construct facilities which are not needed or poorly located and avoids the unnecessary duplication of services and facilities, and the creation of further imbalances among the kinds of services and facilities required. In short, proper planning is the best insurance that large sums of capital funds—Federal, State, and local—are spent wisely. In this connection, it is important to note that approximately $1.3 billion of Federal, State, local, and private funds are spent annually for health facility construction.

NEW MODERNIZATION PROGRAM

A new program of formula grants, for the modernization of health facilities, giving special consideration to those facilities serving densely populated areas, would be authorized. The program would begin on July 1, 1964, and the bill would authorize the appropriation of $50 million for fiscal year 1965, $60 million for 1966, $70 million for 1967, and $80 million for each of the next 2 fiscal years. The new modernization program and the existing program of grants for construction and expansion of hospitals and public health centers are both addressed to further improvements in the network of health facilities throughout the country. It is important, therefore, that a balance be maintained between the construction and expansion of hospital facilities on the one hand and the modernization of those in existence on the other. For this reason the annual appropriation ceiling of $150 million for the existing program would be reduced to $100 million beginning with fiscal year 1965—the year in which the new modernization program becomes operative.

Many facilities throughout the country, and particularly the quality-care hospitals in our urban areas, are functionally or structurally obsolete. Shifts in populations from urban centers to the suburbs, and industrial, commercial, and transportation changes, have also contributed to the inefficient utilization of many of these facilities. A 1960 study, conducted by the Public Health Serv-

ice in cooperation with Hill-Burton State agencies, revealed that it would cost $3.6 billion to modernize and replace existing facilities without increasing the total number of beds.

Projects for the modernization of existing facilities are eligible under the existing Hill-Burton program. However, the legislation requires that priority of projects be based on the relative need of different areas lacking adequate hospital facilities (specially those in rural and financially disadvantaged areas). Under such criteri, projects for the modernization and replacement of urban hospitals (without increasing the number of beds) cannot compete effectively with projects for additional beds. It is therefore essential that funds be specially earmarked for modernization and used in the States under a separate priority system.

Moreover, the legislative formula for distributing funds among the States gives heavy weight to their per capita incomes, thus placing the bulk of the funds appropriated in geographical areas which, while most in need of additional beds and facilities, are not the geographical areas in which the greatest need exists for modernization work. Funds earmarked for modernization projects under the draft bill would therefore be allotted on a different basis which takes into account not only the populations and relative financial need of the States, but also the extent of their needs for modernization.

While the Hill-Burton program is accomplishing its original objective of constructing health facilities where additional beds are most needed, particularly in rural areas, this very accomplishment creates serious imbalances between the modern plants in rural and suburban areas and the relatively obsolete and often inefficient plants in our urban areas. Our system of health facilities—whereby rural and suburban facilities rely on the quality care and the specialized services of the urban hospitals—requires that these urban facilities be modernized and replaced if they are to continue their leadership role in the Nation's health and hospital program.

For the above reasons, the new modernization program represents the highest priority item included in this draft bill.

COMBINING THE CHRONIC DISEASE HOSPITALS AND NURSING HOME CATEGORIES AND INCREASING THE ANNUAL APPROPRIATION CEILING

Separate categories for the construction of chronic disease hospitals and nursing homes tend to create or perpetuate an artificial distinction between these two types of long-term care facilities which has proven to be both undesirable and unrealistic. Problems have resulted from attempts made to plan separately the need for these two similar types of facilities as required in the present legislation. It is important that the legislation encourage and stimulate States and communities to focus attention on the total services and facilities required to meet the long-term care needs (excluding mental and tuberculosis hospitals) of a given area or community rather than attempting to plan separately for facilities having the same general purpose and differing only in the degree to which medical and nursing care is provided.

The draft bill also proposes that the existing combined annual appropriation ceiling of $40 million for chronic disease hospitals and nursing homes be increased to $70 million annually for the new single category of long-term care facilities. Since the Hill-Burton program became operative in 1946, considerable progress has been made in the provision of general hospital beds, particularly in rural areas. While this progress must be continued, we should at the same time make every effort to increase the supply of long-term care beds and facilities, and bring about a better balance between long-term care beds and facilities, and hospital beds and facilities for acute, short-term care.

In 1948, this country had only 59 percent of the general hospital beds which were required. At the present time, 83 percent of the general hospital beds needed are available in this country. At the same time, however, State agencies report that over 500,000 long-term care beds are needed, and the demand of our aged population for care in long-term care facilities and beds is steadily increasing.

MORTGAGE INSURANCE FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER RELATED MEDICAL FACILITIES

A new program is proposed which would authorize the Surgeon General of the Public Health Service to insure mortgage secured loans for the construction or modernization of private nonprofit hospitals, nursing homes and other medical

facilities and of nursing homes operated for profit. The maximum aggregate amount of insurance liability outstanding at any one time could not exceed $250 million, increased by annual increments of $500 million on July 1, 1965, and on July 1 of each of the next 3 years. No contract for insurance could be entered into after June 30, 1969, except pursuant to a commitment to insure issued on or before that date.

To be insurable the loan secured by the mortgage for a private nonprofit hospital or medical facility could not exceed 50 percent of the value of the facility after completion of the project, and when an insured loan is approved in conjunction with a grant the total could not exceed 75 percent of the value of the facility after completion of the project. Insured loans for the construction of a nursing home operated for profit could not exceed 90 percent of the estimated value of the facility when constructed.

The principal obligation secured by the mortgage could not have a maturity date in excess of 40 years. The interest rate could not exceed 5 percent per annum, or, if found necessary to meet the mortgage market, the maximum interest could be increased by the Surgeon General to a rate not exceeding 6 percent per annum. In consideration for the Government insurance the borrower would be required to pay a premium charge fixed by the Surgeon General at a rate adequate to cover expenses and probable losses; this premium charge could not exceed one-half of 1 percent per annum of the loan secured by the mortgage and outstanding at the time.

The draft bill contains provisions designed to assure that the facilities constructed with the aid of mortgage insurance would be adequate and suitable for carrying out the purposes of the program, and are consistent with plans for health facilities developed by the designated State agencies. The usual labor standard provisions would be applicable and various powers essential to the efficient administration of such a program, and customarily conferred upon other Government agencies administering similar programs, would be vested in the Surgeon General for purposes of the mortgage insurance program.

The draft bill authorizes the appropriation of $5 million for the fiscal year ending June 30, 1965, and such additional sums as may be necessary for each of the next four years, to be available for transfer to a medical facilities insurance fund until deposits of premium charges are adequate. The fund would be used for the making of payments in connection with the default of any insured loans and for necessary administrative expenses.

To provide full assurance to mortgagees that adequate Federal funds will be available to meet promptly their claims under mortgage insurance contracts in the event of defaults upon the part of borrowers, the bill authorizes the Surgeon General to borrow from the Treasury the amount needed to pay such claims if at the time the moneys in the mortgage insurance fund are insufficient to pay them in full; amounts so borrowed would bear interest until repaid to the Treasury.

The bill contains amendments to various laws applicable to banking or other investing institutions operated or regulated by the Federal or District of Columbia Governments, and an amendment to the Bankruptcy Act, which amendments would accord the same status to loans secured by mortgages insured under the bill as is accorded loans secured under other Federal insurance programs. In addition, the bill provides that no application for insurance with respect to a mortgage on a nursing home under section 232 of the National Housing Act could be approved by the Federal Housing Commissioner unless such application is filed before the close of the sixth month following the month in which this bill is enacted. This latter provision would effectuate the transfer of the Federal Housing Administration's insured loan program for construction and modernization of nursing homes operated for profit to the Public Health Service, a health-oriented agency. This would enable the Federal Government to improve its coordination of Federal aid in the construction of health facilities by focusing programs of Federal financial aid to profitmaking nursing homes, nonprofit nursing homes, hospitals, and other health facilities in the Public Health Service, which has had long experience in the planning, design, construction, organization, and operation of all kinds of health facilities, including nursing homes.

Other major revisions included in the bill would:

1. Authorize the payment to the State of one-half (or such smaller share as the State may request) of the expenditures found necessary by the Surgeon General for the proper and efficient administration during a fiscal year of the State plan. Such payments would be made from any construction allotment or allotments of funds made available to the State under the draft bill, and

payments could not exceed more than 2 percent of the total of the allotments of such State for a year or $50,000, whichever is less. Any such payments would be paid on condition that there shall be expended from State sources for administration of the State plan not less than the total expended for such purposes during the fiscal year ending June 30, 1964.

2. Delete the requirement that a private nonprofit diagnostic or treatment center must be sponsored by a corporation or association which owns and operates a nonprofit hospital.

In compliance with Public Law 801, 84th Congress, there is enclosed a statement of cost estimates and personnel requirements that would be entailed by enactment of this proposed legislation.

We shall appreciate it if you will refer the enclosed draft bill to the appropriate committee for consideration.

The Bureau of the Budget advises that enactment of this proposed legislation would be in accord with the program of the President.

Sincerely,

ANTHONY J. CELEBREZZE, *Secretary.*

Enclosures.

Hospital and Medical Facilities Amendments of 1964—Estimate of additional cost 1965–69

[Dollar amounts in thousands]

Item	1965	1966	1967	1968	1969
Appropriation requirements:					
Special project planning grants	$5,000	$8,000	$10,000	$10,000	$10,000
Grants or loans for construction:					
Long-term care facilities	70,000	70,000	70,000	70,000	70,000
Diagnostic or treatment centers	20,000	20,000	20,000	20,000	20,000
Rehabilitation facilities	10,000	10,000	10,000	10,000	10,000
Hospitals and public health centers	100,000	100,000	100,000	100,000	100,000
Modernization of health facilities	50,000	60,000	70,000	80,000	80,000
Mortgage insurance for construction of health facilities	5,000	2,000	2,000	2,000	2,000
Operations and technical services	150	250	300	400	400
Total	260,150	270,250	282,300	292,400	292,400
Expenditures:					
Special project planning grants	500	8,000	10,000	10,000	10,000
Grants or loans for construction:					
Long-term care facilities	1,000	21,000	56,000	70,000	70,000
Diagnostic or treatment centers	1,000	6,000	16,000	20,000	20,000
Rehabilitation facilities	500	3,000	8,000	10,000	10,000
Hospitals and public health centers	1,000	30,000	80,000	100,000	100,000
Modernization of health facilities	750	16,000	44,000	62,000	71,000
Mortgage insurance for construction of health facilities	100	500	1,500	2,000	2,500
Operations and technical services	150	250	300	400	400
Total	5,000	84,750	215,800	274,400	283,900
Man-years of employment	15	25	30	40	40

DETAILED ANALYSIS, HOSPITAL AND MEDICAL FACILITIES AMENDMENTS OF 1964

In addition to substantive amendments of greater significance described below, the bill would revise the provisions of the Public Health Service Act relating to assistance in the construction of hospitals and other medical facilities, to improve and to clarify and simplify many of its provisions and eliminate provisions which are executed or no longer of value to the program.

SECTION 1

This section provides that the act may be cited as the "Hospital and Medical Facilities Amendments of 1964."

SECTION 2

Section 2 of the bill would add a new section 318 at the end of title III of the Public Health Service Act to authorize the Surgeon General to make grants to public or nonprofit private agencies for developing and supervising and assisting in carrying out comprehensive regional, metropolitan area, or other local area

plans for coordination of health and related facilities and services. Projects approved by the State agency (designated under sec. 604(a)(1)) would be eligible for a grant of up to 66⅔ percent of the cost of the project; however, during the first 3 years of a project, the Surgeon General would be authorized to make a grant of a larger percentage of such cost. Appropriations of $5 million for fiscal year 1965, and $10 million for each of the next 4 fiscal years would be authorized to enable the Surgeon General to make such grants.

SECTION 3

Section 3(a) of the bill revises title VI of the Public Health Service Act and adds a program for the insurance of mortgage loans for private nonprofit hospitals and medical facilities and proprietary nursing homes.

The existing title VI contains eight parts:

Part A—Declaration of purpose.
Part B—Surveys and planning.
Part C—Construction of hospitals and related facilities.
Part D—Miscellaneous.
Part E—Declaration of purpose with respect to diagnostic or treatment centers, chronic disease hospitals, rehabilitation facilities, and nursing homes.
Part F—Surveys and planning with respect to diagnostic or treatment centers, chronic disease hospitals, rehabilitation facilities, and nursing homes.
Part G—Construction of diagnostic or treatment centers, chronic disease hospitals, rehabilitation facilities, and nursing homes.
Part H—Loans for construction of hospitals and other facilities.

Parts B and F have been executed and their provisions have, consequently, not been continued in the draft bill. The other provisions of the existing title VI which are still appropriate have been continued in parts A and C of the revised title VI. Substantive changes are indicated in the following material, but many of the differences in language between the existing law and the bill are a consequence of the elimination of separate parts dealing with hospitals and public health centers on the one hand and other types of medical facilities on the other.

PART A—ASSISTANCE FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

Declaration of purpose (sec. 600)

The new section 600 provides that the purpose of title VI is—

(*a*) To assist the States in their programs of construction and modernization of public or other nonprofit community medical facilities necessary for furnishing adequate hospital, clinic, or similar services to all their people;

(*b*) To further assist in the construction and modernization of nonprofit private community hospitals and other medical facilities and proprietary nursing homes through the provision of mortgage insurance;

(*c*) To stimulate the development of new or improved types of facilities; and

(*d*) To promote research, experiments, and demonstration, and the coordination thereof, relating to the development and utilization of hospital, clinic, or similar services, facilities, and resources.

The differences in the declaration of purpose from the existing provisions of sections 601 and 641 of the Public Health Service Act reflect the changes in the other provisions of the title.

Authorization of appropriations for construction grants (sec. 601)

This section replaces the present authorizations of appropriations in sections 621 and 651 of the existing law, which expire on June 30, 1964. It authorizes appropriations of the following amounts for grants for construction or modernization of the following types of public or other nonprofit facilities:

(*a*) For each of the fiscal years 1965 through 1969—

(1) $70 million for construction of facilities for long-term care (replacing the existing authorizations of $20 million for grants for chronic disease hospitals and $20 million for grants for nursing homes),

(2) $20 million for construction of diagnostic or treatment centers (same as existing law), and

(3) $10 million for construction of rehabilitation facilities (same as existing law);

(*b*) For construction of hospitals and public health centers, $100 million for each of the fiscal years 1965 through 1969 (the existing authorization is $150 million); and

(*c*) For modernization of the facilities referred to in (*a*) and (*b*), $50 million for fiscal year 1965, $60 million for fiscal year 1966, $70 million for fiscal year 1967, and $80 million for fiscal years 1968 and 1969.

State allotments (sec. 602)

This section provides for allotment among the States of the sums appropriated pursuant to the revised section 601 for each of the types of facilities.

Under subsection (a) of section 602, the allotment to each State for each type of facility for which an appropriation is authorized for construction grants under subsection (a) or (b) of section 601 would be an amount bearing the same ratio to that appropriation as the product of (1) the population of the State, and (2) the square of its allotment percentage, bears to the sum of the corresponding products for all the States. This formula is the same as existing law (secs. 624 and 652), although it would be based on the actual appropriations instead of on the authorized appropriations as under section 621 of existing law. The Surgeon General would, in accordance with regulations, make allotments for grants for modernization of such facilities on the basis of the population, the extent of the need for modernization of such facilities, and the financial need of the respective States.

Subsection (b) would, however, provide a minimum allotment for each State—$50,000 in the case of construction of rehabilitation centers, $100,000 in the case of construction of diagnostic or treatment centers, and $200,000 in the case of construction of facilities for long-term care, construction of hospitals and public health centers, and modernization of all types of facilities referred to above. The existing minimum for construction of hospitals and public health centers is $200,000, and the minimum for diagnostic or treatment centers is $100,000. The minimum in the bill of $200,000 for long-term care facilities combines the existing minimum of $100,000 for chronic disease hospitals and $100,000 for nursing homes. The allotments of the Virgin Islands, American Samoa, and Guam for any year would be increased up to one-half of the minima applicable to the States, but only to the extent that the Surgeon General is satisfied of the ability to use the increased allotment within the 3-year period for which their allotments are available. The increases needed to provide the minimum allotments would be derived by proportionate reduction in the allotments of the remaining States. Existing law does not specify the method of securing the funds needed for the minimum allotments.

Subsection (c) of this section sets forth the meaning of "allotment percentage." As under the existing law (sec. 631(a)), this percentage would be based on the relative fiscal resources of each State, reflected by its relative average per capita income as compared with the average per capita income of the United States, but with a minimum of 33⅓ percent and a maximum of 75 percent, and with the percentage for Puerto Rico, Guam, American Samoa, and the Virgin Islands set at 75 percent.

Also as under existing law (sec. 631(c)), the State populations will be determined on the basis of the latest figures certified by the Department of Commerce.

Under subsection (d) allotments to the States would, remain available for 1 year beyond the year in which allotted. This is the same as existing law (secs. 624 and 652). However, the allotments of the Virgin Islands, American Samoa, and Guam would remain available for 2 years beyond the year in which allotted.

Section 624 of the existing law, which is applicable to hospitals and public health centers, increases the amounts authorized to be appropriated for this category of facilities to the extent of any allotments for such category which are unobligated at the end of the period for which they are available, any amounts authorized to be appropriated but not appropriated for the preceding fiscal year, and any amounts which are not allotted to any State because of its failure to have an approved State plan. These provisions of this section have never been used and their continuation would not appear to serve any useful purpose in the foreseeable future. It should be noted that the present part G, relating to other types of medical facilities, does not contain any provision for increasing the authorization of appropriations in this manner.

Subsection (e) provides for transfer by the Surgeon General, at the request of a State, of a portion of a State's allotment for construction of one type of facility (other than its allotment for rehabilitation facilities) to its allotment for another type of facility or for modernization. However, no transfer could be made from any other allotment to the allotment for construction of hospitals and public health centers.

In order to secure such a transfer from the allotment for long-term care facilities or diagnostic or treatment centers, the State would be required to certify to the Surgeon General that a reasonable opportunity has been afforded to prospective project applicants to submit approvable applications for the utilization of funds in the category for which the allotment was originally made and that there have been no approvable applications in such category. To secure such a transfer from the allotment for construction of hospitals and public health centers, the State would be required either to make such a certification or to certify to the Surgeon General that use of the transferred funds as requested by it would better carry out the purposes of this title of the Public Health Service Act.

Subsection (e) is similar to section 654(b) of existing law. It differs from existing law in that the provisions have been extended to include transfers from (but not to) allotments for hospitals and public health centers and to (but not from) allotments for rehabilitation facilities.

Subsection (f) provides that, in accordance with regulations, a State may file a request with the Surgeon General to transfer a portion of any allotment to it under title VI of the Public Health Service Act for grants for construction or modernization of any type of facility to the corresponding allotment of another State. This addition to allotment of the second State could be used to meet a portion of the Federal share of the cost of construction of that type of facility in the second State, or for modernization of a facility in the other State, as the case may be. The request could be granted by the Surgeon General only if he (and, in the case of a rehabilitation facility, the Secretary of Health, Education, and Welfare) found (1) that construction or modernization of the facility will meet needs in the State making the request and (2) that use of the specified portion of the allotment, as requested by the State, would assist in carrying out the purposes of title VI.

Subsection (f) is the same as section 637 of existing law, except that conforming changes have been made to refer to the allotment for modernization.

General regulations (sec. 603)

This section provides that regulations of the Surgeon General shall be approved by the Federal Hospital Council and the Secretary of Health, Education, and Welfare.

Such regulations shall prescribe the general manner for determining the priority of projects based on the relative need of different areas lacking adequate facilities of the various types. This is similar to existing law (sec. 622(d)), except that the present provision provides that, in addition to area needs, the relative need of different sections of the population shall be a basis for determining priority. As under existing law, special consideration must be given, in the case of projects for hospital construction, to facilities serving rural communities and areas with relatively small financial resources. New provisions would require that special consideration be given, in the cost of projects for construction of rehabilitation facilities, to facilities connected with a university teaching hospital which will provide an integrated program of medical, psychological, social, and vocational evaluation and services under competent supervision; and, in the case of projects for modernization of facilities, to facilities serving densely populated areas.

Such regulations shall require that the State plan provide for adequate hospitals and other medical facilities for persons residing in the State without discrimination on account of race, creed, or color, and that the State plan provide for adequate hospitals and other medical facilities to furnish needed services for persons unable to pay. This is the same as existing law (sec. 622 (f)). Regulations may also require that a State agency, before recommending approval of an application for a project under this title, receive assurance from the applicant that the facility or portion of the facility to be constructed or modernized will be available to all persons residing in the territorial area of the applicant without discrimination on account of race, creed, or color. Existing statutory language (sec. 622 (f)(1)) excepting from the nondiscrimination

requirement cases where facilities are provide population groups on a "separate but equal" basis would not be retained.

The Surgeon General may also require assurance from an applicant that provision will be made in the facility (or portion thereof) to be constructed or modernized for a reasonable volume of services for persons unable to pay, except when this requirement is not financially feasible. Such assurance may be required under existing law (sec. 622(f)(2)).

The regulations must also prescribe general standards of construction and equipment for facilities of different classes and in different types of location, and criteria for determining needs for general hospital and long-term care beds, and for hospitals and other facilities aided under this title, and for developing plans for the distribution of such beds and facilities. Criteria for determining the extent to which existing facilities need modernization would also be prescribed.

Under existing law (sec. 622) the Surgeon General prescribes regulations of the kind referred to above with the approval of the Federal Hospital Council and the Secretary of Health, Education, and Welfare. Administrative regulations need only be approved by the Secretary (sec. 633(a)).

State plans (sec. 604)

This section sets forth the provisions which a State plan must contain in order to be approved for purposes of participation by a State in the program established by title VI of the Public Health Service Act.

A State plan to be approved must—

(1) Designate a single State agency to administer or supervise the administration of the State plan and contain satisfactory evidence of its authority to carry out the plan.

(2) Provide for designation of a State advisory council with representation from the various public or other nonprofit groups concerned with the program and from consumers and with representation from rehabilitation groups (or, if not, the plan must provide for consultation with such groups).

(3) Set forth, in accordance with criteria established in the Surgeon General's regulations and on the basis of a statewide inventory of existing facilities, a survey of need, and (except to the extent provided by regulations) community, regional, or area plans, the number of general and long-term care beds needed to provide adequate facilities for inpatient care, the public health centers needed to provide adequate public health services, the diagnostic or treatment centers needed for minimum diagnostic or treatment services to ambulatory patients, the rehabilitation facilities needed to assure adequate rehabilitation services for disabled persons, and (effective Jan. 1, 1965) the extent to which hospitals and other eligible facilities are in need of modernization.[1] Also a plan would have to be included for distribution for each of the four types of facilties.

(4) Set forth a construction and modernization program, in conformity with the above and criteria established in the Surgeon General's regulations, which provides for construction or modernization of faciliites of the various types which are needed for people residing in the State.

(5) Set forth the relative need for each of the types of facilities and provide for construction or modernization in the order of such need insofar as financial resources available therefor and for maintenance and operation make possible.

(6) Provide minimum standards, to be fixed in the discretion of the State, for the maintenance and operation of facilities providing inpatient care which received assistance under this part or mortgage insurance under part B; and, effective July 1, 1965, provide for the enforcement of these standards applicable to projects approved after June 30, 1964.

(7) Provide such methods of administration as are found by the Surgeon General to be necessary for the proper and efficient operation of the plan, including a merit system for personnel, except that the Surgeon General would be prohibited from exercising any authority with respect to the selection, tenure of office, or compensation, of individuals employed pursuant to such a system.

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[1] Modernization includes alteration, major repair (to the extent permitted in regulations), remodeling, replacement, and renovation of existing facilities.

(8) Provide for a hearing for applicants for construction or modernization projects (other than research projects under sec. 644) and for submission of required reports to the Surgeon General.

(9) Provide for review periodically (but at least annually) of the State agency's construction program and for submission of appropriate modifications.

The requirements referred to in items (1), (2), (7), and (8) above are the same in substance as the requirements in existing law (paragraphs (1), (2), (3), (6), (8), and (9) of the existing sec. 623(a)).

The requirements set forth above in items (3) and (4) are the same in substance as existing law (par. (4) of sec. 623(a)). The requirement in item (5) above is similar to existing law (sec. 623(a)(5)), but refers to modernization as well as construction. The requirement described above in item (6) is substantially the same as the existing law (sec. 623(a)(7)) except for the requirement of inclusion of the enforcement provisions. Under existing law, however, the inclusion of minimum standards of maintenance and operation of federally aided facilities is mandatory only for hospitals and public health centers. The requirement set forth above in item (8) is the same as existing law (sec. 623(a)(10)), except that review of the State plan would be required at least annually.

The Surgeon General would be required to approve any State plan complying with the above requirements. Any disapproval of a plan or modification thereof would be subject to a hearing before the Federal Hospital Council, and to reversal if the Council determined that the plan or modification complied with the statutory requirements. This provision is substantially the same as section 623 (b) of existing law.

The bill does not include the present provision (sec. 623(c)) prohibiting the requirement (by regulation) of any change in a State plan more frequently than every 2 years.

Approval of projects for construction or modernization (sec. 605)

This section sets forth the requirements which must be met by applications for construction or modernization projects. Such applications may be submitted by a State, a political subdivision of a State, or a public or other nonprofit agency, either individually or jointly. The application must include a description of the site; plans and specifications for the project in accordance with the Surgeon General's regulations; and reasonable assurance:

(1) Of title to the site either in the applicant or a public or other nonprofit agency which is to operate the facility;

(2) Of adequate financial support for completion and maintenance and operation of the project:

(3) That prevailing local wage rates will be paid;

(4) A certification by the State agency of the Federal share for the project.

The Surgeon General is to approve any application which meets the above requirements if sufficient funds are available from the applicable State allotment to pay the Federal share of the cost of the project, and if he finds—

(1) That the application meets the requirements set forth above and that the plans and specifications are in accord with the regulations;

(2) That the application is in conformity with the State plan and contains an assurance that in the operation of the project there will be compliance with regulations regarding the provision of facilities without discrimination on account of race, creed, or color, and the furnishing of needed services for persons unable to pay therefor, and compliance with State standards for operation and maintenance; and

(3) That the project is entitled to priority over other projects within the State in accordance with the Surgeon General's regulations.

As under existing law, the Surgeon General may approve an application for a project for construction or modernization of a rehabilitation facility only if it is also approved by the Secretary of Health, Education, and Welfare. The bill would not retain the provision in existing law which requires that a diagnostic or treatment center applicant must either be a public agency or an organization owning and operating a nonprofit hospital (sec. 654(d)).

No application may be disapproved by the Suregon General without affording the State agency an opportunity for a hearing. Amendment of an approved application is subject to approval in the same manner as described above.

The requirements which must be met by an application for a project are substantially the same as the requirements on this subject in the existing law (sec. 625).

Payments for construction or modernization (sec. 606)

This section describes the procedure for making payments to applicants with respect to their approved projects. Upon certification by the State agency, based upon inspection by it, that the applicant has earned an installment through the performance of work or the purchase of materials for a project, the installment due is to be paid. The payment is made to the State, or to the applicant if the State is not authorized to make the payments to the applicant or if the State requests that payments be made directly to the applicant. However, if the Surgeon General has reason to believe that any act, or failure to act, has occurred which might require withholding of funds under section 607, the payment may be withheld pending action under section 607, or corrective action, after the State agency has been given notice of opportunity for a hearing under that section. The total of these payments for a project may not exceed the Federal share of the cost of the project.

Subsection (b) provides that where an amendment to an application has been approved or the estimated cost of the project has been revised, any resulting additional payment with respect to the project may be made from the applicable allotment for the fiscal year in which the amendment is approved. Of course, if funds are still available from the applicable allotment for the fiscal year in which the original application was approved, payment may also be made from that allotment.

Subsections (a) and (b) are substantially the same as the provisions on the same subject in section 625(b) of the existing law. The only difference of substance is the addition of the provision permitting direct payments not only (as provided in existing law) where such payments are not authorized by State law, but also where the State requests that such payments be made directly to the applicant.

Subsection (d) would add a new provision under which not more than 2 percent of the aggregate allotments of a State for any year (but not in excess of $50,000) would be available to pay up to one-half of the cost of administration of the State plan. However, a State would be entitled to such funds only on the condition that expenditures from State sources for such purposes are at least equal to the amount so expended during fiscal year 1964.

Withholding of payments (sec. 607)

This section provides that further payments may be withheld, in whole or in part, from any State if the Surgeon General makes certain findings after affording the State agency reasonable notice and opportunity for hearing. The withholding may occur if the Surgeon General finds failure to comply substantially with any of the provisions required to be included in the State plan, or failure to carry out, or inability to carry out, any assurance required to be given in a project application, or substantial failure to carry out an approved project's plans and specifications, or, finally, failure to provide adequate State funds for administration of the State plan each year.

If the Surgeon General makes any of these findings, further payments may be withheld for all projects involving construction of the particular type of facility involved or for all types of facilities, or for only the particular project or projects affected by the action or inaction which occasioned the hearing. The withholding action, however, would not apply to any project already approved which is not directly affected by this action or inaction. The withholding would continue until there is no longer any failure to comply or, if compliance is not possible, until the State has arranged for repayment or has repaid the Federal funds to which the recipient was not entitled.

This section is the same in substance as section 632(a) of existing law with one exception. Under the existing law withholding may occur upon a finding that Federal funds have been diverted from the purposes for which they have been allotted or paid. Inasmuch as payments to a project applicant are made only after certification by the State agency that the applicant has earned the funds through purchases or performance of work, there would appear to be no need for continuing this provision.

Judicial review (sec. 608)

This section provides that the State agency through which an application for a construction or modernization project was submitted may appeal for judicial review of the Surgeon General's refusal to approve such project, and that the State may appeal for judicial review of his action withholding funds under section 607, by filing a petition with the U.S. court of appeals for the circuit in which the State is located. In such a proceeding the Surgeon General's findings of fact would be conclusive if supported by substantial evidence.

The judgment of the court of appeals would be subject to review in the Supreme Court on certiorari or certification.

This section is substantially the same as section 632(b) of the existing law, except that under the existing provision the Surgeon General's findings are conclusive unless substantially contrary to the weight of the evidence. In addition, a time limit of 60 days would be placed on the filing of a petition for review in the court of appeals.

Recovery (sec. 609)

This section provides for recovery by the United States of its proportionate share of the current value of any facility constructed with the aid of funds under this title of the Public Health Service Act if, within 20 years after construction is completed, the facility is transferred or sold to any person, agency, or organization not qualified to be an applicant for a project under this part or not approved by the State agency or its successor of if, within such period, the facility ceases to be a public or other nonprofit facility. However, this right of recovery could be waived for good cause, as determined in accordance with regulations. The bill provides, however, that this right of recovery shall not constitute a lien on the facility prior to judgment.

This section is the same in substance as section 625(e) of existing law; however, existing law does not include the authority to waive the right of recovery or the disclaimer against creation of a lien.

Loans for construction or modernization of hospitals and other medical facilities (sec. 610)

This section would authorize loans for construction or modernization of hospitals and other medical facilities in accordance with the same procedures and subject to the same limitations and conditions as would be applicable to the making of grants under this part. These loans for projects in a State could be approved only if sufficient funds are available from the State's allotment under section 602 for the type of project involved and the loans would be made from this allotment and paid directly to the applicant.

The amount of any loan, or of any loan and grant, with respect to any project could not exceed the Federal share of the cost of the project. Loans could be made for periods of up to 40 years and would bear interest at a rate arrived at by adding one-fourth of 1 percent per year 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, adjusted to the nearest one-eighth of 1 percent.

The Surgeon General could agree to modify the terms and conditions of any loan to the extent he determined it to be necessary to protect the Federal financial interest.

If, prior to repayment of a loan, the facility with respect to which it was made is transferred to any person, agency, or organization not eligible to file for a grant under this part or not approved by the State agency, or which ceases to be public or nonprofit, the unpaid balance of the loan would become due immediately; and the transferee would also be liable for payment.

This section is the same as part H (sec. 661–664) of existing title VI, except that the loan authorization in existing law expires on July 1, 1964, and the new loan provision refers to modernization as well as construction projects.

PART B—MORTGAGE INSURANCE FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

Mortgage insurance (sec. 621)

Subsection (a) of this section would authorize the Surgeon General to insure mortgages securing loans for the construction or modernization of private nonprofit hospitals and medical facilities and proprietary nursing homes.

Subsection (b) provides that a mortgage may be insured under part B only if—

(1) The application has been submitted through the State agency and has been filed jointly by the mortgagor and the mortgagee, and complies with the provisions of section 605(a)(1)–(5) requiring a description of the site, plans and specifications for the project in accordance with the Surgeon General's regulations issued under section 603, and reasonable assurance of adequate financial support, that title to the site is or will be vested in the applicant, and that prevailing local wage rates will be paid;

(2) The State agency certifies that there is a need for the project in accord with that portion of the State plan which sets forth the need for the various types of facilities and a plan for distribution of such facilities throughout the State;

(3) The application contains assurance from the mortgagor that there will be compliance with State standards for operations and maintenance which are required under section 604(a)(7);

(4) The Surgeon General approves the mortgagor as responsible and able to repay the obligation secured by the mortgage and the mortgagee as responsible and able to service the mortgage properly;

(5) The principal obligation secured by the mortgage has a maturity satisfactory to the Surgeon General but not more than 40 years, and the interest (exclusive of premium charges) does not exceed an annual rate of 5 percent (or 6 percent if found necessary to meet the mortgage market);

(6) The mortgage contains an undertaking that, except as authorized by the Surgeon General and the mortgagee, the property will be used as a hospital or other medical facility until the mortgage has been paid or the insurance otherwise terminated; and

(7) The mortgagor and the mortgagee certify that they will keep records and reports required by the Surgeon General and that the Public Health Service will have access to such records.

Subsection (c) provides that in the case of a project (other than a project for a proprietary nursing home), the maximum amount of the principal obligation secured by the mortgage would be 50 percent of the value of the facility (including other property subject to the mortgage) after completion of the project; and when added to the amount of any grant or loan under part A or under any other Federal law, 75 percent of the value of the facility upon such completion. In the case of a project for a proprietary nursing home, such maximum would be 90 percent of the facility's value after completion of the project. The value of a project would be determined by the Surgeon General.

Subsection (d) provides that the validity of a contract of insurance executed by the Surgeon General shall be incontestable in the hands of an approved mortgagee, except for fraud or misrepresentation on the part of such mortgagee.

Subsection (e) provides that the failure of the mortgagor to make any payment provided for under an insured mortgage constitutes a default, and if such default continues for 30 days the mortgagee shall be entitled to the insurance benefits upon conveyance of title to the property and assignment of all related claims. If the mortgagee has not acquired title by foreclosure or otherwise, he may assign all rights under the mortgage to the Surgeon General, and in such event the insurance benefits would be reduced by 1 percent (instead of the foreclosure and related costs which the mortgagee would have borne if he himself had acquired the title before receiving the insurance benefits). The insurance benefits include the sum of the unpaid principal and the unpaid interest on the loan at the time of default, and also interest on such sum from the date of default to the date of payment on the insurance, at the rate specified by the Secretary of the Treasury for the purpose of section 622(b) for the fiscal year during which the benefits are paid.

Subsection (g) states that forbearance for the benefit of the mortgagor is not precluded when agreed upon by the parties to the mortgage and approved by the Surgeon General, or in the enforcement of the obligation by the Surgeon General after the insurance benefits have been paid.

Subsection (g) authorizes insurance liability under this program up to a maximum aggregate amount of $250 million in fiscal 1965, and additional liability of $500 for each of the next 4 fiscal years.

Financing; medical facilities mortgage insurance fund (sec. 622)

Subsection (a)(1) would establish a medical facilities mortgage insurance fund to be available without fiscal year limitation for the mortgage insurance program. Premium charges and other funds received by the Surgeon General in connection with his operations under the program would be deposited in the fund. The fund would be utilized to pay all operating expenses, including administrative expenses authorized in appropriation acts to be paid from the fund. Moneys not needed for current operations would be invested in obligations of, or guaranteed by, the United States. Any excess capital surplus or reserves of the fund would be deposited in the Treasury as miscellaneous receipts.

Subsection (a)(2) authorizes the appropriation of $5 million in fiscal 1965, and such sums as may be necessary for the next 4 fiscal years, for transfer to the medical facilities mortgage insurance fund at the Surgeon General's direction. Sums appropriated would remain available until expended.

Subsection (b) provides that interest shall accrue to the Treasury on outstanding capital transferred to the fund from appropriations. The interest rate would be based on the current average yields of outstanding public debt obligations of the United States having maturities comparable to insured loans under this part.

Under subsection (c), if the fund is insufficient to make payments on defaulted loans, the Surgeon General would be authorized to borrow from the Treasury by issuing notes or other obligations on which interest would be paid at rates based on the current average yield of outstanding obligations of the United States of comparable maturities.

Provisions applicable to insurance (sec. 623)

Under subsection (a) the Surgeon General would fix premium charges for insurance of mortgages at rates adequate to cover expenses and probable losses, but not in excess of one-half of 1 percent per annum.

Subsection (b) would authorize the Surgeon General to prescribe regulations with the approval of the Secretary of Health, Education, and Welfare; to sue and be sued in the U.S. district courts; to include in any insurance contract such terms relating to repayment of principal and payment of interest, and relating to the obligations and rights of the parties and the Surgeon General in case of default, and such other terms as may be necessary to assure that the purposes of the program will be achieved; but the terms could be modified if the Surgeon General determines that such modification is necessary to protect the financial interest of the United States; to foreclose on property or take other legal action in connection with the insured mortgage and to dispose of property so acquired; and to consent to the release of mortgaged property from the mortgage lien. The Surgeon General would have the authority to enter into agreements to pay annual sums in lieu of taxes to State or local authorities with respect to real property acquired in carrying out his funtcions. Such agreements would only be entered into in order to pay sums in lieu of property taxes which would, in the absence of foreclosure or assignment of the property to the Surgeon General, have been paid by the property owner; there would, in general, be no basis for such an agreement in cases where the mortgaged property had enjoyed exempt status.

Subsection (c) provides that the overtime pay provisions of the Contract Work Hours Standards Act shall be applicable to contracts for work on projects insured under this part, notwithstanding the proviso in that act which excepts work performed on projects assisted by Federal insurance of mortgages from the overtime pay provisions of that act which are applicable to projects aided by Federal grants or loans when the Davis-Bacon prevailing wage provisions are applicable.

Administration (sec. 624)

This section authorizes the Surgeon General to utilize services and facilities of any Federal agency and to pay therefor in accordance with an agreement between the Secretary of Health, Education, and Welfare and the head of such agency.

PART C—GENERAL

Federal Hospital Council and advisory committees (sec. 641)

Subsection (a) of this section provides for a Federal Hospital Council to consult with the Surgeon General in administering title VI of the Public Health Service Act. The Surgeon General would be Chairman of the Council and there would be 12 members appointed by the Secretary of Health, Educa-

tion, and Welfare. Six of the twelve appointees would have to be outstanding in matters pertaining to medical facility and hospital activities; of these six, three would have to be authorities on the operation of hospitals or other types of medical service facilities, one an authority on matters relating to the mentally retarded, and one an authority on matters relating to mental health. The other six appointees would represent consumers of such hospital, clinic, and similar services, and would have to be familiar with the need for such services in urban or rural areas.

Under subsection (b), appointed members of the Council would have 4-year terms of office, except for those appointed to complete an unexpired term. No member could serve continuously for more than two terms.

The Council would, under subsection (c), meet at least once a year. The Surgeon General could also call additional meetings if he felt it necessary to do so. In addition, he would be required to call such a meeting if requested by three or more of the Council members.

Subsection (d) would authorize the Council to appoint advisory and technical committees.

Appointed Council members and members of committees would, under subsection (e), be paid up to $75 per day plus travel and subsistence expenses while serving on business of the Council or a committee.

This section is substantially the same as section 633(b) of existing law, but the maximum on the per diem pay of Council (and committee) members is increased to $75.

Conference of State agencies (sec. 642)

This section provides for conferences of representatives of State agencies responsible for administering State plans approved under title VI of the Public Health Service Act. An annual conference of representatives of all such agencies would be required. A conference of representatives of all such agencies requesting it would also be required if the request is made by at least five agencies. In addition, the Surgeon General could hold a meeting of the representatives of all or any such agencies when he deemed it necessary or proper.

This section is the same in substance as section 634 of the existing law.

State control of operations (sec. 643)

This section prohibits Federal suprevision or control over the administration, personnel maintenance, or operation of any facility aided under this title of the Public Health Service Act, except as otherwise specifically provided.

This section is the same in substance as section 635 of existing law.

Studies and demonstrations relating to coordinated use of hospital facilities (sec. 644)

Subsection (a) of this section provides for the conduct by the Surgeon General of research, experiments, and demonstrations relating to effective development and utilization of services, facilities, and resources of hospitals or other medical facilities. It would also authorize him, after consultation with the Federal Hospital Council, to make grants-in-aid to public or private nonprofit entities, institutions, or organizations for research, experimental, or demonstration projects relating to the development, utilization, or coordination of such services, facilities, or resources.

Awards for projects made in any fiscal year under this section could include such amounts (to be paid from the appropriation for that fiscal year) as the Surgeon General determines to be necessary for succeeding years for completion of the Federal participation in the project.

The total paid under this section with respect to any project for construction of facilities or acquisition of equipment could not exceed $500,000 and, except in unusual cases, could not exceed one-half of so much of the cost of the facility or equipment as the Surgeon General determines is reasonably attributable to experimental or demonstration purposes. The prevailing local wage requirement of section 605 and other appropriate provisions of that section would be applicable to construction projects under this section.

The authorized annual appropriations under this section are $10 million.

Subsection (b) of this section provides for recovery by the United States of its proportionate share of the current value of any facility constructed with the aid of funds under this section if, within 20 years after its completion, (1) the owner ceases to be a public or nonprofit institution, or (2) the facility ceases to be used for the purposes for which it was constructed or for provision

of hospital or other services for which construction projects may be approved under title VI. This subsection also provides that this right to recovery shall not constitute a lien on the facility prior to judgment.

This section is substantially the same as existing law (sec. 636), except that under present law the payments for a construction or equipment project could not exceed two-thirds of the cost attributable to experimental or demonstration purposes. The new provision authorizing grants for construction of experimental or demonstration hospitals or other medical facilities would be limited to construction or demonstration units involving experimental architectural designs or functional layout, the efficiency or economy of which can be tested or evaluated; also, as in section 609, the right of recovery could be waived for good cause shown, as determined in accordance with regulations.

Definitions (sec. 645)

State.—Subsection (a) of section 645 defines State to include the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, and the District of Columbia. This is the same as section 631(d) of existing law.

Federal share.—Subsection (b) of section 645 defines the Federal share as the proportion of the cost of a project to be paid by the United States. It also specifies the methods for determining the percentage of the cost which shall constitute the Federal share.

In the case of projects for which payments are to be made from the allotments for construction of hospitals and public health centers or for modernization of the various types of facilities, the Federal share will be determined in one of two ways. If any State desires, it may include in its State plan standards meeting certain requirements. In such a case the Federal share will be determined in accordance with these standards. These requirements are that the standards provide equitably for variations between projects on the basis of objective criteria related to the economic status of areas and such other factors as the State may desire and may be permitted by regulations. However, these standards may not provide for a Federal share of more than 66⅔ percent or less than 33⅓ percent.

If a State does not include the standards described above in its plan, its Federal share for all projects in the State will be the percentage, specified by it, between a minimum of 33⅓ percent and a maximum of either 66⅔ percent or the State's allotment percentage, whichever is lower.

In the case of projects for the construction of all other types of facilities; i.e., projects for long-term care facilities, diagnostic or treatment centers, or rehabilitation facilities, the States will have one additional choice: the single percentage, applicable to all such projects in the State, of 50 percent.

The State agency would be required to notify the Surgeon General in writing each year of the Federal shares which it had elected for projects in the State approved by the Surgeon General during such fiscal year. This notification would be given prior to the approval by the State of the first project during such fiscal year and the election would be applicable to all projects approved by the Surgeon General during the year.

This definition is the same in substance as the provisions in section 623(e) and 631(k) of existing law, except that under the existing provision relating to the variable Federal share (sec. 623(e)) the factors on which the variations are based much include the relative need for additional facilities. The provision with respect to the other factors to be considered in devising these standards is also slightly different.

Hospital.—Subsection (c) of section 645 defines this term to include general, tuberculosis, and other types of hosiptals. It also includes related facilities operated in connection with hospitals, such as laboratories, outpatient departments, nurses' home and training facilities, and central service facilities. Specifically excluded, however, would be hospitals furnishing primarily domiciliary care.

This definition differs from the definition of "hospital" in section 631(e) of the existing law because the new definition does not include mental hospitals, chronic disease hospitals (see definition of "facility for long-term care," below), and public health centers (see separate definition below).

Public Health Center.—This term is defined (in subsec. (d)) as a publicly owned facility for the provision of public health services. It also includes, if operated in connection with such a facility, other related publicly owned facilities, such as laboratories, clinics, and administrative offices.

This definition is the same as the definition in section 631(f) of existing law except for specific limitation or related facilities to those which are publicly owned.

Nonprofit.—Subsection (e) of section 645 defines the term "nonprofit" as applied to any facility to mean 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.

This is the same in substance as the definition in the existing section 631(g).

Proprietary nursing home.—Subsection (f) defines the term "proprietary nursing home" to mean a facility which is not nonprofit and which is for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care but who require skilled nursing care and related medical services. Such nursing care and medical services must be prescribed by, or performed under the general direction of, persons licensed to provide such care or services in accordance with State law.

Diagnostic or treatment center.—Subsection (g) of section 645 defines this term as a facility for the diagnosis or 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. In the case of dental diagnosis and treatment, patient care must be under the professional supervision of persons licensed to practice dentistry in the State.

This definition is the same as the definition in section 631(l) of existing law.

Rehabilitation facility.—This term is defined (subsec. (h)) as a facility operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical evaluation and services and psychological, social, or vocational evaluation and services, which are rendered under competent professional supervision and in the case of which—

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

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

This definition is the same as the definition in section 631(n) of existing law.

Facility for long-term care.—This facility is defined (in subsec. (i)) as one providing inpatient care for convalescent or chronic disease patients requiring skilled nursing care and related medical services, but only if it is a hospital other than a hospital primarily for the care and treatment of mentally ill or tuberculosis patients or is operated in connection with a hospital or is a facility in which the nursing care and medical services are prescribed by, or are performed under the direction of, a person licensed to practice medicine or surgery in the State.

This definition is a combination of the definition of "hospital for the chronically ill and impaired" and the definition of "nursing home" in subsections (m) and (o), respectively, of the existing section 631, with differences due primarily to the combination of the two.

Construction.—Subsection (j) of section 645 defines this term as including the construction of new buildings, expansion, remodeling, and alteration of existing buildings. It also includes the initial equipment of any such buildings (including medical transportation facilities) and replacement of obsolete built-in (as determined in accordance with regulations) equipment in any of such existing buildings, as well as architects' fees. Excluded, however, are the cost of off-site improvements and, except with respect to public health centers, the cost of the acquisition of land.

This definition is the same as the definition in section 631(h) of existing law.

Cost.—Subsection (k) of section 645 defines the term "cost" as applied to construction or modernization to mean the amount found by the Surgeon General to be necessary for construction or modernization of a project. However, any amount found by the Surgeon General to be attributable to expansion of the bed capacity of a facility could not be included in the cost of a modernization project.

Modernization.—This term is defined (subsec. (l)) to include (in addition to modernization) alteration, major repair (to the extent permitted in regulations), remodeling, replacement, and renovation of existing buildings. It also includes initial equipment and replacement of obsolete built-in (as determined in accordance with regulations) equipment of any such buildings.

Title.—Subsection (k) defines the term title, when used with reference to a site for a project, as a fee simple or any other estate or interest (including a leasehold if the rental therefor does not exceed 4 percent of the land's value) which the Surgeon General finds sufficient to assure at least 50 years' undisturbed use and possession for the project.

This is the same as the definition in section 631(j) of the existing law.

Mortgage.—The term "mortgage" is defined in subsection (n) to mean a first mortgage (1) on real estate, in fee simple, or (2) on such other estate or interest (including a leasehold on which the rental does not exceed 4 percent of the land's value) as the Surgeon General finds sufficient to secure the mortgage debt and to assure, for a period of at least 50 years from the execution date of the mortgage, undisturbed use and possession for the project. The term "first mortgage" is defined to mean such classes of first liens as are commonly given to secure advances on, or the unpaid purchase price of, real estate under State law, together with any credit instrument secured thereby, and any such mortgage may create a security interest in initial equipment, whether or not attached to the realty.

Mortgagee.—Subsection (o) provides that the term "mortgagee" shall include the original lender under a mortgage, and his or its successors and assigns, and the holders of credit instruments issued under a trust mortgage or deed of trust who act by and through a trustee named therein.

Mortgagor.—Subsection (p) provides that the term "mortgagor" shall include the original borrower under a mortgage and its successors and assigns.

EFFECTIVE DATES

Section 3(b) of the bill provides the effective dates for the revision of title VI of the Public Health Service Act which would be effected by section 3(a) of the bill.

The revision would in general be effective upon the date of enactment. However, applications approved by the Surgeon General under the existing law prior to such date, and allotments of sums appropriated prior to such date, would be governed by the existing law. In addition, the allotment percentages which would otherwise be promulgated by the Surgeon General for purposes of title VI of the Public Health Service Act during 1962 will be effective for fiscal year 1965. The terms of office of the members of the Federal Hospital Council who are serving on the Council on the date of enactment will expire on the date they would have expired if this bill had not been enacted. This will assure continuation of the staggering of the terms of office of present members of the Council. An application for a modernization project may not be approved before January 1, 1965, and may be approved after such date only if the requirements of section 604 (with respect to the State plan) have been met, including the requirement that the State plan set forth the extent to which existing hospitals and other medical facilities are in need of modernization.

Section 3(c) of the bill provides that no application for insurance with respect to a mortgage on a nursing home under section 232 of the National Housing Act (12 U.S.C. 1715w) shall be approved by the Federal Housing Commissioner unless such application is filed before the close of the sixth month after enactment. (This would permit the Federal Housing Administration to process applications on which work has been done preparatory to the actual filing thereof.) In connection with the transfer of the mortgage insurance program for proprietary nursing homes to the Public Health Service, as part of the new mortgage insurance program which this bill would authorize, it should be noted that the present provisions in section 232 of the National Housing Act which require State or local standards of licensure and methods of operation and assurance of enforcement with respect to such nursing homes would be replaced by the requirement in section 604(a)(4)(7) that States provide and enforce minimum standards of maintenance and operation and the requirement that the applicant give assurance of compliance with such standards. These requirements will be applicable to all projects assisted or provided mortgage insurance under title VI (including private nonprofit facilities for long-term care).

Section 3(d) of the bill contains amendments to various Federal laws applicable to banking or other investing institutions operated or regulated by the Federal Government or the District of Columbia, and an amendment to the Bankruptcy Act, which amendments would accord the same status to loans

secured by mortgages insured under the bill as that accorded to loans secured under other Federal loan insurance programs.

The CHAIRMAN. We are glad to have the Secretary with us this morning. Mr. Secretary, we welcome you back to this committee. We realize fully the importance of this program and the difficulties that we are having with it, but we do observe the tremendous accomplishments of it over the past several years throughout the United States. We will be glad to have your presentation. In the meantime, before you start, it might be helpful for the record if you would identify your associates this morning who have assisted you in the development of the proposal.

STATEMENT OF HON. ANTHONY J. CELEBREZZE, SECRETARY; ACCOMPANIED BY WILBUR J. COHEN, ASSISTANT SECRETARY (FOR LEGISLATION); BOISFEUILLET JONES, SPECIAL ASSISTANT TO THE SECRETARY (HEALTH AND MEDICAL AFFAIRS); DR. DAVID E. PRICE, ACTING SURGEON GENERAL, PUBLIC HEALTH SERVICE; DR. HARALD M. GRANING, CHIEF, DIVISION OF HOSPITAL AND MEDICAL FACILITIES, BUREAU OF STATE SERVICES, PUBLIC HEALTH SERVICE; AND WILLIAM B. BURLEIGH, SPECIAL ASSISTANT, DIVISION OF HOSPITAL AND MEDICAL FACILITIES, BUREAU OF STATE SERVICES, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Secretary CELEBREZZE. Mr. Chairman, I have with me this morning Wilbur J. Cohen, Assistant Secretary; Boisfeuillet Jones, Special Assistant to the Secretary (Health and Medical Affairs); Dr. David E. Price, Acting Surgeon General; Dr. Harold M. Graning, Chief, Division of Hospital and Medical Facilities of the Bureau of State Services of the Public Health Service; and William B. Burleigh, Special Assistant, Division of Hospital and Medical Facilities, Bureau of State Services of the Public Health Service.

Mr. Chairman, if it pleases the committee, I would like permission to present my opening statement in full.

The CHAIRMAN. You may proceed.

Secretary CELEBREZZE. I am pleased to have the opportunity to appear before you today regarding H.R. 10041, the Hospital and Medical Facilities Amendments of 1964, introduced by the distinguished chairman of this committee, Mr. Harris.

The bill, which is identical in most major respects to the draft bill submitted by the administration to the Congress, proposes to enlarge the Hill-Burton program of Federal aid for the construction of health facilities and to authorize operation of the revised program for an additional 5 years.

The great success of this program over the last 17 years speaks for itself. It is one of the most widely known and well-accepted programs of the Department of Health, Education, and Welfare. Enactment of the Hill-Burton legislation in August 1946 marked the beginning of a national policy recognizing the responsibility of the Federal Government to assist in the construction of needed hospital and other health facilities throughout the land. These facilities are now a part

of our national resources and are essential to the growth and strength of the country.

It has helped to improve the health of our citizens in a very practical way—by assisting communities to plan and build needed hospitals and other health facilities. It has accomplished this by relying primarily on the States for direct administration and supervision of the program and on community initiative for the design and construction of the facilities.

The Federal Government sets the broad requirements and relies on the States for the initial selection of projects. The results of this combination of a worthwhile program and local initiative can be measured by the modern and efficient hospitals which have been built throughout the country, particularly in smaller towns and rural areas.

As of June 30, 1963, a total of 6,810 Hill-Burton projects had been approved. The total cost of these projects is $6.19 billion, involving Federal funds in the amount of $1.96 billion. These funds have been transformed into 290,000 general, mental, tuberculosis, and chronic-disease hospital and nursing-home beds.

In addition, Hill-Burton funds have helped construct 1,992 rehabilitation facilities, public health centers, diagnostic and treatment centers, and State health laboratories.

In 1948, for example, this country had only 59 percent of the general hospital beds it needed—today, 83 percent of current need has been met. But State agencies report that we still need 133,000 additional new beds if the Nation's requirements are to be adequately met.

Systematic planning of hospitals and other medical facilities has been undertaken in this country on a continuing basis as a result of the Hill-Burton program. It has stimulated improved hospital design and construction, raised State licensing standards for maintenance and operation and for construction and equipment, and encouraged efficient and economical care through coordinated planning for hospitals and other health facilities.

Further, by encouraging more even distribution of health facilities throughout the country, the program has helped attract vitally needed physicians and other health specialists to rural areas.

Despite these gains in improving and expanding the Nation's health facilities, many unfinished tasks remain. Our hospitals have to keep pace with a constantly expanding and shifting population. Serious shortages still exist in many fast-growing suburbs, in the central cities of metropolitan areas, and in some sparsely settled rural areas. Older hospitals in our cities are deteriorating at a disturbing rate.

New concepts of treatment and care require new kinds of facilities to provide services to the aging and the chronically ill. Changes in our society have occurred which should be reflected through program emphasis and direction in the Hill-Burton program. Since the Hill-Burton authorization expires this coming June 30, 1964, we should adjust its provisions to meet additional needs and extend its life for an additional period of years. The bill before you proposed to extend the program to June 30, 1969.

During the last session of the Congress, we saw the enactment of legislation to develop the facilities so badly needed for the mentally retarded and the mentally ill. The proposed amendments to the Hill-Burton legislation will help close other significant gaps in our plan-

ning and health-facility needs. I should like now to review briefly each of the major amendments contained in the bill and explain why I think they will extend and expand the Hill-Burton program to meet the changing health needs of the Nation.

Under planning, because of the number and variety of facilities, services, and organizations in most communities today, which are concerned with the health of their citizens, no community facility stands alone. It is part of an interrelated and interdependent web of facilities and services. The program decisions of one organization frequently influence the program needs and decisions of several others. Organizations and consumer groups can react and accommodate themselves as best they can to the decisions of other organizations, or they can come together and agree on some common approach to their problems. Areawide health-facility planning is a mechanism for achieving this goal.

While State-level planning has improved significantly under the Hill-Burton program, most Hill-Burton State agencies are not staffed or equipped to coordinate or conduct detailed planning in metropolitan areas and apply the complex planning techniques which have evolved in recent years.

Accordingly, more planning must be developed in regions, metropolitan areas, and local areas to implement plans for the construction and coordination of health facilities.

Proper planning is the best guarantee that large sums of capital funds—Federal, State, and local—are spent wisely. Approximately $1.5 billion is spent annually for construction of health facilities. For these reasons, the bill authorizes $45 million over a 5-year period for special project grants to responsible groups in communities and metropolitan areas for comprehensive planning of health facilities.

A limited amount of aid has been provided to some communities in the last 3 years to demonstrate the role and feasibility of areawide health-facility planning agencies. The response from communities and from those in the hospital field, we feel, justifies going forward on a more formal basis.

In other words, the areawide planning agency is no longer a hopeful experiment but an accomplished fact that has demonstrated its value in almost 30 major metropolitan areas.

Sponsorship by the Public Health Service of the development of areawide health-facility planning agencies represents in my opinion, an effective effort by the Federal Government to encourage maximum value received for each health-facility dollar expended.

Under the terms of the bill, $5 million would be authorized during fiscal year 1965 and $10 million for each of the next 4 fiscal years. Public and nonprofit agencies and organizations would be eligible for grants paying up to two-thirds of the cost of an approved project. However, the Surgeon General may, if he feels it is necessary to stimulate the local planning agency, make a grant of a larger percentage of the cost during the first 3 years of the project.

In keeping with the philosophy of the Hill-Burton program of State responsibility and to assure statewide coordination, the bill provides that a planning grant will be made only if it has been first approved by the State Hill-Burton agency.

Not only should each health facility be related to the whole network of health facilities and services in the community and metropolitan area, but it should also be planned in relation to the neighborhood, community, and urban area in which it is located.

Therefore, the Surgeon General will take steps to assure that health facilities and services are developed in close coordination with plans and planning for the general development of communities and metropolitan areas.

In addition, we recognize the need for coordinated efforts by Federal agencies and plan to take all appropriate steps to assure coordination with other Federal programs which are related to ours.

In the area of modernization, in spite of the success of the Hill-Burton program in bringing needed health facilities to many areas, an additional serious growing problem has emerged which needs to be met. Many of our big city hospitals are becoming obsolete and increasingly inefficient to operate. Yet these are the hospitals on which we rely for specialized services and for setting standards of quality care. These are the hospitals which conduct research, put into practice the latest advance in medical science, and help train our future health specialists. They are, in short, the cornerstone of quality hospital care.

There is no more urgent need in the hospital field today than the modernization of these facilities. A 1960 Public Health Service study indicated that it would cost an estimated $3.6 billion just to modernize and replace existing hospitals without attempting to construct additional beds. This estimate, undoubtedly, would exceed $4 billion today.

The bill would authorize, beginning July 1, 1965, a program of grants to States for needed modernization of public and nonprofit hospitals and other medical facilities. The amount of Federal funds authorized to be allocated to the States for modernization is set forth in the bill as a specific fraction of the total annual sums appropriated for new hospital and public health center construction and for modernization.

Over a 5-year period, $840 million would be authorized for both programs. The bill, for example, provides that one-eighth of the amount appropriated for the fiscal year beginning July 1, 1965, would be allotted to the States for modernization of hospitals and public health centers. Thus, if the full authorization of $160 million were appropriated in that fiscal year, $20 million—that is, one-eighth of $160 million—would be available for modernization and $140 million for new hospital construction. Each year slightly larger fractions are specified in the bill for modernization.

The bill would also authorize a State to request the Surgeon General to transfer a specified fraction of its modernization allotment each year to its allotment for new hospital construction if the State Hill-Burton agency certifies that the need for new hospitals and public health centers is substantially greater than the need for modernization of health facilities. The fraction of a State's modernization allotment which could be transferred each year is one-half in fiscal year 1966, three-sevenths in 1967, two-fifths in 1968, and five-elevenths in 1969.

Funds for modernization would be allocated to States according to a formula based on population, extent of need for modernization, and the financial need of the respective States. Each State would receive an annual allotment of at least $200,000, except that the Virgin Islands, American Samoa, and Guam would be eligible to receive a minimum allotment of $100,000.

The extent of Federal participation would range between one-third and two-thirds of the eligible costs of an approved project, with the exact Federal share to be set by the State agency each year. The program would be administered by the existing State Hill-Burton agencies which, as under the present law, would develop a plan, establish a priority system based on the relative need for modernization among projects, select projects and recommend them for approval, and maintain surveillance over projects under construction.

The financing provisions outlined above for the modernization program differ from those in the administration's draft bill submitted to the Congress. The administration's proposal would authorize a separate category of funds for modernization of $50 million for the first year, $60 million for the second year, $70 million for the third year, and $80 million for the fourth and fifth years, totaling $340 million over a 5-year period.

In contrast, the bill under consideration would authorize funds for modernization beginning with $20 million in the second year, $35 million in the third year, $50 million in the fourth year, and $55 million in the fifth year, totaling $160 million over a 4-year period.

The CHAIRMAN. Mr. Secretary, I think it would be appropriate to interrupt at this point so we can complete the story on this particular change which I mentioned in my opening statement. I am not going to interrupt you to get into questions at this time, but to clear this point just a little bit so the record will be clear and so the members can get a full understanding of the change that was made.

Under present law, and as it has been administered for several years, there has been a total of $150 million a year for hospital construction under what is called the Hill-Burton program.

Now, you propose, as you have just explained here, that $100 million be carried on for this purpose under the present formula and that the $50 million, a third of what has been the total heretofore, be allocated to a modernization program under a different formula.

Secretary CELEBREZZE. That is correct.

The CHAIRMAN. Do I state it correctly?

Secretary CELEBREZZE. That is correct. I think, Congressman, we should start with the assumption that the total amount appropriated, either under the Harris bill or under the administration bill, is the same. It is $150 million.

The CHAIRMAN. Yes, but $100 million of it carries out the program under the formula that we have had all these years.

Secretary CELEBREZZE. Yes, that is correct.

The CHAIRMAN. And $50 million would be under a new formula which we have added.

Secretary CELEBREZZE. Yes.

The CHAIRMAN. The bill would maintain the $150 million authorization, as you have just stated. It would start with the $150 million under present law and under the formula of the present law. Then in

the second year it would reduce that amount to $140 million under this formula.

Secretary CELEBREZZE. That is right.

The CHAIRMAN. It would authorize an additional $20 million under the new proposed formula, but with an additional proviso that $10 million of that may be transferred for construction under the present Hill-Burton program under the new formula.

Secretary CELEBREZZE. That is right.

The CHAIRMAN. I hope my colleagues get this. It is a little difficult at first to understand, but when you do understand it it is very easy.

In the third year the $150 million that has been carried on is reduced to $135 million, isn't it?

Secretary CELEBREZZE. That is right.

The CHAIRMAN. Then the modernization is increased to $35 million. Then of that $35 million, $15 million of it under the new formula could be transferred if so desired by the States for the construction of hospitals.

Secretary CELEBREZZE. Yes, that is right.

The CHAIRMAN. Without being used for the modernization program.

Secretary CELEBREZZE. Yes, that is correct.

The CHAIRMAN. Which by this graduated change maintains the level of $150 million, though a part of it as it goes on would be under the new formula and the major part under the old formula.

Secretary CELEBREZZE. That is correct.

The CHAIRMAN. That is what I wanted explained to the members of the committee so we would have this in mind for our own consideration as we continue with the hearings and ultimately consider what the committee would like to do about it.

Secretary CELEBREZZE. Projects for modernization are eligible under the present Hill-Burton program. However, the allotment formula and the priority principles contained in the existing law have favored rural areas on the basis of their relatively greater need for additional beds. The creation of a separate authorization for modernization is highly desirable because it provides greater assurance of meeting our needs for a modern hospital system.

While urban areas tend to show a relatively high level of available beds, the beds are often in increasingly obsolete and undesirable facilities. Because of the legislative formula under existing law, priorities for Hill-Burton funds in these areas are often very low. It is preferable, therefore, to assure the fiscal and program identity of modernization funds by providing for their appropriation as a separate category.

Under long-term care facilities, in the vast majority of States, there is a shortage of long-term care facilities. This must be corrected if we are to minimize the utilization of expensive general hospital beds by chronic-disease patients and achieve adequate care and treatment for these patients at more reasonable rates. State Hill-Burton agencies report that over 530,000 additional long-term care beds are required.

The future will present even more serious deficiencies unless action is taken. In 1960, the population aged 65 and older numbered nearly

17 million. By 1980, the elderly group will probably exceed 24 million. Special effort is needed, therefore, not only to correct present deficiencies but also to prevent the gap between existing and needed facilities from widening as the numbers of aged increase. Additional long-term care facilities will tend to ease the pressures for hospital beds in some areas by permitting chronic-disease patients to be cared for in nursing homes rather than in expensive hospital beds.

The bill proposes to combine the two existing categories in the Hill-Burton legislation for chronic-disease hospitals and nursing homes into a new category entitled "Long-term care facilities." The present annual appropriation ceiling of $20 million for each of the categories would also be combined and increased to $70 million annually.

Separate categories for chronic-disease hospitals and nursing homes have tended to create and perpetuate an artificial distinction between the two types of long-term care facilities. Combining the two categories would stimulate States to focus attention on the total service and facility requirements of the aged while affording them maximum flexibility to encourage community planning of facilities most appropriate to local needs.

A relatively small number of long-term care beds—slightly over 40,000—have been built under the Hill-Burton program. The current annual Federal expenditures of $40 million for long-term care facilities produce 8,000 beds annually, which by themselves are not enough to keep up with increases in our aged population. Increasing Federal expenditures for long-term care facilities to $70 million would produce about 15,000 beds annually. This when combined with the estimated 30,000 long-term care beds constructed outside the program each year, would produce a total of 45,000 beds which is enough to keep up with population increases and the obsolescence rate and also reduce the backlog by more than 26,000 beds each year.

Mortgage insurance for hospital and medical facility construction: In spite of the grant programs authorized by the Congress through the years, the demands for Hill-Burton grant funds will inevitably exceed the amounts available for needed construction. Many worthwhile projects, therefore, will fail to be built unless the necessary funds can be found elsewhere.

Also, in some areas nonprofit organizations have been unable to raise sufficient local matching funds when Hill-Burton grants were available.

In some instances loans may not be available from private sources. In others, only short-term loans calling for large annual payments of principal and interest may be obtained. Such loans can threaten the financial soundness of some health facilities or force sharp increases in the already spiraling costs of hospital care.

We anticipate, for example, that, as large hospitals in urban areas undertake essential modernization, they will find it necessary, in many instances, to finance a significant portion of their expenditures from private lending sources. Experience in the Hill-Burton program, however, has shown that relatively few health facilities have been able to obtain long-term loans for construction purposes. The average term of such loans has been 14 years for general hospitals and 12.5 years for nursing homes.

The bill would alleviate this situation by authorizing as of July 1, 1964, the creation of a mortgage loan insurance program for the construction or modernization of private nonprofit hospitals, nursing homes, and other medical facilities.

To improve coordination of Federal health programs, it is also desirable to place within a single health-oriented agency responsibility for Federal financial assistance programs for the construction of health facilities. The bill, therefore, would authorize the Surgeon General to guarantee private loans made in connection with the construction of proprietary nursing homes, and would in effect, transfer the present mortgage insurance program for proprietary nursing homes from the Federal Housing Administration.

The bill would authorize during the first fiscal year a maximum aggregate amount of outstanding insurance liability not exceeding $250 million. This amount would be increased by annual increments of $500 million on July 1, 1965, and on July 1 of each of the next 3 years.

The amount of the principal obligation secured by a mortgage could not, in the case of a project sponsored by a public or nonprofit facility, exceed 50 percent of the value of the completed facility. When a Federal grant or loan is approved in connection with an insured loan, the total may not exceed 75 percent of the value of the completed facility. If the loan to be insured will be used to construct a proprietary nursing home, however, the amount of the principal obligation may be as much as 90 percent of the value of the completed facility. This latter percentage is identical to that now set by the FHA insurance program for proprietary nursing homes.

The maximum interest rate to be charged could not exceed 5 percent per annum, except, in order to meet the mortgage market, it could be increased to a rate not in excess of 6 percent. The maximum length of an insured loan could not exceed 40 years.

A premium not exceeding one-half of 1 percent per annum would be charged to the mortgagee for insuring a loan. The bill contains provisions designed to assure that the facilities built with the aid of mortgage insurance will meet required construction standards, will be consistent with the plans of designated State agencies, and that the Hill-Burton State agency has determined that the project is needed.

The bill authorizes an appropriation of $5 million for the first fiscal year and such additional sums as may be needed for each of the next 4 years for making payments in connection with possible insured loan defaults and for administrative expenses.

Two other amendments to the existing legislation which should be mentioned briefly are:

First, the bill would delete the requirement that a private nonprofit diagnostic or treatment center must be sponsored by a corporation or association which owns and operates a nonprofit hospital. From time to time the present provision has prevented the approval of worthwhile construction projects in areas where they were very much needed to meet community requirements.

The second amendment is in keeping with repeated requests from State agencies. It would permit those States which wish to do so to request the Public Health Service to earmark up to 2 percent of the construction funds allocated to that State or $50,000, whichever is less. The State agency would receive such funds upon submittal of

a plan indicating their proposed utilization for the proper and effective administration of the State plan.

Any payment would be made on condition that the State would expend State funds to administer the Hill-Burton plan in an amount not less than the total amount expended by the State for that purpose during the fiscal year ending June 30, 1964.

This latter provision would prevent the substitution of Federal funds for State funds. This amendment is important to the continued successful role of State agencies in the Hill-Burton program and would enable them to assume greater responsibility in planning and administering their programs.

Nondiscrimination provisions: Since its inception, the Hill-Burton Act has contained a provision that a "State plan shall provide for adequate hospital facilities for the people residing in a State, without discrimination on account of race, creed, or color."

However, the statute also contains a provision authorizing construction with Hill-Burton aid of separate facilities for separate population groups if the State plan makes equitable provision on the basis of need for facilities and services of like quality for each population group.

H.R. 10041 proposes to eliminate the "separate but equal" provision of the Hill-Burton legislation and to require that the State plan shall provide for adequate facilities "for all persons residing in the State." It would authorize a requirement that the "facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant."

We should much prefer the language of the administration proposal, that is, "without discrimination on account of race, creed, or color," because we feel it more clearly expresses the national policy on this matter.

Any consideration of this question must be made in the light of the recent decision of the Fourth Circuit Court of Appeals in the case of *Simkins* v. *Moses H. Cone Memorial Hospital.* Just last week the U.S. Supreme Court refused to review this decision which declared that the "separate but equal" provision of the Hill-Burton Act is unconstitutional and which established the right of individuals as well as physicians and dentists to obtain injunctive relief against the denial, on the grounds of race, creed, or color, of admission of individuals as patients or of staff privileges to physicians or dentists in non-Government hospitals aided by Hill-Burton funds.

This court decision states the public policy which now guides us in this program. When the court of appeals decision was first handed down, I directed that no further "separate but equal" facilities be approved.

Following last week's action by the Supreme Court, I directed that the following additional steps be taken:

(1) That we make permanent the earlier decision to approve no new applications under the "separate but equal" provision of the law;

(2) That we require a nondiscrimination assurance in admittance from those pending projects previously approved on a "separate but equal" basis;

(3) That we seek from all pending projects an assurance that there will be no discrimination on the basis of race, creed, or color in granting staff privileges; and

(4) That the application forms to be used hereafter be amended to require of all applicants whose application has not been finally approved a nondiscrimination assurance covering staff privileges and admissions, and that all portions and services of the facilities be made available without discrimination on account of race, creed, or color.

Finally, Mr. Chairman, consideration is being given to calling a meeting of the leaders in organized medicine, in the hospital and other appropriate health fields, with the view toward implementing a program for voluntary compliance with these policies. I would hope that such a voluntary program would encompass not only Hill-Burton hospital facilities but all hospitals in the United States.

Our urgent responsibility is to assure adequate health care to all Americans. I would think that none would deny that consideration of race or color has no place with regard to the ailing body or the healing hand. I believe we have an opportunity to demonstrate a constructive and positive approach to assuring equal opportunity in this important area of health care that will have wide significance in these changing times.

Mr. Chairman, we urge your favorable consideration of legislation improving and extending the Hill-Burton program, and, in particular, that H.R. 10041 be amended to include the administration's proposals in regard to new construction, modernization, and nondiscrimination in the use of Hill-Burton facilities. I shall be pleased to answer any question submitted by the committee.

The CHAIRMAN. Mr. Secretary, in view of the facts of life which you have just recognized in your statement, and which have been called to the attention of all of the American people by the decision of the Supreme Court in its refusal to accept the case of North Carolina, this business of discrimination is completely moot, isn't it?

Secretary CELEBREZZE. In the laying down of the *Simkins* decision, together with other restrictions, I don't know whether it is a moot question. I think we had to take some action also in assurance, but I think that basically we have no alternative but to follow the decision of the *Simkins* case here.

The CHAIRMAN. In other words, the matter has been settled.

Secretary CELEBREZZE. The matter has been settled by the courts.

The CHAIRMAN. The law is the law.

Secretary CELEBREZZE. That is right.

The CHAIRMAN. And you had taken action even before the Supreme Court denied certiorari.

Secretary CELEBREZZE. Yes. I had to take action.

The CHAIRMAN. Why should we get into a fuss and argument? Even though I don't agree with the Supreme Court decision and I am not in accord, as you know, with some of the matters regarding the civil rights proposal, nevertheless, that happens to be the law today, isn't it?

Secretary CELEBREZZE. That is right. I merely called it to the committee's attention so that the committee was fully informed of what action the administration has taken.

The CHAIRMAN. However, there is no particular reason for us to get into any dogfight because of controversy over that question here now, is there?

Secretary CELEBREZZE. No. If it is the law of the land it becomes the law and there isn't much we can do about it. The courts have spoken on it.

The CHAIRMAN. Therefore it seems to me the language in the bill with reference to this particular item should satisfy the situation.

Secretary CELEBREZZE. Except that we feel that the words should be kept in the bill, "without regard to race, creed, or color."

The CHAIRMAN. I know you feel that way, but it doesn't add anything, does it, except your feelings.

Secretary CELEBREZZE. No; I think it makes it more explicit. Did you say my feelings?

The CHAIRMAN. I said it didn't add anything except your feelings. You said you feel that it should be included. I said it doesn't add anything except your feelings.

Secretary CELEBREZZE. When I use the word "feeling" I am using it it a broad sense as a lawyer uses it.

The CHAIRMAN. I use it in that sense too. The point I am trying to suggest for the record here is that I see no reason, in this sensitive, touchy area, when it has been decided for us, to take a lot of time arguing about a moot question.

Secretary CELEBREZZE. I am fearful, Mr. Chairman, that in the administration of the Harris bill which omits the words, "without regard to race, creed, or color" that we are getting into an area, a much, much broader area, as to the definition of what is meant: Do you mean that the hospitals then should include professional people which they do not include now?

I am talking about osteopaths, or the other professional group. Is that what you mean? When you button discrimination down to the three causes, then we are guided by those three causes—you can't discriminate because of race, creed, or color.

The way it is in the present bill I think it would be rather difficult to draw the line as to what is meant by discrimination and I think that is the reason for defining it and limiting it to the three categories.

The CHAIRMAN. I suggest you are just asking for a fuss; that is all there is to it. If you read the decision in the circuit court appeals case, I believe it is the circuit court of appeals, in Mississippi in connection with the Airport Construction Act I think it would relieve your mind completely as to what the present law is.

The other matter where there is a change from the bill that you originally sent up has to do with the formula. I am a little bit surprised that you are saying to the committee that you want to go back to your language because I would recall to your mind that in the discussion of this matter with your people in trying to get to a resolution of it on the modernization the proposal was made by your own staff of what is contained in the bill and I accepted it.

Secretary CELEBREZZE. Are you referring now to modernization?

The CHAIRMAN. The language in the present bill, trying to resolve the differences which have been raised about the change of the formula for modernization versus construction of new hospitals. In an effort to arrive at some satisfactory solution to the problem—I will just put

it from my standpoint—the suggestion of this particular change was made in our discussions with your staff, and they went back and considered it and brought it back and said it was satisfactory, and I introduced the bill, feeling it was satisfactory.

If I was mistaken I want the record to show that very clearly.

Secretary CELEBREZZE. Are you referring now, Mr. Chairman, to the amounts to be allocated?

The CHAIRMAN. I am referring to the amounts contained in the bill for the extension of the present Hospital Construction Act under the existing formula with the modernization formula beginning with the second year on a graduated basis as compared with what you sent up originally with the total program to be reduced under the Hill-Burton program by one-third, that amount to go into modernization under the new formula.

Secretary CELEBREZZE. The bill as submitted by the administration, Mr. Harris, called for maintaining the present level of expenditure under Hill-Burton at the rate of $150 million. We divided that by taking $50 million of the $150 million and placing it—I am referring to the administration bill—in a special category for modernization, so we would have $100 million under the existing Hill-Burton, and $50 million for modernization, increasing over a 5-year period.

The formula as contained in the Harris bill calls also for the total expenditure of $150 million. However, under the Harris bill there would be no allocation for modernization in the first year. There would be a declining rate of modernization from that proposed by the administration in the administration bill in the second, third, and fourth years. Under your bill you would expend a total, as I recall, of $160 million over a 4-year period for modernization purposes.

Under the administration bill we would allocate $340 million for modernization over a 5-year period. That was the administration proposal, Mr. Chairman, originally.

The CHAIRMAN. That is exactly right, and what I am saying, though, for the record and information of all of us, is that what is included in the bill that you referred to as the Harris bill was a suggested formula as a result of the conference I had with your staff which took the proposal and considered it and came back and told me it was satisfactory.

Secretary CELEBREZZE. If that is what the chairman was informed, I will abide by that decision.

The CHAIRMAN. What I want to do is to be sure that we have an understanding about it. If I had had a misunderstanding at the time I introduced it I would want to know it now because, after all, what we want to do here is devise the best possible program that we can. We all want the best possible program that we can get through to meet the greatest posible need.

Secretary CELEBREZZE. Yes; that is our basic concern.

The CHAIRMAN. I didn't bring this up for discussion to embarrass anybody, not myself or anybody else, but I do think under the circumstances, in view of the presentation, we should know what the entire background of this thing is for our consideration so we can come up, I hope, with the best possible program.

Mr. Springer.

Mr. SPRINGER. Mr. Secretary, I think you made an excellent statement here of your position and also the suggested new amendments. What I want to do first is to find out where this bill differs from Hill-Burton legislation thus far enacted. What I want to know first is what are the new provisions.

Secretary CELEBREZZE. The new provisions I covered in my opening statement, but let me run them down for you.

First of all, it extends the present bill for 5 years.

Mr. SPRINGER. What term did the old legislation cover?

Secretary CELEBREZZE. The old legislation was for 5 years. At one time we extended it for 3 years instead of 5 years.

Mr. SPRINGER. That is the same.

Secretary CELEBREZZE. Yes.

Mr. SPRINGER. How much is the amount? What is the difference in the amount?

Secretary CELEBREZZE. It reduces the appropriations authorization for new hospitals begininng with fiscal year 1965 from $150 to $100 million.

Mr. SPRINGER. You are talking about the administration bill?

Secretary CELEBREZZE. I am talking about the administration bill.

Mr. BROTZMAN. Would the gentleman yield? I didn't get those figures.

Mr. SPRINGER. Mr. Secretary, would you repeat those for some of the committee?

Secretary CELEBREZZE. Yes. It reduces the appropriation authorization for new hospitals beginning with the fiscal year 1965 from $150 to $100 million and adds a new 5-year program of grants to the States for hospital modernization, principally in urban areas, with $50 million in the first year, 1965, $60 milloin in the second year, $70 million in the third year, and $80 million in the fourth and fifth years.

That is the administration proposal. Do you want a comparison with the Harris bill?

Mr. SPRINGER. Mr. Secretary, $50, $60, $70, $80, and $80 million?

Secretary CELEBREZZE. Yes.

Mr. SPRINGER. How much or what percentage of the modernization funds suggested under your bill may be transferred to the old Hill-Burton formula?

Secretary CELEBREZZE. None. They would be placed in a special category for modernization only.

Mr. SPRINGER. And that would mean then by the time you got to the fifth year all that would be left of Hill-Burton would be $70 million?

Secretary CELEBREZZE. No, no. It would remain at $100 million because you appropriate $100 million for that purpose.

Mr. SPRINGER. It would stay at $100 million.

Secretary CELEBREZZE. Yes.

Mr. SPRINGER. What you are in effect doing is each year you are adding to the modernization.

Secretary CELEBREZZE. That is right.

Mr. SPRINGER. Your bill would cost how much more than the Harris bill?

Secretary CELEBREZZE. The Harris bill would cost for modernization $160 million. Our bill would cost $340 million, so that is $180 million more.

Mr. SPRINGER. Per year?

Secretary CELEBREZZE. The total cost is the same, though.

Mr. SPRINGER. How much more would your bill cost over the 5-year period than Mr. Harris' bill?

Secretary CELEBREZZE. The total cost of the bills is the same. It is just the matter of how much we appropriate to the modernization program that would be different. The total overall budget is the same.

Mr. SPRINGER. Under the administration plan none of that $150 million that you have set aside for modernization could be transferred to the old Hill-Burton formula?

Secretary CELEBREZZE. No; we didn't set aside $150 million. We set aside $50 million the first year, working on up. The $100 million stays under the Hill-Burton program. None of the $50 million for modernization can be transferred back to Hill-Burton.

Mr. SPRINGER. Under which bill?

Secretary CELEBREZZE. Under the administration bill.

Mr. SPRINGER. What does the Senate bill do in that same provision?

Secretary CELEBREZZE. The Senate bill, or the Harris bill?

Mr. SPRINGER. The Senate bill.

Secretary CELEBREZZE. As I recall it, under the Senate bill we would still appropriate $150 million, one-third of which can be transferred over to modernization at the request of the State. It would leave it to the discretion of the State as to whether it would be used under the Hill-Burton program or whether $50 million would be used for modernization.

The decision is left to the State.

Mr. SPRINGER. And that would be a flat $50 million in each of the 5 years?

Secretary CELEBREZZE. Well, it cannot exceed one-third.

Mr. SPRINGER. One-third. Now, would you just give me again what the Harris bill does?

Secretary CELEBREZZE. In the Harris bill, of the $150 million, which is a ceiling, for 1965 there would be zero for modernization. In 1966 there would be $20 million for modernization. In 1967 there would be $35 million for modernization, in 1968 there would be $50 million for modernization. In 1969 there would be $55 million for modernization, or a total of $160 million.

Mr. SPRINGER. Now, will you tell me where your definition of modernization is contained? Let's look at the Harris bill. Could you point out where that is?

Secretary CELEBREZZE. Yes. It is in the bill.

Mr. SPRINGER. What page is that?

Secretary CELEBREZZE. Page 53 of the bill, line 19.

The term "modernization" includes alteration, major repair (to the extent permitted by regulations), remodeling, replacement, and renovation of existing buildings (including initial equipment thereof) and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

Mr. SPRINGER. I take it, Mr. Secretary, that this modernization would cover just about anything that can be done with those existing buildings. Is that right?

Secretary CELEBREZZE. Of course it would be left up to the determination of the State agency, because even a modernization project has to go through the State agency and that State agency in its total planning of facilities would take into consideration just how far to go. I will admit that the definition is broad, but we, in general, accept what the State agency refers to us as the need for modernization.

Mr. SPRINGER. Would they set the regulations for this, or would you? You mentioned regulations I believe in two places, "(As determined in accordance with regulations)," and "(to the extent permitted by the regulations)."

Who writes those regulations?

Secretary CELEBREZZE. We adopt them, but our practice has been to secure the approval of the Federal Hospital Council.

Under both bills, the administration bill, the Surgeon General can adopt regulations with the approval of the Secretary of Health, Education, and Welfare, but we intend to secure the approval of the Federal Hospital Council.

Mr. SPRINGER. That is in accordance with existing law?

Secretary CELEBREZZE. It isn't changed under either law.

Mr. SPRINGER. But the point I am trying to make is how much then are you putting on the States with their hospitals, or the local community, if you do all this?

Secretary CELEBREZZE. How much are we putting on the States for modernization?

Mr. SPRINGER. You are taking a hospital now, we will say. I take it you could go in and do anything with this with reference to remodeling anything, take walls, lighting, equipment or anything. You use the words "initial equipment" here and I presume that would be new equipment, as I understand initial equipment to mean new equipment.

Secretary CELEBREZZE. That is correct.

Mr. SPRINGER. What do you expect the local communities, the State, and the counties to do in connection with the program?

Secretary CELEBREZZE. The local communities have to put up their proportionate share of the total.

Mr. SPRINGER. That is what you would expect them to do under this bill? In other words, your formula here would be the same as it is under Hill-Burton, 33⅓ and 66⅔?

Secretary CELEBREZZE. For new hospital construction.

Mr. SPRINGER. Is that the same formula to be applied for renovation?

Secretary CELEBREZZE. Yes.

Mr. SPRINGER. For modernization the same formula would apply?

Secretary CELEBREZZE. Yes.

Mr. HEMPHILL. Would the gentleman yield to me at this point?

Mr. SPRINGER. Yes.

Mr. HEMPHILL. Mr. Secretary, but doesn't the Surgeon General have some authority to change the formula under certain conditions?

Secretary CELEBREZZE. Yes, subject to certain limitations he may

change the allotment formula, but not the formula for determining the State or local share.

Mr. HEMPHILL. Is that as to a grant, or loan, or as to both?

Secretary CELEBREZZE. It is under the grant provision.

Mr. HEMPHILL. Thank you.

Mr. SPRINGER. Now, Mr. Secretary, may I go to the second point. I am going to list them so I don't take up all of the time of the committee and give some one else a chance to ask questions.

This is on page 4, and I noted these as I ran through this and tried to note what you read.

Secretary CELEBREZZE. Are you referring to my testimony?

Mr. SPRINGER. I am referring to your statement, page 4. Mostly page 4 has to do with planning. Is that a new section in the bill?

Secretary CELEBREZZE. Yes. That is completely new, in the bill. That is not in existing law at the present time.

Mr. SPRINGER. Is it your feeling that there is a great deal of need for this kind of money to be spent?

Secretary CELEBREZZE. It is my feeling that in this type of program, as in many of our Federal programs, we can receive greater value for our dollars when there is proper planning, before you construct the projects. I think that in the long run the planning grants that we make will offset themselves in greater efficiency and less cost; if you don't have proper planning in a program of this magnitude, then you are going to have inefficiency. So we think it is best, as I tried to bring forth in my statement, that you have a total community approach to health facilities planning; so that by having proper planning you don't have duplication if you are going into a really comprehensive health facility program in a particular State.

Mr. SPRINGER. Let me ask you this. Suppose that I want to build a hospital, we will say in Decatur, Ill. That is all I want to do, period. Is planning money provided under this? I don't want to make any plan for a region. I want to build a hospital at Decatur, Ill. Is planning money provided?

Secretary CELEBREZZE. To the hospital specifically?

Mr. SPRINGER. Yes.

Secretary CELEBREZZE. No. Not under this provision.

Mr. SPRINGER. That kind of planning money is not involved in any one hospital?

Secretary CELEBREZZE. No, because you would have no control over it. Every hospital in the community would come in and say, "We want money for planning," and then you would be giving money to 100 different people just for planning which may not accomplish anything.

That is why we are trying to get a comprehensive program through the State agencies.

Mr. SPRINGER. Is this for a city, a region, or what is the extent of the planning?

Secretary CELEBREZZE. We have definitions of the areas, what is referred to as a medical trade or service area. For a greater explanation of that I will have to refer you to Dr. Graning.

Mr. SPRINGER. All right, if he would. I think it is interesting to know what is included under the planning.

Dr. GRANING. Sir, in your State there are some illustrations of planning groups. There has been one operating in Chicago, Ill. In essence a planning group takes into consideration the presence of existing hospitals. When a particular group, let us say, is thinking about putting in a cobalt bomb and another nearby hospital who is also thinking about a cobalt bomb, they make an effort to get these people together. There is give and take in the development of a coordinated plan, for what would be best for the Decatur area, or the Lake County area, as the case might be.

Mr. SPRINGER. Then this is a large area planning.

Dr. GRANING. It is, sir.

Mr. SPRINGER. I think we have covered modernization and replacement. On page 10 of your statement this mortgage insurance is new. Is that correct?

Secretary CELEBREZZE. Yes, this is mortgage insurance. I think it will help you, Congressman, if I say there is a mortgage insurance program existing now under the FHA for proprietary nursing homes.

Mr. SPRINGER. Yes, I am familiar with that. This would be in the nature of the same thing applicable to hospitals?

Secretary CELEBREZZE. Yes, hospital and other nonprofit health facilities.

Mr. SPRINGER. At the bottom of page 11 and top of page 12, you say:

> If the loan to be insured will be used to construct a proprietary nursing home, however, the amount of the principal obligation may be as much as 90 percent of the value of the complete facility.

In this you are going to insure how much.

Secretary CELEBREZZE. The 90 percent only refers to proprietary nursing home loans.

Mr. SPRINGER. That is correct. How much are you going to spend?

Secretary CELEBREZZE. On the nonprofit facilities we can make a loan of 50 percent of the actual value of the facility when it is completed.

Mr. SPRINGER. How much did you say?

Secretary CELEBREZZE. Fifty percent. We are talking about loans now.

Mr. SPRINGER. And this is as much as you would guarantee?

Secretary CELEBREZZE. Yes.

Mr. SPRINGER. That is 50 percent of the completed facility. Is that correct?

Secretary CELEBREZZE. For nonprofit facilities.

Mr. SPRINGER. All right. Suppose that we make them a grant of 66⅔. They have a third?

Secretary CELEBREZZE. Yes.

Mr. SPRINGER. Then we come along in the second step and we insure the completed facility for 50 percent of its value.

Secretary CELEBREZZE. No, you can't do that under law. The total grant and the loan cannot exceed 75 percent of the total value of the project when it is completed.

Mr. SPRINGER. Would you repeat that?

Secretary CELEBREZZE. We are talking now about nonprofit facilities. The total value of any loan plus a grant cannot exceed 75 percent of the value of the total facility when it is completed.

Mr. SPRINGER. Then if we insure—how much? Fifty percent of that, how much is that?

Secretary CELEBREZZE. If you insure 50 percent of it, then you can only take a 25-percent grant. I think the logical thing would be to take the grant and take a lesser loan; but in answer to your question, you can only get a 25-percent grant.

Mr. SPRINGER. Then how much would still be outstanding after that? You get 25 percent of 33⅓ percent? I am trying to get the risk that is being taken. I still don't get your formula for the risk that is being taken by the local community.

Secretary CELEBREZZE. I am not sure I follow you. Let's take a concrete example.

Mr. SPRINGER. Say a building costs $100,000. You give them a 66⅔ grant. How much may they get under your mortgage out of that remaining?

Secretary CELEBREZZE. That is the difference between 66⅔ and 75 percent.

Mr. SPRINGER. Fifty percent of that?

Secretary CELEBREZZE. No; all of it. All of the difference up to 75 percent. The total grant plus insured loan cannot exceed 75 percent. So, therefore, if you get a grant of 66⅔, you may get the balance, up to 75 percent, as an insured loan.

Dr. GRANING. Eight and a third percent.

Mr. SPRINGER. Eight and a third percent would be insured, is that correct?

Dr. GRANING. Yes, sir.

Mr. SPRINGER. In that, since 8⅓ percent would be all that would be insured——

Dr. GRANING. Yes, sir.

Mr. SPRINGER. They would have to produce——

Dr. GRANING. Twenty-five percent.

Mr. SPRINGER. Twenty-five percent?

Dr. GRANING. Yes, sir.

Mr. SPRINGER. With respect to your amendments, on page 12 you say:

> First, the bill would delete the requirement that a private nonprofit diagnostic or treatment center must be sponsored by a corporation or association which owns and operates a nonprofit hospital. From time to time the present provision has prevented the approval of worthwhile construction projects in areas where they were very much needed to meet community requirements.

You would delete this requirement that a private nonprofit diagnostic or treatment center be sponsored by a corporation or association which owns a nonprofit hospital?

Secretary CELEBREZZE. Yes. We found certain instances where a hardship was being worked. Suppose I have Dr. Graning, who has worked in this area, give you an example.

Mr. SPRINGER. All right.

Dr. GRANING. Sir, we recently had a very good illustration of this in Fort Worth, Tex. There were six voluntary health agencies that were interested in getting together to provide services for handicapped children. They had an excellent staff. The six agencies wanted to minimize the duplication of services and build a facility that would meet their joint needs.

The State agency was in favor of this. We were in favor of it. We could not approve the facility under the existing law because of the stipulation that it has to be affiliated with a nonprofit hospital. We are seeking permission in the law so that in such instances when it is truly a worthwhile activity the Surgeon General may approve such cases.

Mr. SPRINGER. Mr. Secretary, I want to come back to these three bills and then I am through. The Senate bill would cost how much money over 5 years?

Secretary CELEBREZZE. $840 million for hospital construction and modernization.

Mr. SPRINGER. That is the Senate bill?

Secretary CELEBREZZE. $150 million for 1965 for hospital construction and modernization.

Mr. SPRINGER. The Senate bill would cost how much? $840 million?

Secretary CELEBREZZE. You mean the total cost in all three bills?

Mr. SPRINGER. Yes.

Secretary CELEBREZZE. The ceiling is $840 million in all three of the bills for hospital construction and modernization.

Mr. SPRINGER. In other words, all of them have $840 million?

Secretary CELEBREZZE. That is right.

Mr. SPRINGER. $150 million a year?

Secretary CELEBREZZE. Well, it will vary.

Mr. SPRINGER. I see what you mean, but the average would be $150 million a year, wouldn't it?

Secretary CELEBREZZE. It goes up in the Senate bill from $150 to $180 million, so it isn't $150 million every year.

Mr. SPRINGER. But it all would cost——

Secretary CELEBREZZE. It all would cost $840 million for construction and modernization of hospitals. The only difference is the way in which we divide the $840 million.

Mr. SPRINGER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Moss.

Mr. MOSS. I have no questions, Mr. Chairman, at this time. I would like to state, however, Mr. Secretary, that I believe you have given us an excellent statement, one most helpful to the committee as we restudy this legislation. Thank you.

Secretary CELEBREZZE. Thank you.

The CHAIRMAN. There is not thing you didn't cover, as I gathered. I thought we should have a clear understanding that I don't believe has been fully developed yet. That is the formula used for allotments to States for the hospital construction part of the bill is different from the formula used for the allotments to the States of the amount that goes to the modernization program. Did you get that?

Mr. SPRINGER. I got the difference between your bill and his bill, but I don't think I got the Senate bill.

The CHAIRMAN. You got the difference in the amounts, but you didn't get the difference in the formula used. The formula used for the allotment for the construction of new hospitals is one thing. The formula that is used for modernization is another thing.

The amounts to the States under the formula for hospital construction will differ from the amounts the States are entitled to under the modernization part of the bill.

Isn't that right?

Secretary CELEBREZZE. Yes, that is right.

The CHAIRMAN. That is what I think everybody ought to understand.

Mr. SPRINGER. Why don't we cover it then, Mr. Chairman?

The CHAIRMAN. Mr. Springer asked you, Mr. Secretary, about modernization, what it meant, and you referred to the definition on page 53, which is true, but you didn't then proceed to explain the difference in the formula that is going to be used, and which I believe is on page 5, isn't it?

Secretary CELEBREZZE. Mr. Springer asked for a definition of the word "modernization" and I gave him the definition which was in the bill.

The CHAIRMAN. Yes, he said the definition for modernization and the formula used. Then you went ahead on the definition, but you did not then come to the formula.

Secretary CELEBREZZE. It was not my intention to evade the question.

The CHAIRMAN. Yes, I know that is true, but I bring this up to show that I don't believe we have the full picture yet and I think if you would explain to us the formula that is used it would be helpful.

Secretary CELEBREZZE. Under the administration bill?

The CHAIRMAN. I think the formula is the same under the administration bill that you brought to me and the bill I introduced. It is the amounts that are different.

Secretary CELEBREZZE. Yes. There is no doubt that the amount for construction of hospitals would be greater under your formula than under the administration formula.

Now, under the existing law, under the Hill-Burton formula, there are two factors taken into consideration. The population times the per capita income factor squared. Under the new modernization formula the bill provides that the allotment be made on the basis of three factors and not two factors.

The CHAIRMAN. Where are those three? Where is it in the bill? Refer us to it so the members can turn to it. It is on page 6, is it not?

Secretary CELEBREZZE. Page 6, line 10.

The CHAIRMAN. What is the first one?

Secretary CELEBREZZE. "On the basis of the population," so that is your population. Next is "the extent of need for modernization."

The CHAIRMAN. That is two.

Secretary CELEBREZZE. And the financial needs of the State.

The CHAIRMAN. And three is the financial needs.

Secretary CELEBREZZE. Those are the three factors which are in the bill.

The CHAIRMAN. Those are the three factors used on the modernization authorization?

Secretary CELEBREZZE. Yes.

The CHAIRMAN. The result of this formula, so we will all know it, is that the larger States will get a break on the modernization formula.

Secretary CELEBREZZE. Yes.

The CHAIRMAN. In other words, the larger the State, the more allotment under the new formula would that State get.

Secretary CELEBREZZE. That is correct.

The CHAIRMAN. And under the old formula, under the hospital construction formula, it is weighted a little bit in favor of the smaller populated States.

Secretary CELEBREZZE. That is right.

The CHAIRMAN. That is the thing that I think we all ought to understand.

Mr. SPRINGER. I come back, Mr. Chairman, very hurriedly. Did you say that the cost of this was $840 million for all three programs?

The CHAIRMAN. That is only the hospital construction part.

Secretary CELEBREZZE. Hospital construction and modernization. It doesn't cover the mortgage insurance cost. It doesn't cover the long-term facilities.

Now, you want the total cost of all of the facilities included in the bill, is that it?

Mr. SPRINGER. Yes, sir. I though that was what you gave me.

Secretary CELEBREZZE. We were talking about the total cost for 1965 would be $260,150,000.

Mr. SPRINGER. Wouldn't the total of your bill be $1,397,500,000? That is the figure I have here.

Secretary CELEBREZZE. Yes. All three bill come to the same total.

Mr. SPRINGER. Do all of them come to $1,397,500,000?

Secretary CELEBREZZE. Yes.

Mr. SPRINGER. All three bills come to that?

Secretary CELEBREZZE. Yes, sir. The only difference is in the manner in which we allocate the money. It is the same ceiling in all three bills.

Mr. SPRINGER. Let me ask you this. Is this budgeted for this year?

Secretary CELEBREZZE. Yes, this is in this year's budget.

Mr. SPRINGER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Schenck?

Mr. SCHENCK. Mr. Chairman, one question has just been answered and that money to pay for the authorization in this measure is now included the budget request this year, Mr. Secretary.

Secretary CELEBREZZE. Yes, it is.

Mr. SCHENCK. As has been discussed here previously, there is a change in the insuring of loans. Is that not true?

Secretary CELEBREZZE. Yes. We do not insure nonprofit facilities. Proprietary nursing home construction loans are insured by FHA.

Mr. SCHENCK. But you are now setting up, Mr. Secretary, a provision to be exercised in the Surgeon General's Office to insure these loans, are you not?

Secretary CELEBREZZE. That is correct.

Mr. SCHENCK. By what stretch of the imagination can that procedure be justified? I have great confidence in the Surgeon General and his competency in public health matters, but what competency does he have in the insuring of mortgage loans?

Secretary CELEBREZZE. You mean has the Surgeon General enough experience to handle a loan insurance program?

Mr. SCHENCK. That is right.

Secretary CELEBREZZE. His Office is qualified because they handle these grant programs, so I have no doubt that the Office can handle it.

Mr. SCHENCK. Mr. Secretary, that means also that the Surgeon

General is going to have to set up an additional bureaucracy in his Office to handle the insuring of these mortgage loans, whereas this function is already being performed by the competent hands in the Housing and Home Finance Agency.

Secretary CELEBREZZE. May I refer to Dr. Graning?

Mr. SCHENCK. Certainly.

Dr. GRANING. Sir, the administrative rationale for placing the mortgage loan insurance program in the Public Health Service stems in large measure from the fact that before an applicant can get a loan guarantee he will have to demonstrate priority need within the individual State's plan. The application will have to be approved by the State agency, acted upon by the regional office of the Public Health Service and then our headquarters office. In an effort to minimize duplication of facilities, and in planning for new facilities for a particular area, the agency of Government that will be most cognizant of the actual need for building the facility would be the Public Health Service.

While I am speaking I would like to point out a feature of this loan guarantee program coupled with grants that has not been brought out as yet. If you were living in a community that was a relatively poor community within a wealthy State and let us say that the Federal participation percentage for that State was 33⅓ percent, it has heretofore been incumbent upon the applicant to raise through community resources the entire sum of money, the difference between 33⅓ and 100 percent.

With this feature in the legislation it will be possible for any community, irrespective of whether it happens to be in a wealthy State or in a poor State, irrespective of what the Federal participation percentage would be, to have the opportunity to have a hospital, providing it can raise 25 percent of the money with its own local resources.

This feature that the Secretary has spoken about, a combination of the grant program and the loan program, is what makes this possible. We think that in order to have a good administrative coordination of the program it would not be feasible to have the grant program in the one agency of Government and the loan program in another.

We recognize, sir, that this is a new field for the Public Health Service, but the applicant would be getting his money from a commercial loan company and the Federal Government would simply insure the loan.

Mr. SCHENCK. Mr. Secretary, I would say for myself that what Dr. Graning has said as to establishing need is only one phase of the program, but the competency in judging construction standards, costs of building, appraisement of those costs, the feasibility of the loans, the soundness of the loans, and so on are all a part of the competency of the Housing and Home Finance Agency and certainly it would just mean that there would be an additional administrative expense added on top of all the other administrative expense. Certainly with the President's idea of economy in Government, you are going to get it best by leaving it with the most competent people in the field and those are the housing and construction people. I would think that certainly insuring the needed loans, and the decision as to their economic feasibility, and costs, and everything else connected with financing this program ought to be left with the agency that now has that competency to make a good judgment.

Secretary CELEBREZZE. You have the same situation in the field of education where the Office of Education is handling loans.

Mr. SCHENCK. You are not insuring loans there.

Secretary CELEBREZZE. No, but I am talking about providing construction money. I think that the primary purpose of this provision is to bring the health features under a health organization. The Office of Education in the administration of its school program works with the FHA. We pay their men so that we don't have duplication of staff. We pay their men to draft the plans, to supervise the construction.

Our basic concern here was to make it possible for health facilities to be under one roof. The proprietary nursing home program now is under FHA. We are trying to bring the same type of program to nonprofit hospital and health organizations. Health profession people, particularly the hospitals, want to work with health people. They don't want to work with others and I think if you bring them under this umbrella you will get much more efficiency than you will by having it outside of the Surgeon General's office.

Mr. SCHENCK. Now, Mr. Secretary, you mentioned I think the fact that you want certain language in this bill that has to do with race, creed, or color.

What other controls do you exercise over hospital construction and hospital use?

Secretary CELEBREZZE. What other controls?

Mr. SCHENCK. Yes. If you are going to make grants certainly you have to have some safeguards, do you not?

Secretary CELEBREZZE. Using "use" in the broad sense, we have no control over the use of the hospital. On the construction side, the State must do certain things under Hill-Burton, such as as determining need and establishing the type of facility; under the regulations as adopted by the Surgeon General and the provisions of law for the Hill-Burton program, we have no control over the use of the hospital.

Mr. SCHENCK. Do you not also have questions of discrimination in the various healing arts that are permitted to practice their healing arts within the hospitals?

Secretary CELEBREZZE. No, not that I know of; no, sir.

Mr. SCHENCK. You mean you are going to leave the question of whether osteopaths can practice in a given hospital entirely up to that hospital?

Secretary CELEBREZZE. That is a matter of internal staffing of a hospital—as to whom it shall have on its staff. It is a question for the hospital to determine and not for the Federal Government to determine. That is expressly prohibited under the Harris bill, the Senate bill, and the existing law.

Mr. SCHENCK. You mean then that your discretion is only going to be to the discrimination on race, creed, and color?

Secretary CELEBREZZE. It is not under our discretion; it is provided for under the law and as enforced by the court decision; and that is why we say that it would be a more limited thing to administer than the broad principles of "without discrimination" without defining it.

Mr. SCHENCK. Then you are justifying your grants for hospitals only through the service in those hospitals by certain healing arts

professions that you or the local State has approved. Is that correct?

Secretary CELEBREZZE. If it is a licensed hospital in the State and it is an accredited hospital, that is all we are concerned with. We have no control over what facilities the hospital affords or the area of treatment.

Mr. SCHENCK. Mr. Chairman, I think that is all at the present time. I think this phase ought to be explored further.

The CHAIRMAN. Mr. Dingell.

Mr. DINGELL. Thank you, Mr. Chairman. Mr. Secretary, I want to pay you a very high tribute for what I think is perhaps the best testimony on this subject that I have ever seen before. As you remember, you and I have had our differences on a number of subjects over the years. I have always thought you made a very fine Secretary and I think that your very splendid testimony offers abundant truth of the fact to the committee.

Mr. Secretary, I would like to start, if I may, with the very difficult question in your testimony. You refer to the nondiscrimination provision on page 13. I want to say before I ask you any questions on this I think it is an extremely fine action in the public interest that you and the Department of Health, Education, and Welfare have taken in this regard and I think the Nation owes you a vote of thanks, but I would like to get down, if I may, to a particular question here.

You indicate that you would prefer the language of the original administration proposal with regard to the nondiscriminatory section, but you point out a number of very fine actions which you have taken since the decision in the *Moses Cone* case has become final through refusal of the Supreme Court to grant certiorari. Would I be fair in inferring that, were you to have the language of the administration bill, you would administer this section any differently than you would under the language of H.R. 10041 before the committee today.

Secretary CELEBREZZE. No, except that it places a greater administrative burden as to what you mean by discrimination. If you don't take women doctors in, does that fall under discrimination? If it is wholly a woman's hospital and it doesn't take men in is that discrimination? You get us in a broad area trying to define discrimination, whereas under the existing law it is limited to three basic things—race, creed, or color.

Mr. DINGELL. Mr. Secretary, now to go forward, if I may, with a different points on this bill, you lay great stress on the need for modernization of hospital facilities in your statement. Particularly on page 6, pointed out that there is no more urgent need in the hospital field today than modernization of these facilities. You indicate that a Public Health Service study indicated that it would cost $3.6 billion just to modernize and replace existing hospitals without attempting to construct additional beds.

This estimate, you go on, would exceed $4 billion today. In the language of H.R. 10041 there are certain provisions with regard to modernization. You have already indicated to us the level of expenditures under this so I won't belabor the committee with this point, but I would be interested in having from you, either at this time, Mr. Secretary, or for the record at a future time, the number of hospital rooms that would be modernized under this or the percentage if you choose to give it in a percentage figure, with the $3.6 billion in 1960

or the $4 billion figure in 1964, which would be upgraded and modernized and brought in conformity with present day needs.

Secretary CELEBREZZE. Of course we can furnish that. Modernization, of course, does not mean that you will create greater hospital beds, as I tried to point out.

Mr. DINGELL. Yes.

Secretary CELEBREZZE. Your operating room may be absolutely obsolete by today's standards so that wouldn't reflect any increase in hospital beds.

Mr. DINGELL. The reason was I was trying to achieve some standard of objective comparison; in other words, to find out just how much of this need would be taken care of and would be met by the bill which is before the committee, and I will permit you, if you choose, to submit this for the record.

Secretary CELEBREZZE. I will submit it for the record.

(The information referred to appears on p. 107.)

Mr. DINGELL. I think by way of comparison it would be very helpful to us to have a comparison with the amount of new construction in terms of beds or some other figure which you have set forth in your testimony in relation to the need which exists at this time.

I note that the two overall figures in terms of construction and modernization come out to the same figure, being $840 million, but I know that in the one figure, as in H.R. 10041 before the committee today, we have a situation where there is a significantly less expenditure going into modernization than is going into new construction.

Perhaps, Mr. Secretary, in order to perfect the record you might find it desirable to make available to us a contrast between the new construction and the modernization which would take place in terms of upgrading facilities. I will let you use any standard you choose, between H.R. 10041 and the other proposal, the administration proposal which was originally sent up here.

Mr. Secretary, I would like to conclude by asking you just one more question, if I may, and that is on page 6. This was discussed previously and I noted this. Since we are today creating legislative history it appears to be quite appropriate to discuss this.

Secretary CELEBREZZE. Page 6 of the bill?

Mr. DINGELL. Page 6 of the bill. It appears on line 13, Mr. Secretary. You mentioned that the Surgeon General would make allotments in connection with three criteria.

Secretary CELEBREZZE. Yes.

Mr. DINGELL. You mentioned the last of the three being financial need of the respective States. The first question, Mr. Chairman, is this: Has that standard ever been applied in connection with Hill-Burton before?

Secretary CELEBREZZE. Every year.

Mr. DINGELL. It has been every year?

Secretary CELEBREZZE. Yes.

Mr. DINGELL. I had the impression that that standard there was per capita income as opposed to financial need.

Dr. GRANING. Per capita income is used as an index for financial need, sir.

Mr. DINGELL. But the previous Hill-Burton statute did say per capita income, did it not?

Dr. GRANING. Yes, sir.

Secretary CELEBREZZE. The Hill-Burton statute just took the formula of population times per capita income factor squared. The one that we are proposing for modernization will take the population, financial need of the State, and the extent of need for modernization of the facilities.

Mr. DINGELL. The thing that concerns me is what is the financial need?

Secretary CELEBREZZE. There is no doubt you would get less money under the present bill which the chairman has than under the administration bill for modernization purposes.

Mr. DINGELL. What I am trying to figure out, though, is what is financial need. How do we interpret financial need? We are giving you a responsibility. I want to be sure that we define that responsibility sufficiently, Mr. Secretary, so that you will be able to determine what your responsibility and duties will be pursuant to that.

Dr. GRANING. Mr. Dingell, sir, it is essentially no different than it has been in previous legislation. We get these figures from the Department of Commerce and we are talking about the per capita income of each State and use this as an index of financial need.

Mr. DINGELL. Do you intend then to use financial need of the respective States as synonymous with per capita income?

Dr. GRANING. We obtain the information from the Department of Commerce on per capita income and this factor is squared in the formula and is used as an index of financial need. It is no different than it has been since 1946.

The CHAIRMAN. Would the gentleman yield?

Mr. DINGELL. Be happy to yield to the chairman.

The CHAIRMAN. The matter of financial need in the modernization proposal, insofar as it is applicable to that part, is exactly the same as financial need under the previous formula for the hospital construction.

Mr. DINGELL. Let me then ask you one more question, if I may. Do you have elsewhere in the bill a restatement of similar standards insofar as grants to the several States under perhaps another section?

Dr. GRANING. On page 5, sir, are the State allotment factors.

Mr. DINGELL. We have been dealing with construction grants here. What I was wondering was do you have a similar formula or perhaps a similar formula change from the previous Hill-Burton formula for grants to the several States. I would like to see whether or not you might have made a change similar to this elsewhere in the proposed statute?

Dr. GRANING. There are no changes, sir, except as they relate to the modernization category.

Mr. DINGELL. What are the standards for grants under modernization? Are they substantially the same?

Dr. GRANING. They are set forth on page 6.

Mr. DINGELL. What is the standard then for your financial need with regard to construction?

Dr. GRANING. On page 5.

Mr. DINGELL. That is the population of each State and the square of its allotment percentage?

Dr. GRANING. Yes, sir.

Mr. DINGELL. Is that the same as had previously been under Hill-Burton?

Dr. GRANING. Yes, sir.

Mr. DINGELL. That is just a reenactment of existing Hill-Burton language?

Dr. GRANING. Yes.

Mr. DINGELL. Why do we insert different language for modernization as regards financial need from what we do with regard to the other section, the construction section?

Dr. GRANING. As the chairman indicated, the financial need portion of the modernization money is exactly the same as in other allotments of the act. The modernization category is a separate, new category and as such induces a concept of need of modernization.

Mr. DINGELL. What you intend to do, though—I am talking about financial need of the respective States—is you intend to construe that section the same as you always do.

Dr. GRANING. Yes, sir.

Mr. DINGELL. Very well. Thank you, Mr. Chairman.

The CHAIRMAN. Would it be convenient for you to come back at 2 o'clock, Mr. Secretary, for a while?

Secretary CELEBREZZE. Yes.

The CHAIRMAN. I was hoping the time wouldn't run out on us.

Mr. ROGERS of Florida. Mr. Chairman, I wonder if we could have prepared for us by the Department, as they did with the mental health bill and retardation bill, a chart showing the three bills, the new programs, the formula, and how it applies. That was most helpful I think to the committee in the consideration of the mental health bill, and I think it would be very simple to do.

The CHAIRMAN. That will be all right.

Mr. ROGERS of Florida. I thought it would be helpful in chart form, and would aid the members in understanding them.

The CHAIRMAN. I think probably in view of the record this morning and under the circumstances, so we have all the information before us, it might be all right to go ahead and do it and have the three results.

Secretary CELEBREZZE. So that I understand you correctly, Congressman, you want a chart showing the differences between the three bills?

Mr. ROGERS of Florida. In other words, the various programs in each bill, the amounts allocated in each bill.

The CHAIRMAN. Let's have an understanding, not showing the differences in them in a sense, but showing what each one of them will do.

Secretary CELEBREZZE. Dollarwise?

Mr. ROGERS of Florida. Dollarwise and how the formula applies, Mr. Chairman, whether there is any difference or not.

Secretary CELEBREZZE. All right.

(The information referred to appears on p. 94.)

The CHAIRMAN. We will adjourn until 2 o'clock.

(Whereupon, at 12:10 p.m., the committee recessed to reconvene at 2 p.m. the same day.)

AFTERNOON SESSION

The CHAIRMAN. The committee will come to order.

STATEMENT OF HON. ANTHONY J. CELEBREZZE, SECRETARY; ACCOMPANIED BY WILBUR J. COHEN, ASSISTANT SECRETARY (FOR LEGISLATION); BOISFEUILLET JONES, SPECIAL ASSISTANT TO THE SECRETARY (HEALTH AND MEDICAL AFFAIRS); DR. DAVID E. PRICE, ACTING SURGEON GENERAL, PUBLIC HEALTH SERVICE; DR. HARALD M. GRANING, CHIEF, DIVISION OF HOSPITAL AND MEDICAL FACILITIES, BUREAU OF STATE SERVICES, PUBLIC HEALTH SERVICE; AND WILLIAM B. BURLEIGH, SPECIAL ASSISTANT, DIVISION OF HOSPITAL AND MEDICAL FACILITIES, BUREAU OF STATE SERVICES, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—Resumed

The CHAIRMAN. Mr. Rogers, you may proceed.

Mr. ROGERS of Florida. Thank you, Mr. Chairman.

Mr. Secretary, I join with others in saying how fine your statement is. I am interested, however, in a few points. As I understand it, general hospital beds are about 83 percent of what is required right now.

Secretary CELEBREZZE. That is correct.

Mr. ROGERS of Florida. I think it is stated that we need 132,000 general hospital beds.

Secretary CELEBREZZE. That is according to the State reports, yes.

Mr. ROGERS of Florida. What other beds are needed? I notice you have long-term care beds listed.

Secretary CELEBREZZE. You have general hospital beds. Of course, you have mental hospital beds.

Mr. ROGERS of Florida. What is the need for mental hospital beds? I just want to get a brief picture.

Secretary CELEBREZZE. For example, let's start with all categories, give you the total and then I will break it down. I think that will help. These are 1965 figures.

Additional needs needed in all categories is 1,116,067.

That is broken down as follows: General hospital beds, 132,936; mental hospital beds, 448,598; tuberculosis hospital beds, 2,330; long-term care beds—that is, primarily the chronically ill—532,203.

Mr. ROGERS of Florida. That is the total breakdown?

Secretary CELEBREZZE. Yes.

The CHAIRMAN. Would it be all right for that table you are reading from to be included in the record so that we will have it in the record?

Secretary CELEBREZZE. Yes. I think it will be very helpful, because it goes all the way back to 1948, and you can see the gains that we have made under the Hill-Burton, too. I will submit it for the purpose of the record.

(The table, to be furnished, follows:)

Beds for inpatient care,[1] United States and possessions, 1948–63

Year [2]	Total beds needed [3]	Existing beds				Additional beds needed
		Total	Acceptable		Non-acceptable [4]	
			Number	Percent of total need		
	All categories					
1963	2,564,358	1,786,461	1,448,291	56.5	338,170	1,116,067
1962	2,554,955	1,744,648	1,421,100	55.5	332,548	1,132,855
1961	2,529,829	1,703,825	1,376,048	54.4	327,777	1,153,781
1960	2,487,196	1,641,191	1,346,059	54.1	295,132	1,141,137
1959	2,450,900	1,568,028	1,286,489	52.5	281,539	1,164,411
1958	2,420,241	1,521,849	1,238,770	51.2	283,079	1,181,471
1957	2,374,383	1,505,695	1,220,546	51.4	285,149	1,153,837
	General hospital beds					
1963	781,977	729,514	649,041	83.0	80,473	132,936
1962	787,455	709,241	632,444	80.3	76,797	155,011
1961	778,081	694,696	619,666	79.6	75,030	158,415
1960	765,765	678,481	607,338	79.3	71,143	158,427
1959	761,610	653,082	587,318	77.1	65,764	174,292
1958	745,594	632,674	559,818	75.1	72,856	185,776
1957	727,399	620,922	547,473	75.3	73,449	179,926
1956	722,112	614,020	541,363	75.0	72,657	180,749
1955	720,001	601,241	526,458	73.1	74,783	193,543
1954	704,400	589,611	515,980	73.3	73,631	188,420
1953	714,469	572,555	495,247	69.3	77,308	219,222
1952	708,574	554,084	474,334	66.9	79,750	234,240
1951	700,952	548,798	469,192	66.9	79,606	231,760
1950	682,601	513,814	437,786	64.1	76,028	244,815
1949	652,611	474,532	397,168	60.9	77,364	255,443
1948	652,974	469,398	388,144	59.4	81,254	264,830
	Mental hospital beds					
1963	907,015	543,094	458,417	50.5	84,677	448,598
1962	888,045	551,710	459,348	51.7	92,362	428,697
1961	884,721	554,775	456,940	51.6	97,835	427,781
1960	870,313	541,931	449,532	51.7	92,399	420,781
1959	857,583	533,587	445,009	51.9	88,578	412,574
1958	842,410	528,406	441,691	52.4	86,715	400,719
1957	823,040	525,455	435,453	52.9	90,002	387,587
1956	808,929	520,010	449,706	55.6	70,304	359,223
1955	793,789	513,278	441,440	55.6	71,838	352,349
1954	774,648	500,568	437,659	56.5	62,909	336,989
1953	767,683	490,598	431,007	56.1	59,591	336,676
1952	755,097	482,733	412,932	54.7	69,801	342,165
1951	744,323	483,310	415,530	55.8	67,780	328,793
1950	725,203	462,859	399,138	55.0	63,721	326,065
1949	692,150	428,931	381,627	55.1	47,304	310,523
1948	690,381	427,201	380,343	55.1	46,858	310,038

See footnotes at end of table.

Beds for inpatient care,[1] United States and possession, 1948–63—Continued

Year [2]	Total beds needed [3]	Existing beds				Additional beds needed
		Total	Acceptable		Non-acceptable [4]	
			Number	Percent of total need		
	Tuberculosis hospital beds					
1963	62,889	64,171	60,559	96.3	3,612	2,330
1962	66,721	68,343	64,411	96.5	3,932	2,310
1961	74,959	72,893	68,768	91.7	4,125	6,191
1960	81,327	78,334	73,274	90.1	5,060	8,053
1959	85,313	84,445	76,685	89.9	7,760	8,628
1958	87,758	88,549	80,105	91.3	8,444	7,653
1957	92,770	91,962	82,152	88.6	9,810	10,618
1956	101,022	96,929	85,584	84.7	11,345	15,438
1955	107,174	100,885	86,552	80.8	14,333	20,622
1954	108,350	102,076	86,686	80.0	15,390	21,664
1953	117,374	100,204	86,698	73.9	13,506	30,676
1952	133,899	99,147	87,550	65.4	11,597	46,349
1951	140,391	96,955	85,351	60.8	11,604	55,040
1950	148,936	94,024	81,511	54.7	12,513	67,425
1949	155,101	85,466	72,560	46.8	12,906	82,541
1948	156,693	84,864	71,857	45.9	13,007	84,836
	Long-term care beds [5]					
1963	812,477	449,682	280,274	34.5	169,408	532,203
1962	802,734	415,354	255,897	31.9	159,457	546,837
1961	792,068	381,461	230,674	29.1	150,787	561,394
1960	769,791	342,445	215,915	28.0	126,530	553,876
1959	746,394	296,914	177,477	23.8	119,437	568,917
1958	744,479	272,220	157,156	21.1	115,064	587,323
1957	731,174	267,356	155,468	21.3	111,888	575,706

[1] Excluding Federal facilities.
[2] As of Jan. 1, each year.
[3] Based on bed needs as reported in State plans submitted by Hill-Burton State agencies under title VI of the Public Health Service Act and regulations thereunder.
[4] Classified by State agencies on the basis of fire and health hazards.
[5] Includes beds in chronic disease hospitals and skilled nursing homes.

Source: State plans for hospital construction, approved under title VI of the Public Health Service Act.

Mr. ROGERS of Florida. Let me ask you: What will this legislation do to solve the need that you have just stated?

Secretary CELEBREZZE. Under the "long-term care" category, both the administration proposal and the Harris and Hill bills——

Mr. ROGERS of Florida. Would it be as convenient for you just to go down through the same breakdown? In other words, what is the total number of hospital beds anticipated that this legislation will bring about, in the general, mental, tuberculosis, and long-term?

Secretary CELEBREZZE. I will start with long-term care beds. Under the bill, there will be an additional 15,000 beds annually; but that 15,000 would be added to, I think, the 30,000 that are built outside the program, for a total of 45,000. But the bill, itself, will produce only 15,000 long-term care beds.

Mr. ROGERS of Florida. Is that in consideration of the mortgage provisions as well, or is this under the grant program?

Secretary CELEBREZZE. This is wholly under the grant program.

Mr. ROGERS of Florida. So that is 15,000 under the grant program alone for long-term care.

Secretary CELEBREZZE. That is right.

Mr. ROGERS of Florida. All right, sir.

Secretary CELEBREZZE. Then the $100 million annually for hospitals and health centers would produce approximately 11,700 additional general beds each year.

Mr. ROGERS of Florida. Is that over the total 5-year program or per year?

Secretary CELEBREZZE. Per year. We are taking about per year now. All the figures are on a per year basis.

Mr. ROGERS of Florida. I see.

Secretary CELEBREZZE. That is under Hill-Burton—of course, there are others, about 14,000 general beds built outside of the program.

Mr. ROGERS of Florida. About 14,000 built outside of the program each year?

Secretary CELEBREZZE. That is right.

Mr. ROGERS of Florida. What do you envision from the provision of the mortgage insurance for hospital and medical facility construction?

Secretary CELEBREZZE. We anticipate that with the assistance under the proposed new mortgage insurance program, there will be a considerable impact on the need for $2.8 billion in general hospital modernization.

Mr. ROGERS of Florida. Over the 5-year period?

Secretary CELEBREZZE. Yes. That is a 5-year period. That is as against the $3.6 billion needed, as I testified earlier. So this doesn't completely cut off the total backlog of modernization. We need about $3.6 billion in modernization work which was on the basis of the 1960 survey. We anticipate it will be about $4 billion now. We anticipate that under this modernization program, and the proposed mortgage insurance program, about $2 billion of modernization work would be produced. I am informed by Dr. Graning that this is over a 10-year period.

Mr. ROGERS of Florida. On the mortgage?

Secretary CELEBREZZE. On the mortgage and grant programs for a 10-year period.

Mr. ROGERS of Florida. Are we approving in this legislation a 10-year mortgage program?

Secretary CELEBREZZE. No. Actually authority is requested for a 5-year program. But, of course, your mortgages can run as high as 40 years. It is a 5-year program, however.

Mr. ROGERS of Florida. It must be committed within the 5 years?

Secretary CELEBREZZE. Yes. There is a provision in the bill puting a termination date as to when you can make the last loans within the 5-year period.

Mr. ROGERS of Florida. But in projection of this figure for 10 years, you figure that perhaps they will not have constructed those buildings for 8 or 10 years?

Secretary CELEBREZZE. What happens, Mr. Rogers, as you know, generally by the time they get their planning out, by the time they get their mortgage issued, a year or a year and a half has gone by, generally; so that there would be a carryover.

Mr. ROGERS of Florida. What does this figure relate to as far as hospital beds, the $2.8 billion?

Secretary CELEBREZZE. I testified in my opening statement, Mr. Rogers, that with the modernization of general hospitals alone requires $2.8 billion—there would be no additional beds produced since this is wholly a modernization program.

Mr. ROGERS of Florida. On the mortgage?

Secretary CELEBREZZE. The $2.8 billion is the need for modernization of general hospitals. There would be no additional beds. It would be merely bringing the present facilities up to today's requirements in health facilities.

Mr. ROGERS of Florida. Then your mortgage program will do nothing except modernizing?

Secretary CELEBREZZE. No, the mortgage program applies across the board. What I am trying to get is the figures. You want the figures as to work produced outside of the modernization program.

We have to take—and I will furnish greater detail for you for the record—an example. I am informed that a $150 million expenditure of grant funds would produce about 17,595 additional general beds.

Mr. ROGERS of Florida. This is the loan program?

Secretary CELEBREZZE. This is the grant program.

Mr. ROGERS of Florida. That is $150 million?

Secretary CELEBREZZE. Yes. The factor that we are having a difficult time taking into consideration is that there are actually being built today 30,000 additional beds under private or other loan programs. Just how much of that will be absorbed over to our program of mortgage insurance, we are unable to tell at this time.

Mr. ROGERS of Florida. Do we know the extent now of FHA participation in this program?

Secretary CELEBREZZE. The FHA, of course, is limited to the proprietary nursing homes.

Mr. ROGERS of Florida. So it is not in the nonprofit field at all now?

Secretary CELEBREZZE. No. The FHA has no application whatever to general hospital beds. Its program applies only to proprietary nursing homes.

Mr. ROGERS of Florida. Isn't your program going to apply also to proprietary, your mortgage loans?

Secretary CELEBREZZE. No. Our program will apply to nonprofit health facilities as well as proprietary nursing homes. This is where we get into difficulty; the proprietary program is now being conducted by FHA, and we ask that it be transferred over so that it is all under one unit.

Mr. ROGERS of Florida. Maybe you don't have these figures, but how much is FHA now contributing to the proprietary program that you will include in your figures?

Secretary CELEBREZZE. I would like to furnish that for the record. We do not know. May I furnish that?

Mr. ROGERS of Florida. Yes.

In other words, if you could give us for the record a complete picture on hospital needs, what this legislation will do, and a breakdown—that is really what I am trying to get at—with the present program under FHA which would be assumed by your department under this proposed legislation, it would be of assistance.

(The information regarding the Federal Housing Administration follows:)

FEDERAL HOUSING ADMINISTRATION.—*Proprietary nursing home project data, fiscal years 1960–63*

APPLICATIONS RECEIVED

Fiscal year	Number	Number of beds	Amount of mortgage
1960	5	378	$1,672,000
1961	55	4,699	24,788,000
1962	133	11,418	71,662,000
1963	222	21,060	146,879,000

COMMITMENTS ISSUED

1960	1	75	$200,000
1961	25	1,936	10,024,000
1962	90	7,347	41,524,000
1963	127	12,219	75,295,000

INSURED

1960	(1)	(1)	(1)
1961	8	616	$2,884,000
1962	48	4,277	25,191,000
1963	94	8,318	52,114,000

[1] None.

Mr. ROGERS of Florida. If this program is adopted, FHA will no longer participate, is that correct?

Secretary CELEBREZZE. In the proprietary, that is correct. Under the present bill, all we are doing is transferring the proprietary nursing home loan insurance program—the same as in the Harris proposal and the Hill bill. These insured loans can go up to 90 percent. We will furnish that information for you, Congressman.

Mr. ROGERS of Florida. Can you make any estimate as to the possible termination date, or do you feel this is a program that will have to continue many years beyond? Have you any information at all?

Secretary CELEBREZZE. Of course, there is a termination date in the bill as to loans. The extent of it is always a difficult question, because 5 years from now we just don't know what the conditions are going to be. We don't know whether additional legislation may have been passed which may affect some of these programs.

My suggestion would be that perhaps, because of the tremendous backlog, there will have to be some kind of renewal of the program. Just what the extent of it will be, the amount, you cannot project very accurately, past the 5 years. But to answer your question specifically, based on this 5-year period, I would say there would have to be some extension later on to take up the backlog of hospital beds and modernization work.

Mr. ROGERS of Florida. I believe there is a different formula that was discussed this morning. Could you give us just a quick explanation as to what programs that will apply to?

Secretary CELEBREZZE. I am going to have Dr. Graning do that, if you don't mind.

Dr. GRANING. Sir, the reference this morning to a separate formula is applicable only to the modernization feature of the Administration proposal and the Harris bill. This modernization category is provided for in the Harris bill, the Hill bill, and the Administration proposal.

In essence, the modernization formula simply is a method for allocating money to States on the basis of their need for modernizing their hospital facilities. The first available information on a national scale, available to the U.S. Government, is the inventory of beds reported by States in 1948. These beds have been undergoing obsolescence, and it is in this manner that we provide the scale for modernization.

Mr. ROGERS of Florida. What time element do you consider being the determining factor? Do I understand you to say that if beds had been in existence since 1948, that they are now considered a proper subject for modernization? What is your criteria?

Dr. GRANING. The older the bed, the more likely it is to be in need of obsolescence. Each State would have to develop a plan in the Harris bill for apprising its modernization needs. The State agencies, working with the people, the hospital people in the State, the professional people, will develop a plan allocating, on the basis of modernization need, their proposed utilization of modernization money.

Mr. ROGERS of Florida. What are your guidelines?

Dr. GRANING. Our guidelines to the State agency? We do not specifically tell them what constitutes a bed that needs modernization. The modernization formula is indicated in the bill, merely relates to how much money they will get for modernization. But the Federal Government, as such, is not going to tell them that they should replace this hospital or renovate that one. This is entirely a matter for community and State decision.

Mr. ROGERS of Florida. Then one State could come in and say, "We want to modernize the beds in this hospital that is 5 years old," and another State may come in with one 3 years old, another 10, one 20, and one 50. How do you determine that?

Dr. GRANING. The State would have to make this determination. It is possible, sir, that this could happen, but not very likely.

Mr. ROGERS of Florida. If there are no guidelines, I would think it could be quite possible; couldn't it?

Dr. GRANING. The competition for funds within the States of Florida, Georgia, and so forth, is such that only those that had the greatest need for modernization would be likely to get it.

Mr. ROGERS of Florida. This is what I wonder. Are you going to set it at a point of time?

Dr. GRANING. It might be useful at this point to say that every State must have an advisory council. This is made up of representative people throughout the State. It is a public matter in terms of how they allocate their money. It is carefully considered. No ill-advised proposal is likely to get approval by the advisory council to the State agency.

Mr. ROGERS of Florida. Do you have any acceptance or rejection of such a proposal?

Dr. GRANING. There are hospitals today that have been inspected, for instance, by the Joint Commission on Accreditation for Hospitals, where they have been advised about things that need to be done to their hospital. There are State hospital licensing authorities that have made inspections and have pointed out serious deficiencies in hospitals. I am sure State agencies would take this into consideration in terms of allocating money.

Mr. ROGERS of Florida. You haven't answered my question. Do you have any say-so on that at all?

Dr. GRANING. The Federal Government will not make the decisions for the State agencies. We have architectural guidelines, of course, in construction of new hospitals. There are safety standards and codes that have to be met so far as Federal regulations are concerned.

Mr. ROGERS of Florida. You say these funds are to be allocated on the basis of three criteria?

Dr. GRANING. Yes, sir.

Mr. ROGERS of Florida. If one of the criteria is need, who determines the allocation of money? If the need will be determined by the State, that is.

Dr. GRANING. Each State gets an allotment on the basis of the formula. After they get their allotment—perhaps I misunderstood your question—they then make decisions in terms of the utilization of the allotment.

Mr. ROGERS of Florida. I haven't phrased this very well. How do you make the allotment when you must consider—as I understand it, one of three criteria is need; and that is not determined by you, you say, but it is determined by the States. How do you decide what the allotment is, then, in the original proposition?

Dr. GRANING. Mr. Rogers, in the event the State of Florida had had 2 percent of the hospital beds that were existent in 1948, as far as need for modernization is concerned, you would get 2 percent of whatever amount of money was allocated on the basis of modernization need; because you had 2 percent of the beds in 1948.

Mr. ROGERS of Florida. We are coming to your criteria. This is what I want to know. You are going to judge from your report in 1948?

Dr. GRANING. Which the State agency developed.

Mr. ROGERS of Florida. Yes. All of the States developed it and submitted it as information.

Dr. GRANING. Yes, sir.

Mr. ROGERS of Florida. And they had so many beds that needed to be modernized?

Dr. GRANING. No, sir. This is all beds.

Mr. ROGERS of Florida. How many hospitals beds they had as of that date?

Dr. GRANING. Yes.

Mr. ROGERS of Florida. Then you take that number, the percentage of the State's number of beds, to the United States number of beds?

Dr. GRANING. Yes, sir.

Mr. ROGERS of Florida. And that determines the allocation of the modernization funds to all of the States?

Dr. GRANING. It is our measurement of modernization need; yes sir.

Mr. ROGERS of Florida. That is exactly what I wanted to find out. So your need—I see the formula now. It is based on 1948, the number of hospitals beds in the State. Then the need within the State is determined by the State for their modernization.

Dr. GRANING. Yes, sir.

The CHAIRMAN. Will the gentleman yield on that?

Mr. ROGERS of Florida. Yes.

The CHAIRMAN. Why do you go back to 1948 to decide what the need is? We are in 1964.

Dr. GRANING. Mr. Chairman, the first available factual information that we had about beds in the United States is 1948.

The CHAIRMAN. I grant you that is true. But that was 1948. This formula says——

Dr. GRANING. We are talking about the modernization.

The CHAIRMAN. The need for modernization of the facilities referred to. It doesn't say the need for modernization in 1948.

Dr. GRANING. Yes, sir; but we have operated on the premise that a hospital that was built in 1948 is much more likely to be in need of modernization. This doesn't mean that all hospitals that were extant in 1948 are in need of modernization, but the hospitals that were existing in 1948 are much more likely to be in need of modernization than a hospital that was built in 1962.

The CHAIRMAN. Well, here is a hospital that was built in 1948.

Mr. ROGERS of Florida. Or before.

The CHAIRMAN. I was going to use an example.

The hospital was built in 1948. It was built out of material that didn't lend itself to a strong institution and, therefore, didn't last very long. Here is another one that was built in 1940, and it was built of good, solid material under certain standards required; and it is just as good today as it was in 1940.

Dr. GRANING. Very true, sir.

The CHAIRMAN. How are you going to say that these are going to be the criteria, as to when it was put there, as to the need?

Dr. GRANING. Sir, the State would, in that situation that you just outlined, I would assume, give assistance for modernization to the hospital that was built in 1948 and not to the one that was built in 1940; because the one built in 1940 is in less need of help. The decision in terms of utilization of modernization money in your proposal is left up to the State agency.

I assumed that we had been discussing the matter of how the money is allocated to the State agency.

The CHAIRMAN. That is the thing I have had some serious problem with ever since it was suggested to me. I don't get it yet. I think, frankly, that there ought to be some specific standards that you could rely upon. It just seems to me—and I am not talking about you, and there is no reflection or criticism, Mr. Secretary, I want you to know that— that unfortunately there are a lot of people in this country and our districts who think that we decide where these things are going and how much. But we don't always do it. However, we do get accused of it anyway.

Dr. GRANING. If, for instance, the University of Arkansas Medical School had built something even as recently as 1950——

The CHAIRMAN. And which they did.

Dr. GRANING (continuing). But because of some new development in a portion of their hospital this section of it was obsolescent and needed to be redone because some new advances had come along and they wanted to renovate, they wanted to modernize. The State agency in Arkansas would be cognizant of this need and would unquestionably give support to it, even though it was built in 1952.

The CHAIRMAN. To carry that on to its logical conclusion, you could get another hospital that was built a year before last and when they come along with a new device, a new invention, and so forth, you could say that it needed to be included in a modernization program.

Dr. GRANING. If it is really a functionally obsolete unit, then the individual hospitals and the State agency, certainly not the Federal Government, should make the decisions in each instance as to what is obsolete.

The CHAIRMAN. Thank you.

Mr. ROGERS of Florida. I understand, I think. Since 1948 was the first time that you really had a survey in this country; is that right?

Dr. GRANING. That is right.

The CHAIRMAN. That is when the Hill-Burton program began to become effective.

Mr. ROGERS of Florida. So you have said that from this basis, it is most likely that those States who had hospitals in operation as of that date will probably need modernization funds for those hospitals.

Dr. GRANING. Yes, sir.

Mr. ROGERS of Florida. So we will divide our money on that basis, but allow the prerogative of making the decision as to what shall be done within that State with these funds based on the 1948 survey.

Dr. GRANING. Yes.

Mr. ROGERS of Florida. So a hospital that was built only 2 years ago, if they need an X-ray machine, where they had a very obsolete one, could come before the State people and have this determination made, that it was obsolete and the modernization would take place.

Dr. GRANING. The decision would have to be made by the State agency.

Mr. ROGERS of Florida. Then you don't overrule the State agency on any of this business?

Dr. GRANING. No, sir; we do not.

Mr. BROTZMAN. Will the gentleman yield for one question?

Mr. ROGERS of Florida. Yes.

Mr. BROTZMAN. I would understand, Doctor, that the original concept of the Hill-Burton Act was to construct hospitals. Is that correct?

Dr. GRANING. Yes, sir.

Mr. BROTZMAN. Looking at the Secretary's statement on page 2, I note that it provides that we still need 133,000 additional new beds if the Nation's requirements are to be adequately met. The thing that is puzzling me somewhat is this: assuming we have so much money as a Nation to spend on this particular area, should we be providing for the new beds and construction, or should we be modernizing the old structures? Or is there some combination?

Secretary CELEBREZZE. I would like to correct one thing. The present Hill-Burton bill does also provide for modernization. But

under the formula which is provided, we can't get to modernization; because the formula is weighted for the smaller community. So, the naked statement that it only applies to building of hospital beds isn't quite true. Modernization work is eligible under existing legislation.

We want to broaden it because of the need.

Mr. BROTZMAN. Let's take it on your statement, then, Mr. Secretary.

Secretary CELEBREZZE. I will refer the question back to Dr. Graning. I just wanted to get that clear.

Mr. BROTZMAN. Assuming that there is a modernization feature; still, in the interest of the country, should the money be spent for modernization, or should it be spent to satisfy the requirements for new beds?

Dr. GRANING. Mr. Brotzman, as indicated in the Secretary's testimony, we are striving for a better sense of balance between the construction of new hospital beds and the need for modernization of existing beds. When a person goes to a hospital, he really goes to a hospital to get care. There are today in our hospitals, existing hospitals, a number of facilities that have good beds so that the beds have to be counted, as far as the State agency is concerned; but there are some serious services within the hospital that need attention, perhaps the operating room, the delivery room. They may be quite obsolete and may have been criticized.

If the beds, if the structure of the beds themselves, in terms of being in fireproof buildings, are adjudged by the State standards to be acceptable, it has not been possible to give help to a community in which there has been a serious need for fixing up something in the hospital. The modernization category contained in the Harris bill makes it possible for the States to distribute the money on a different basis. At the present time, the distribution of funds has to relate to whether you need beds in relationship to population. If your bed situation in relationship to population is good, it is not possible for the State to give you help, no matter how much they may want to give you help; because the present formula indicates that the States have to allocate money on a bed need basis.

The concepts of modernization as set forth in the Harris bill will make it possible for State agencies to allocate money on the basis of need for modernization. Thus, they could give assistance to a particular area where the bed needs are met but where there may be some serious deficiencies within the hospital.

Mr. BROTZMAN. I thank the gentleman for yielding. I will pursue this more on my own time.

Mr. ROGERS of Florida. Then, as I understand it, under the proposed bill there are two formulas, the old Hill-Burton formula, to be used for the general construction of hospital——

Dr. GRANING. Yes, sir.

Mr. ROGERS of Florida (continuing). And that is based on the population of the States and the allotted percentage?

Dr. GRANING. Yes, sir.

Mr. ROGERS of Florida. And then this one, which we just discussed, for modernization, which has the three criteria.

Dr. GRANING. Yes, sir.

Mr. ROGERS of Florida. What percentage of contribution is provided in this bill for the construction? The Surgeon General can go up to what amount, 75 percent, 66⅔, or what?

Dr. GRANING. One-third to two-thirds as in existing legislation.

Mr. ROGERS of Florida. There is no change in the basic Hill-Burton formula?

Dr. GRANING. No, sir; and it is applicable to all categories in the proposed bill and the existing bill.

Mr. ROGERS of Florida. And this is true also in the modernization feature?

Dr. GRANING. Yes, sir.

Mr. ROGERS of Florida. Thank you very much, Mr. Chairman.

The CHAIRMAN. Mr. Younger.

Mr. YOUNGER. Thank you, Mr. Chairman.

Mr. Secretary, what advantage can be obtained by setting up a new insurance bureau under the Surgeon General?

Secretary CELEBREZZE. About two-thirds of the things that we have to do under the insured loan program as to architectural features and other matters, we already do under the grant program. It is just a question of getting greater efficiency by coordination.

Let me give you some concrete examples, Congressman. The personnel of the Public Health Service now is engaged in extensive review of all projects under the Hill-Burton program as to cost feature, as to design feature, as to availability of financing by the responsible source, and comparable questions which would otherwise be involved in the administration loan program. For nursing homes, we do two-thirds of this now, but we don't control the insurance program for proprietary nursing homes. That is under the FHA. It seems to us that since we are already doing two-thirds of the kind of work involved in insuring loans, and it seems that there would be less duplication if the Public Health Service reviewed the financial integrity of the proposed project than there would be if the FHA were to review the public health concerns. We have the additional factor that this is a guaranteed program, and such loans would certainly be reviewed by the lending institution.

So, in addition to this that we already do, the law provides for the utilization of services and facilities of other Federal agencies—we do that now under our Office of Education. We contract with FHA to use their architects, their appraisers, so that we don't have a duplication of service. Primarily, in addition to this, we feel that health matters are to be joined together under a health program. Since we feel that most of the work is being done now under the Surgeon General in this one area, we can just absorb this without any substantial additional costs and less duplication between that which FHA and the Surgeon General are now doing.

Mr. YOUNGER. Under your program for the elder citizens, that is under you, isn't it, under your Department?

Secretary CELEBREZZE. No, the program for housing for elder citizens——

Mr. YOUNGER. I know that. But I mean the rest of the program.

Secretary CELEBREZZE. The aging program?

Mr. YOUNGER. Yes.

Secretary CELEBREZZE. The aging program is assigned to the Department of Health, Education, and Welfare for the purpose of coordinating all of the separate facets in the other departments, too. It is run by the President's Council on Aging, primarily, of which the Secretary of Health, Education, and Welfare happens to be Chairman. These other departments are also involved. Part of it is handled under Agriculture, part of it is handled under FHA. We are the coordinating effort on it.

Mr. YOUNGER. When it comes to the insuring of those facilities, the housing facilities and all that in connection with insurance, it is still under the Housing and Home Finance Agency?

Secretary CELEBREZZE. Yes, it is under HHFA, the same as public housing authority is.

Mr. YOUNGER. They have their offices all over the country and they have the facilities, the builders, the contractors, they are used to dealing with them.

Secretary CELEBREZZE. We have offices all over the country, too. We have regional offices and then we have specific offices, too, Congressman.

Mr. YOUNGER. Maybe we had better reduce some of those, rather than turn out lights in the White House for savings. Maybe we can save more money by combining some of them. That is what I had in mind. It seems to me that we go quite far afield when we start setting up another agency of insurance.

Secretary CELEBREZZE. You are not setting up another bureau. As I say, two-thirds of what will be required we are already doing. As a matter of fact, two-thirds of the job we are already doing. So you are saving three-quarters; in the insured mortgage program. HHFA is handling the total program now.

Mr. YOUNGER. I am not questioning the two-thirds or one-third. We will take your figures for it. But even then, the question of having the insurance, the accounting of the insurance program, under the experience of people that are accustomed to handling the insurance seems to me to have advantages.

Secretary CELEBREZZE. That is nothing unusual. Under the new education legislation, the Office of Education is going to provide loan features, too. There again, they work in cooperation with the HHFA. I think we are in a better position in a health province of centralizing all facets dealing with that health problem insofar as money is concerned.

Mr. YOUNGER. Mr. Secretary, where in the education program do they insure mortgages?

Secretary CELEBREZZE. There is no insurance of mortgages, but there is a loan feature under the educational bill. It seems to me that a direct loan program as compared to an insurance program is much more complicated.

Mr. YOUNGER. That is entirely different. That is out of the field of HHFA. They do not make direct loans. We have direct loans under the VA. But that is outside the field of insuring loans. It seems to me that when we start in insuring a structure, whether it is a hospital or an old folks home, a rest home, housing, we ought to concentrate it in one place, so long as it is insurance.

True, you can set up your standards, the type of buildings, and so forth, which will probably have to be approved by you and your Department. But so far as the actual insuring of it, the supervising of the construction and all after it is insured, and seeing to it that the specifications are lived up to, and all that ought to be concentrated in one department.

Secretary CELEBREZZE. We do all that now under our grant program. Whenever we make a grant for a construction purpose, we have to supervise that construction purpose. We are doing that phase of it.

Mr. YOUNGER. Under your grant program, yes.

Secretary CELEBREZZE. Yes.

Mr. YOUNGER. That is right. But that is a different thing than under the insurance program.

Secretary CELEBREZZE. It is still a process of supervision. It is a construction program and this other is a construction program, just as well.

Mr. YOUNGER. I can see we are not getting very far. Apparently you are determined that that kind of insurance ought to be in your Department.

Secretary CELEBREZZE. No, the point I am trying to make, Congressman, is that I think the determination and the help on all health matters ought to come under a central organization, the same as in your State. Then you can take a look at the total picture required, both as to whether to make grants, or whether to make loans. I think it ought to be brought under one umbrella.

Most of this comes out of State recommendations, again. I just wanted to make the point that I think if you are going to deal with a health program, and you have half of it under HHFA and half of it under the Public Health Service, very often and strictly because of the magnitude and responsibilities of separate departments, HHFA may not know what the Public Health Service is doing. No. 2, if they come in under this new bill, under the modernization, for a grant, and at the same time they are over at HHFA for a guaranteed loan, we say under the Harris bill and under the administration proposal that the grant plus the loan can't exceed 75 percent. So if it is under one roof, you will find it out in a hurry. If it is under two roofs, you will have difficulty.

Mr. YOUNGER. There is no question of it being under one roof to that extent. But when it comes to the extent of insuring a loan, once you have approved it, it is, in my opinion, an entirely different situation. No one is asking to take away anything that you have. But to start up another insurance fund, under the Surgeon General, when you already have an insurance fund and you already have years of experience in insuring mortgages, and you throw that all away, it seems to me to be a waste.

I have one other question. Are all the expenses, everything that is included in this bill of every kind and nature, including the repairs, renovation, everything that is called for, provided in the budget for 1965?

Secretary CELEBREZZE. Dr. Graning can explain that to you.

Dr. GRANING. Sir, as we testified, the President made reference to this in his health message, but when we actually testified before both the House and Senate Appropriations Committees, both committees

were cognizant that the authorization for construction expired on the 30th of June. Therefore, we were not permited to testify at the time we had our regular hearings for the construction amounts. Both committees are conversant with the amounts contained in the proposal. We expect to go before them after this piece of legislation has been passed, if it is passed.

Mr. YOUNGER. That is not the question. I am asking, did the President in his budget for 1965, anticipating this bill, include all of the money in this bill?

Dr. GRANING. Yes, sir; he has.

Mr. YOUNGER. Of every kind and description?

Dr. GRANING. Yes, sir.

Mr. YOUNGER. It is in the Presidential budget?

Dr. GRANING. Yes, sir.

Mr. YOUNGER. That is all, Mr. Chairman.

The CHAIRMAN. Mr. Pickle.

Mr. PICKLE. Let me ask you, does any of this money go for administration and personnel in a hospital once there has been construction?

Dr. GRANING. No, sir.

Mr. PICKLE. And you have no control over personnel?

Secretary CELEBREZZE. No control. The only difference between the existing legislation, which may affect administration, is that under the Harris bill and the administration proposal, and Senator Hill's bill, we are authorized to set aside 2 percent for the State, but not to exceed $50,000, for the purpose of administration over and above what they are doing now. Whatever sums are allocated to them are deducted from the total allocation to the State.

But otherwise, there is no money whatsoever that goes for the administration of the program. That is on a straight State basis.

Mr. PICKLE. Assuming that there would be an amount in terms of $50,000, there would be no control over the administration of personnel?

Secretary CELEBREZZE. The $50,000, as I understand it, is for State administration. There is no control over the personnel, except for the general merit system requirement for the State employees.

Mr. PICKLE. There would be control over planning purposes?

Dr. GRANING. No.

I assume you are referring to the State agency and not the hospital?

Mr. PICKLE. The hospital.

Dr. GRANING. No. In the State agency there is no control over the personnel.

Mr. PICKLE. They would not have to abide by a merit system in operation?

Dr. GRANING. Yes, the States have to.

Mr. PICKLE. The State agency, but would the hospital?

Dr. GRANING. Not the hospital, but the State agency must, by legislation.

Mr. PICKLE. I noticed in your planning section that you set a maximum of 75 percent for grants, for planning purposes, except that you made one exception; that the Surgeon General could exceed that if he thought it was in the best interest of the country. Give me an example as to why you would give him authority to exceed that amount.

Secretary CELEBREZZE. There may be a case where the community has made every effort it possibly can and there is such a drastic need for planning that he would grant them over the 66⅔ percent. Let's assume that there is a community in really a critical need, and all they can raise would be some 20 or 15 percent. Under that criteria, which would be very seldom used by the Surgeon General, the Surgeon General, because of the need factor, could in this rare case give them up to 85 or 80 percent, where there has been an honest but unsuccessful effort on the part of the community to raise the 25 percent.

Mr. PICKLE. Do you think it is this important to have that in there, to give him that exception?

Secretary CELEBREZZE. I think it is important. I think that the Surgeon General will have to use a great deal of diligence, and I am sure he will.

Mr. PICKLE. Let me ask you one other question, which may have been covered by Mr. Rogers. In the preparation of your chart, which I assume has not yet been prepared or completed, I hope you show the comparative costs, but in addition show the difference in language between these bills.

Secretary CELEBREZZE. Yes; that will be furnished to you. I will give you the difference in language between them. I will give a comparison of the three bills and where they differ. I should amend that to say the two bills and the administration proposal. Where they differ, I will indicate it; and where they are the same, I will indicate it.

Mr. PICKLE. And the charts to show difference in cost as well as mortgage insurance and modernization, and other places where they differ.

Secretary CELEBREZZE. Yes. We will provide that for you.

The CHAIRMAN. Mr. Brotzman.

Mr. BROTZMAN. Thank you, Mr. Chairman.

How many hospitals are there in this Nation now?

Secretary CELEBREZZE. Well, 6,700 to 6,800. That is total hospitals.

Mr. BROTZMAN. Does that mean that all hospitals have been constructed by Hill-Burton?

Secretary CELEBREZZE. Not that all, but many of them come in two and three times, as you know, as they add a wing or make an addition. One hospital, the same hospital, may have participated two or three times.

Mr. BROTZMAN. Your statement says, "as of June 30, 1963, a total of 6,810 Hill-Burton projects have been approved——"

Secretary CELEBREZZE. That is all kinds. That includes nursing homes and the other categories, too. That doesn't just include general hospitals.

Mr. BROTZMAN. So your answer is that that there are approximately 6,800 hospitals in this country; is that right?

Secretary CELEBREZZE. Yes. That is the information that we have.

Mr. BROTZMAN. Containing how many beds?

Secretary CELEBREZZE. 289,489 beds in Hill-Burton approved projects. Those are the total beds. I have broken those down already for Mr. Rogers a while ago. Do you want me to break them down again?

Mr. BROTZMAN. No; that is not necessary. I just wanted to get that figure in my mind.

Secretary CELEBREZZE. I can furnish for the record the breakdown of the 6,810 projects. I can submit that for the record, give you the figures, how it is broken down between general hospitals, mental hospitals, tuberculosis hospitals, chronic diseases, et cetera.

Mr. BROTZMAN. I have no desire to put that into the record. I am just trying to get a little background.

I would assume that part of this 6,810 Hill-Burton projects, which is the overall total, includes also modernization of some hospitals; is that correct?

Secretary CELEBREZZE. Yes. Very little.

Mr. BROTZMAN. One thing I am not quite clear on is how you presently handle this modernization factor. I realize that the doctor was answering that a moment ago, but I am not quite clear on what percentage of the moneys are presently used for that purpose.

Secretary CELEBREZZE. Are you referrring now, Congressman, to under existing law?

Mr. BROTZMAN. Yes.

Secretary CELEBREZZE. Under existing law how do we apply money for modernization?

Mr. BROTZMAN. Correct.

Secretary CELEBREZZE. I will have the doctor answer that.

Dr. GRANING. Sir, in a number of instances, when a hospital is in a geographical area where it can be reached on a bed-need basis, the hospital in thinking about its need has, in many instances, both added additional beds and taken care of the renovation needs within the hospital incidental to the additional beds.

In those situations where they have added both beds and made some necessary changes within the hospital, we do not have a breakdown of how much of the money went for the new bed portion and how much of it was for modernization; but the important element or important thing to remember is that as of the present time it has not been possible to help a hospital unless it was in an area that needed additional beds.

Once you can reach a hospital on a bed-need basis, then you can also help them renovate, if there is a need for renovation or modernization. But the States have not been able to be helpful to many areas within the State. In the State of Colorado, for instance, where the bed-need situation in Denver is more adequately met than in some of the rural sections of Colorado, there have been hospitals that have needed to have things done that could not be reached under the formula, in terms of the bed-need situation. But once you have an opportunity to reach them, you can modernize.

Mr. BROTZMAN. This term "modernization," does that mean to maintain the capital improvement, or does this mean something in addition thereto? This is a word that is perhaps bothering me the most. I do not know if you are trying to keep the plant going or if you are trying to build something new for new ideas and new techniques.

Dr. GRANING. It may be, for instance, that the laundry is just all wornout and needs to be replaced. We are talking about physical or functional obsolescence.

Mr. BROTZMAN. Let me ask you another question:

If they find—and it is pretty hard for a lawyer to give too good a hypothetical case in this area—let us assume they find a new method

of performing brain surgery and it takes some new facilities. Would this sort of thing be included under the scope of modernizing?

Dr. GRANING. Yes, sir; it would.

Secretary CELEBREZZE. Being a lawyer, I am having the doctor answer that.

Dr. GRANING. Yes, sir; it would, Mr. Brotzman.

Mr. BROTZMAN. I don't know how all these hospitals are financed that we are talking about, this 6,800, but in my hometown there is a local hospital board, for one thing. Part of the money comes from that local community for its support, and part of it, I assume, from the State of Colorado, some tax dollars.

Dr. GRANING. No, sir.

Mr. BROTZMAN. None at all?

Dr. GRANING. None whatsoever.

Mr. BROTZMAN. Is that the case across the country? Is this money provided for hospitals, either coming from the Federal source or from the strictly local effort? Is that the pattern of hospitals across the Nation?

Dr. GRANING. When the Hill-Burton program first came underway, there were some States that had specific State appropriations to supplement Federal funds.

Mr. Burleigh, do you know if anyone is still doing this?

Mr. BURLEIGH. California and Georgia.

Dr. GRANING. The States of California and Georgia are doing this at the moment.

Mr. BROTZMAN. In other words, California and Georgia do have appropriations?

Dr. GRANING. Yes, sir.

Mr. BROTZMAN. Regular appropriations to be used for this purpose?

Dr. GRANING. They have some funds to supplement the poorer areas of the State.

Secretary CELEBREZZE. I think you can also draw a distinction between hospitals that are connected with medical schools in State universities.

Dr. GRANING. I assume you are talking about construction costs, and not operating costs?

Mr. BROTZMAN. I was talking about the construction costs.

Dr. GRANING. Yes, sir.

Mr. BROTZMAN. I was thinking of this case. If you use more of this money for construction as opposed to modernization—I realize we are changing the factor here, or this is suggested by, I think, all three of the bills, by the so-called Harris bill, by the administration proposal, and by the Senate version. I am not quite clear where all of the bills are coming from, but I have heard three mentioned.

Secretary CELEBREZZE. The administration has a proposal. There has been no bill introduced.

Mr. BROTZMAN. I see.

It is your considered opinion, however, that to meet the health needs of the country that this amount, as you have proposed it, should go for modernization as distinguished from construction of new beds?

I never did quite understand your answer a while ago. Frankly, I was talking about the 133,000 additional new beds. I am not quite clear what your answer was relative to the expenditures of money for new construction or new beds versus modernizing old facilities.

Dr. GRANING. Sir, I intended to communicate that it is not an either/or proposition. We would be derelict, indeed, if both programs did not advance in as quick and fine a manner as can be arranged. Some of the facilities that are currently in need of modernization funds are also facilities that are being used as teaching centers. They are located in your urban areas. Some teaching hospitals that are involved. They are involved in the production of our health manpower. On the other hand, there obviously have to be hospitals available for people in terms of where they live. We are certainly not abandoning our interest in building hospitals in rural areas. Our intent is to make it possible for State agencies to allocate some money on a different basis than on a straight bed-need basis.

Mr. BROTZMAN. What is the Hill-Burton Act agency in my State, for example?

Dr. GRANING. It is the State health department.

Mr. BROTZMAN. You mentioned that this bill had been budgeted for 1965.

Dr. GRANING. Yes, sir.

Mr. BROTZMAN. Do you know the amount that you budgeted for this particular measure, for fiscal year 1965?

Dr. GRANING. The full amount requested in the measure.

Mr. BROTZMAN. Do you have the figures there?

Dr. GRANING. $260 million.

Secretary CELEBREZZE. $260,150,000.

Mr. BROTZMAN. It shows $270 million in the one that I have.

Dr. GRANING. This is because our authorization for research grants and demonstration does not expire. This is a $10 million ceiling. So the difference between them is our research and demonstration grants program. This is not affected by this particular piece of legislation.

Mr. BROTZMAN. Did you predicate your budget request upon the Harris bill? Was it on H.R. 10041?

Dr. GRANING. No, sir. But since the sums are the same in the Harris measure, the Hill bill and the administration proposal, the amounts planned for are identical with those in the Harris bill.

Mr. BROTZMAN. I want to be sure I understand. This will only take a moment.

I assume your budget on the areawide planning projects is $10 million?

Dr. GRANING. $5 million, sir.

Mr. BROTZMAN. $5 million there?

Dr. GRANING. Yes. For 1965, the special project planning grants.

Mr. BROTZMAN. This comes out, though, to $45 million for the total amount for this item. Is that not the amount that is in the bill?

Secretary CELEBREZZE. No, it is not.

Dr. GRANING. It is 45 in the bill.

Mr. BROTZMAN. Forty-five in the bill.

Now, what do you have in the budget for that item for fiscal year 1965?

Dr. GRANING. $5 million.

Mr. BROTZMAN. That is all there is the first year?

Dr. GRANING. Yes, sir.

Mr. BROTZMAN. Then you have a figure of $70 million for 5 years?

Dr. GRANING. Yes, sir; for long-term facilities.

Mr. BROTZMAN. Then you have $20 million for nonprofit facilities for diagnostic or treatment purposes; right?

Dr. GRANING. Yes, sir.

Mr. BROTZMAN. Then you have $10 million for rehabilitation; right?

Dr. GRANING. Yes, sir.

Mr. BROTZMAN. Then you would show $150 million for construction and modernization?

Dr. GRANING. Combined; yes, sir.

Mr. BROTZMAN. Combined?

Dr. GRANING. Yes, sir; it does, with additional allowances for mortgage insurance.

Mr. BROTZMAN. Pardon me?

Dr. GRANING. With the allowances contained in there for mortgage insurance and operation and technical services.

Mr. BROTZMAN. What did you put in for mortgage insurance?

Dr. GRANING. $5 million the first year; $2 million in the second.

Mr. BROTZMAN. Now I just have one more question that I want to be sure I understand, relative to civil rights. I think we started out with it this morning.

I have not had a chance to compare the bills, but do I understand this: 10041, the Harris bill, provides merely this, that the State plans shall provide for adequate facilities "for all persons residing in the States?"

Secretary CELEBREZZE. That is right; with no limitation as to race, creed, or color.

Mr. BROTZMAN. Is it your position that it is a legal requirement, or is this a moral requirement, to state it as you have just stated it?

Secretary CELEBREZZE. No; it is my understanding that the Harris bill wording would be administered the same as we are administering now "without regard to race, creed, or color." The only question we have or raise was for a finer definition, and that we determine, as in the Hill-Burton now, that it applies to race, creed, or color. If you stop without that, then it may apply to many other things and we get into a series of situations where we might be called upon, for example, to determine if discrimination goes to sex. Is that what the bill wants to go to, discrimination in terms of geriatrics, TB hospitals, or cancer hospitals? If someone comes in with a contagious disease not handled by that hospital, he can say "Under this, you have to take all people," and if they don't take them in, is that discrimination? The words of race, creed, or color give us a finer definition. But I am sure that the chairman and others would agree that wording in there is the same, referring to race, creed, or color. We would like to have that better defined.

Mr. YOUNGER. Will the gentleman yield for one question?

Mr. BROTZMAN. Can I finish one thought and then I certainly will.

You say it clearly expresses the national policy on this matter. It is my recollection that after the civil rights bill, the public policy on this matter also precludes discrimination because of sex. I believe we passed the amendment the other day which broadens the public policy. I am not being argumentative.

Secretary CELEBREZZE. I konw. I am just referring to the existing legislation now. If you add specific categories and say race, color,

and creed or sex, then you are making it definite, too. Or if you have another bill which provides you can't discriminate because of sex or something else, then it is definite. The word "discriminate" can cover a wide variety of situations. I have conveyed to this committee how we intend to apply the language as the language now exists in there. I thought ours was more of a limitation and more definitive because there are many other types of discrimination, as you know, Congressman, besides race, color, or creed. That is the thing we are trying to point out.

Mr. BROTZMAN. In other words, if I understand your concept, you want to use these as words of limitation, not merely as a statement of national policy. But you would like to tighten up on the meaning of the act and limit the word "discrimination."

Secretary CELEBREZZE. Yes. When I said the national policy, I meant as of existing law today.

Mr. BROTZMAN. I see.

I yield to the gentleman from California.

Mr. YOUNGER. On the question of the hospitals, do you consider it is not discriminating if they have colored patients all on one floor or two floors?

Secretary CELEBREZZE. In my opening statement, I covered that, that you can have as much segregation within an institution as you have within two separate institutions.

Mr. YOUNGER. In other words——

Secretary CELEBREZZE. You cannot segregate on that basis. You might be able to segregate because of contagious disease, but not on the basis that you asked me.

Mr. YOUNGER. That is all.

Mr. BROTZMAN. Thank you, Mr. Chairman. I have no further questions.

The CHAIRMAN. Without getting back into a protracted discussion on this, let me read you what I included in the bill, at page 14, line 11, in talking about what the State plans shall provide:

> For all persons residing in the State—

And further on the same page, lines 19 and 20:

> Will be made available to all persons residing in the territorial area of the applicant.

I had in mind, I think, it ought to include all people. That is what I intended and that is what we did include. We tried to eliminate the politics from it. The Court has spoken on this. It doesn't make any difference what we do or don't do.

Mr. Moss, did you have any questions?

Mr. Moss. In reading the language of the chairman I think that, at least in my judgment, we are not faced with any serious problem. It seems to me that there would have to be a reaching to rather ridiculous extremes to say that a hospital specializing in the treatment of tuberculosis would have to accept patients in other categories. It would accept all patients who might require treatment for tuberculosis.

Secretary CELEBREZZE. That is not what it says. Under the Hill-Burton, it must be open to all people.

Mr. Moss. How about consistent——

Secretary CELEBREZZE. You and I would agree that that would be farfetched, but it is possible.

Mr. Moss. Would it be clarified by merely tying it to the regular purpose for which the hospital was constructed? If you are going to take care of TB you will take care of TB and that is all you will take care of. Obviously you cannot have in one hospital all of the facilities which might be required to treat all types of medical problems. If you are going to have nursing homes, with long-term care, I do not think it would be reasonable to assume that you would have to accept the emergency cases that might come along.

Secretary CELEBREZZE. That is true. But suppose that under this bill a person says he is discriminated against. Then do you have to set up hearing procedures, or do you have to go out and investigate it? You are getting us in a very broad field of complaints. That is the point we are trying to cut it down on, to where it says discrimination in these three categories. If you want to add sex, that is something else, so long as you define it.

Mr. Moss. We do not have to add sex. We did not accept that for the public facilities section of the bill. As I recall, there was a flash of recognition that we would have some practical problems with some rather necessary requirements where segregation is desirable on the basis of sex. So the House rejected that particular part.

Secretary CELEBREZZE. Let me say, so that there is no misunderstanding, that under the Harris bill, the administration will administer the bill to the same effect, taking into consideration as it does now take into consideration the particular case.

That is our plan in the administration. If you want to broaden it to the other areas, that is something else again.

The CHAIRMAN. Since 1946 we have had various construction projects, and you have just said today that there have been a total of 6,810 projects, at the cost of $6.19 billion in Federal funds. During all these years, I have never heard one complaint about anyone being turned down, or who was denied service because of sex or the nature of a disease, or even any fuss of that nature at all. The only question that has ever been raised is the question of civil rights, integration of certain cases. So there is no need of us trying to read something into this that is not here. The facts are the facts, and we don't have to worry about anything else.

Secretary CELEBREZZE. I will accept that statement, Mr. Chairman.

The CHAIRMAN. It is the problem of the day, and I think we would be anything but realistic if we did not recognize it.

I believe you are going to have your staff prepare a chart requested by Mr. Rogers, and further information requested by Mr. Pickle, of what each of the three propositions will do.

Secretary CELEBREZZE. Yes.

The CHAIRMAN. That will include the authorization under each proposal for a particular purpose? I think it would be properly advisable to say that it will go into the record at this point.

The CHAIRMAN. While we are talking about it, for 1965 I would appreciate it if you would prepare for me what each State would be entitled to have under the Harris bill.

Secretary CELEBREZZE. We will prepare it for you.

The CHAIRMAN. That is as you have designated it. I thought at the time I introduced it it would become the administration bill. But

we will get the proper designation so that we will each understand what we are talking about. I would like to have covered for 1965, the amount each State would be entitled to out of the $150 million authorized for hospital construction under the formula. You would have no problem about that?

Secretary CELEBREZZE. Under the Harris bill?

The CHAIRMAN. Yes.

Secretary CELEBREZZE. Yes, we will do that for you.

The CHAIRMAN. Under the administration proposal, as it has been so designated, there would be $100 million for 1965 for this same purpose. I want you to give me the information as to what each State would be entitled to out of that $100 million.

If you can, I want you to give the committee the information as to what each State would be entitled to have under the new formula out of the other $50 million.

Secretary CELEBREZZE. Yes, sir.

The CHAIRMAN. Have you reached the point that you can do that?

Secretary CELEBREZZE. Yes, we can.

The CHAIRMAN. I think that would be helpful.

(The information to be submitted appears on pp. 101–104.)

The CHAIRMAN. Without asking too much, suppose we take the fifth year and do the same thing.

Secretary CELEBREZZE. We can do that.

The CHAIRMAN. Then we can get a picture of what the differences will be.

I think it will be helpful and help some of the members to clarify this, as to how many differences there are.

Secretary CELEBREZZE. There are differences under the formula.

The CHAIRMAN. The difference runs a total of between $160 and $340 million. That is substantial, I would say.

Secretary CELEBREZZE. There would be a difference in allocation.

(The information to be submitted follows:)

Major features of bills and major differences

HEW proposal	H.R. 10041	S. 2531
1. Authorizes grants to public or nonprofit agencies to assist in developing and carrying out areawide plans for health facilities. $5,000,000 authorized for fiscal year 1965 and $10,000,000 for each of the next 4 years (sec. 318). 2. Extends Hill-Burton program for 5 years (sec. 601). 3. (a) Authorizes appropriations as follows for 1965 fiscal year and each of next 4 years (sec. 601 (a) and (b)): *Million* For long-term care facilities ... $70 For diagnostic or treatment centers ... 20 For rehabilitation facilities ... 10 For hospitals and public health centers ... 100 (b) Also authorizes appropriation of following sums for modernization program (sec. 601(c): *Million*: 1965 ... $50; 1966 ... 60; 1967 ... 70; 1968 ... $80; 1969 ... 90	Same as HEW. Same as HEW. 3. (a) Authorizes appropriations as follows for 1965 fiscal year and each of next 4 years: *Million* For long-term care ... $70 For diagnostic or treatment centers ... 20 For rehabilitation facilities ... 10 (b) Authorizes appropriations as follows (assuming full appropriations): 		For hospitals and public health centers	For modernization
	Millions	*Millions*
1965	$150	0
1966	140	$20
1967	135	35
1968	130	50
1969	125	55		Same as HEW. Same as HEW. 3. (a) Same as H.R. 10041. (b) Authorizes appropriations as follows for hospital and public health centers and for modernization with authority vested in States to transfer up to ¼ of such amounts for modernization program: *Million*: 1965 ... $150; 1966 ... 160; 1967 ... 170; 1968 ... $180; 1969 ... 180
4. Funds for all programs, except modernization, allotted on basis of existing Hill-Burton formula—population and square of allotment percentage (the latter is based on per capita income). Modernization funds to be allotted on basis of regulations which take into account population, financial need, and extent of the need (sec. 602(a)).	Same as HEW.	All funds allotted on basis of existing Hill-Burton formula.
5. Minimum allotments (sec. 602(b)): For rehabilitation centers ... $50,000 For diagnostic or treatment centers ... 100,000 For long-term care facilities ... 200,000 For hospitals and public health centers ... 200,000 For modernization ... 200,000 NOTE.—Virgin Islands, American Samoa, or Guam entitled to ½ of each of above if they demonstrate the need therefor to Surgeon General.	Same as HEW.	Same as HEW, except that only 1 minimum allotment of $200,000 for combined categories of hospitals, public health centers, and modernization.

6. Appropriated construction funds to be available for year in which appropriated and next succeeding year, except that for Virgin Islands, American Samoa, and Guam such funds are available for year in which appropriated and next 2 fiscal years (sec. 602(d)).	Same as HEW.	Same as HEW.
7. Intrastate transfer of allotments (sec. 602(e)): (a) Would authorize transfer between long-term care facilities and diagnostic or treatment center allotments or from either of them to rehabilitation facilities to modernization allotments on State certification of no approvable projects for the portion to be transferred.	Same as HEW bill, except that transfer from modernization allotment would be authorized (1) on to any of the other allotments State certification of no approvable project for portion to be transferred, or (2) to new hospital construction allotment on State certification of substantially greater need for new hospital construction provided that State could not transfer more than 1/5 of its 1966 modernization allotment; 3/5 of 1967 allotment; 3/5 of 1968 allotment; and 5/11 of 1969 allotment.	(a) Would authorize transfer between long-term care facility and diagnostic or treatment center allotments or from either of them to rehabilitation facility, hospital construction or modernization allotment upon State certification of no approvable project for portion to be transferred.
(b) Would authorize transfer from hospital and public health center construction allotment to any of above allotments on certification of no approvable project or certification that this would better carry out purpose of title.	Same as HEW.	(b) Would authorize transfer from hospital construction allotment modernization allotment on certification of no approvable project for portion to be transferred.
8. Interstate transfer of allotment (sec. 602(f)): Would authorize transfer of portion of any construction allotment of one State to the corresponding construction allotment of another State to help meet the Federal share of the cost of constructing or modernizing a health facility which would help meet the need of the State from which funds are transferred. Such transfer to be made only on approval of Surgeon General or Surgeon General and Secretary in case of rehabilitation facility allotments.	Same as HEW.	Same as HEW.
9. General regulations (sec. 603(a)-(d)): The Surgeon General with approval of Federal Hospital Council and Secretary shall by regulation prescribe— (a) The general manner in which State agencies shall determine priority of projects. (b) General standards of construction and equipment. (c) Criteria for determining needs for beds and facilities and for developing plans for distribution of beds and facilities. (d) Criteria for determining the extent to which facilities are in need of modernization.	Same as HEW.	Same as HEW.
10. Nondiscrimination: (a) Requires regulations requiring State plan to provide adequate medical facilities for persons residing in State without discrimination on account of race, creed, color; (b) authorizes regulations requiring assurance by project applicant that project will be available to all persons residing in territorial area of applicant without such discrimination (sec. 603(e)).	(a) Inserts "all" before "persons"; omits reference to discrimination.	Same as House bill.
11. State plans (sec. 604): Each state must submit State plan which includes (a) construction and modernization program based on survey of need and to the extent provided by regulations, community, area, or regional plans showing (among other things) (a) the need for beds and facilities and plans for distributing needed beds and facilities throughout the State, (b) the relative need for projects and facilities, (c) minimum standards for maintenance and operation of important facilities receiving aid, (d) methods of administration of State plan, and (e) fair hearing procedure.	Same as HEW.	Same as HEW.
12. Project approvals (sec. 605): Sets forth the application requirements and findings essential to project approval.	Same as HEW.	Same as HEW.
13. Payments (sec. 606(a)): Sets forth the payment procedure which is based on State agency inspection of project and certification that payment is due. Payments made to State unless State is not authorized to receive and make payment or State agency requests that payment be made directly to applicant.	Same as HEW.	Same as HEW.

Major features of bills and major differences—Continued

HEW proposal	H.R. 10041	S. 2531
14. Financial aid to State agency: This is a new provision under which not more than 2 percent of the aggregate allotments to a State for any year (but not in excess of $50,000) would be available to pay up to ½ of the cost of administering the State plan. A State would be entitled to such funds only on condition that expenditures from State sources for such purposes are at least equal to the amount expended from State resources during fiscal year 1964.	Same as HEW.	Same as HEW.
15. Withholding of payments: These provisions are essentially the same as in existing legislation. Withholding would be authorized if there is a failure to comply substantially with provisions required to be included in State plans or failure to carry out assurances required to be given in application, or failure to carry out approved plans and specifications, or failure to provide adequate State funds for administration of State plan.	Same as HEW.	Same as HEW.
16. Judicial review (sec. 608): These provisions are essentially the same as those included in existing legislation. Provision is made for judicial review of the Surgeon General's refusal to approve a project or his action of withholding funds.	Same as HEW.	Same as HEW.
17. Recovery (sec. 609): This section provides for recovery by the United States of its proportionate share of the current value of any facility constructed with the aid of funds under this title of the Public Health Service Act if, within 20 years after construction is completed, the facility is transferred or sold to any person, agency, or organization not qualified to be an applicant for a project under this part or not approved by the State agency or its successor or if, within such period, the facility ceases to be a public or other nonprofit facility. As distinguished from existing legislative provisions, the right of recovery could be waived for good cause shown, as determined in accordance with regulations, and the bill provides that the right of recovery shall not constitute a lien on the facility prior to judgment.	Same as HEW.	Same as HEW.
18. Loans for construction or modernization of hospitals and other medical facilities (sec. 610): This section is the same as the existing legislation. This section would authorize loans for construction or modernization of hospitals and other medical facilities in accordance with the same procedures and subject to the same limitations and conditions as would be applicable to the making of grants under this part. These loans for projects in a State could be approved only if sufficient funds are available from the State's allotment under sec. 602 for the type of project involved—and the loans would be made from this allotment and paid directly to the applicant. The amount of any loan, or of any loan and grant, with respect to any project could not exceed the Federal share of the cost of the project. Loans could be made for periods of up to 40 years and would bear interest at a rate arrived at by adding ¼ of 1 percent per year 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, adjusted to the nearest ⅛ of 1 percent.	Same as HEW.	Same as HEW.
19. Mortgage insurance (sec. 621): Would authorize the Surgeon General to insure mortgages securing loans for the construction of modernization of private nonprofit hospitals and medical facilities and proprietary nursing homes. Applications must be submitted through the State agency, and the State	Same as HEW.	Same as HEW.

agency must certify that there is a need for the project in accord with the State plan. The mortgagor must assure that there will be compliance with State standards for operations and maintenance. The principal obligations secured by the mortgage must have a maturity satisfactory to the Surgeon General but not more than 40 years, and the interest (exclusive of premium charges) can not exceed an annual rate of 5 percent (or 6 percent if found necessary to meet the mortgage market). In the case of a project (other than a project for a proprietary nursing home), the maximum amount of the principal obligation secured by the mortgage cannot exceed 50 percent of the value of the facility, and when added to the amount of any Federal grant or loan not in excess of 75 percent of the value of the facility. In the case of a project for a proprietary nursing home, such maximum would be 90 percent of the facility's value. Authorizes insurance liability under this program up to a maximum aggregate amount of $250,000,000 in fiscal year 1965, and additional liability of $500,000,000 for each of the next 4 fiscal years. Would establish a medical facilities mortgage insurance fund to be available without fiscal year limitation for the mortgage insurance program. Premium charges and other funds received by the Surgeon General in connection with his operations under the program would be deposited in the fund. The fund would be utilized to pay all operating expenses, including administrative expenses authorized in appropriation acts to be paid from the fund. Authorizes the appropriation of $5,000,000 in fiscal 1965, and such sums as may be necessary for the next 4 fiscal years, for transfer to the medical facilities mortgage insurance fund at the Surgeon General's direction. Sums appropriated would remain available until expended. If the fund is insufficient to make payments on defaulted loans, the Surgeon General would be authorized to borrow from the Treasury by issuing notes or other obligations on which interest would be paid at rates based on the current average yield of outstanding obligations of the United States of comparable maturities. The Surgeon General would fix premium charges for insurance of mortgages at rates adequate to cover expenses and probable losses, but not in excess of ½ of 1 percent per annum.		
20. Federal Hospital Council (sec. 641): This section is substantially the same as existing legislation. Per diem rate increased to $75.	Same as HEW.	Same as HEW.
21. Research studies and demonstrations (sec. 644(a)): As in existing legislation, this section provides for the conduct by the Surgeon General of research, experiments, and demonstrations relating to effective development and utilization of services, facilities, and resources of hospitals or other medical facilities. It would also authorize him, after consultation with the Federal Hospital Council, to make grants-in-aid to public or private nonprofit entities, institutions, or organizations for research, experimental, or demonstration projects relating to the development, utilization, or coordination of such services, facilities, or resources. As new provisions, this section provides that, except in unusual cases, the total paid for experimental or demonstration construction or equipment could not exceed $500,000, and could not exceed ½ of so much of the cost of the facility or equipment as the Surgeon General determines is reasonably attributable to experimental or demonstration purposes. (Participation under existing legislation has, through appropriation language, been restricted to 66⅔ percent.)	Same as HEW.	Same as HEW.

Tentative State allotments for modernization of hospitals and related health facilities (for selected years) under administration proposal and H.R. 10041 (Harris bill)[1]

State	Fiscal year 1965		Fiscal year 1966		Fiscal year 1969	
	Administration proposal	H.R. 10041 (Harris bill)[2]	Administration proposal	H.R. 10041 (Harris bill)	Administration proposal	H.R. 10041 (Harris bill)
Total	$50,000,000	----------	$60,000,000	$20,000,000	$80,000,000	$55,000,000
Alabama	1,375,304	----------	1,659,580	484,264	2,224,279	1,517,898
Alaska	200,000	----------	200,000	200,000	200,000	200,000
Arizona	358,045	----------	432,052	200,000	579,066	395,167
Arkansas	894,645	----------	1,079,568	315,017	1,446,910	987,404
California	2,470,262	----------	2,980,866	869,815	3,995,156	2,726,384
Colorado	436,186	----------	526,345	200,000	705,443	481,410
Connecticut	425,135	----------	513,010	200,000	687,571	469,214
Delaware	200,000	----------	200,000	200,000	200,000	200,000
District of Columbia	200,000	----------	231,791	200,000	310,662	212,003
Florida	1,295,910	----------	1,563,775	456,309	2,095,876	1,430,272
Georgia	1,534,017	----------	1,851,099	540,149	2,480,967	1,693,067
Hawaii	200,000	----------	206,277	200,000	276,466	200,000
Idaho	208,245	----------	251,290	200,000	336,795	229,837
Illinois	1,834,794	----------	2,214,047	646,057	2,967,414	2,025,029
Indiana	1,155,467	----------	1,394,303	406,857	1,868,738	1,275,269
Iowa	822,987	----------	993,099	289,785	1,331,017	908,315
Kansas	611,795	----------	738,253	215,422	989,456	675,227
Kentucky	1,263,961	----------	1,525,223	445,059	2,044,205	1,395,011
Louisiana	1,244,070	----------	1,501,220	438,055	2,012,035	1,373,058
Maine	341,149	----------	411,665	200,000	551,741	376,520
Maryland	680,751	----------	821,463	239,702	1,100,979	751,334
Massachusetts	1,247,459	----------	1,505,309	439,248	2,017,516	1,376,798
Michigan	1,787,939	----------	2,157,507	629,559	2,891,635	1,973,316
Minnesota	1,013,109	----------	1,222,519	356,730	1,638,502	1,118,151
Mississippi	1,130,836	----------	1,364,581	398,184	1,828,902	1,248,084
Missouri	1,229,606	----------	1,483,766	432,962	1,988,642	1,357,093
Montana	200,000	----------	228,057	200,000	305,658	208,588
Nebraska	439,918	----------	530,850	200,000	711,480	485,530
Nevada	200,000	----------	200,000	200,000	200,000	200,000
New Hamsphire	200,000	----------	232,917	200,000	312,171	213,033
New Jersey	1,143,974	----------	1,380,435	402,810	1,850,150	1,262,584
New Mexico	287,221	----------	346,590	200,000	464,523	317,001
New York	3,118,745	----------	3,763,391	1,098,155	5,043,948	3,442,103
North Carolina	1,829,367	----------	2,207,498	644,146	2,958,636	2,019,040
North Dakota	219,173	----------	264,477	200,000	354,469	241,898
Ohio	2,128,621	----------	2,568,609	749,518	3,442,621	2,349,322
Oklahoma	893,859	----------	1,078,620	314,741	1,445,639	986,537
Oregon	436,308	----------	526,494	200,000	705,642	481,545
Pennsylvania	2,936,530	----------	3,543,512	1,033,995	4,749,252	3,240,996
Rhode Island	233,220	----------	281,427	200,000	377,187	257,400
South Carolina	1,029,390	----------	1,242,166	362,463	1,664,834	1,136,120
South Dakota	235,504	----------	284,183	200,000	380,881	259,922
Tennessee	1,411,452	----------	1,703,200	496,993	2,282,742	1,557,794
Texas	2,859,592	----------	3,450,672	1,006,904	4,624,820	3,156,081
Utah	260,110	----------	313,875	200,000	420,676	287,079
Vermont	200,000	----------	200,000	200,000	226,344	200,000
Virginia	1,305,586	----------	1,575,451	459,715	2,111,524	1,440,951
Washington	699,022	----------	843,510	246,136	1,130,528	771,499
West Virginia	718,962	----------	867,572	253,157	1,162,778	793,506
Wisconsin	1,108,416	----------	1,337,526	390,289	1,792,641	1,223,339
Wyoming	200,000	----------	200,000	200,000	200,000	200,000
American Samoa	100,000	----------	100,000	100,000	100,000	100,000
Guam	100,000	----------	100,000	100,000	100,000	100,000
Puerto Rico	1,243,358	----------	1,500,360	437,804	2,010,883	1,372,271
Virgin Islands	100,000	----------	100,000	100,000	100,000	100,000

[1] These allotments are tentative and will be adjusted to conform with regulations as approved by the Federal Hospital Council and the Secretary, and on the basis of current population and per capita income data.

Modernization funds distributed as follows: ½ of funds distributed on basis of need, (i.e., beds in existence as of Jan. 1, 1949, as reported in Hill-Burton State plans and Hill-Burton allotments to States, 1949–53, and ½ distributed on basis of population and per capita income factor squared.

[2] No provision for modernization funds in fiscal year 1965.

Tentative total State allotments for construction and modernization of hospitals and related health facilities under administration proposal, H.R. 10041 (Harris bill) and S. 2531 (Hill bill) [1]

State	Fiscal year 1965			Fiscal year 1966			Fiscal year 1969		
	Administration proposal	H.R. 10041 (Harris bill)	S. 2531 (Hill bill)	Administration proposal	H.R. 10041 (Harris bill)	S. 2531 (Hill bill)	Administration proposal	H.R. 10041 (Harris bill)	S. 2531 (Hill bill)
Total	$150,000,000	$150,000,000	$150,000,000	$160,000,000	$160,000,000	$160,000,000	$180,000,000	$180,000,000	$180,000,000
Alabama	4,349,129	4,476,858	4,476,858	4,633,405	4,661,064	4,776,915	5,198,104	5,244,382	5,377,030
Alaska	400,000	200,000	200,000	400,000	400,000	200,000	400,000	400,000	200,000
Arizona	1,275,929	1,381,802	1,381,802	1,349,936	1,489,188	1,474,415	1,496,950	1,545,363	1,659,644
Arkansas	2,645,984	2,636,502	2,636,502	2,830,907	2,744,809	2,813,211	3,198,249	3,181,997	3,166,629
California	7,617,773	7,749,168	7,749,168	8,128,377	8,099,602	8,268,549	9,142,667	9,176,701	9,307,312
Colorado	1,331,397	1,347,668	1,347,668	1,421,556	1,457,342	1,437,995	1,600,654	1,603,193	1,618,647
Connecticut	1,109,521	1,030,288	1,030,288	1,197,396	1,161,234	1,099,342	1,371,957	1,326,814	1,237,451
Delaware	400,000	200,000	200,000	400,000	400,000	200,000	400,000	400,000	200,000
District of Columbia	400,000	263,785	263,785	431,791	446,105	281,465	510,662	431,575	316,825
Florida	4,747,716	5,211,473	5,211,473	5,025,581	5,318,488	5,560,768	5,557,682	5,768,244	6,259,357
Georgia	4,857,195	5,002,781	5,002,781	5,174,277	5,277,623	5,338,088	5,804,145	5,857,324	6,008,702
Hawaii	532,298	486,700	486,700	529,575	654,079	519,320	599,764	605,123	584,561
Idaho	709,451	754,527	754,527	752,496	903,955	805,098	838,001	857,896	906,241
Illinois	5,174,679	5,027,932	5,027,932	5,553,932	5,336,996	5,364,924	6,309,299	6,210,221	6,038,910
Indiana	3,572,197	3,638,196	3,638,196	3,811,033	3,801,206	3,882,042	4,285,468	4,303,661	4,369,736
Iowa	2,423,367	2,409,245	2,409,245	2,593,479	2,537,553	2,570,723	2,931,397	2,913,743	2,893,678
Kansas	1,867,099	1,889,760	1,889,760	1,993,557	1,978,522	2,016,419	2,244,760	2,248,241	2,269,738
Kentucky	3,835,628	3,871,440	3,871,440	4,096,890	4,057,019	4,130,920	4,615,872	4,617,553	4,649,880
Louisiana	3,973,856	4,109,475	4,109,475	4,231,006	4,272,096	4,384,909	4,741,821	4,793,737	4,935,777
Maine	1,006,640	1,001,844	1,001,844	1,077,156	1,134,696	1,068,991	1,217,232	1,210,443	1,203,287
Maryland	2,044,252	2,052,642	2,052,642	2,184,964	2,154,767	2,190,218	2,464,480	2,459,929	2,465,371
Massachusetts	3,176,507	2,904,029	2,904,029	3,434,357	3,148,637	3,098,669	3,946,564	3,794,078	3,487,949
Michigan	5,565,584	5,686,945	5,686,945	5,935,152	5,935,341	6,068,107	6,669,280	6,707,063	6,830,432
Minnesota	2,979,649	2,960,469	2,960,469	3,189,059	3,118,776	3,158,892	3,605,042	3,582,411	3,555,738
Mississippi	3,561,190	3,658,705	3,658,705	3,794,935	3,811,668	3,903,927	4,259,256	4,293,548	4,394,370
Missouri	3,387,678	3,248,806	3,248,806	3,641,838	3,464,020	3,466,554	4,146,714	4,061,361	3,902,051
Montana	624,235	638,653	638,653	652,292	795,848	681,458	729,893	740,195	767,068
Nebraska	1,238,865	1,202,751	1,202,751	1,329,797	1,322,138	1,283,365	1,510,427	1,486,686	1,444,591
Nevada	400,000	200,000	200,000	400,000	400,000	200,000	400,000	400,000	200,000
New Hampshire	552,038	529,965	529,965	584,955	694,445	565,486	664,209	654,170	636,527
New Jersey	3,193,949	3,086,074	3,086,074	3,430,410	3,282,042	3,292,915	3,900,125	3,831,396	3,706,598
New Mexico	989,905	1,057,834	1,057,834	1,049,274	1,186,934	1,128,735	1,167,207	1,197,530	1,270,536
New York	7,948,725	7,271,151	7,271,151	8,593,371	7,881,964	7,758,494	9,873,928	9,494,525	8,733,179
North Carolina	5,758,866	5,915,548	5,915,548	6,136,997	6,163,210	6,312,033	6,888,135	6,943,074	7,105,002
North Dakota	720,877	755,275	755,275	766,181	904,653	805,897	856,173	870,580	907,140
Ohio	6,703,125	6,886,552	6,886,552	7,143,113	7,174,505	7,348,118	8,017,125	8,081,608	8,271,248
Oklahoma	2,579,365	2,537,395	2,537,395	2,764,126	2,682,069	2,707,462	3,131,145	3,098,635	3,047,595
Oregon	1,323,066	1,334,943	1,334,943	1,413,252	1,445,470	1,424,417	1,592,400	1,592,736	1,603,363
Pennsylvania	8,459,647	8,314,614	8,314,614	9,066,629	8,791,329	8,871,893	10,272,369	10,161,984	9,986,453

Tentative total State allotments for construction and modernization of hospitals and related health facilities under administration proposal, H.R. 10041 (Harris bill) and S. 2531 (Hill bill)[1]—Continued

State	Fiscal year 1965			Fiscal year 1966			Fiscal year 1969		
	Administration proposal	H.R. 10041 (Harris bill)	S. 2531 (Hill bill)	Administration proposal	H.R. 10041 (Harris bill)	S. 2531 (Hill bill)	Administration proposal	H.R. 10041 (Harris bill)	S. 2531 (Hill bill)
Rhode Island	$678,439	$670,241	$670,241	$726,646	$825,319	$715,164	$822,406	$815,301	$805,008
South Carolina	3,356,221	3,502,860	3,502,860	3,568,997	3,630,547	3,737,636	3,991,665	4,051,860	4,207,188
South Dakota	769,528	803,930	803,930	818,207	950,047	857,813	914,905	929,104	965,578
Tennessee	4,497,850	4,646,327	4,646,327	4,789,598	4,831,904	4,957,743	5,369,140	5,425,343	5,580,575
Texas	9,280,406	9,666,025	9,666,025	9,871,486	10,025,072	10,313,882	11,045,634	11,201,968	11,609,595
Utah	881,845	935,972	935,972	935,610	1,073,240	998,705	1,042,411	1,066,171	1,124,170
Vermont	459,454	390,587	390,587	459,454	564,408	416,766	485,798	525,120	469,124
Virginia	4,204,927	4,364,727	4,364,727	4,474,792	4,531,900	4,657,269	5,010,865	5,074,099	5,242,353
Washington	2,072,865	2,068,211	2,068,211	2,217,353	2,175,727	2,206,831	2,504,371	2,493,054	2,484,072
West Virginia	2,088,032	2,061,025	2,061,025	2,236,642	2,176,044	2,199,164	2,531,848	2,509,080	2,475,441
Wisconsin	3,217,262	3,174,701	3,174,701	3,446,372	3,352,208	3,387,482	3,901,487	3,865,923	3,813,045
Wyoming	400,000	240,131	240,131	400,000	424,036	256,226	400,000	400,000	288,415
American Samoa	200,000	100,000	100,000	230,000	200,000	100,000	230,000	200,000	100,000
Guam	200,000	111,083	111,083	200,000	203,638	118,528	200,000	200,000	133,419
Puerto Rico	4,054,789	4,232,385	4,232,385	4,311,719	4,386,517	4,516,057	4,822,314	4,895,259	5,083,401
Virgin Islands	200,000	100,000	100,000	200,000	200,000	100,000	200,000	200,000	100,000

[1] These allotments are tentative and will be adjusted to conform with regulations as approved by the Federal Hospital Council and the Secretary, and on the basis of current population and per capita income data.

Tentative total, State allotments for construction and modernization of hospitals and related health facilities under current legislative proposals, fiscal year 1965, with actual allocations to States for fiscal year 1964 [1]

State	Actual 1964 allocation for construction of hospitals and public health centers	Administration proposal			H.R. 10041 (Harris bill)—Total for new construction of hospitals and public health centers	S. 2531 (Hill bill)—Total for construction and modernization of hospitals and public health centers
		Total	$100,000,000 new construction	$50,000,000 modernization [2]		
	(1)	(2)	(3)	(4)	(5)	(6)
Total	$150,000,000	$150,000,000	$100,000,000	$50,000,000	[3] $150,000,000	[4] $150,000,000
Alabama	4,504,107	4,349,129	2,973,825	1,375,304	4,476,858	4,476,858
Alaska	200,000	400,000	200,000	200,000	200,000	200,000
Arizona	1,337,030	1,275,929	917,884	358,045	1,381,802	1,381,802
Arkansas	2,653,387	2,645,984	1,751,339	894,645	2,636,502	2,636,502
California	7,615,905	7,617,773	5,147,511	2,470,262	7,749,168	7,749,168
Colorado	1,320,701	1,331,397	895,211	436,186	1,347,668	1,347,668
Connecticut	1,029,776	1,109,521	684,386	425,135	1,030,288	1,030,288
Delaware	200,000	400,000	200,000	200,000	200,000	200,000
District of Columbia	264,710	400,000	200,000	200,000	263,785	263,785
Florida	5,086,558	4,747,716	3,461,806	1,295,910	5,211,473	5,211,473
Georgia	5,008,808	4,857,195	3,323,178	1,534,017	5,002,781	5,002,781
Hawaii	493,315	523,298	323,298	200,000	486,700	486,700
Idaho	752,033	709,451	501,206	208,245	754,527	754,527
Illinois	5,062,289	5,174,679	3,339,885	1,834,794	5,027,932	5,027,932
Indiana	3,669,081	3,572,197	2,416,730	1,155,467	3,683,196	3,638,196
Iowa	2,440,511	2,423,367	1,600,380	822,987	2,409,245	2,409,245
Kansas	1,909,894	1,867,099	1,255,304	611,795	1,889,760	1,889,760
Kentucky	3,916,263	3,835,628	2,571,667	1,263,961	3,871,440	3,871,440
Louisiana	4,114,608	3,973,856	2,729,786	1,244,070	4,109,475	4,109,475
Maine	1,012,997	1,006,640	665,491	341,149	1,001,844	1,001,844
Maryland	2,048,316	2,044,252	1,363,501	680,751	2,052,642	2,052,642
Massachusetts	2,931,130	3,176,507	1,929,048	1,247,459	2,904,029	2,904,029
Michigan	5,711,404	5,565,584	3,777,645	1,787,939	5,686,945	5,686,945
Minnesota	2,972,027	2,979,649	1,966,540	1,013,109	2,960,469	2,960,469
Mississippi	3,667,283	3,561,190	2,430,354	1,130,836	3,658,705	3,658,704
Missouri	3,289,020	3,387,678	2,158,072	1,229,606	3,248,806	3,248,805
Montana	639,078	624,235	424,235	200,000	638,653	638,653
Nebraska	1,209,245	1,238,865	798,947	439,918	1,202,751	1,202,751
Nevada	200,000	400,000	200,000	200,000	200,000	200,000
New Hampshire	533,763	552,038	352,038	200,000	529,965	529,965
New Jersey	3,078,241	3,193,949	2,049,975	1,143,974	3,086,074	3,086,074
New Mexico	1,051,797	989,905	702,684	287,221	1,057,834	1,057,834
New York	7,294,119	7,948,725	4,829,980	3,118,745	7,271,151	7,271,151
North Carolina	5,934,767	5,758,866	3,929,499	1,829,367	5,915,548	5,915,548
North Dakota	765,665	720,877	501,704	219,173	755,275	755,275
Ohio	6,898,478	6,703,125	4,574,504	2,128,621	6,886,552	6,886,552
Oklahoma	2,535,639	2,579,365	1,685,506	893,859	2,537,395	2,537,395
Oregon	1,341,075	1,323,066	886,758	436,308	1,334,943	1,334,943
Pennsylvania	8,409,884	8,459,647	5,523,117	2,936,530	8,314,614	8,314,614
Rhode Island	675,032	678,439	445,219	233,220	670,241	670,241
South Carolina	3,505,941	3,356,221	2,326,831	1,029,390	3,502,860	3,502,860
South Dakota	798,473	769,528	534,024	235,504	803,930	803,930
Tennessee	4,663,202	4,497,850	3,086,398	1,411,452	4,646,327	4,646,327
Texas	9,621,825	9,280,406	6,420,814	2,859,592	9,666,025	9,666,025
Utah	925,959	881,845	621,735	260,110	935,972	935,972
Vermont	393,544	459,454	259,454	200,000	390,587	390,587
Virginia	4,346,060	4,204,927	2,899,341	1,305,586	4,364,727	4,364,727
Washington	2,071,985	2,072,865	1,373,843	699,022	2,068,211	2,068,211
West Virginia	2,113,632	2,088,032	1,369,070	718,962	2,061,025	2,061,025
Wisconsin	3,189,698	3,217,262	2,108,846	1,108,416	3,174,701	3,174,701
Wyoming	240,141	400,000	200,000	200,000	240,131	240,131
American Samoa		200,000	100,000	100,000	100,000	100,000
Guam	112,805	200,000	100,000	100,000	111,083	111,083
Puerto Rico	4,179,475	4,054,789	2,811,431	1,243,358	4,232,385	4,232,385
Virgin Islands	59,324	200,000	100,000	100,000	100,000	100,000

[1] These allotments are tentative and will be adjusted to conform with regulations as approved by the Federal Hospital Council and the Secretary, and on the basis of current population and per capita income data.

[2] Modernization funds distributed as follows: ½ of funds distributed on basis of need (i.e., beds in existence as of Jan. 1, 1949, as reported in Hill-Burton State plans and Hill-Burton allotments to States, 1949-53, and ½ distributed on basis of population and per capita income factor squared).

[3] Under H.R. 10041, for fiscal year 1965, a full 100 percent of the funds authorized are available for new construction only.

[4] Under S. 2531, funds appropriated are allotted among the States on the basis of population and allotment percentage squared, i.e., the existing Hill-Burton formula. The States are then authorized to set aside no more than ⅓ of the total allotment for grants for modernization of hospitals and other health facilities. Differences from allotments shown in col. 1 are accounted for by inclusion of American Samoa and the establishment of minimum allotments for American Samoa, Guam, and the Virgin Islands under S. 2531, and the use of more current population and per capita income data.

Tentative total, State allotments for construction and modernization of hospitals and related health facilities under current legislative proposals, fiscal year 1966, with actual allocations to States for fiscal year 1964 [1]

State	Actual 1964 allocation for construction of hospitals and public health centers	Administration proposal			H.R. 10041 (Harris bill)			S. 2531 (Hill bill)—Total for construction and modernization of hospitals and public health centers
		Total	$100,000,000 new construction	$60,000,000 modernization [2]	Total	$140,000,000 new construction	$20,000,000 modernization [2]	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Total	$150,000,000	$160,000,000	$100,000,000	$60,000,000	$160,000,000	$140,000,000	$20,000,000	[3] $160,000,000
Alabama	4,504,107	4,633,405	2,973,825	1,659,580	4,661,064	4,176,800	484,264	4,776,915
Alaska	200,000	400,000	200,000	200,000	400,000	200,000	200,000	200,000
Arizona	1,337,030	1,349,936	917,884	432,052	1,489,188	1,289,188	200,000	1,474,415
Arkansas	2,653,387	2,830,907	1,751,339	1,079,568	2,774,809	2,459,792	315,017	2,813,211
California	7,615,905	8,128,377	5,147,511	2,980,866	8,099,602	7,229,787	869,815	8,268,549
Colorado	1,320,701	1,421,556	895,211	526,345	1,457,342	1,257,342	200,000	1,437,995
Connecticut	1,029,776	1,197,396	684,386	513,010	1,161,234	961,234	200,000	1,099,342
Delaware	200,000	400,000	200,000	200,000	400,000	200,000	200,000	200,000
District of Columbia	264,710	431,791	200,000	231,791	446,105	246,105	200,000	281,465
Florida	5,086,558	5,025,581	3,461,806	1,563,775	5,318,488	4,862,179	456,309	5,560,768
Georgia	5,008,808	5,174,277	3,323,178	851,099	5,207,623	4,667,474	540,149	5,338,088
Hawaii	493,315	529,575	323,298	206,277	654,079	454,079	200,000	519,320
Idaho	752,033	752,496	501,206	251,290	903,955	703,955	200,000	805,098
Illinois	5,062,289	5,553,932	3,339,885	2,214,047	5,336,996	4,690,939	646,057	5,364,924
Indiana	3,669,081	3,811,033	2,416,730	1,394,303	3,801,206	3,394,349	406,857	3,882,042
Iowa	2,440,511	2,593,479	1,600,380	993,099	2,537,553	2,247,768	289,785	2,57,0723
Kansas	1,909,894	1,993,557	1,255,304	738,253	1,978,522	1,763,100	215,422	2,016,419
Kentucky	3,916,263	4,096,890	2,571,667	1,525,223	4,057,019	3,611,960	445,059	4,130,920
Louisiana	4,114,608	4,231,006	2,729,786	1,501,220	4,272,096	3,834,041	438,055	4,384,909
Maine	1,012,997	1,077,156	665,491	411,665	1,134,696	934,696	200,000	1,068,991
Maryland	2,048,316	2,184,964	1,363,501	821,463	2,154,767	1,915,065	239,702	2,190,218
Massachusetts	2,931,130	3,434,357	1,929,048	1,505,309	3,148,637	2,709,389	439,248	3,098,669
Michigan	5,711,404	5,935,152	3,777,645	2,157,507	5,935,341	5,305,782	629,559	6,068,107
Minnesota	2,972,027	3,189,059	1,966,540	1,222,519	3,118,776	2,762,046	356,730	3,158,892
Mississippi	3,667,283	3,794,935	2,430,354	1,364,581	3,811,668	3,413,484	398,184	3,903,927
Missouri	3,289,020	3,641,838	2,158,072	1,483,766	3,464,020	3,031,058	432,962	3,466,554
Montana	639,078	652,292	424,235	228,057	795,848	595,848	200,000	681,458
Nebraska	1,209,245	1,329,797	798,947	530,850	1,322,138	1,122,138	200,000	1,283,365
Nevada	200,000	400,000	200,000	200,000	400,000	200,000	200,000	200,000
New Hampshire	533,763	584,955	352,038	232,917	694,445	494,445	200,000	565,486
New Jersey	3,078,241	3,430,410	2,049,975	1,380,435	3,282,042	2,879,232	402,810	3,292,915
New Mexico	1,051,797	1,049,274	702,684	346,590	1,186,934	986,934	200,000	1,128,735
New York	7,294,119	8,593,371	4,829,980	3,763,391	7,881,964	6,783,809	1,098,155	7,758,494
North Carolina	5,934,767	6,136,997	3,929,499	2,207,498	6,163,210	5,519,064	644,146	6,312,033

North Dakota	765,665	766,181	501,704	264,477	904,653	704,653	200,000	805,897
Ohio	6,898,478	7,143,113	4,574,504	2,568,609	7,174,505	6,424,987	749,518	7,348,118
Oklahoma	2,535,639	2,764,126	1,685,506	1,078,620	2,682,069	2,367,328	314,741	2,707,462
Oregon	1,341,075	1,413,252	886,758	526,494	1,445,470	1,245,470	200,000	1,424,417
Pennsylvania	8,409,884	9,066,629	5,523,117	3,543,512	8,791,329	7,757,334	1,033,995	8,871,893
Rhode Island	675,032	726,646	445,219	281,427	825,319	625,319	200,000	715,164
South Carolina	3,505,941	3,568,997	2,326,831	1,242,166	3,630,547	3,268,084	362,463	3,787,636
South Dakota	798,473	818,207	534,024	284,183	950,047	750,047	200,000	857,813
Tennessee	4,663,202	4,789,598	3,086,398	1,703,200	4,831,904	4,334,911	496,993	4,957,743
Texas	9,621,825	9,871,486	6,420,814	3,450,672	10,025,072	9,018,168	1,006,904	10,313,882
Utah	925,959	935,610	621,735	313,875	1,073,240	873,240	200,000	998,705
Vermont	393,544	459,454	259,454	200,000	564,408	364,408	200,000	416,766
Virginia	4,346,060	4,474,792	2,899,341	1,575,451	4,531,900	4,072,185	459,715	4,657,269
Washington	2,071,985	2,217,353	1,373,843	843,510	2,175,727	1,929,591	246,136	2,206,831
West Virginia	2,113,632	2,236,642	1,369,070	867,572	2,176,044	1,922,887	253,157	2,199,164
Wisconsin	3,189,698	3,446,372	2,108,846	1,337,526	3,352,208	2,961,919	390,289	3,387,482
Wyoming	240,141	400,000	200,000	200,000	424,036	224,036	200,000	256,226
American Samoa		200,000	100,000	100,000	200,000	100,000	100,000	100,000
Guam	112,805	200,000	100,000	100,000	203,638	103,638	100,000	118,528
Puerto Rico	4,179,475	4,311,791	2,811,431	1,500,360	4,386,517	3,948,713	437,804	4,516,057
Virgin Islands	59,324	200,000	100,000	100,000	200,000	100,000	100,000	100,000

[1] These allotments are tentative and will be adjusted to conform with regulations as approved by the Federal Hospital Council and the Secretary, and on the basis of current population and per capita income data.

[2] Modernization funds distributed as follows: ½ of funds distributed on basis of need (i.e., beds in existence as of Jan. 1, 1949, as reported in Hill-Burton State plans and Hill-Burton allotments to States, 1949-53, and ½ distributed on basis of population and per capital income factor squared).

[3] Under S. 2531, funds appropriated are allotted among the States on the basis of population and allotment percentage squared, i.e., the existing Hill-Burton formula. The States are then authorized to set aside no more than ⅓ of the total allotment for grants for modernization of hospitals and other health facilities.

Tentative total, State allotments for construction and modernization of hospitals and related health facilities under current legislative proposals; fiscal year 1969, with actual allocations to States for fiscal year 1964 [1]

State	Actual 1964 allocation for construction of hospitals and public health centers	Administration proposal			H.R. 10041 (Harris Bill)			S. 2531 (Hill bill)—Total for construction and modernization of hospitals and public health centers
		Total	$100,000,000 new construction	$80,000,000 modernization [2]	Total	$125,000,000 new construction	$55,000,000 modernization [2]	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Total	$150,000,000	$180,000,000	$100,000,000	$80,000,000	$180,000,000	$125,000,000	$55,000,000	[3] $180,000,000
Alabama	4,504,107	5,198,104	2,973,825	2,224,279	5,244,382	3,726,484	1,517,898	5,377,030
Alaska	200,000	400,000	200,000	200,000	400,000	200,000	200,000	200,000
Arizona	1,337,030	1,496,950	917,884	579,066	1,545,363	1,150,196	395,167	1,659,644
Arkansas	2,653,387	3,198,249	1,751,339	1,446,910	3,181,997	2,194,593	987,404	3,166,629
California	7,615,905	9,142,667	5,147,511	3,995,156	9,176,701	6,450,317	2,726,384	9,307,312
Colorado	1,320,701	1,600,654	895,211	705,443	1,603,193	1,121,783	481,410	1,618,647
Connecticut	1,029,776	1,371,957	684,386	687,571	1,326,814	857,600	469,214	1,237,451
Delaware	200,000	400,000	200,000	200,000	400,000	200,000	200,000	200,000
District of Columbia	264,710	510,662	200,000	310,662	431,575	219,572	212,003	316,825
Florida	5,086,558	5,557,682	3,461,806	2,095,876	5,768,242	4,337,970	1,430,272	6,259,357
Georgia	5,008,808	5,804,145	3,323,178	2,480,967	5,857,324	4,164,257	1,693,067	6,008,702
Hawaii	493,315	599,764	323,298	276,466	605,123	405,123	200,000	584,561
Idaho	752,033	838,001	501,206	336,795	857,896	628,059	229,837	906,241
Illinois	5,062,289	6,307,299	3,339,885	2,967,414	6,210,221	4,185,192	2,025,029	6,038,910
Indiana	3,669,081	4,285,468	2,416,730	1,868,738	4,303,661	3,028,392	1,275,269	4,369,736
Iowa	2,440,511	2,931,397	1,600,380	1,331,017	2,913,743	2,005,428	908,315	2,893,678
Kansas	1,909,894	2,244,760	1,255,304	989,456	2,248,241	1,573,014	675,227	2,239,738
Kentucky	3,916,263	4,615,872	2,571,667	2,044,205	4,617,553	3,222,542	1,395,011	4,649,880
Louisiana	4,114,608	4,741,821	2,729,786	2,012,035	4,793,737	3,420,679	1,373,058	4,935,777
Maine	1,012,997	1,217,232	665,491	551,741	1,210,443	833,923	376,520	1,203,287
Maryland	2,048,316	2,464,480	1,363,501	1,100,979	2,459,929	1,708,595	751,334	2,465,371
Massachusetts	2,931,130	3,946,564	1,929,048	2,017,516	3,794,078	2,417,280	1,376,798	3,487,949
Michigan	5,711,404	6,669,280	3,777,645	2,891,635	6,707,063	4,733,747	1,973,316	6,830,432
Minnesota	2,972,027	3,605,042	1,966,540	1,638,502	3,582,411	2,464,260	1,118,151	3,555,738
Mississippi	3,667,283	4,259,256	2,430,354	1,828,902	4,293,548	3,045,464	1,248,084	4,394,370
Missouri	3,289,020	4,146,714	2,158,072	1,988,642	4,061,361	2,704,268	1,357,093	3,902,051
Montana	639,078	729,893	424,235	305,658	740,195	531,607	208,588	767,068
Nebraska	1,209,245	1,510,427	798,947	711,480	1,486,686	1,001,156	485,530	1,444,591
Nevada	200,000	400,000	200,000	200,000	400,000	200,000	200,000	200,000
New Hampshire	533,763	664,209	352,038	312,171	654,170	441,137	213,033	636,527
New Jersey	3,078,241	3,900,125	2,049,975	1,850,150	3,831,396	2,568,812	1,262,584	3,706,598
New Mexico	1,051,797	1,167,207	702,684	464,523	1,197,530	880,529	317,001	1,270,536
New York	7,294,119	9,873,928	4,829,980	5,043,948	9,494,525	6,052,422	3,442,103	8,733,179
North Carolina	5,934,767	6,888,135	3,929,499	2,958,636	6,943,074	4,924,034	2,019,040	7,105,002

North Dakota	765,665	856,173	501,704	354,469	870,580	628,682	241,898	907,140
Ohio	6,898,478	8,017,125	4,574,504	3,442,621	8,081,608	5,732,286	2,349,322	8,271,248
Oklahoma	2,535,639	3,131,145	1,685,506	1,445,639	3,098,635	2,112,098	986,537	3,047,595
Oregon	1,341,075	1,592,400	886,758	705,642	1,592,736	1,111,191	481,545	1,603,363
Pennsylvania	8,409,884	10,272,369	5,523,117	4,749,252	10,161,984	6,920,988	3,240,996	9,986,453
Rhode Island	675,032	822,406	445,219	377,187	815,301	557,901	257,400	805,008
South Carolina	3,505,941	3,991,665	2,326,831	1,664,834	4,051,860	2,915,740	1,136,120	4,207,188
South Dakota	798,473	914,905	534,024	380,881	929,104	669,182	259,922	965,578
Tennessee	4,663,202	5,369,140	3,086,398	2,282,742	5,425,343	3,867,549	1,557,794	5,580,575
Texas	9,621,825	11,045,634	6,420,814	4,624,820	11,201,968	8,045,887	3,156,081	11,609,595
Utah	925,959	1,042,411	621,735	420,676	1,066,171	779,092	287,079	1,124,170
Vermont	393,544	485,798	259,454	226,344	525,120	325,120	200,000	469,124
Virginia	4,346,060	5,010,865	2,899,341	2,111,524	5,074,099	3,633,148	1,440,951	5,242,353
Washington	2,071,985	2,504,371	1,373,843	1,130,528	2,493,054	1,721,555	771,499	2,484,072
West Virginia	2,113,632	2,531,848	1,369,070	1,162,778	2,509,080	1,715,574	793,506	2,475,441
Wisconsin	3,189,698	3,901,487	2,108,846	1,792,641	3,865,923	2,642,584	1,223,339	3,813,045
Wyoming	240,141	400,000	200,000	200,000	400,000	200,000	200,000	288,415
American Samoa		200,000	100,000	100,000	200,000	100,000	100,000	100,000
Guam	112,805	200,000	100,000	100,000	200,000	100,000	100,000	133,419
Puerto Rico	4,179,475	4,822,314	2,811,431	2,010,883	4,895,259	3,522,988	1,372,271	5,083,401
Virgin Islands	59,324	200,000	100,000	100,000	200,000	100,000	100,000	100,000

[1] These allotments are tentative and will be adjusted to conform with regulations as approved by the Federal Hospital Council and the Secretary, and on the basis of current population and per capita income data.

[2] Modernization funds distributed as follows: ½ of funds distributed on basis of need (i.e., beds in existence as of Jan. 1, 1949, as reported in Hill-Burton State plans and Hill-Burton allotments to States, 1949-53, and ½ distributed on basis of population and per capita income factor squared).

[3] Under S. 2531, funds appropriated are alloted among the States, on the basis of population and allotment percentage squared, i.e., the existing Hill-Burton formula. The States are then authorized to set aside no more than ⅓ of the total allotment for grants for modernization of hospitals and other health facilities.

Tentative allocations for construction of long-term care facilities, diagnostic or treatment centers, and rehabilitation facilities under the administration proposal, H.R. 10041 (Harris bill), and S. 2531 (Hill bill)

State	Fiscal year 1965				
	Total	Long-term care facilities	Diagnostic or treatment centers	Rehabilitation facilities	5-year total, 1965–69
Total	$100,000,000	$70,000,000	$20,000,000	$10,000,000	$500,000,000
Alabama	2,936,901	2,069,341	578,373	289,187	14,684,505
Alaska	350,000	200,000	100,000	50,000	1,750,000
Arizona	906,487	638,711	178,517	89,259	4,532,435
Arkansas	1,729,593	1,218,672	340,614	170,307	8,467,965
California	5,083,596	3,581,903	1,001,129	500,564	25,417,980
Colorado	884,096	622,934	174,108	87,054	4,420,480
Connecticut	675,888	476,231	133,105	66,552	3,397,440
Delaware	350,000	200,000	100,000	50,000	1,750,000
District of Columbia	350,000	200,000	100,000	50,000	1,750,000
Florida	3,418,822	2,408,903	673,279	336,640	17,094,110
Georgia	3,281,916	2,312,439	646,318	323,159	16,409,580
Hawaii	374,967	224,967	100,000	50,000	1,874,835
Idaho	498,765	348,765	100,000	50,000	2,493,825
Illinois	3,298,415	2,324,064	649,567	324,784	16,492,075
Indiana	2,386,722	1,681,685	470,025	235,012	11,933,610
Iowa	1,580,509	1,113,627	311,255	155,627	7,902,545
Kansas	1,239,717	873,505	244,141	122,071	6,189,585
Kentucky	2,539,735	1,789,498	500,158	250,079	12,698,675
Louisiana	2,695,890	1,899,525	530,910	265,455	13,479,450
Maine	657,228	463,083	129,430	64,715	3,286,140
Maryland	1,346,570	948,794	265,184	132,592	6,732,850
Massachusetts	1,905,096	1,342,331	375,177	187,588	9,525,480
Michigan	3,730,739	2,628,680	734,706	367,353	18,653,695
Minnesota	1,942,121	1,368,419	382,468	191,234	9,710,605
Mississippi	2,400,178	1,691,166	472,671	236,337	12,000,890
Missouri	2,131,276	1,501,698	419,719	209,859	10,656,380
Montana	445,205	295,205	100,000	50,000	2,226,025
Nebraska	789,028	555,949	155,386	77,693	3,945,140
Nevada	350,000	200,000	100,000	50,000	1,750,000
New Hampshire	394,966	244,966	100,000	50,000	1,974,830
New Jersey	2,024,521	1,426,478	398,695	199,348	10,122,605
New Mexico	693,958	488,963	136,663	68,332	3,469,790
New York	4,770,008	3,360,949	939,373	469,686	23,850,040
North Carolina	3,880,708	2,734,348	764,240	382,120	19,403,540
North Dakota	499,111	349,111	100,000	50,000	2,495,555
Ohio	4,517,705	3,183,176	889,686	444,843	22,588,525
Oklahoma	1,664,578	1,172,862	327,811	163,905	8,322,890
Oregon	875,748	617,052	172,464	86,232	4,378,740
Pennsylvania	5,454,539	3,843,269	1,074,180	537,090	27,272,695
Rhode Island	459,806	309,806	100,000	50,000	2,299,030
South Carolina	2,297,940	1,619,129	452,541	226,270	11,489,700
South Dakota	527,393	371,601	103,861	51,931	2,636,965
Tennessee	3,048,076	2,147,675	600,267	300,134	15,240,380
Texas	6,341,089	4,467,933	1,248,771	624,385	31,705,445
Utah	614,015	432,635	120,920	60,460	3,070,075
Vermont	350,000	200,000	100,000	50,000	1,750,000
Virginia	2,863,340	2,017,510	563,887	281,943	14,316,700
Washington	1,356,785	955,991	267,196	133,598	6,783,925
West Virginia	1,352,070	952,669	266,267	133,134	6,760,350
Wisconsin	2,082,662	1,467,444	410,145	205,073	10,413,310
Wyoming	350,000	200,000	100,000	50,000	1,750,000
American Samoa	175,000	100,000	50,000	25,000	875,000
Guam	175,000	100,000	50,000	25,000	875,000
Puerto Rico	2,776,522	1,956,338	546,789	273,395	13,882,610
Virgin Islands	175,000	100,000	50,000	25,000	875,000

Basis of allocations, per statutory formula:
(*a*) Total population, as estimated by the Bureau of the Census: (1) Provisional estimates of the United States and Puerto Rico, July 1, 1963 (series P–25, No. 273, Oct. 4, 1963); (2) American Samoa, Guam, and Virgin Islands estimated population as of July 1, 1962 (series P–25, No. 272, Sept. 20, 1963).
(*b*) Allocation percentage rfiscal years 1964 and 1965, as promulgated in the Federal Register, Sept. 13, 1962.

MODERNIZATION

At the present time there is a reported backlog of at least $3.6 billion in needed health facility modernization work. For general hospitals alone, a modernization need totaling $2.8 billion is reported. Funds provided by each of the three legislative proposals would reduce the backlog over the 5-year period 1965–69 as follows:

	Total grant funds authorized 1965–69 (millions)	Total program produced by grant funds under each proposal, 1965–69 (millions) [1]	Total need (millions)	Percent of dollar need met
HEW proposal	$340	$1,020	$3,648	28.0
Harris bill	160	480	3,648	13.2
Hill bill	[2] 280	[2] 840	3,648	23.0

[1] Assuming that Federal share on a national basis will approximate ⅓ of total cost as is the case in the Hill-Burton program.
[2] This assumes that each State uses ⅓ of its total allotment for modernization work as authorized under the Hill bill.

NEW CONSTRUCTION OF GENERAL HOSPITAL BEDS AND FACILITIES

The HEW proposal and the Harris and Hill bills would authorize grant appropriations for new hospital and health center construction as follows:

[In millions]

Proposal	Fiscal years					Total 1965–69
	1965	1966	1967	1968	1969	
HEW	$100	$100	$100	$100	$100	$500
Harris	150	140	135	130	125	680
Hill [1]	100	107	113	120	120	560

[1] Under the Hill bill, States are authorized to use an amount not to exceed ⅓ of their total allotments for modernization work. These estimates assume that States would use ⅔ of their allotments for new construction.

NEED

State Hill-Burton agencies estimate that we need an additional 135,000 general hospital beds. Over the next 5-year period, a total of some 65,000 additional general beds will be needed to meet the requirements for increases in the population. The amounts of grant appropriations authorized by the HEW proposal and the Harris and Hill bills which are used for general hospital bed construction for the period 1965–69, would provide general beds, as follows:

CONSTRUCTION OF FACILITIES UNDER PENDING PROPOSALS

Estimated number of general beds needed

Present deficit	135,000
Requirement for population increase, 1965–69	65,000
Total deficit as of 1969	200,000

Estimated number of general hospital beds to be constructed, 1965–69

With grants provided under	Without grant assistance	Total produced by 1969
HEW proposal, 58,500	70,000	128,500
Harris bill, 79,500	70,000	149,500
Hill bill, 65,500	70,000	135,500

Mr. Moss. Could we have for each of the 5 years under the formula in H.R. 10041 and the administration proposal which was referred to in the Secretary's testimony?

The CHAIRMAN. We could. I am trying to save him from having to do so much. No 2 years are alike.

Secretary CELEBREZZE. I don't quite understand what the request is, Congressman.

The CHAIRMAN. His request is that you take the second, third, and fourth years and do the same thing.

Secretary CELEBREZZE. Well, it is a long, long way around. We can do it, but I think the general idea you are trying to get can be quickly presented, without going into the specific in each of the years. That will take a lot of calculation and a lot of papework. It can be done.

Mr. Moss. Mr. Chairman, while we are on the discussion of the modernization needs I understand this is tied to a study made in 1948 in all the States.

Secretary CELEBREZZE. No; a study made in 1960.

Mr. Moss. Based on a survey made in 1948?

Secretary CELEBREZZE. No, sir; in 1948, one of the criteria was to take the number of beds in the State, in relation to the total number of the beds in 1948 in the whole Nation. We used that as a basis for a formula, because that is the earliest study that was made, as I understand, in 1948. But that was not on modernization. That is total hospital beds.

Mr. Moss. How do you determine the modernization needs? I thought you tied it to the same basis.

Dr. GRANING. The present estimate of the modernization need was made on the 1960 study.

Secretary CELEBREZZE. The present estimate that we testified to today was based on the 1960 estimate.

Mr. Moss. I am asking for the determination that was made on page 6, I believe it is. The extent of the need for modernization of facilities referred to in paragraphs (a) and (b) of section 601, lines 11, 12, and 13 on page 6. I had understood that it was tied to that 1948 survey.

Dr. GRANING. Sir, since we discussed this at length earlier, would it be satisfactory to you, sir, if we talk to you about it individually? Would you like to know at the present time or can we give you some material on it?

Mr. Moss. I had been told that it was tied to the 1948 survey.

Dr. GRANING. Yes, sir.

Mr. Moss. The needs for the hospitals' operation in 1948 were tied to the survey.

Dr. GRANING. The first available information about the bed counts in the United States was in 1948. If, for purposes of discussion, a State had 2 percent of the beds that prevailed in the United States in 1948, then they would get for that factor that relates to modernization 2 percent of the moneys allocated to the States because beds built in 1948 are the oldest beds and, therefore, in the greatest probable need of modernization. This does not imply that all beds built in 1948 are obsolescent.

Mr. Moss. Your answer, then, to my question, is "Yes." You have gone a long way around the bush, but the answer is "Yes." This is the basic factor in determining the needs of a State for modernization.

Dr. GRANING.The needs, sir, are much greater than the amount of money that they are going to get. The Secretary testified the needs were $3.6 billion.

Mr. Moss. I have H.R. 2102 before me, which was going to deal with this subject separately from the usual extension of Hill-Burton. I recognize this very real need, in many respects a more pressing need than for some of the new construction.

Dr. GRANING. But the 1948 beds count will be the criteria; yes, sir.

Mr. Moss. What relation, other than the fact that they are told—and we know that because they existed in 1948—is there that says that a hospital built in 1946 is less modern than one built in 1949?

Dr. GRANING. We are not saying that.

Mr. Moss. I know you are not saying it. But I am interested in demonstrated needs for modernization. I am trying to determine the very point that was raised, the need for perhaps some more precise criteria. At what point in the period since 1948 did we reach, in the evolution of the design of hospitals, and the installation of facilities, the most radical departure from the past existing prior to 1948? There were a lot of hospitals built under the pressure of accumulated needs, unmet during the suspension of construction in many communities during World War II. My State has many of these problems. I am not convinced that in that period immediately prior to 1948 or immediately after 1948 we were then building, under the pressure of exploding population, the most modern facilities we could have, had we had the means. I don't want to see us have such a narrow base in determining the need for modernization. In some of these areas where there is a critical need for modernization, the judgment has been too small. There has been a remarkable change in the design of hospitals, but when did it occur? In the late fifties, the midfifties, the late forties?

Dr. GRANING. Mr. Moss, I believe you will be very pleased when you see the tables that we are going to prepare in terms of the meaning of this program for the State of California.

Mr. Moss. I trust I will be very pleased because anything represents improvement. I am not seeking to get more for my State than it would need, but I am wondering, if we relate it to 1948, if it is as valid as relating it to some other point that has more significance in the evolution of the design for hospitals.

Secretary CELEBREZZE. The only reason we took the 1948 figure is because those are the figures available for hospital beds. As to modernization, as I said, we conducted a study, or a study was conducted in 1960, as to the price of modernization. That is where we came up with the $3.6 billion. The formula of 1948 is used in conjunction with the other two factors necessary in arriving at how much money is going to each particular State. If you move it up or down—if you moved above 1948, into 1950 or 1960, we have no concrete evidence exactly as to what the situation is. So in developing the formula, we tried to get the basic figures available in 1948 to start everybody off on that basis without a guess figure later on, so as to be more exacting as to the amount of moneys going to each particular State. That was the basic reason for it. But that standing alone does not determine it. You have to take into consideration the population, you have to take into consideration the per capita income, and take into con-

sideration the hospital beds in 1948 as compared to the total national hospital beds in 1948, to come out with your basic formula, which, I might say, looks like a chemistry formula after you get through with it.

Mr. Moss. I appreciate all that, Mr. Secretary. But it seems to me that the relevancy of 1948 is that we had a study that existed, and therefore, we were utilizing it.

Secretary CELEBREZZE. Yes.

Mr. Moss. My question is whether it is the best we have or could devise. It is not really relevant to the question of whether a hospital might be modern.

Secretary CELEBREZZE. No. A hospital could have been built in 1958 and been outmoded today. The question is not whether the hospital that was built in 1948 is further outmoded than a hospital that was built in 1938, for example, because the one in 1938 may have been kept up better. We are trying to get at a formula basis by which we would have some comparison to know the total needs and, therefore, puts all the States back, using the 1948 formula as our basis.

Mr. Moss. My State has at least twice as many people today as it had in 1948.

Secretary CELEBREZZE. Yes.

Mr. Moss. In the period from 1945 to the middle 1950's, we probably had our greatest acceleration in population. We built a lot of hospitals in that period. Were they any more modern, were the design techniques any more modern for those hospitals than the ones built prior to 1948?

Secretary CELEBREZZE. Those hospitals can come in for modernization. We don't say hospitals built in 1948 are the only ones eligible for modernization.

Mr. Moss. Nor do I. But if you tie me to the pre-1948 figure, you might be doing me grave injustice, if that is the basic factor. I am merely trying to see a more valid point that relates actually to the question of a modern hospital or an outmoded hospital.

Secretary CELEBREZZE. There would be a difference, there is no doubt. If you have increased in population and had a greater influx in people in your particular area, that would make a difference, because of your population.

Mr. Moss. This happened in my home state, and a number of the other Western States—Arizona, New Mexico—where you have had tremendous increase, and Mr. Roger's State of Florida faced a similar problem.

Secretary CELEBREZZE. It is possible. On the other hand, it is also possible that your per capita income might have gone up. These are figures that you have to figure. That is why we take the three criteria rather than just one criterion. But I think I know what you are referring to.

The CHAIRMAN. Mr. Secretary, you have been on this before, but there seems to be a good deal of question about the mortgage insurance phase of this for construction and modernization of hosiptals. Do I understand that you have an agency for this purpose which will be set up in your Department?

Secretary CELEBREZZE. We do not have an agency now that does precisely this job.

The CHAIRMAN. But you would have, under this program?

Secretary CELEBREZZE. We would have it under the Surgeon General for this purpose. It would not be a separate agency. As I tried to convey to Congressman Younger, three-fourths of what is required we already have to do under our grant program.

The CHAIRMAN. I heard you say that and that is the reason I came back to it. What is the three-fourths you are talking about?

Secretary CELEBREZZE. The architectural design, the supervision of construction. We already have to do that. And, of course, the granting of moneys.

Mr. PICKLE. Do you have to meet FHA specifications now in the design?

Secretary CELEBREZZE. FHA has adopted our specifications for nursing home construction. We have worked together. We have been working with FHA on it, or HHFA.

The CHAIRMAN. Maybe I don't understand. Three-fourths of what is required you are doing now—engineering, design, and architectural plans, approving design.

Secretary CELEBREZZE. And we have to go into cost factors, design features; we have to go into the availability of financing, because we don't put up 100 percent of the funds.

The CHAIRMAN. What you mean to say is that three-fourths of the work required by the agency is required now under your program?

Secretary CELEBREZZE. Three-fourths of the work that could be required under the loan program is required now under our grants.

The CHAIRMAN. Yes, but you do not now in any of your Department have authority to approve any mortgages.

Secretary CELEBREZZE. No, we do not have any authority to approve the mortgages.

The CHAIRMAN. On this mortgage program that you approved here, the mortgage insurance for such construction, where do you get your backing, your guarantee—from the Treasury, the insurance agency, FHA, or where? Is the U.S. Treasury behind it?

Secretary CELEBREZZE. Yes, the U.S. Treasury is the guarantor the same as under the FHA, or the Federal housing authority.

The CHAIRMAN. In other words, you are now proposing that your authority be extended in the mortgage insurance business just as FHA is for housing at the present time?

Secretary CELEBREZZE. In the one area of proprietary nursing homes, and nonprofit hospitals, and other medical facilities.

The CHAIRMAN. Nonprofit hospitals?

Secretary CELEBREZZE. Yes. HHFA is now handling proprietary nursing home mortgage loans. Under the new bill, we would take care of the nonprofit and we are trying to join the two together.

The CHAIRMAN. Presently, HHFA provides mortgage insurance for certain nursing homes?

Secretary CELEBREZZE. Yes; that is correct.

The CHAIRMAN. Where does the authority for that come from?

Secretary CELEBREZZE. Under the FHA authority, not under our authority.

The CHAIRMAN. Is that in cooperation with one category of our program now?

Secretary CELEBREZZE. Yes; with proprietary nursing facilities.

The CHAIRMAN. Does FHA insure a nonprofit hospital or any part of it?

Secretary CELEBREZZE. No.

The CHAIRMAN. Why is it that if FHA can insure a nursing home under one category of the authority from the Public Health Service Act, it cannot approve insurance for the construction of a nonprofit hospital?

Secretary CELEBREZZE. There you are getting into two features. In the proprietary homes, there are no grants for them. Under the nonprofits, we have basically a grant situation.

Mr. YOUNGER. Mr. Secretary, do I understand that you propose to have a mortgage on the same hospital that you have a grant on?

Secretary CELEBREZZE. It is possible. Providing it does not exceed 75 percent of the total value of the facility at the time of its completion.

Mr. YOUNGER. In the construction of a hospital, sponsors are supposed to furnish one-third. They can borrow that.

Secretary CELEBREZZE. Yes; they can borrow it.

Mr. YOUNGER. They don't have to raise it locally, but they can put a mortgage on the hospital for one-third of the cost.

Secretary CELEBREZZE. They can raise it locally, if they want. In any event, the moneys that they would borrow and we would insure, together with the grant moneys, cannot exceed 75 percent. So in any event, they still have to go out and raise another 25 percent through some other means.

Mr. YOUNGER. Then your mortgage would be only the difference between 66⅔ and 75 percent?

Secretary CELEBREZZE. That is right, assuming that the grant was for 66⅔ percent. The grant might be for only 50 percent. It varies from 33⅓ up to 66⅔ percent.

Mr. YOUNGER. I should think you could get a mortgage of that type very easily without having to even insure it.

Secretary CELEBREZZE. As I tried to point out in my opening statement, our analysis of our mortgage loans show that the average life is only about 14 years, whereas this then puts a greater burden upon particularly the nonprofit hospitals meeting, within a telescoped time of 14 years, their payments, whereas under the Harris bill they could extend those payments up to 40 years, thus lowering their yearly payments.

Mr. YOUNGER. You could insure a mortgage with the payments for 40 years just as well as you could insure the payments for 14 years. All you would have to do is grant that privilege, the same as we do in housing.

Secretary CELEBREZZE. Yes, but our experience has been that private lending institutions in this type of loan only go up to 14 or 15 years, and not to 40 years. That was the whole purpose.

Mr. YOUNGER. When they are only loaning 7 or 8 percent of the cost?

Secretary CELEBREZZE. That is a different situation there.

Mr. YOUNGER. Just the difference between 66⅔ and 75 percent. That is what you say the mortgage will be.

Secretary CELEBREZZE. If they get a grant of a third, or up to two-thirds, on the grounds of one-third you still have 66⅔ of your cost factor.

Mr. YOUNGER. How do you discriminate between a hospital on which you say you will only grant a third and the one on which you will grant 66⅔?

Secretary CELEBREZZE. That is based on a State allotment percentage.

The CHAIRMAN. You say that under the present procedure, anyone who wants to provide a nursing home under one of the categories authorized in the Public Health Service Act can also get a mortgage under FHA?

Secretary CELEBREZZE. That is only the profit nursing homes. They are restricted from making any loans to nonprofit. So FHA only applies to proprietary nursing homes.

Mr. Moss. Mr. Chairman, I wonder if we could have clarification? As I understand it, the loans to nursing homes are not under this act, but were under the housing amendments passed, I believe, back in 1959 or 1960.

Secretary CELEBREZZE. No, there is no provision under existing Hill-Burton for the making of loans of this kind. The only provision for making loans to this type of institution, to proprietary institutions, is under the HHFA loan. We have no authority under existing law to make any kind of loan.

The CHAIRMAN. In other words, under the Public Health Service Act, there can be no FHA mortgage loan.

Secretary CELEBREZZE. That is true.

The CHAIRMAN. That is what I want to get clear, because it is going to become an issue, I think. If we can get the facts clearly before the members of the committee, we will be in a much better position to analyze what is actually proposed.

It has been contended that the authority for nursing homes is presently administered under mortgage insurance with FHA. That is true, for profitmaking institutions. It also has been contended that if this is approved, it will transfer what has heretofore been a program under FHA for profit operating nursing homes to HEW. Is that true?

Secretary CELEBREZZE. That is correct. But you have to take the total, Mr. Chairman. That is providing the provision under your bill dealing with nonprofit is passed. Then we say the two ought to be joined. But if that provision in your bill is stricken from your bill, and we only have the question of loans to proprietaries, then it is best to leave it in HHFA. The two have to go together. That is the point we are trying to make.

The CHAIRMAN. Taking nursing homes as an example, because we have under the Public Health Service Construction Act one category of $20 million annually for nonprofit nursing homes, to be administered by your agency under the same formula of allocations or allotments as it is in hospital construction.

Secretary CELEBREZZE. That is correct.

The CHAIRMAN. Under that category of nursing homes, you can get from 33⅓ to 66⅔ percent Federal funds for the construction of a nonprofit nursing home in a given community.

Secretary CELEBREZZE. That is right.

The CHAIRMAN. You cannot, then, obtain FHA insurance loans as a part of that nonprofit nursing home?

Secretary CELEBREZZE. No. There is no provision in the law.

The CHAIRMAN. Under the present law, FHA will insure loans for a profit operated nursing home.

Secretary CELEBREZZE. That is correct.

The CHAIRMAN. Do I understand this to be true—you would bring the two programs together in one under your proposal?

Secretary CELEBREZZE. That is right.

The CHAIRMAN. Would HHFA in the future have authority to continue to insure loans if it so desired?

Secretary CELEBREZZE. No, under the bill, that function is transferred over to the Department of HEW.

The CHAIRMAN. That would be specifically transferred from HHFA to HEW?

Secretary CELEBREZZE. This has been thoroughly discussed with HHFA before we proposed it.

The CHAIRMAN. I would assume so. That was going to be my next question. And HHFA has given its approval?

Secretary CELEBREZZE. Yes, sir. They have no objection to it.

The CHAIRMAN. You can understand why I am developing this, because we don't want to get into a jurisdictional squabble with another committee of Congress. I want to be sure to avoid that.

After thorough discussion with that agency which administers the program, and those who are involved, such as the Bureau of the Budget and so forth, it was decided that this program, bringing the two procedures together, would work better in the interest of doing something for those kinds of people.

Secretary CELEBREZZE. That is correct, with greater efficiency, too. You would not have so much of a duplication.

The CHAIRMAN. Can't the profitmaking institution come to HEW under this program and say, "We want to build a nursing home which will be a profitmaking institution to take care of certain people, provide a certain need, and we want to get you to approve the loan, or insure the loan, for this purpose?" Can that be done?

Secretary CELEBREZZE. At the present time, no.

The CHAIRMAN. Under the present law, no. But I am talking about under this proposal.

Without the grant provision——

Secretary CELEBREZZE. There will be no grants to profitmaking institutions.

The CHAIRMAN. Suppose a nonprofitmaking institution wants to get a grant and it does get a grant from you? Can it also make application and get you to insure a loan?

Secretary CELEBREZZE. Yes, providing the total of the two do not exceed 75 percent of the total cost of the facility.

The CHAIRMAN. In other words, under no condition could a sponsor and applicant construct such an institution with HEW assistance unless it put up at least 25 percent of the cost?

Secretary CELEBREZZE. Nonprofit. Under the profit, it is different. But that is right, 25 percent of the cost.

The CHAIRMAN. How much would a profitmaking institution have to put up?

Secretary CELEBREZZE. Ten percent. We can insure up to 90 percent.

The CHAIRMAN. In other words, you can insure a profitmaking institution up to the same level as HHFA presently insures?

Secretary CELEBREZZE. That is correct.

The CHAIRMAN. What rate of interest could be charged?

Secretary CELEBREZZE. Five percent, and in certain instances it would go up not to exceed 6 percent, with a service charge of one-half of 1 percent for administration.

The CHAIRMAN. Would the charge have to be 5 percent? Your minimum would be 5 percent?

Secretary CELEBREZZE. No, the language reads not to exceed 5 percent.

The CHAIRMAN. Could you get your other lawyer to point out just where that is?

Secretary CELEBREZZE. At a rate not to exceed 5 percent per annum, at page 32, line 10, of the bill. And not to exceed 6 percent per annum as the Surgeon General finds necessary to meet the mortgage market. So it would depend upon the mortgage market.

The CHAIRMAN. In other words, if conditions and circumstances would seem to justify it, the interest rate could be the 3 percent?

Secretary CELEBREZZE. Yes. That is about the same rule as followed now, where the Federal Government is making loans of this nature. It is generally based upon the Treasury going rate at that particular time. So it could be 3 percent, it could be three and a half percent, it could be 4 percent, depending upon the mortgage market.

The CHAIRMAN. In other words, then, getting away from the nursing home, under this proposal you could have a hospital that would cost x numbers of dollars for the construction. They could make an application for a grant—this is a nonprofit hospital by the sponsor who could qualify—and say they got a 50-percent grant for the total construction of the hospital. They then could apply to you also and get insurance on a mortgage loan of 25 percent.

Secretary CELEBREZZE. That is right.

The CHAIRMAN. But that is as much as they could get.

Secretary CELEBREZZE. That is right. That is the maximum. That is the maximum in that particular instance.

Mr. CHAIRMAN. I would like to clarify one statement I made a while ago. The interest rate is determined by the lending institution, that we cannot exceed 5 percent. In other words, if you go to your private bank, which you would do under the normal procedure, and their interest rate is 5 percent, we could guarantee it. We could go up to 6 percent, but never exceed 6 percent. So the interest rate would be controlled by the lending institution where you have made your application.

The CHAIRMAN. And if that institution said that it was 6½ percent?

Secretary CELEBREZZE. We could not guarantee the loan.

The CHAIRMAN. You could guarantee the loan with 5 percent interest?

Secretary CELEBREZZE. We could guarantee up to 6 percent.

The CHAIRMAN. You would have to meet the market.

Secretary CELEBREZZE. Yes.

The CHAIRMAN. But if you did not find that necessary, you could guarantee loans with an interest rate up to 5 percent only.

Secretary CELEBREZZE. That is right.

The CHAIRMAN. And the lending institution would have to be responsible for the other 1½ percent?

Mr. YOUNGER. If the interest rate is more, you could not insure the loan, could you?

Secretray CELEBREZZE. We could not insure, no. We cannot insure any mortgage which exceeds 5 percent unless the going market rate is higher, but not to exceed 6 percent.

Mr. Moss. I was going to raise the same point. This conforms with VA and FHA. If the rate is beyond that permitted, then you can't participate in the loan as an insurer or otherwise.

The CHAIRMAN. I wanted to get all of this on the record. You have heard the questions that my colleagues on the committee raised here today about this phase of the proposal. As one member this morning said, why are you going to transfer or what are you going to transfer, the construction of these profit operating nursing homes to HEW, taking it away from HHFA. What is the answer to that question? You said a while ago because you get greater efficiency. That is desirable.

Secretary CELEBREZZE. That, of course, has to be taken in conjunction with my previous statement of assuming both features under your bill are adopted. In other words, if we go to loans for nonprofit, which we don't do now, we will have that phase of it to handle regardless of FHA. If we go to that, and then we are going also to proprietary loans, which are now under the authority of FHA, you are going to have a duplication of services.

The CHAIRMAN. In other words, what you are saying here is if we do not extend this to nonprofit institutions, then leave it alone at FHA.

Secretary CELEBREZZE. Yes. That is our position.

The CHAIRMAN. So, now we know what you have in mind.

Secretary CELEBREZZE. That is our position.

The CHAIRMAN. I think you are justified in that.

Mr. YOUNGER. I can see the necessity of doing this. The only thing is if you are going to extend the mortgage insurance to nonprofit institutions, there is no reason why FHA can't insure a nonprofit institution just as well as they could insure a proprietary institution, because they have the experience.

Secretary CELEBREZZE. Only in this instance, the FHA would have to get into the hospital field and start working with the State agencies.

Mr. YOUNGER. No. That phase of it would be approved by you, the same as you do it now.

Secretary CELEBREZZE. Mr. Younger, I think that under the provisions of the bill, if it is under our jurisdiction, the bill as it now is written authorizes us to make use of the HHFA facilities. But I say to you that if you are going into nonprofit, which involves all these detailed matters with State agencies, dealing with hospital problems, I suggest that it not go to HHFA. I think it is obvious from the questions that were asked today how complicated this matter can get. I think if the two are to be joined, the right place to be joined is in the Public Health Service using, wherever necessary, the facilities of HHFA as provided for under the law.

Mr. YOUNGER. I can see the necessity for that up to the point of the insurance. But you want to start a new insurance fund. You want to start a new system of bookkeeping. You want to start a new department in your institution to insure loans.

Secretary CELEBREZZE. Believe me, Mr. Younger, I am not looking for more work or more departments in my Department. I have too many now, believe me.

Mr. YOUNGER. But that is what you would have to do. I say you have a fine agency now that is competent for the insurance. After the bank has agreed to make the loan and you have approved the facility and it is approved by the State, then the insurance, the issuance of the insurance, and the keeping of the books on the insurance and so forth, ought to be left with the FHA. That is my position.

The CHAIRMAN. Of course, we do not have authority under our jurisdiction to amend the law to provide for such insurance for the FHA.

Mr. YOUNGER. But they have the authority to use the FHA insurance if they want to, rather than create——

Secretary CELEBREZZE. The FHA cannot make any loan of any kind today to a nonprofit organization.

Mr. Moss. We would have to amend their act.

The CHAIRMAN. FHA cannot today insure a loan made to a nonprofit hospital.

Mr. YOUNGER. That is right. They cannot insure the loan.

But I say in your act you have the authority to employ the FHA if you wish, or any other agency.

Secretary CELEBREZZE. We do that, too, under the educational system.

Mr. YOUNGER. You can make an arrangement with them to carry the insurance.

Secretary CELEBREZZE. Yes, but we still have the obligation under the nonprofit grants of getting our men into the field on construction, on architectural design, and working with the State. It seems to me that the FHA could not possibly enter into that field with any degree of success.

Mr. YOUNGER. Nobody is asking them to.

Secretary CELEBREZZE. Then the question is, Do you leave proprietaries with the HHFA and do you have us set up our machinery which would require about another quarter? Because, as I said, we do about three-quarters of the work now, under the jurisdiction of the Public Health Service, yet we are both trying to focus on the same thing, which is care in the area of chronic diseases. You are both focusing on the one point. I think basically what we are primarily concerned with is getting as many of these facilities built to meet the necessary needs that we face today and will face.

The CHAIRMAN. I am determined to come to some understanding about it.

Mr. Younger has just said again, and you answered in the affirmative to it, that you could use FHA anyway. You wanted to. That is not as I understand it.

Secretary CELEBREZZE. No, I can't use FHA. I can use their facilities.

Mr. YOUNGER. They can use their facilities.

Mr. Moss. You would have to amend the basic FHA act to permit them to undertake the role of insurer and insure under contract. We should explore, then, the cost that FHA might require to undertake the insuring of the mortgage insuring amounts, of $250 million the first year and $500 million each for 4 or 5 years. It is about $2.4 billion worth of additional insurance.

You are proposing to do it with a fund of $5 million the first year, $2 million the second. What is the ultimate fund, other than premiums paid, for the third and succeeding appropriation years? It boils down to a matter of economics, I would imagine.

Secretary CELEBREZZE. Mr. Chairman, under the present bill, under section 624, on page 42, line 16, dealing with administration, the language is:

> With a view to avoiding unnecessary duplication of existing staffs and facilities of the Federal Government, the Surgeon General is authorized to utilize available services and facilities of any agency of the Federal Government in carrying out the provisions of this part, and to pay for such services and facilities either in advance or by way of reimbursement in accordance with an agreement between the Secretary of Health, Education, and Welfare, and the head of such agency.

A similar provision is in the present law also.

The CHAIRMAN. Of course, the difference is that you answered in the affirmative as to what would be included in this act. Mr. Younger asked you the question as to what the present law was today.

Secretary CELEBREZZE. Yes.

The CHAIRMAN. That does make a lot of difference.

Are there any further questions?

Mr. Secretary, we have kept you much longer than we intended to.

Did you have anyone else in your agency who wanted to give any statement or further information to us?

Secretary CELEBREZZE. No, sir; not unless the committee requests anything further.

The CHAIRMAN. You have been very kind and generous today, with not only your time but with your sincere desire to get this program underway. We want to thank you for it. I am sorry that we have detained you as long as we have, but this is a very important program. I know you are tremendously concerned with it and interested in it.

We thank you for your appearance.

Secretary CELEBREZZE. Thank you, Mr. Chairman.

The CHAIRMAN. The committee will recess until 10 o'clock in the morning.

(Whereupon, at 4:20 p.m., the committee was recessed, to be reconvened at 10 a.m., March 10, 1964.)

EXTENSION AND REVISION OF HILL-BURTON HOSPITAL CONSTRUCTION PROGRAM

TUESDAY, MARCH 10, 1964

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

The committee met at 10 a.m., pursuant to recess, in room 1334, Longworth Building, Hon. Oren Harris (chairman of the committee) presiding.

The CHAIRMAN. The committee will come to order.

In continuing the hearings on H.R. 10041, revision and extension of the Hospital Construction Act, the first witness this morning will be Mr. Graham Nixon, director of the Arkansas Hospital Association. Mr. Nixon, we are glad to have you and we will be pleased to have your presentation at this time. Let me personally extend to you a cordial welcome.

I notice you have several associates with you. Perhaps you will identify them for the record.

STATEMENT OF GRAHAM NIXON, DIRECTOR, ARKANSAS HOSPITAL ASSOCIATION; ACCOMPANIED BY DR. MARTIN R. STEINBERG, DIRECTOR, MOUNT SINAI HOSPITAL, NEW YORK, N.Y.; AND KENNETH WILLIAMSON, ASSOCIATE DIRECTOR OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. NIXON. That is right.

Mr. Chairman and members of the committee, my name is Graham Nixon. I am executive director of the Arkansas Hospital Association and a member of the Council on Government Relations of the American Hospital Association. I am also a member of the Senate of the State of Arkansas.

With me is Dr. Martin R. Steinberg, who is director of Mount Sinai Hospital in New York City. Dr. Steinberg is also a member of the Hospital Review and Planning Council of Southern New York. We are accompanied by Kenneth Williamson, associate director of the American Hospital Association.

On behalf of this association, I first wish to express our appreciation for the opportunity to discuss with you the operation and accomplishments of the Hospital Survey and Construction Act and our views with respect to H.R. 10041, the Hospital and Medical Facilities Amendment of 1964.

With your permission, we would like to divide our formal testimony into two parts. I will present the background information and the

role of the American Hospital Association in the development of the program and its accomplishments, as well as the association's concern with the matter of modernization and steps which we have taken in that regard.

Dr. Steinberg will then discuss the detailed provisions of the bill and specific recommendations of the association concerning the legislation.

The American Hospital Association, which has supported this program since its inception in 1946, is a voluntary, nonprofit membership organization including within its membership the great majority of all types of hospitals, among which are 90 percent of the Nation's general hospital beds which in 1962 admitted more than 26.5 million patients and treated over 99 million in their outpatient facilities. 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.

During the years of the depression and the years of the Second World War, which followed, there had been very little hospital construction in the Nation. Many communities throughout the country were without hospitals and other health facilities, and consequently, without doctors. To millions of Americans, there was very little sense in talking about the miracles of modern medicine because lacking hospitals they were deprived of the benefits of this new day in medicine.

Basic studies sponsored by this association, beginning in 1944, through the Commission on Hospital Care documented the problem and supplied the framework on which the Hospital Survey and Construction Act was built. We take pride in this, in having some of the background research that set up the original program. Throughout the 18 years since its enactment, we have followed the program closely. We have maintained continuous and close communication with the hospital field regarding the operation of the program. We have worked with the State agencies responsible for the operation of the program. We have worked closely with the Surgeon General and his staff.

Officers of the association have been members of the advisory council to the program. We have sponsored conferences throughout the country for the discussion of the program and its operation. We have consistently supported appropriations before the House and Senate Appropriation Committees.

In more recent years, we have worked closely with the Surgeon General in regional planning studies. Throughout the years, as there have been hearings before congressional committees, we have appeared and presented our views with respect to the program and our recommendations for its continued improvement. We have been gratified that the Congress has in most instances accepted our recommendations.

Under the Hospital Survey and Construction Act, hospitals have been built in several hundred communities where hospital care had not previously been available. Doctors followed the building of the hospitals and thus were brought into these communities.

In a total of 7,061 projects, which were approved as of June 30, 1963, 271,478 hospital beds have been built or are under construction, 28,864 nursing home beds, 974 public health centers, 588 diagnostic

and treatment facilities, and 280 rehabilitation facilities have been completed or are under construction.

Despite the encouraging progress, however, much still remains to be done. There appears to be a continued race between obsolescence of existing facilities, increased need for care, and population expansion.

It is our belief that the Federal Government through this act is doing much more than providing dollars for construction. The Government through the program has become a major force in shaping the kind of health services we are to have in this country. It is thus influencing the cost of care, the quality of care, and the quantity of care to be made available.

Since the time the Congress first enacted the Hospital Survey and Construction Act, there have been many changes in patterns of care and needs. For years relatively few hospitals provided emergency services. This has now become a nearly universal practice.

However, a definite change has taken place. The public is now coming to hospitals in tremendous numbers as ambulatory patients seeking a wide range of medical care and not just emergency care.

This past year, 99 million such ambulatory patients received care in general hospitals. A broad spectrum of diagnostic and treatment facilities is needed. One particular example is in respect to the treatment of mentally ill patients.

The change that has taken place in medicine and in hospitals is seen most forceably in the fact that 18 years ago 65 to 75 percent of the total area constructed in hospitals went into patient bed areas. The balance of the space went to meet all other service needs. Today perhaps 20 percent of the total area constructed goes to patient beds and the balance for diagnostic and treatment facilities and service areas needed to serve the patients.

You are well aware of the fact that the cost of care has increased greatly. This cost involved medical progress and change, facility and equipment costs; but most of all, personnel costs. This latter is perhaps 75 percent of the total. Personnel needs have gone from 1.5 personnel per patient 18 years ago to 2.8 personnel per patient on the average today.

Though great improvement has been made in the salaries of hospital personnel, there is still considerable need for further improvement to make these salaries comparable to the education, qualification, and responsibility of the individuals involved. This is going to take a lot more money.

The original cost of the hospital is its least cost. The year-by-year cost of operation is the really big factor. Empty and unused beds are wasteful and increase the cost of care to patients who are occupying beds. This is a serious problem for smaller hospitals since many of them run an occupancy rate of well, well below what is considered to be an economic level. Even greater care must be taken that we do not construct unneeded hospital facilities and that we avoid wasteful duplication of both facilities and services. Better planning and greater cooperation and control are an absolute necessity.

Great pressure is being exerted both from within and without the health field for higher standards of care. Higher standards and improved quality generally mean higher costs. Higher quality of health

care will require more and better, larger hospitals and a greater concentration of very costly diagnostic facilities together with the most efficient use of highly skilled personnel who are in short supply. It also means higher standards of care in small facilities and stricter adherence to limiting the care undertaken in such facilities to relative levels of ability.

As the diagnosis and treatment of patients becomes ever more intricate and specialized, it behooves us to concentrate facilities and services and strengthen the ability of such centers to perform.

There is ample evidence of the necessity for basic changes of emphasis in facility planning and construction, and for the kind of thorough reappraisal of the Hospital Survey and Construction Act and the role of the Federal Government which you have arranged before this committee.

The voluntary health system of the country is unique. It has enormous potential for the future. To move ahead in some area of need we must have the help of Government. We most earnestly urge that the Federal Government now plan to assist the country to move ahead in this area of serious neglect; that of modernization of existing hospital plants.

To do this may require a reappraisal of Government expenditures for totally new facilities, but we do hope also with a resulting decision to provide substantial new financing. We have some specific recommendations in this regard which Dr. Steinberg will discuss with you.

In 1958, when we appeared before the committee, the cost of construction of hospitals averaged somewhat in excess of $17,000 per bed. The cost today is over $20,000 per bed. Thus the delay in meeting needs becomes ever more costly.

In 1958 we appeared before this committee and outlines the situation with respect to hospital construction. I wish to quote the following statement presented at that time:

> While the Hospital Survey and Construction Act has accomplished a great deal to improve the Nation's hospital plant, it has done this primarily in terms of new construction and has left largely untouched a serious and rapid growing need for renovation and modernization of our older hospital facilities. The channeling of these funds so largely into new construction rather than renovation, together with the emphasis which the act places on rural areas, has produced in many cases a pattern of modern and efficient small hospitals in regions surrounding metropolitan areas, while the metropolitan areas themselves are served by institutions many of which are far from being either modern or efficient. The plight of these urban hospitals and the growing deficiency of their physical plant are important to the total health picture, not only because of the large population served by these hospitals, but because as centers of both medical research and professional training they exert influences which are felt throughout the Nation.

The picture has not improved; it has simply become worse.

In 1956 the association conducted a survey, in collaboration with the U.S. Public Health Service, of the modernization needs of hospitals. This study indicated at that time a total need of well over $1 billion. Of the 2,634 hospitals covered by this survey, 435, or one in six, were more than 50 years of age.

There are obsolete facilities in every section of the country. In 1960, the Public Health Service, in a further effort to determine the magnitude of the problem of modernization, undertook a nationwide study in cooperation with the State hospital construction agencies

and metropolitan planning bodies. Direct reports were obtained from 25 metropolitan areas each having more than 2,500 general hospital beds, and that is 2,500 in each area, and sample reports were received from 32 smaller metropolitan areas.

This study indicated a total cost of need for modernization of $3.6 billion. This figure was indicated to be approximately 20 percent of the total assets of hospitals in the United States. Obsolescence, I should point out, is not solely a matter of age; rapid advances in medical techniques have rendered many institutions inefficient despite their relatively recent construction.

We believe the Hospital Survey and Construction Act is a unique and highly successful demonstration of Federal-State relations at their best. It derives its real strength—

*** * * from the fact that it is Government and voluntary enterprise working together.**

We believe that the following basic principles which were built into the program have had much to do with its success:

1. A demonstrated need, substantiated by study and survey.
2. Local decision of greatest need and priority for expenditure of funds.
3. Maximum administrative authority given to the States.
4. Joint financing by all parties concerned.
5. General coordination and supervision by the responsible Federal Government agency.
6. Requirement that there be assurance of local responsibility and intent for the operation of any facility.
7. A Federal council to review administrative procedures to insure that the Federal administrator does not act in an arbitrary manner.
8. A formula for the division of funds which recognizes the relative needs of different sections of the country and their ability to meet these needs.
9. Procedures which minimize political influence.

In conclusion and before Dr. Steinberg discusses the details of the bill, I wish to emphasize the belief of the American Hospital Association that the Hospital Survey and Construction Act is still urgently needed and should be continued for the provision of new facilities; and that various changes should be made in the act to improve its operation and that it should be restructured so that a major new addition in the form of a program for modernization of facilities is added to the act.

This completes my formal statement, Mr. Chairman. Dr. Steinberg will continue with the second part of our testimony.

The CHAIRMAN. Thank you, Mr. Nixon. I believe it would be appropriate for us to have the complete story from the association before we attempt any questions that members might have, so, Dr. Steinberg, you may continue.

Dr. STEINBERG. Thank you, Mr. Chairman. I am Dr. Martin Steinberg, having already been kindly introduced by Mr. Nixon. I would like to say a word, however, about our particular role in New York in this very pertinent field of renovation and modernization. I am the chairman of the Committee on Physical Facilities of the Hospital Survey and Planning Council of Southern New York, which encompasses an area of 14 counties, including in and around New York City, and

our job is to study and know all of the hospital facilities in the 14 counties and to advise governmental, philanthropic, and other agencies with regard to these facilities and to study them completely.

We also are the local agency for the State hospital survey and construction authorities in Albany, N.Y., and so we have built up over many years a very intimate knowledge of some of the things in this bill. I thought I would give you an overview of that.

There are several provisions in H.R. 10041 in which the American Hospital Association has a particular interest. We are in general agreement with the intent of the bill. However, I will devote a major part of my comments to the area of modernization which is, we feel, the most important new subject set forth in the bill.

I will discuss in order the sections, titles, and paragraphs as they appear in the bill for your own ability to follow. I start with section 318, special project grants for assisting in the area-wide planning of health and related facilities.

We strongly support the need for area-wide planning of health facilities. The continued cost involved in the operation of health facilities demands that there be advance planning and control so as to avoid any unnecessary duplication of facilities and service within a given community.

Recently our association joined the United States Public Health Service in an extensive study of this subject and in the development of a basic document setting forth the principles which should guide area planning agencies. This document, called area-wide health planning for hospitals and related facilities, has been widely distributed and is considered as a fundamental guide. I have a copy of this text which I will be glad to leave with you, Mr. Chairman, if you desire.

The CHAIRMAN. You say starting with section 318 in the bill.

Dr. STEINBERG. Yes.

The CHAIRMAN. What page is that on?

Dr. STEINRERG. Page 2, line 1.

The CHAIRMAN. All right.

Dr. STEINBERG. At the time the Hospital Survey and Construction Act was initiated, we all had a vision that the program would gradually work toward coordinated planning and operation of health facilities. We have not as yet moved very far in this direction. However, it seems to us ever clearer that we must now begin to take such steps. We believe that area-wide planning is the best mechanism to bring this about.

We have for several years recorded our support of the Federal Government providing "seed money" to develop areawide planning and to assist in demonstrations which would provide experience and guidance that is needed. Through the research and demonstration funds provided under the Hospital Survey and Construction Act, a good start has been made. However, we have not felt that Government support should be provided for the continued operation of such endeavors beyond the initial stages of development.

These areawide planning agencies are intended to be voluntary community organizations, and we believe that their support should come from voluntary sources.

The proposal in the bill, which suggests continued financing of area-wide planning agencies for the full period of 5 years, may well carry

such support beyond the point of initiation and demonstration and, in essence, might become continued Federal financing for their operation. We would suggest, therefore, that the proposal be amended to limit such support to a 3-year period for any given project. This should have the further advantage of providing the means to assist a greater number of projects than would otherwise be possible.

TITLE 6, SECTION 600—ASSISTANCE FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

With the exception of two new provisions, the remaining provisions of this section are generally those which have existed in the past under the Hospital Survey and Construction Act. The two provisions are those providing for proprietary nursing homes and for modernization of facilities.

We look upon the inclusion of proprietary nursing homes in the program with considerable misgiving. The association strongly supported the passage of legislation providing for guaranteed mortgage loans to proprietary nursing homes under the Housing Act.

At that time, we urged an amendment to the legislation which was accepted. Our recommendation was that determinations as to the need for proprietary nursing homes in a given area should be certified to by the United States Public Health Service on the basis of criteria developed under the Hospital Survey and Construction Act. We felt that such determinations were necessary to make sure that the Federal Government would exercise some control over the construction of both nonprofit nursing home facilities and proprietary facilities.

It seemed to us that, with such certification by the health arm of the Government, it was quite satisfactory that the administrative and banking aspects of the program were handled by the Federal Housing Agency which was already staffed and knowledgeable in such matters.

To the best of our knowledge, this has worked satisfactorily. We have serious doubts as to the wisdom of mingling nonprofit facilities and proprietary facilities in the same program.

We are particularly pleased that the bill does include the encouragement toward new developments and improvements in health facilities and their planning by the provisions for demonstration and research. We have always supported the need for Federal financing for medical research, and we believe it is highly essential that this move ahead, hand in hand, with research pertaining to health facilities and their administration.

SECTION 601—AUTHORIZATION OF APPROPRIATIONS

We fully support the expanded funds proposed for construction of long-term care facilities and the combining of the previous separate categories of chronic disease and nursing homes. The unmet need for such facilities amply supports the proposal for a substantial increase in the funds to be made available.

The bill proposes to continue grants for the construction of rehabilitation facilities. We support the need for Federal assistance to provide such facilities. However, we were pleased that the Congress amended the Hospital Survey and Construction Act in 1961 to assure

that encouragement would be provided for the development of such facilities on a broad basis. We recognize the special need of "comprehensive" facilities which involve services other than purely medical services; that is, vocational and social guidance.

However, we feel that encouragement should be given for the widest possible development of rehabilitation facilities even though they not be comprehensive in character. Therefore, we oppose the provision that would practically limit rehabilitation facilities to university centers. We feel this provision will make for less facilities than are clearly needed throughout the country.

The CHAIRMAN. I don't like to interrupt you, but will you make that statement over again. You said it a little different from what we have in our prepared statement. Let me see if you said the same thing in a different way.

Dr. STEINBERG. Good. I will read it again and then I would like to say a word about it. Therefore, we oppose the provision that would practically limit rehabilitation facilities to university centers. We feel this provision will make for less facilities than are clearly needed throughout the country.

The point there is that we, of course, want the most comprehensive rehabilitation facilities and we recognize that these can best be constructed in the university centers. We are concerned, however, in a practical situation that there just aren't enough university centers to furnish the rehabilitation needs of the country and we would hope, therefore, in addition to these, that latitude be given for the development of complimentary centers which are not as comprehensive.

We are talking now about the relatively small number of university centers. We are not arguing against quality here. What we are saying is that we would hope to complement the best of quality with perhaps less comprehensive centers in areas other than university hospitals.

The CHAIRMAN. Doctor, as I said, I did not want to interrupt you, but when we need a clarification I think interruptions are justified. You have just said that the provision in the bill as you interpret it would limit the development of such facilities to university centers. You said in your statement that the bill would establish a priority for rehabilitation facilities in university centers.

To me those are two different things. Which do you understand to be the fact? Does it establish a priority, or does it limit the development to university centers.

Dr. STEINBERG. It establishes priority, and in the sentence I said, "would practically limit." We feel that in practice it would be very difficult to supplement these. It is a matter of degree.

The CHAIRMAN. All right; just so we have it clear.

SECTION 601 (B) MODERNIZATION OF HOSPITAL FACILITIES AND OTHER MEDICAL FACILITIES

Dr. STEINBERG. As Mr. Nixon has already stated, the Hospital Survey and Construction Act has since its enactment in 1946 made a substantial contribution to the development of needed health facilities in the Nation. At the time the program was started, it was essential that first priority and particular attention be given to areas of the country

which were without hospital facilities, and therefore, where the public was not likely to have available to them the benefits of modern medical advances.

It was further sensible to direct the program toward providing new beds. The picture today is vastly different. Though a considerable need still exists for additional beds and other health facilities, the urgent need of rural areas has been met in substantial part in most sections of the country. We believe we are now at the point where the great unmet needs of our large urban population centers must be cared for. We consider the surmounting and major problem of health facility needs in the Nation today to be that of the older outmoded hospital and with inefficient and often unsafe plants. This problem, though it exists in large part in metropolitan centers and in the older cities of the country, also exists to an appreciable extent in older small facilities in small cities and towns.

As Mr. Nixon stated, a growing awareness of the problem induced the association to make a nationwide questionnaire study. This revealed a need for modernization of over $1 billion and a later and more comprehensive study made by the U.S. Public Health Service indicated a figure of $3.6 billion was needed for modernization.

Since that time, several areas have undertaken regional or metropolitan studies. In the city of New York a project was underwritten whereby a team of architects and engineers visited individual hospitals and developed detailed figures on the basis of on-the-spot surveys. For that city alone, it was determined that the modernization of existing hospitals would require an expenditure of $250 million.

This study in New York serves to validate the opinion of many experts that the nationwide figures have understated the size of the problem. In New York it was found, for instance, that the expenditure of $120 million was necessary merely to replace non-fire-resistant facilities, and I tell you that the $250 million figure is really understated because by the time we reached that figure we were trying to get up the needs so that we could mount a capital fund drive among the population and corporations in New York, and when we reached the $250 million things slowed down. There was just no use in going on. We never did have the drive.

I might say even among the few very large hospitals in New York right now there are two hospitals there, the Cornell and Columbia teaching centers, Presbyterian and New York Hospitals, which have surveyed their own plants and would need about $30 million, two of them, just to bring their plants up to what they would consider the modernization standard.

Mount Sinai, which I represent, would need about $11 million if we were to do all of the things that we think are necessary.

I do want to say at this point one thing, Mr. Chairman, and that is that when we talk about modernization, we must deal with it in statistics, of course, but actually to the administrator and the staff of a hospital these are terribly important things because the business of good transport, of efficient facilities, is actually a very important incident in the health of our patients. We really feel that they are being compromised unless we can do this well, and there is another and important point and that is really an economical one.

You heard Mr. Nixon tell you about the fact that almost 75 percent of our expenses are in payroll. That payroll is not going to be reduced by reducing the levels of pay, because they are not very high today, but we can look forward, we hope, to such things as pneumatic tubes, and automatic elevators, and other devices which will finally give us some sort of purchase on this ever increasing cost, so we are talking both in terms of patient health and in terms of economy.

Mr. SCHENCK. Mr. Chairman, may I interrupt there?

The CHAIRMAN. Yes.

Mr. SCHENCK. Referring to automatic elevators, that seems to be a difficult question, doesn't it? An automatically operated elevator is going to go all the way up or all the way down, isn't this true, and you can't change its direction in the event of a dangerous situation, fire or anything else. You can't evacuate patients. Isn't that true?

Dr. STEINBERG. Mr. Schenck, you share what was our great concern when we first studied the problem of automatic elevators in hospitals. We were worried just about the things you talk about, but, as a matter of fact, we have solved these things and in practice all modern, new hospital buildings have automatic elevators and they work perfectly well. The practice has simply taught us that they can.

We tried gingerly at the beginning, but there are devices to stop an elevator in an emergency. The attendant who needs the elevator for emergency puts the key in and stops it, et cetera, and patients when they come on elevators are attended. A patient doesn't get on an elevator in the hospital without an attendant, so we are not concerned about that. It works perfectly well.

Mr. SCHENCK. You are expressing the hope that there is someone with a key available to operate the elevator to evacuate not only patients but visitors if you have a fire. Isn't that true?

Dr. STEINBERG. These elevators have the row of buttons that you have in the commercial elevators and can be operated with closed door or open buttons, and all the instructions are there, and I suppose we would be better off if we had an elevator there at the time of fire. I can only say that these things have worked out very well. I have never heard of any hazard with them. They have all sorts of safety devices.

For instance, the elevator door cannot close as long as a patient or a person is within 8 inches of the outside of the door, so that the electrostatic buildup of the body itself holds the door open, and they have been surrounded by many automatic devices.

I must say, however, when we talk about automatic elevators in renovation that our elevators are old. If we had to do any sort of renovation on our elevators, for instance, in New York City, we would have to give them up. They are no longer acceptable under new standards. Therefore, we go into automatic elevators. An automatic elevator is a tremendous economy device and, as a matter of fact, happens to be tremendously more efficient than a manned elevator, at least in hospitals, but I do recognize you are recognizing the same fear we had in the beginning. In practice they have worked out.

Mr. SCHENCK. I am a bit concerned about this, the same as I am concerned about automatic pushbutton missiles in warfare. I per-

sonally don't believe you can replace the judgment of a man in a manned bomber any more than an elevator operator can be replaced with safety by an automatic pushbutton elevator.

Dr. STEINBERG. The concern, of course, is a real one, but I can only say that throughout the country, at least in the large cities, as I take a look at our buildings, we are going in for automatic elevators. I don't know of a single installation that doesn't have them, even in hospitals.

To proceed, the large urban teaching hospitals are the key to the whole health structure of this Nation. It is these hospitals which provide the essential education for physicians, nurses, dietitians, medical record librarians, physical therapists, and the other people who make up the health team. It is interesting in this regard that medicine now has become an 8-year discipline. With very few exceptions, our medical students at the end of 4 years of medical college go into a hospital not for 1 year but for a year of internship and 2, 3, or 4 years of residency, so that practically a very large percentage of the doctors get their training not only in the medical schools but in the larger hospitals in this country. This is a tremendous factor today because if for some reason this training were to stop, I believe in about a decade we would no longer enjoy the fruits of medicine. We are spending vast amounts of money for medical research in the county. Much of this research must be carried out in these large older teaching hospitals, and it is important that they continue the research.

The benefits are made available promptly for patient care. I would like at this point to tell the committee, if they don't already know, that so important a discovery as penicillin by Sir Alexandria Fleming actually was in the laboratory, having been discovered almost 10 years before it was used widely for patient care. You can imagine what this would have meant to the world if it had been done earlier, because it was done in a scientific laboratory, not in a hospital, and it simply wasn't used for patient care for almost 10 years. To give you another example, it was discovered in England about 2 or 3 years ago that if you radiated a cancer patient in a room where a vacuum had been produced, the effect of the radiation seemed to be more advantageous, and so they began to build vacuum chambers for this particular purpose. They called them vacuum chambers. Then we began the study all together of what happens when you change the air pressure in other regards in medicine, and what has developed there has been a movement to construct chambers where we don't have a vacuum, but which actually produce two or three atmospheres of pressure. These are called hyperbaris chambers.

The remarkable thing is that these things, having developed in hospitals and being used practically out of the laboratory stage, are already beginning to be constructed in some of the larger hospitals, and we happen to be one of them, in this country.

The promise of these things and such things as the treatment of coronary artery disease and the treatment of apoplexy is very, very exciting, so much so as to warrant the expenditure of a fair amount of money for these things.

I am discussing now the necessity that the research go on in the larger hospitals because our patient care is so close that these things are transferred very promptly and very effectively. We believe that

the American public, which in large part depends upon the older and outmoded hospitals of the Nation, deserves fair and larger expenditures for hospital renovation. The need for modernization has reached such proportions and is of such severity that we must meet it with action.

We are, therefore, extremely pleased that this bill at least recognizes the problem and the need for the Federal Government's participation in working toward a solution.

However, we must call attention to the fact that any appreciable impact on the problem will require the expenditure of large amounts of money and large amounts of Federal assistance, and that the amounts provided in H.R. 10041; that is, $160 million for a 5-year period of modernization, are likely to effect little, if any, impact.

We recommend that the bill be amended so that for the fiscal year ending June 30, 1965, $50 million be provided for the fiscal year ending June 30, 1966, $70 million, and for each of the following 3 years, $100 million, making a total of $420 million in grants for a 5-year period.

We believe, in fact, that this is a minimum amount of money to be considered if an adequate beginning is to be made in attacking the problem. We feel it is unnecessary to lose the first year as this bill provides. Many projects could move ahead rapidly if funds were made available.

We recommend further that $100 million be provided annually in each of the 5 years covered by the bill for the construction of new hospitals and other medical facilities. It will produce only an adequate beginning.

We recognize that, and these amounts are recommended in addition to the $100 million provided for long-term care facilities, diagnostic and treatment centers, and rehabilitation facilities.

We say this with respect to the fact that there is a limited amount of money available. We would rather hope that that $100 million for new construction might be $150 million indeed, but with an eye to what is feasible these are our recommendations.

The bill provides that States may transfer renovation and modernization funds into the new construction category. We believe this to be an unwise provision and recommend that funds provided for modernization purposes be earmarked exclusively for this purpose.

GEOGRAPHIC VARIATIONS

It is recognized that the extent of the problem varies in different sections of the country. Though hospitals in larger, older cities predominate, a need also exists in hospitals in small towns and cities. The bill recognizes this fact in that it allocates funds to areas of greatest need, departing for renovation purposes from the standard allotment formula. We do have some concern for the imposing of financial need of the State as a remaining consideration in the area of renovation, because we feel that this unnecessarily complicates what could be a relatively simple determination. We are talking now about the renovation needs for the existing facilities. These existing facilities are in large metropolitan areas so that the population factor is already a determinant of where these things are.

The fact that the renovation needs exist means that there hasn't been the money, the communities do not have the money to renovate; and therefore these two remaining things need not go into consideration. The consideration can be in this case actually an addition of the actual local needs, area by area, State by State, to build up the total formula of total need, and these can then be allocated on the basis of proportionate need of the individual project.

THE SIZE OF THE INDIVIDUAL PROJECTS

Individual projects for modernization often require large expenditures which in the cases of many hospitals will amount to several million dollars. As a matter of fact, in our 1958 study we found that the hospitals of over 500 beds had an average need of $1,377,000 for renovation purposes, average.

Under the Hospital Survey and Construction Act, by administrative decision, limited amounts of money have been provided for a single project. This was necessary to enable the fund to assist as many projects as possible.

These were smaller projects than the ones we are talking about for modernization. A different philosophy for the allocation of funds is essential if the boards of trustees of individual hospitals are to be enabled to raise the funds for large-scale modernization projects.

A grant formula will be required that differs from that used in the Hospital Survey and Construction Act where grants run from 33⅓ to 66⅔ percent, depending upon the financial position and decision of the State.

We recommend that the minimum grant for renovation be 50 percent in order to accomplish a substantial amount of modernization.

FINANCING OF BORROWED MONEY

Even with 50-percent grants, project sponsors will have to obtain large amounts of additional funds, thereby creating a heavy burden of debt. This indebtedness will be borne largely by paying patients and will cause an appreciable increase in the price of hospital care. Attached to this statement is a table indicating additional patient-day costs which would result from varying amounts of indebtedness at different rates.

The table also relates the figures for hospitals of varying size. This is the last page in the statement you have before you, and what it shows is that the difference between a lower and a higher percent—wo go up to the six and a half percent certainly—might be as much as about $1.50 per day in the bill of the patient.

Mr. Nixon informed you about 26 million admissions and perhaps eight or nine times as many patient-days. Begin to do some multiplication there and you realize what sort of enormous bill you are adding to the hospital bill of the community unless these interest charges are kept low. The size of this indebtedness is a matter of serious concern to boards of trustees and would, we believe, discourage many of them from going ahead with needed projects if they are subject to the interest rates of the commercial money market.

We strongly disapprove of the proposal in this bill for insured mortgage loans which may run as high as 6 percent with an additional

one-half percent for premium charges, which may be passed on to the mortgagor. As a matter of basic principle, it is felt that the needs of modernization must be approached so as to cause the least possible increase in the cost of hospital care. We recommend, therefore, that the bill be amended to provide for a program of direct Federal loans rather than insured mortgage loans.

Such a program of loans is proposed in H.R. 2102, introduced by Congressman John Moss of this committee. It is our belief that the Federal Government could provide a great incentive for modernization of hospital facilities if it were willing to underwrite in part the cost of the money to be provided by bringing the interest rate down to around 2 percent.

However, if such a subsidized rate of interest is not feasible, we urge at least a system of direct Federal loans at interest rates available to the Federal Government. We agree with Mr. Moss that projects sponsored should be enabled to receive a 50-percent grant from the Federal Government and to borrow additional needed funds from the Federal Government through direct, low-interest loans up to a maximum of 80 percent of the total project cost.

METHODS OF ALLOCATIONS

The segregation of allocations for modernization as proposed in the bill is highly essential, we believe.

RELATIONSHIP TO NEW CONSTRUCTION

We believe that the legislation should provide for two separate programs, as we have recommended, with one program providing money for new construction, the second program providing money exclusively for modernization. The two programs would be parallel and complement one another.

GENERAL REGULATIONS, SECTION 203

This deals with new bed construction. This section provides for special consideration to facilities serving rural communities. At the time the program was started, such a provision was indicated. Through the years, rural areas have received preferred treatment and first priority in the allocation of funds. As a consequence, the most acute rural needs have been met. The rapid growth of population in urban areas has resulted in unmet needs for new urban facilities.

We believe that the rural priority no longer is needed and we recommend, therefore, that the provisions granting priority to rural areas be stricken from the bill and the language be amended to permit the States to give special consideration to areas of greatest need.

This section of the bill also provides that special consideration be given to rehabilitation facilities in university teaching hospitals. We have questioned the wisdom of this provision, not because we are in any way opposed to comprehensive rehabilitation centers in universities, but, rather, that we believe the States should be free to provide the additional, although less than comprehensive, programs needed in many areas.

The bill also provides that special consideration be given to densely populated areas for modernization facilities. We believe that, at this time, such a provision is indicated, since the bulk of the need lies in such areas.

The bill also authorizes the Surgeon General to develop criteria for determining the need for hospital beds and facilities in a given area, thus removing the previous statutory provisions establishing ceilings. These ceilings have not been helpful, being too high in some areas and too low in others. We feel the language in the bill is a decided improvement and it will encourage more intelligent planning.

SECTION 604, STATE PLANS

The bill provides for the establishment of State advisory councils, and names the types of individuals to be selected to serve on such councils. We would recommend that the language be amended so as to provide for the inclusion of an individual who is authoritative in the field of mental health.

The recently passed mental health-mental retardation program will be administered in some States by the same State agency which administers the hospital survey and construction program. In all States, there is a need to coordinate planning activities between mental facilities and others.

It is noted that the bill requires the appointment of mental health experts to the Federal Hospital Council, and we suggest a similar requirement for State advisory councils.

SECTION 621, MORTGAGE INSURANCE

As previously stated, we oppose the principle of insured mortgage loans for nonprofit institutions. However, we wish to point out an inequitable position in the existing language in the case of nursing homes. The bill provides that a secured mortgage for a nonprofit nursing home could not exceed 50 percent of the value of the facility, whereas a proprietary nursing home may secure such a mortgage not to exceed 90 percent.

In addition to the inequity referred to between the maximum financing as between nonprofit and proprietary facilities we strongly feel that the Federal financing of all kinds, whether grants or loans, in any form, or a combination of the two, should not exceed 80 percent of the total project cost.

We believe the sponsors of the project should be required to invest a sufficient amount themselves in order to provide the Federal Government with the assurances as to their interest in the project. This is especially true with respect to proprietary nursing homes which attract speculators.

If this bill were passed, we can visualize numerous instances where a nonprofit nursing home may be unable to obtain a Federal grant and, therefore, might be forced to borrow the total amount. We believe the nonprofit homes should be able to borrow, as is provided for proprietary homes up to a maximum of 80 percent. The bill provides that proprietary homes may borrow up to 90 percent.

In cases where a nonprofit nursing home received a grant, they should be able to borrow additional funds not to exceed 80 percent, including the grant and the loan.

In conclusion, we have greatly appreciated the opportunity of appearing before this committee and presenting the views of the American Hospital Association. We sincerely hope that our comments and recommendations will prove helpful in the final development of legislation.

We wish to commend the committee sincerely for the enormous contribution it has made in the past to advance the health and welfare of the American people. We are most appreciative of the forward look which the committee is giving to the facility needs of the Nation. We feel that your consideration of the need for modernization of our older health facilities is a major step forward.

The pace of medical advancement in the United States is such that we must move ahead without delay in providing facilities, personnel, and organization necessary, and we hope to make these advances available to all people. The American Hospital Association stands ready to be of all possible assistance to this committee. Thank you.

The CHAIRMAN. Doctor, let me thank you on behalf of the committee, as I have already thanked Senator Nixon, for your appearance here and your presentation of the views of the American Hospital Association.

We have known of the long interest of the American Hospital Association and the tremendous contribution you have made to the programs which this committee has considered over the years. We appreciate the valuable assistance that you have continuously given to us out of the continuing studies that you have made with reference to the need.

Mr. Williams, have you any questions?

Mr. WILLIAMS. No, Mr. Chairman.

The CHAIRMAN. Mr. Springer?

Mr. SPRINGER. Mr. Chairman, may I say to Senator Nixon, and to Dr. Steinberg, this certainly is an excellent statement of their position, and I think it has been done rather thoroughly and exhaustively. We will certainly benefit a great deal from it in understanding what their position is.

Dr. Steinberg, were you director of Mt. Sinai Hospital in 1946?

Dr. STEINBERG. Yes, I was, sir.

Mr. SPRINGER. Are you acquainted with the early hearings and the position generally with reference to the Hill-Burton Act?

Dr. STEINBERG. Completely, no. I have some familiarity with it.

Mr. SPRINGER. Are you familiar with the philosophy or the theory on which Hill-Burton was founded?

Mr. STEINBERG. I think I am.

Mr. SPRINGER. Would you tell me what you think that was?

Dr. STEINBERG. That was the desire on the part of responsible government to make Federal help available to the community hospital facilities which were not available without some sort of Federal funding. The idea was to stimulate a partnership of Government funds and local aid, in order to get the hospital needs of rural communities, smaller communities, as well as some of the larger ones, into focus and closer to need.

Mr. SPRINGER. But the philosophy behind that was essentially putting hospitals where there were no hospitals, essentially because the economic condition in that area could not supply a hosiptal without this kind of help.

Isn't that essentially what it was, regardless of where it was? It was to put a hospital or to put an additional hospital in an area, regardless of whether is was city or rural, which essentially, economically, didn't have what it took to get it without this kind of help.

Dr. STEINBERG. That is a closeup.

Mr. SPRINGER. Now, what is the philosophy today behind modernization?

Dr. STEINBERG. The philosophy behind modernization is the philosophy that meets a practical, existing situation just as did the Hill-Burton bill, the survey reconstruction bill, in its inception. We are faced with hundreds of large and important hospital plants. These hospital plants physically—their physical facilities—have not been kept up. They have not been kept up not because of lack of community interest or lack of the interest on the part of the trustees but they have not been kept up because the relatively scarce dollar has been spent in areas where they had to be spent for medical progress, with tremendous demands on them. We are faced with this practical situation.

The philosophy then, it would seem to me, would be to do something about this. Nothing has been done. This is not new. This has been going on and is getting worse for the past couple of decades.

So here we are faced with this situation, and the philosophy is to meet it. Apparently local funds cannot do it alone. So the call is for some Federal help.

Mr. SPRINGER. Are you saying that the city of New York cannot supply the medical needs of the city of New York?

Dr. STEINBERG. The city of New York is supplying the medical needs at the expense of the physical plants of the hospitals. By that I mean that there isn't a hospital in the city of New York that funds its depreciation. They simply can't do it. So there are no funds to bring the hospital physical plants up to par. When you feel that you have a little bit of money for more than just the emergency repairs, then come the hyperbolic chambers and the new 20-million-volt linear accelerators and the other things which eat up the money.

In addition to that, of course, there has come over the past decade the recognition that we must pay our employees much closer to a living scale. So I say sure we can meet the need of New York City, but we are meeting it at a constant drain on our physical facilities.

We think it has come now to a critical point where we actually might fall down in meeting the need.

Mr. SPRINGER. How about this system of priorities you have talked about in this bill. Suppose you have $240 or $290 million, as set out in this bill. Suppose that the evidence finally taken before this committee indicates that that $240 or $290 million as set out over a 5-year period ought to be devoted to areas which have no hospitals.

What is your feeling about that?

Dr. STEINBERG. Are you saying, Mr. Springer, suppose we find that there is just no money for renovation?

Mr. SPRINGER. Well, we have to make a choice of priorities.

Dr. STEINBERG. Yes. We stated in this paper that in such a case we would urge you to put some—we feel a good bit—of your money in renovations, despite the fact that there are areas still unmet, because we have been meeting these areas and they are relatively smaller, whereas, this other need we feel is critical and is going up. Therefore, in a direct answer, I would say you would have to think very seriously of putting your money in renovation.

Mr. SPRINGER. Let's say you were the director of the program in the State of Illinois, or New York, for that matter. We will take as an example in my congressional district there are three counties in which there are no hospitals, period. That means that those people who want to be served in those instances would have to drive, I believe to the nearest, 17 miles, and the farthest being some 57 miles to a hospital.

Would you believe under those circumstances that if an application is submitted to the director of the State of Illinois for a hospital in one of those three counties, that it should or should not have priority over the renovation of a hospital, we will say, in Chicago?

Dr. STEINBERG. You see, I don't want to spar on this thing, but I would say, of course, given a rural area with no hospital and, therefore, disadvantaged by no physicians because physicians don't like to practice and usually don't practice where there are no hospitals, I would say, of course, the need is great. I would immediately say, however, that this is becoming a smaller problem, and that there ought to be an allocation that takes this into account.

Mr. SPRINGER. You have used the words "It is a smaller problem." Now we come to the question of how small is that problem, since you have used the word "smaller." I am advised by the director of the State of Illinois that there has not been any 1 year in the last 5 years when there were not more applications for existing hospitals, talking about the physical facilities, either additions to hospitals in areas that badly need it, which are in the areas that were set up under the original Hill-Burton bill, or new hospitals.

You are at the same time asking him next year to divert from the original purpose of the Hill-Burton Act, because there was not sufficient money in the State of Illinois, and to divert roughly this, if you used this as a percentage—I believe it is around 25 percent, isn't it?——

Dr. STEINBERG. Yes, it is that. It is a little more than that.

Mr. SPRINGER (continuing). Around 25 percent you are asking him to divert from the original purpose of the Hill-Burton Act which was to put hospitals where there were no hospitals; to serve people who had no other means of getting to a hospital; to the renovation of a hospital in a city that is already existing.

Do you want that kind of a philosophy? Do you want it changed that way?

Dr. STEINBERG. Mr. Springer, if you ask me what we want, I said in the testimony that we would hope that the bill, as written, which provides for $150 million for the purpose you just discussed, should continue to provide that $150 million. We would hope, however, that the renovation, and this is the first time that this has been seriously considered, the first bill that we have had a chance to study, the subject before this committee, that this now be given its due value.

Therefore, I would say that, certainly, we would hope that no

situation where there is no hospital, should be left unmet. We rather think that $100 million would do this in the present complexion. However, if we are wrong, we are wrong quantitatively and you are talking about $150 million.

We say, however, whether that is $100 or $150 million, that the need in the other area, which is an enormous need, and it is the same people and certainly the same health program, ought to be met.

Mr. SPRINGER. I will just put this to you: Shall I, as a Congressman—and I might very well have hospitals that I have been in in my own district, and I try to get into every one of them once a year—that might be applying for renovation. If I am faced with a choice as to whether I shall use my influence in behalf of one of these areas that has no hospital or in behalf of this area that has a hospital but wants it renovated, I would simply have to say, Dr. Steinberg, to the one that wants to renovate: "I am sorry, I can't be for you in this program until the needs are met in these areas where people have no hospitals."

I am just questioning whether or not we ought to change the original philosophy. I just now have gone back to get the report that accompanied the original bill to the floor in 1946, and it is certainly replete with this theory and philosophy of taking care of people, economically, in areas who simply did not have any way of receiving hospital assistance unless this were supplied.

The fact of it is, as I read the original report, it was to stay away from areas that had hospitals and were able to supply hospitals. I can say that there are at least two large communities in my own area that I think ought to take care of their own hospital needs.

What you are doing here is something entirely different from what we planned. I was rather surprised when I heard the Secretary taking this position yesterday. I haven't come to any conclusion, but this is certainly my theory when I analyze it, and take the original act, go through the year. When I talk to the director in Illinois, I find that in none of the last 5 years had he had sufficient funds to take care of the original act and now we are asking that 25 percent of the funds proposed under this be diverted from the original act to areas which, in my estimation, can probably take care of themselves by stepping on the gas a little bit.

But we are now planning to go into areas which, in my estimation, could take care of their own needs. This is a sharp change, but I wanted to get what your thinking was and to express to you mine.

I would like to come, if I could, to just this one thing: You are talking about the city of New York, which has $250 million in so-called modernization needs. I have not read all of this report, but I think, since the Hill-Burton Act, we have had about 3 out of every 4, or 4 out of every 5 hospitals built in this country, or additions, which have been taken care of by private assistance, without any Hill-Burton; is that right?

Dr. STEINBERG. I think that is the larger proportion.

Mr. SPRINGER. Assuming that the city of New York took care of 3 out of 5, or 4 out of 5 of its needs, you certainly cut the $450 million way down, even if New York were to get some portion of this.

Dr. STEINBERG. Our philosophy is that the Government does not step in and do this job entirely. We are talking about assistance.

But you must face up to the fact that in New York, in Chicago, in Little Rock, and in every city of the country, there are large complexes of hospitals, many of them old, a large portion over 50 years old, which have not been renovated. The fact is that they have not been, and not because of any ignorance of this fact. They have not been renovated because apparently the money is not forthcoming.

To say, "Well, this is just a failure on the part of a community, and they ought to produce the money" is, perhaps, one way to do it. We felt that New York, which has a very honorable history for philanthropy, and which has raised enormous amounts, we felt that this sum was entirely too large to try to go out to the community to get, and we felt that we had to stimulate the boards of the several hospitals by some sort of aid.

This was not an irresponsible thought. But actually, this is a tremendous need, just as is the need for hospitals where there are none. We are talking now about weighing the relative needs.

We remind you again that the small hospital that is going to be built will be a very, very handicapped hospital unless the methods and procedures that it is going to adopt are evolved, and they can only be evolved in these larger complexes. Unless it is done, they will not be evolved. It has to be done. We are rather hopeful that it will be done, and we come to tell you that we are very pleased about the fact that it is recognized.

Mr. SPRINGER. Do you have a hospital tax in the State of New York?

Dr. STEINBERG. No, sir.

Mr. SPRINGER. You do not?

Dr. STEINBERG. No.

Mr. SPRINGER. But we do in Illinois.

Would you think that if we insisted that every community that takes advantage of this put the maximum tax, hospital tax, that is possible, under the act? Don't you think a local community ought to do this, if it could?

Dr. STEINBERG. I think it certainly would be helpful. I do want to tell you, though, that in New York City, while there is no special hospital tax, the city of New York provides $32 to $36 a day to the hospitals for the treatment of medically indigent New Yorkers, so that there is a great deal of tax money flowing into the hospitals.

It simply hasn't solved this business of the renovation, anyhow. But if what you are saying is could there be enough produced locally in additional taxes to cover this, I would say I would rather hope so. We are terribly troubled in New York by the fact that the taxes don't cover our educational needs, an a good many others.

I am not an authority on the public tax situation. I am sure you are more of an authority. But I would hope that there would be some way of meeting this teriffic problem, whether it is local taxes or not.

Mr. SPRINGER. That is all, Mr. Chairman.

The CHAIRMAN. Mr. Staggers?

Mr. STAGGERS. Mr. Chairman, I have no questions. I would like to compliment Dr. Steinberg and also Mr. Nixon for their presentation to the committee this morning.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Schenck.

Mr. SCHENCK. Thank you, Mr. Chairman.

Dr. Steinberg, I certainly want to commend you on your very fine statement. I am sorry I did not hear Senator Nixon's statement.

I am personally very deeply concerned about the matter of health care for our people, and I am also concerned about another situation, and frankly, I just don't know the answers. I am sure as a physician you are eminently qualified from a professional point of view on human health needs and so on, and I am sure also, as director of a hospital, you have had a great deal of financial and administrative experience, which is very valuable to our committee.

The point is that the Federal Government has absolutely no money except what it collects from people in the form of taxes, the very same taxpayers who pay all other taxes, or borrowings, and the only source of borrowing is from the savings of people or the institutions which manage these savings.

We have many programs presented to us which have tremendous merit and need, yet we have to work out some way to finance them. You are asking for money, for example, at 2 percent. The Federal Government has to borrow that money to loan it to you. The Federal Government has to borrow money at the going rate, which is 4 or 5 percent.

How can you recommend that the Federal Government, which has no money except from taxes paid by the same people that support New York, or borrow the money from those same people and then loan it out at less interest rate and thus increase the taxes to pay the difference?

Dr. STEINBERG. In our statement, what we said was that it would be considerably more effective in terms of getting things done if the patient's bill were not increased by a high percentage, but, rather we recommend a lower percentage.

We said, however, immediately, recognizing that this may be getting us into an area which you just sopke about, where there just isn't the money to do this, and it would be difficult to find the money to do it because of the many requirements of Government. We said, therefore, that at least the Government ought to make available for this thing moneys which are available to it at a lower interest rate than would be necessary in the commercial market.

We said this only because if the Government then were to say "All right, we will lend you this money," and the record of the hospitals as borrowers has been a very, very honorable one and a very efficient one—they have paid back—"We will lend you this money at the same rate we get the money," and we are even talking about adding a quarter of a precent for administrative purposes, for handling purposes, that this would at least not increase the patient's bill if the facility were renovated to the higher extent that would be necessary if the money were taken on the commercial money market.

We talked about a rather significant increase in bills. So what we are saying is, yes, if you, in your wisdom, find that the Government can, in its system of priorities, considering what it has and what it has to do, make this available at a lower interest rate, fine. This certainly would give us a much faster start. But if you cannot, then we would hope that you would make available money which is available to you, at whatever rate it is available to the Government. This would be

at no cost because we are talking about a quarter of a percent for the administrative costs.

Mr. SCHENCK. You are asking the Federal Government to enter the commercial lending field which, in order to handle it, would require a considerable amount of additional administrative expense and, consequently, a larger Federal Government. You see no difficulty in increasing the size and the operations of personnel in the Federal Government.

Dr. STEINBERG. We had thought that the quarter percent would pay for the expenses of handling and administration. Of course, I don't know. I take that from the Moss bill, and from other Government lending programs.

As to the size, like all of us here, I would like to have the Government proceed on the most compact size, et cetera, but, on the other hand, the size that is sufficient for the job it must do. I am no authority on whether you can do it with less or more. But I would hope, and this is a field that I do know, we are dealing now with something which transcends almost anything else except war and peace, and that is the health of our community.

I say to you that I think that this can't be done without Government assistance because the job is much too big. It hasn't been done, certainly. I would hope, therefore, that a high priority be established within Government for this sort of thing.

Especially, I think, we are reasonable when we talk about at least giving the institutions the benefit of what rate is available to the Government, rather than taxing our people when they are sick at a much higher rate. I am talking about the high hospital bills, which you have heard about, too, I am sure.

Mr. SCHENCK. I have also experienced them.

Mr. WILLIAMS. Would the gentleman yield at that point?

Mr. SCHENCK. I have just this one thought in mind: Dr. Steinberg, we in the Congress are faced with extremely difficult decisions to make. We recognize the real need for, the merit of and son on, of many very desirable programs, and necessary programs.

We are also faced with the very difficult situation of reducing taxes, as we have recently done, and then trying to spend still more money on the basis of putting a debt over on our children's children, which puts us in a very unenviable position, I think.

We have a difficult job in arriving at a decision to do what you want to do and what perhaps ought to be done, from the standpoint of need, merit, and so on. Yet, we must do so, while also observing a sound fiscal responsibility and with complete responsibility to future generations.

I will yield.

Mr. WILLIAMS. Doctor, did I understand that the purpose in wanting to get the interest rate down was for the purpose of saving money?

Dr. STEINBERG. That is precisely it.

Mr. WILLIAMS. Would the same argument apply to a suggestion that the Davis-Bacon provision be removed from this act?

Dr. STEINBERG. We are now in a social area. I am saying that where you can make available to hospitals the same interest that is available to the Government, you are reducing the burden on the sick patient.

Perhaps you are depriving some commercial interest of banking profits, but this is an area in health where we are justified to do this, I think. But when you talk about the other provisions, saving money by other means, I would certainly like to take a look and see the negative as well as the positive side.

Mr. WILLIAMS. If the Davis-Bacon Act increases the cost of construction, and apparently it does, wouldn't the same argument apply on that as applies on the other, on the interest proposition?

Dr. STEINBERG. The Davis-Bacon Act was an act passed by the Congress. What you are saying is, How do I feel about the act?

Mr. WILLIAMS. Yes.

Dr. STEINBERG. I really don't know. I am not an authority on the act.

Mr. WILLIAMS. Thank you very much.

Mr. SCHENCK. I have no further questions.

The CHAIRMAN. Mr. Friedel.

Mr. FRIEDEL. Mr. Chairman, I have no questions. I just want to compliment Dr. Steinberg and Senator Nixon for their very fine statements.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. Thank you, Mr. Chairman.

I, too, would like to thank both of you for the contributions you have made, and your recommendations.

Senator Nixon, in your statement you talked about the empty and the unused beds which are wasted. Yesterday in the Secretary's statement he said we still need 133,000 additional new beds. Have you any figures at all to substantiate that?

Mr. NIXON. I don't know how many. I am sure that we do need new beds. The problem that you mentioned on unused beds is one that we can't build a hospital in the community for the average amount of patients we must reach to the needed amount in an emergency. Consequently, we just don't operate hospitals at 100 percent of capacity.

Mr. YOUNGER. That is true. But do you have any figures at all to substantiate the need today of 133,000 additional new beds?

Mr. NIXON. I don't have this; no, sir.

Mr. YOUNGER. You don't know what the need is today?

Mr. NIXON. I could only answer you nearer to the needs in our own State. I couldn't go beyond that. I am fairly close to the public health commission there on the planning at home.

Mr. YOUNGER. You have made no survey at all, nationwide?

Mr. NIXON. No, sir.

Mr. YOUNGER. How much of a job would it be to your association to make a survey, a special survey, as to the need?

Mr. NIXON. I think this is coming very close. In the planning that is going on over the country, and as soon as this develops a little more, I think we will have it.

Mr. YOUNGER. Apparently, Doctor, you have some objection to locating these facilities in connection with a university medical school.

Dr. STEINBERG. Rehabilitation facilities?

Mr. YOUNGER. Yes.

Dr. STEINBERG. No objection at all. We would hope that every university teaching center would have one of these fully comprehensive rehabilitation facilities.

We say, however, were that to occur, and that hasn't occurred yet, we will still need many other rehabilitation facilities that are less comprehensive.

Mr. YOUNGER. How about the construction of new hospitals?

Dr. STEINBERG. This goes into the question that you just asked, do we need more beds, not as replacements—you are talking about new hospitals?

Mr. YOUNGER. New hospitals and their connection with the university medical schools.

Dr. STEINBERG. Actually, the new hospital construction is a kind of thing which, if you say "Do we need new hospitals," I would say, "Where"? Certainly in some areas of the country we need them. Apparently from what you have said, when you quoted the statement of the Secretary that we need 133,000 beds, it means we need a certain number of hospitals. But if your question is, "What about in the construction of these hospitals should we construct or plan for rehabilitation centers"? Is that your question?

Mr. YOUNGER. No, it is whether they should be limited to areas where there is a medical school.

Dr. STEINBERG. We would certainly hope that they would not be limited to areas where there is a medical school, for only one reason. That is, if every medical school had a rehabilitation center, there would still be a need for more, you see. So what we are saying is, by all means locate them at medical schools; but then let's go ahead and have additional centers, because they are necessary.

Mr. YOUNGER. You are aware that the Veterans' Administration will not build a new hospital except in connection with a medical school?

Dr. STEINBERG. I am very happy about that, because I do think that wherever possible a new hospital should be built in such a location and in such a fashion that it will have the advantage of the umbrella of the staff of a large university teaching hospital. This would be the ideal hospital practice. I would hope that all hospitals would reach for this. I am very happy about the fact that the Veterans' Administration has moved so close to the teaching institutions. I think it has done a great deal of good in this country.

Mr. YOUNGER. I agree with you that there has to be some change in this bill in regard to the treatment of the private and proprietary nursing homes, or hospitals, for that matter, in the way of insuring loans. I believe we should insure the loans instead of making direct loans. We have a direct loan provision in the legislation now. But there are some agencies which do not want grants—and why the direct loans were put in originally—and there are certain even noprofit hospitals that did not want grants. They wanted to stand on their own feet. They wanted to borrow the money and pay it back, rather than get a grant. That is why loans were put in there originally.

If they prefer to borrow the money, they certainly ought to be privileged to borrow the money and be covered under the same terms as a proprietary institution. Don't you think that would be true?

Dr. STEINBERG. That is like saying that the poor, as well as the rich, cannot sleep under the bridge. You are asking me if they should be privileged to borrow at a higher rate. I would say that if they can afford to do the job that is before them, then we wouldn't be here. The

fact is that we are saying they can't afford to do it. You are saying, "Well, they ought to be able to borrow money at higher rates."

Mr. YOUNGER. No, I didn't say that. I said at a higher percentage.

Dr. STEINBERG. You mean a higher percentage of the total cost?

Mr. YOUNGER. Yes.

Dr. STEINBERG. I am sorry, I misunderstood you. I think that that would be a helpful provision, yes. The closer they get to the full job, the easier we make it for them, the sooner we will have these modernized facilities. I would agree with you.

Mr. YOUNGER. I am not talking about the rate.

Dr. STEINBERG. I would agree with you, Mr. Younger, yes.

Mr. YOUNGER. For instance, you will have States where they are out of money. The State agency will say, "Here is a community that needs a hospital, but we have no money for a grant." Certainly, they ought to be permitted, even though they are a nonprofit institution, to be able to borrow on a 90-percent insured loan just the same as a proprietary facility.

Dr. STEINBERG. We certainly agree with you, absolutely.

Mr. YOUNGER. So your recommendation, with some adjustments, I think is very good. In my opinion, we will have to change this provision in the bill.

Dr. STEINBERG. Thank you.

Mr. YOUNGER. Thank you very much.

The CHAIRMAN. Mr. Moss.

Mr. Moss. Doctor, I want to thank both you and Senator Nixon for a very excellent statement.

On the matter of modernization of hospitals, where would the concentration of hospitals having the most critical need for modernization be? Would they be in urban centers, the larger urban communities, or the smaller communities?

Dr. STEINBERG. They would be in the urban centers. As a matter of fact, not exclusively, but certainly the larger need would be there. The study of the Public Health Service indicated, dividing the country into regions: Middle Atlantic, New England, and so on, indicated that the greatest concentration of need was in the Atlantic seashore, the Middle Atlantic States; that the second greatest area of need was the central lake region; and the third in order were the Pacific coast, California, and the Pacific coast States. But the greatest need was in the larger metropolitan areas, areas which had a concentration of beds of, let's say, 2,500 or more in one metropolitan area. There is where the greatest need exists.

Mr. Moss. In those areas, isn't it true that the very hospitals needing modernization serve far beyond their community?

Dr. STEINBERG. That is almost universally true; yes, sir.

Mr. Moss. And they provide facilities, highly specialized skills and techniques, unavailable even in the smaller and newer hospitals?

Dr. STEINBERG. That is true.

Mr. Moss. As you have pointed out here, of great significance to the practice of medicine throughout the Nation, they undertake the training of the doctors who ultimately will go into the smaller centers.

Dr. STEINBERG. Certainly.

Mr. Moss. So, we are concerned here, not only with the modernization of a plant to serve the large community, but, in fact, the modern-

ization of plants which are called upon to provide the more sophisticated services to all communities in the Nation.

Dr. STEINBERG. I wish I could say it so eloquently, Mr. Moss.

Mr. Moss. In New York, certainly, you receive patients from many sections of the country, who come to Mount Sinai Hospital, for example. I know that, in San Francisco and Los Angeles, the large hospitals there frequently take care of people from the rural areas where the specialties are not available, the very costly equipment is not available.

So it is not solely the question of the ability of these communities to underwrite this need, but it is one where they can legitimately seek the assistance of others in meeting needs from which others will also benefit.

Dr. STEINBERG. True.

Mr. Moss. I think the table on interest rates, related to cost per patient per day, attached to your statement, is most significant. The proposal for direct loans is in an area, is it not, where a hospital is faced with problems that are rather unique in attempting to finance expansion or improvements?

Dr. STEINBERG. That is true.

Mr. Moss. They haven't the ready availability of money, or it is not on terms which would be comparable to businesses or undertakings of more of a profit characteristic. I think the Secretary yesterday pointed out the average length of time for most of these mortgages goes between 12 and 14 years. So, this isn't an area where there is the large group of private financial interests anxious to undertake the writing of these mortgages. If Government entered in, it would not be, in a sense, the competitor that it might be if it decided to finance the construction of offices.

Dr. STEINBERG. That seems to be so.

Mr. Moss. If you were able to get the money at the average rates the Treasury pays for the funds borrowed by our Government, it might give you a 1 percent advantage. In looking at your table, I notice that the difference between, say, 4.5, which might be the effective rate if the average Government rate were used, and 6.5, which could well be the rate if private financing were used, amounts to approximately $1 per day per patient.

Dr. STEINBERG. True.

Mr. Moss. If we go to the contemplated rate mentioned in the bill, of 5 percent, plus the half percent for services and mortgage insurance funds, there is a 50-cent differential per patient per day. So, it is of significance in the budget of the average patient; yet, it would not add materially to the cost of Government in undertaking to use its credit to enable the hospitals to finance their improvements at a rate that is less than the open market would provide.

Dr. STEINBERG. That is very true.

Mr. Moss. I think you have given us a great deal to think about, and I share your concern over the need for some very firm answers in meeting the problem of modernization. Thank you.

The CHAIRMAN. Mr. Keith.

Mr. KEITH. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Dingell.

Mr. DINGELL. Gentlemen, I was not able to be present when you gave your statement, but I have read it with a great deal of interest. I believe it will be a very helpful statement to the committee, and I commend you for it.

You have discussed several points which I think deserve particular attention by the committee. First is the problem of modernization of existing plants. I assume you gentlemen strongly endorse, as I note in your statement, the principle that the Federal Government should revamp the Hill-Burton program to provide for substantial expenditure of funds on the Federal-State cooperative level on existing plants. Am I correct on this?

Dr. STEINBERG. You are entirely correct.

Mr. DINGELL. I note that you give comments as to the method of expenditure of these funds. Am I correct in infering that you believe that there should be a higher level of expenditure of funds than that which is provided in H.R. 10041?

Dr. STEINBERG. That is what we ask for.

Mr. DINGELL. I believe your statement points out the level of funds expended for this purpose which you gentlemen feel is necessary; am I correct?

Dr. STEINBERG. That is true.

Mr. DINGELL. Could you give us, either at this time or by submitting additional information to the committee, an understanding of what percentage of the real needs for modernization would be met by the committee bill, H.R. 10041, and by the administration proposal, and also by the proposal which you discussed this morning, which I believe is substantially the same as the administration's proposal—am I correct?

Dr. STEINBERG. I believe it is. We talked in terms of $420 million over the life of the bill, as compared with $160 million, which is written into the present bill.

Mr. DINGELL. And I believe the administration proposal is $380 million.

Mr. WILLIAMSON. $340 million.

Mr. DINGELL. Would you give us your best estimate, if you could, gentlemen, of the amount of revamping and modernization of the hospital structures of this Nation, in relation to the need that would be accomplished under these three different proposals?

Dr. STEINBERG. I said in the statement, Mr. Dingell, that if we, indeed, were to go to $420 million, this would really supply an effective beginning; and I said that advisedly. This is our position. The latest full study which was conducted by the U.S. Public Health Service, in association with our association indicated that $3.6 billion would be necessary to meet the modernization needs. Mind you, this does not add any beds or any new facilities, or new types of facilities. This is just to replace or to modernize existing facilities which are needed. Therefore, we are talking in terms of $420 million.

Mr. DINGELL. It would be about one-tenth of the facilities, then.

Dr. STEINBERG. And that is over a period of years. I must call your attention to the fact that, as each year goes by, the bill gets bigger. One hundred million dollars a year, it seems to us, as we looked at—and I am not sure of the statement—was just about the rate of obsolescence. On the basis of the $3.6 billion estimate of nationwide needs

for modernization developed by the Public Health Service, it would appear that, using a 50 percent average matching grant, the proposal of the American Hospital Association would result in meeting 23 percent of the national need over a 5-year period. The administration's proposal would meet nearly 19 percent of the need, and H.R. 10041 would meet less than 9 percent of the need.

Mr. DINGELL. I think this is so, and, of course, I am in complete sympathy with your viewpoint on this. I would like to treat, if I may, very briefly, a couple of other things that concern me.

You state that you look upon the inclusion of the proprietary nursing homes with considerable misgiving. You are aware that this is a transfer of a program, which has previously been administered by FHA, over to the administration by the U.S. Public Health Service. I think you gentlemen, and the fine organization which you represent, would not view this with great concern. Am I correct?

Dr. STEINBERG. We are concerned about the implications and what this might bring. We think they are doing pretty well. We were indeed among those that advocated that they do get mortgage insurance, because we recognize that there will simply have to be more nursing homes and there are not enough volunteering. Proprietary will have to be in there. We felt this could be adequately handled, as it has been, according to the best of our knowledge, by another agency. If we get them into the same kind of a bill, the same kind of a program as the nonprofit people are in, you begin to mix two kind of things, such as oil and water. They don't mix. What we are concerned about is that either the nonprofit will suffer or the proprietary will begin to get some of the considerations that they are not entitled to.

This is not just a dog-in-a-manger attitude. What we are saying is, on the one case we are talking about agencies who have a communal job to do and do it on the basis of need. On the other hand, you have a group who are doing a job, which is useful, but who do it on a profit basis. We think that the two don't mix. We are concerned about what is going to begin to happen if you mix them under a program. We feel it is not particularly necessary.

Mr. DINGELL. I note there is no mixing under the program provided for in H.R. 10041. They are simply all brought under the same bill and all brought under the administration of the same agency. I am sure that you will agree that FHA has less understanding of hospital and health problems than does the Public Health Service.

Dr. STEINBERG. They do, except with regard to the financing of the mortgages. That is the only part we are discussing now.

Mr. DINGELL. I am sure that the understanding of the two agencies with regard to financing would be approximately equal. Isn't this a fact?

Dr. STEINBERG. I am not sure that this would be a fact. What we are concerned about is that once you get them under the umbrella of an agency, such as the Public Health Service, which is thinking in terms of an enormous bill, an enormous job, and how it is to be done by the institutions which are nonprofit institutions, that in order to now begin to think in terms of proprietary hospitals, except with regard to the financing of mortgages, would be, we think, an unnecessary complication. We would hope that they would not be brought

in. We don't see the value of bringing them in when they apparently are getting their mortgage financing through another agency. As far as we know, it is being done all right.

There are points at which we disagree—very few, I am glad to say.

Mr. DINGELL. Gentlemen, I do appreciate your appearance this morning and your very fine statement.

Thank you.

The CHAIRMAN. Mr. Broyhill?

Mr. BROYHILL. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Rogers.

Mr. ROGERS of Florida. Thank you, Mr. Chairman.

As I understand from your statement, Doctor, or perhaps it is something that Senator Nixon has covered, the largest cost now is because of personnel.

Dr. STEINBERG. Right.

Mr. ROGERS of Florida. And this is reflected in the room charge, I presume?

Mr. NIXON. Not necessarily. The room charge many times is identified as cost, but it can't be a key always to it. This is the total cost.

Mr. ROGERS of Florida. There are two or three statements that I wish to go into, if I may.

As I understand it, you say your organization does not have the facts necessary to give the committee as to the actual need for hospital beds.

Mr. NIXON. That is correct.

Mr. ROGERS of Florida. Is this a function of your organization to try to keep up with this?

Mr. NIXON. This is an area we are moving into, more and more, and more concerned with than the planning program. But, generally speaking, the association concerns itself and its program primarily with the operation.

Mr. ROGERS of Florida. With the operation?

Mr. NIXON. Right. But it is concerned with it because of community interest.

Mr. ROGERS of Florida. Let me ask you this question. Do you think there should be included in this bill for any hospital which receives aid under the bill, a provision saying that for any patient recommended by a doctor to be admitted to such a hospital, admittance shall not be predicated in any way by the financial status of that person? I don't know whether this happens often or not, but I hear reports now and then of people who say "I went to the hospital, but before I could get in I had to fill out a financial form. Here I am ill, and so forth, and all this had to be done before I could be admitted."

And some people will say, "Well, I was turned away, because I couldn't get in, I couldn't put up a deposit."

What is your feeling on that?

Mr. NIXON. My feeling is, and I think this is generally true, there may be cases—and generally there might be a case of not having beds available—that the hospital provides care for the man who comes there. H.R. 10041 contains a provision under general regulations, section 603, that the State plan shall include adequate hospitals, and other facilities, to furnish needed services for persons unable to pay, therefore. The regulations may also require "there will be made available in the facility for a portion thereof to be constructed or modern-

ized a reasonable volume of service to persons unable to pay, therefore; but exception shall be made if such a requirement is not feasible from a financial viewpoint."

This provision which has been a part of the hospital survey and construction act recognizes that the ability of hospitals to provide services to those unable to pay varies. A number of factors must be evaluated in the individual hospital which preclude establishing any more specific requirement in legislation.

Mr. ROGERS of Florida. I am sure this is generally true. I was thinking of these instances where this may come up. Would you see any objection in including such provision in this bill?

Mr. NIXON. I can see none.

Mr. ROGERS of Florida. Would your organization perhaps help us draft some language that might be helpful and which you think would be proper along those lines?

Mr. NIXON. Surely.

Mr. ROGERS of Florida. That would be helpful to the committee.

Let me ask you about the basis that the Department of Health, Education, and Welfare would determine need for modernization, or the amount of money to be allocated to the States for that purpose. As I understood the testimony yesterday, it goes back to a 1948 survey. They take the number of hospitals then existing, in 1948, and the State percentage compared to the overall hospital facilities in the United States is the percentage of money that would be allocated to that State for modernization. But I noticed in your statement today, on page 8, you say that in 1956 your association conducted a survey in collaboration with the U.S. Public Health Service of the modernization needs of hospitals, and you determined then it was about a billion dollars.

What does your organization feel about the 1948 basis for the allocation of money if studies had been made in 1956—and I even see one later, in 1960? How do you feel about this basis of 1948 for the allocation of funds, when you have an actual study that has been done to meet the problem directly?

Dr. STEINBERG. We think the simpler method would be to assess the current need for modernization. This, we don't believe is a very complex job. We have done it in a number of metropolitan areas. Once the Surgeon General gives you the standards, whether they be the standards of the Survey and Construction Act or some other standards, then a plant-by-plant examination by competent people can be done in a relatively short time. Then you would have before you the actual current needs. We think this is the thing to which we should address ourselves. Then the allocation might be, indeed, the percentage within that particular State or area.

Mr. ROGERS of Florida. I would look with some favor upon that myself, rather than just going back to an arbitrary figure of 1948, whether the need existed or not.

Let me ask you about a statement on page 23, talking about the Department's criteria for determining the hospital needs and facilities in certain areas. You say that the bill would authorize the Surgeon General to do this, thus removing the previous statutory provision establishing the ceilings.

Could you give some ramification on the effect of this?

Dr. STEINBERG. Actually, the determination of the bed needs for an area is not a simple thing, nor is it the kind of thing which is unanimously agreed upon. In the act, there was an arbitrary figure, a ceiling, not more than so many, not less than so many, per unit of population. But we find this is a rather crude way of determining it, because there are many factors that must go into it. We are now talking about specialty beds, specialty hospitals, long-term hospitals, convalescent hospitals, and so forth. Therefore, to determine how many beds you need for an area is the kind of job that must be done by an adequate local body.

We have such local bodies. These are statewide bodies and regional bodies in every State in this country who are acquainted with the local situation, et cetera. What needs to be done is that there either be an agreement that some sort of rough standard be adduced and that the local people then apply this, sculpture it to their own area, and come up, each local area, with a beds need; or that there be, if possible, even more exact standards of what we mean by the bed needs. I must say, however, this is not a unanimously agreed upon index. There is no unanimously agreed upon index now. This gives us the difficulty.

We will tell you that New York City does not need any beds, that they are overbedded. If you talk to physicians in large areas of population, they will tell you that patients can't get into a hospital. Do you need beds or don't you? This is a very complex thing.

Mr. ROGERS of Florida. That is why I was wondering about the statement on page 15, as to whether the urgent needs of rural areas had actually been met. Do you feel they have been?

Dr. STEINBERG. You know how long the bill has been going on, how much money has been put in, and the number of hospitals built. We say on the face of it that, therefore, certainly a considerable impact has been had upon this original urgent need. We haven't said quantitatively yet that it is completely met. We say at the very beginning that there is a remaining need for this thing, and we are talking about a need that is expressed in terms of large factors of billions of dollars. We are talking about 100 to 200 million dollars a year for 5 years.

So, we think nevertheless, we must say, that as compared with the beginning a considerable amount of this has been met.

Mr. WILLIAMSON. One figure, Mr. Rogers, when the act was started, this country was divided up into areas, population areas. It was found that there were as I recall, 2,530 population areas, 25 percent of which contained no hospital. The figure is now 4 percent. So 21 percent of the areas having no hospitals now have hospitals.

Mr. BROTZMAN. Would the gentleman yield for one question?

Mr. ROGERS of Florida. Yes.

Mr. BROTZMAN. I don't see how you, as an organization, and you are nationwide I am sure, can so strongly recommend modernization of existing facilities without knowing what the needs are for new construction. I take your word on the fact that you are interested in the national health of this country. I think most people, from what I have observed in the Congress, are more liberal in this regard. How can you take this very strong position for modernization and spending x number of dollars for that particular purpose without knowing this other factor?

Dr. STEINBERG. We know fairly accurately the need for modernization; that is, we have put together enough pieces. These are in metropolitan areas, largely.

Mr. BROTZMAN. I will take your word for that.

Dr. STEINBERG. We know also that the need for new beds has been met partially by this bill over a period of years. What we are saying is that nothing about the continuing need for this thing, we nevertheless say here is a problem which has not been met at all, or met in a very small percent; and that we need help.

Again I go back, and we are not saying that we have stopped all new construction or all aid for new construction and gone over into this program. We are talking about two programs. We can't, for instance, assess the need for new hospital construction as a static thing, because you know what is happening to the population of this country. We also know what is happening to medical advances. These are hard things to determine. We know that there is a need for construction. We can't particularize that, except to say that we have been building small hospitals under Hill-Burton, under this Survey Construction Act, for years now. We have done nothing about this problem of modernization, and nobody else has been doing anything much about this; so we say, do it.

In answer to your question, I would say, without being able to pinpoint the exact quantity of new construction, we say that there ought to be new construction and there certainly ought to be a beginning effort in this area.

Mr. BROTZMAN. But you are taking a position much stronger than that. I should not take any more of the gentleman's time.

Mr. ROGERS of Florida. I have one question that I would like to get over quickly, if I might.

Mr. BROTZMAN. I only wanted to ask that question because it was suggested at this point.

I will let the Congressman proceed.

Mr. ROGERS of Florida. I wanted to question your statement on page 20 about the change in the percentage of grant in the construction from 33⅓ to 66⅔. Then you recommend for modernization a minimum of 50 percent. Why would it not be better to allow some discretion in the Surgeon General, just as we do in the construction programs, to also allow this same discretion from 33⅓ to 66⅔ in the modernization program?

Dr. STEINBERG. Because in the conduct of the bill, you will find that the large metropolitan areas of the States that have most of the larger areas have adopted the lower of these things, the 33⅓. This is true of the larger States, et cetera. But these are precisely the States that are going to need most of the money for the modernization, and we would hope, therefore, that we impose a higher floor.

This is what we are talking about. We are afraid it is going to be 33⅓, and we rather hope it would be higher; and we suggest 50.

Mr. ROGERS of Florida. Thank you very much.

The CHAIRMAN. Mr. Brotzman.

Mr. BROTZMAN. To reorient your thinking to this preliminary question we were going through a moment ago, the only figure that I have heard relative to new construction to date in almost 2 days of testimony is that Secretary of HEW, Mr. Celebrezze, testified yesterday, "We

still need 133,000 additional new beds if the Nation's requirements are to be adequately met."

I have listened to your testimony, and I don't hear any solid figures, perhaps because you don't have them. But, nevertheless, you have taken a firm position that the money should be spent for modernization, or at least the larger amount. Specifically, on page 19 of your testimony, you say "The bill provides that States may transfer renovation and modernization funds into new construction categories. We believe this to be an unwise provision and recommend that funds provided for modernization be earmarked entirely for this purpose."

I don't agree with that proposition, and you have given me no reason to believe that we here can say this money absolutely should go for modernization, when they might actually have a need in a State for new construction and this gives them some flexibility. Do you want to comment on that?

Dr. STEINBERG. Yes. We are putting a great deal of emphasis, to be sure, on modernization, because of the many reasons that we have adduced. I don't want to take up time to repeat them. We are quite concrned about the fact that if the bill does make an approach to modernization, that it be maintained. We are worried about the fact that some of this money which we feel is inadequate is going to be moved out. This is the same kind of worry that governed with the rehabilitation centers. This is a special and very urgent need. It is of the same interest.

Actually, this is what we are saying: We would rather hope that since there isn't enough and there is not going to be enough, that at least what is in there stays in there.

The CHAIRMAN. Mr. Long, do you have any questions?

Did you have any questions, Mr. Kornegay?

Mr. KORNEGAY. No, sir.

Mr. LONG. My congratulations along with the other members on both of you gentlemen's statements.

Senator Nixon, how long have you been executive director of the Arkansas Hospital Association?

Senator NIXON. Since 1958, Mr. Long.

Mr. LONG. That experience you have had there, and your membership on the council of government relations of the American Hospital Association, and also your political experience as a member of the State Senate of the State of Arkansas, in my opinion, uniquely qualifies you to give an overall appraisal of the effectiveness of the Hill-Burton program over the years.

I think you, in your statement, recognized your experience in this field and commented to some extent upon this. I interpreted your feelings as to the success of the program, that it has been successful.

Mr. NIXON. Right.

Mr. LONG. Of course, as you know, three of the points that you made were the freedom of political interference from, I assume you intended, all levels; second, maximum administrative authority given to the States; and, third, the requirement that there be assurance of local responsibility and intent for the operation of any facility.

Mr. NIXON. That is right.

Mr. LONG. You cited these as three of the major points in your opinion leading to the success of the program.

Mr. NIXON. That is right.

Mr. LONG. As you know, during the past few weeks, there has been a major change in this area because of the opinion of the Court of Appeals of, I believe it was, the Fourth Circuit, in *Simkins* v. *The Moses H. Cohen Memorial Hospital*. This discussion in effect—and this is perhaps an oversimplification—declared that the separate but equal provision of the Hill-Burton Act is unconstitutional.

As the chairman stated yesterday, to some extent this makes some of the language, proposed by the Secretary of HEW a moot question as the law seems to have been settled by this case.

In view of your long experience, both as a political leader, as an active man in the field of hospitalization, and being from an area of the United States where this is a major problem, what, in your opinion, is going to be the effect of this decision upon the operation of hospitals and the effectiveness of this program?

Mr. NIXON. I see no great change in our situation. The question earlier by, I believe it was, Mr. Dingell, asked about anyone coming to the hospital, would he be cared for; he was thinking primarily of finance. Regardless of who he is, what he is, where he is from, or his financial condition, in my State he is taken care of. I am sure that there will be a lot read into it, and a lot of times there is, but I see no great problem.

Mr. LONG. You don't see a large scale of turning down or not proceeding of applications as a result of this change in the law?

Mr. NIXON. I think we have had refusal to accept Hill-Burton funds in the past because of this. This is true in a number of areas in my State, because they wanted to set up their own policies, still taking care of all people. But they wanted to do it themselves. I don't see any slowing down of Hill-Burton because of this particular point in my State.

Mr. LONG. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Van Deerlin?

Mr. VAN DEERLIN. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Pickle?

Mr. PICKLE. No questions, Mr. Chairman.

The CHAIRMAN. I had in mind a few questions, I will say to both of you, with reference to your recommendation on part B of the act with reference to mortgage insurance. I think you have made your position clear. We can be sure that this is going to be a controversial subject. I am hopeful there is some way we can work it out, somewhere between what you recommend, the recommendations of the HEW yesterday, and what others would recommend, including the feelings of the other committee involved. There is a jurisdictional problem.

Suppose we would continue existing procedures under the FHA regarding proprietary nursing homes, and suppose also that we do not adopt your recommendation to make available direct Government loans at a very low rate? Do you think some provision ought to be made whereby nonprofit institutions should have available loans in order to help the construction of such facilities?

Dr. STEINBERG. We certainly would hope that nonprofit institutions would be given the opportunity to borrow at the lower rates; and we hope that this will be the case. Obviously, they must be simulated to do what now is not being done, and apparently cannot be done financially.

The CHAIRMAN. Thank you very much.

The committee is sorry, Dr. Teague, we have not been able to get to you today. Are you going to be here overnight?

Dr. TEAGUE. I can, sir. My statement is less than 10 minutes long.

The CHAIRMAN. I know, but the bells have already rung for the second round. We have gone as far as we can today, I am sorry.

Dr. TEAGUE. I will stay over.

The CHAIRMAN. We will hear you the first thing in the morning.

The committee will adjourn until 10 o'clock tomorrow morning, at which time Dr. Teague will be the first witness.

Thank you again, gentlemen, and let me compliment you on your fine statements.

(Whereupon, at 12:15 p.m., the committee recessed to reconvene at 10 a.m. Wednesday, March 11, 1964.)

EXTENSION AND REVISION OF HILL-BURTON HOSPITAL CONSTRUCTION PROGRAM

WEDNESDAY, MARCH 11, 1964

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

The committee met at 10 a.m., pursuant to recess, in room 1334, Longworth Building, Hon. Oren Harris (chairman of the committee) presiding.

The CHAIRMAN. The committee will come to order.

Our first witness this morning is our colleague from New Jersey, the Honorable Edward J. Patten. Mr. Patten, we will be glad to hear you at this time.

STATEMENT OF HON. EDWARD J. PATTEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PATTEN. Mr. Chairman and members of the House Interstate and Foreign Commerce Committee, there is an urgent need throughout the Nation for modernizing existing hospital facilities. Many hospitals, particularly those in large cities, require modernization, but lack the funds to implement their plans.

Since the modernization projects often involve heavy expenditures, the Federal Government should authorize and appropriate adequate funds to satisfy modernization needs. The modernization projects now eligible under the Hill-Burton program amount to little. This program should be greatly expanded and liberalized.

I strongly urge the Interstate and Foreign Commerce Committee of the House of Representatives to authorize $340 million for Federal aid for modernizing hospitals, instead of the $160 million recommended in H.R. 10041. Even the $340 million advocated by Secretary Celebrezze recently would not satisfy the modernization requirements of our hospitals, but $160 million would be even more inadequate.

A 5-year modernization program of Federal grants, ranging from one-third to two-thirds, would enable many hospitals to replace some of their obsolete facilities and improve operating efficiency and patient comfort.

There are many hospitals in the State of New Jersey that would welcome Federal aid of this kind.

To illustrate how pressing this problem is, Lloyd B. Wescott, president of the State Board of Control of Institutions and Agencies of New Jersey, recently stated:

> There are old hospitals desperately in need of modernization. These hospitals by and large carry heavy indigent loads and unlike hospitals in suburban or newely developing areas, find it increasingly hard to secure contributions.

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This is the time to demonstrate our concern for the mounting financial plight of the aging hospitals of this growing Nation, and also the time to show our desire to help them achieve modernization, so that their patients, staffs, and communities will benefit.

I also recommend that H.R. 10041 include the nondiscriminatory wording suggested by Secretary Celebrezze, "without discrimination on account of race, creed, or color."

There should be absolutely no doubt about a hospital constructed or modernized with Hill-Burton funds accepting any person, regardless of race, creed, or color. H.R. 10041 would eliminate the "separate but equal" wording in the present act, but I prefer the suggested wording of the administration over the proposed bill.

The CHAIRMAN. Are there any questions? If not, we thank you for your testimony, Mr. Patten.

Mr. PATTEN. Thank you, Mr. Chairman.

The CHAIRMAN. I observe this morning the presence of our colleague from Georgia, Mr. Weltner. We are glad to have you with us this morning. I personally have known of your interest in this program for some time. We appreciate it. Do you have a statement that you wish to make for the record?

STATEMENT OF HON. CHARLES L. WELTNER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. WELTNER. Thank you, Mr. Chairman. I was here to introduce at the proper time my constituent, Charles Emmerich, from De Kalb County, Ga. I understand the scheduling is necessarily determined by the other business of the House today. I did wish to introduce Mr. Emmerich to the committee, and, as his representative, simply to state that he is a man who is well versed in county affairs. I am sure that this committee is familiar with his many talents along those lines.

The CHAIRMAN. Thank you very much. We are committed to Dr. Teague as the first witness. He was scheduled yesterday, and we held him over. I understand that his presentation will not take very long, after which we shall be glad to have you present Mr. Emmerich.

Mr. WELTNER. Thank you, sir.

The CHAIRMAN. Dr. Russell E. Teague. Dr. Teague is Commissioner of Health from Frankfort, Ky. Dr. Teague, I am sorry that we were unable to get to you yesterday. You observed the situation.

STATEMENT OF DR. RUSSELL E. TEAGUE, COMMISSIONER OF HEALTH, STATE DEPARTMENT OF HEALTH, FRANKFORT, KY.

Dr. TEAGUE. I was very glad to stay over, sir.

The CHAIRMAN. We hope we have not inconvenienced you too much. We do appreciate your interest in this program, and would be glad to have your testimony.

Dr. TEAGUE. Thank you, sir.

Mr. Chairman and members of the committee, my name is Dr. Russell E. Teague. I am commissioner of health of the Kentucky State Department of Health. In addition to a degree in medicine, I have a degree in public health. I have had 9 years' experience in my present

capacity. I have also served in public health programs as a county health officer, as the chief executive officer of the Pennsylvania Department of Health, and with the U.S. Public Health Service.

I appear before you today, as I have previously, as the representative of, and to present the views and opinions of, the American Public Health Association. It is my privilege to serve as chairman of that association's committee on public policy and legislation.

This committee reviews the policies of the association, including those which bear upon both Federal and State legislation, then presents recommendations to the executive board and to the governing council of our association, where the will of the majority decides what shall be the position of the American Public Health Association.

I am proud to represent the world's largest association of public health workers, with over 14,000 members and with in excess of 25,000 additional members of State-affiliated public health associations. These members, dedicated to public service in both official and voluntary health agencies, serve not only in home communities but with State and national organizations.

I believe that it would not be unduly immodest to suggest that our association's members represent a degree of competence which makes our suggestions of some value on the question now before this committee.

The American Public Health Association is a longtime supporter of the hospital construction, the Hill-Burton program. Our support stems from a firsthand realization of the program's contribution to the bettered health of our Nation, a commodity too often taken for granted and one to which we, along with you, are committed. This contribution has been manifested in a number of different ways, including not only the added general hospitals, tuberculosis hospitals, and mental hospitals, but public health centers, public health laboratory facilities, and rehabilitation facilities. And there have resulted new chronic-disease hospitals and nursing homes, especially vital necessities as medical capabilities to preserve life become ever more sophisticated.

No simple reciting of pertinent figures really tells the story; over $6 billion expended, the construction of almost 300,000 hospital and nursing-home beds, nearly 1,000 public health centers, or 29 State public health laboratories, or 551 diagnostic and treatment centers, or 272 rehabilitation centers; or that 224,000 general-hospital beds have resulted, along with 18,000 beds in mental hospitals, of 7,200 beds in tuberculosis hospitals, or 14,000 beds for chronic diseases, or 26,000 beds in nursing homes.

These, and the many more statistics which could be authentically cited, are essentially without meaning unless you are that person who has been relieved of pain or disability, where a few years ago there was no hospital; or where by having a hospital, with its attendant medical compentencies close at hand, meant the difference between life and death; or who, but a few years ago, went to a tuberculosis hospital with a chance to live instead of just staying home to infect your family with this dread disease; or the one who, previously, had no alternative but to see a family member suffering some mental illness go to a mental hospital hopelessly overcrowded; or that person whose aged mother or father needs care beyond that which your family can provide, and

who can be best cared for in a good nursing home, not a place which profits on misery. Unless you have lived an experience such as this, it is almost impossible to really appreciate what this program has meant to the people of this Nation. Without apology, we support the Hill-Burton program.

Through official actions by the governing council of the American Public Health Association, and I shall enumerate them, we have developed suggestions as to ways the hospital construction and complementary programs might be improved.

Each of these actions would, in our opinion, make this program even more effective. First, we urge full racial integration of health services and facilities. In our opinion, not to do so is an unnecessary waste of inadequate funds, of trained talent, and a needless compromising of the quality of medical care to which we believe every American is entitled.

Compliance with this position will, we believe, result in a more complete exchange of scientific knowledge, with a resultant improvement in professional skill, as well as decreased duplication and inefficiency of services.

Second, we support Federal aid for the construction of standard-meeting, hospital affiliated, nonprofit nursing homes, and the raising of standards of care to insure high-quality services in nursing homes. Although it may be an objective beyond immediate attainment, we believe the nursing-home needs of the majority of American people can be best supplied by nonprofit, hospital-affiliated, nursing homes which provide a complete spectrum of skilled services.

In the interest of bettered health for all the people of our Nation, we cannot accept another consideration being given a higher priority. It is a fact of life that, in this area, a simple equation is all too descriptive: the less service, the greater the profit. We reject this philosophy without equivocation.

Third, the American Public Health Association supports amendment of the Hill-Burton Act by deletion of the eligibility requirement, whereby an applicant must own or operate a hospital to receive aid in the construction of a diagnostic or treatment center. This we believe to be impracticable in much of the rural area of our Nation.

Fourth, we support low-interest loans for construction of public nursing homes and for modernization of public and nonprofit hospitals. Remedying this well-documented need with its attendant astronomical cost is, in our opinion, beyond the capability of the Hill-Burton grant procedure and merits the mortgage loan approach in addition.

Fifth, for the past several years, the APHA has been concerned about the increasing deterioration of hospital facilities, especially in urban areas. This is an acknowledged deficiency in our health armamentarium. The American Public Health Association believes that it is most important to reverse this trend, and we urge this committee to give serious consideration to procedures by which remedial action will not be further deferred.

Finally, may I point out that it is the considered judgment of the APHA that the original purpose of the Congress to aid the Nation in the provision of hospital and related facilities and the means of providing funds for assistance exhibited inordinate wisdom—that

amendments to the original act have been in the best interests of the Nation, that the program should be continued, and that it is timely now, as it has been on past occasions, to further amend this very important Federal-State community program.

At this point, I believe it is pertinent to interject a basic premise of the American Public Health Association, that all legitimate latitude be allowed States and communities to decide which kinds of facilities and services will best suit its own needs and the method whereby they are to be provided.

We recognize and we agreed that the Congress has every right to expect performance within the reasonable limits established by the Congress. With this firm policy in mind, it is the recommendation of the American Public Health Association (1) that the present Hospital Construction Act be extended, (2) that to an appropriate degree the present emphasis on construction of hospitals in rural areas be diminished with a corresponding increased emphasis on construction of new or remodeling of existing hospitals in urban areas, (3) that additional authority, if needed, and funds be authorized for the modernization of existing hospitals particularly in urban areas, (4) that funds be made available to assist States and communities in planning logically for needed health and hospital facilities, and (5) that within limits acceptable to the Congress the greatest possible latitude of decision be granted to each State planning agency to develop plans for the wisest expenditure of, not just the $1 from the Federal Government, but the 2, 3, or 4 State and local dollars also used.

May I express for the American Public Health Association our gratitude for this opportunity to express our views of this important legislation upon which your recommendations will be so important. Thank you very much.

Mr. STAGGERS (presiding). We of the committee appreciate your coming here to give your views to the committee. I think they are very short, very concise, and very emphatic on your endorsement of the legislation.

Mr. Rogers, do you have any questions?

Mr. ROGERS of Florida. No questions, except we do appreciate your testimony that you have given today. Thank you.

Dr. TEAGUE. Thank you.

Mr. STAGGERS. Mr. Schenck?

Mr. SCHENCK. No questions.

Mr. STAGGERS. Mr. Hemphill?

Mr. HEMPHILL. Thank you, Mr. Chairman. I want to congratulate you on your statement. I have listened to testimony here and one thought has occurred to me and I think it is critical. I think it is an obligation of the Conrgess, a responsibility, to continue the Hill-Burton program, and I favor the legislation; but one of the real problems in public health today and in hospitalization today is the problem of personnel. We find down in the South—and I am sure it is no different from other places—that we don't have the trained personnel to carry out the normal nursing duties, even such little things as giving nacotics—what we call shots in common vernacular—and I would like your comment on that, sir. It is in a companion bill, but I think that we ought to consider it because there is no use building brick and mortar if we are not going to be able to put the people in there.

Dr. TEAGUE. That is absolutely correct, Congressman. I agree with you 100 percent. The modern hospital today, in addition to servicing the people, is a training center for personnel. We are in dire need of more and better schools for the training of graduate registered nurses and for the training of licensed practical nurses and for the training of nurses aids and other ancillary personnel such as physical therapists, occupational therapists, all of the ancillary personnel that goes into the modern treatment of the patient.

You can't have this without good, modern hospitals. The hospital is the center in which the training of these kinds of people exists, and we have seen a revolution in the 16 years that the Hill-Burton bill has been in effect in these big, modern hospitals around which are built good nursing and other schools, and we are beginning to get these people into the field now. The schools were late in getting started, but many States have developed a number of these new schools, and the hospital made it possible.

We have a special program in my State health department, and I know other States do, in which we provide consulting services to all the hospitals and nursing homes and help them recruit people and train people.

Does that answer your question, or do you feel that there is a need for some special funds to provide for training aid to training centers?

Mr. HEMPHILL. I may be far afield in my conception of my understanding, but it seems to me there is a lack of coordination somewhere along the line.

For instance, we have under the Area Redevelopment Administration the privilege, and I say privilege, of instituting training programs at the various hospitals in this country, and the Area Redevelopment Administration in my opinion has not only done a good job, but is waiting for somebody to give them the assistance and the direction which professionally they need.

One of the things that has concerned me is the fact that apparently the hospitals of this country have not taken advantage of this and so we have a vacuum where we should have an effort. Would you comment on that please?

Dr. TEAGUE. Yes; I agree that under the manpower redevelopment and ARA programs there hasn't been enough use of the funds that are available to communities. Possibly this was due to a lack of leadership at the State level in picking it up or knowing it was available. We have started some training centers in my State that are financed through this ARA manpower redevelopment program and it is working very fine, but we just got them started in the last few months.

Mr. HEMPHILL. My point is that somebody like you has the stature to institute the coordination. I am just suggesting; I am certainly not criticizing. There is no use in building the finest hospital on earth if you can't put people in it to give the people proper service. It is ridiculous for us to consider one without the other.

Dr. TEAGUE. I agree. The U.S. Public Health Service has an interest in this; the Association of State and Territorial Health Officers has an interest in it, as do the American Public Health Association, American Medical Association, American Nurses Association, American Hospital Association, and we will carry this message back to them and urge that they exert some leadership in these areas.

Your suggestion is a good one I believe.

Mr. HEMPHILL. There is one other question I would ask because of your experience. What do you think accounts for the low pay of nurses as compared with other people in the other professional fields that women are accustomed to entering, such as the secretarial and so on.

Dr. TEAGUE. I don't know, but this is a fact of life. The nurses are dedicated people. Most every nurse that I have known in my life, and I have known thousands of them, is dedicated. The dollar sign hasn't meant so much to them. They are not organized in the sense of a union of any sort and they just haven't fought for themselves, I suppose. Their interest on a day-to-day basis and all night long is taking care of the sick. I agree with you. I don't think they are paid enough. I agree that they are the lowest paid of all professional people dealing with sick people.

Mr. HEMPHILL. If mothers and nurses don't go to heaven, the rest of us better not try. Do you have any solution that you would offer to this very critical problem of getting people to go into the nursing field? They can be secretaries in 2 years and come out and come to Washington and get a pretty good job making $300 to $350 a month to start with, and then if they have something on the ball can go on up the scale.

You put a young lady into nursing training for—what is it—4 years?——

Dr. TEAGUE. Yes.

Mr. HEMPHILL (continuing). Where she is just a servant and when she gets out, unless she does private duty on the side, which she is physically able to do as a young person perhaps, but an older person I assume would have some difficulty, except for the dedication and the fact that it is a great Christian service, there is no really practical monetary appeal for her, is there?

Dr. TEAGUE. That is right. Of the 40,000 members of the American Public Health Association, almost half are public health nurses. The public health nurse is on a civil service merit system basis and she gets a fairly good salary. It ranges anywhere from $4,000 up to $10,000. As to the hospital nurses, in many areas their pay is very low. The per diem cost of operating hospitals, you know, is inordinately high.

Mr. HEMPHILL. Yes.

Dr. TEAGUE. And the hospital administration tries to keep their personnel costs as low as they can; this is a fact. The answer is not forthcoming to me right now. I don't know how we can get the hospitals to recognize that the nurses are professional people and should be paid properly for their services.

Mr. HEMPHILL. You may answer this or not. I am not trying to belabor the point. I favored the King-Anderson program openly, because I believe everybody ought to have hospitalization in a great country like this. You may comment or refuse to comment. Do you think that the fact that people are going to have the money to have the hospitalization, if that legislation is enacted, would help in taking care of the costs in a hospital to such an extent that we could hope to raise the nurses' pay and get more people into the service?

Dr. TEAGUE. It would help; yes, sir. In my State, and some of the other States are doing this, the State health department and welfare

department operate a medical care program for the indigent and the aged. This is a mixture of the Kerr-Mills legislation, the Public Assistance Act, and some general assistance that the State has appropriated.

Before we started our program we found that 20 percent of all the patients in hospitals in my State didn't pay anything. They were charity cases. The other 80 percent that were in the hospitals were paying the cost for themselves plus this other 20 percent.

In other words, the cost was added on to the paying patient to pay for the other 20 percent, and this was a burden on a person who was ill at a time when he could least afford to pay for somebody else's care. We felt very strongly that the cost of the indigent 20 percent should be borne by the taxpayers as a whole rather than the sick people in the hospital.

That is why we implemented very early the comprehensive, across-the-board Kerr-Mills program which pays for hospitalization, full per diem cost, pays for nursing homes up to 120 days, pays doctors for home and office bills. We also pay the drug bills and dentists for dental care. We still have other things we want to add to this program in the future, such as rehabilitation service. As to your question on the King-Anderson type legislation, our organization, the American Public Health Association, is on record as favoring the social security mechanism for financing the care for the aging. Some medical organizations, you know, like the American Medical Association, are opposed to this method of financing. It is just a matter of determining how you are going to finance it, whether it is paid out of the general tax dollar or out of social security taxes, because it is costly whichever way you do it.

Mr. HEMPHILL. I thank you for your responses to my questions and for appearing before the committee. Thank you, Mr. Chairman. I appreciate your giving me that much time.

Mr. STAGGERS. Thank you. Mr. Devine.

Mr. DEVINE. I have no questions.

Mr. STAGGERS. Mr. Kornegay?

Mr. KORNEGAY. Thank you, Mr. Chairman. Dr. Teague, I would like to ask you a question about the financing of nonprofit nursing homes. What assistance is available at the present time to a group of people, private citizens, who want to get together and organize, and construct, and operate a private nonprofit nursing home?

Dr. TEAGUE. Under the existing Hill-Burton Act a grant from the Hill-Burton Federal funds on a matching basis can be made in an amount determined by the State planning agency, which is the authority in that State, and I happen to be the authority in my own State.

Mr. KORNEGAY. In Kentucky?

Dr. TEAGUE. Yes. We have decided on a 50–50 matching basis in our State for hospitals and nursing homes. If a person puts up half the cost we put up the other half to build the nursing home if it meets the Federal standards that are set up by the Public Health Service, and our standards.

There are other methods of borrowing money under the HHFA. Private nonprofit nursing homes can borrow up to 90 or 95 percent of the total cost of the nursing home and can construct them in the community as a nonprofit organization.

Mr. KORNEGAY. Can they go both routes?

Dr. TEAGUE. They can go both routes; yes.

Mr. KORNEGAY. In other words, you can borrow the money through the Federal Housing and Home Finance and then also participate in these other funds.

Dr. TEAGUE. These long-term loans that are amortized over, say, 40 years, are very helpful to these kinds of nonprofit associations who want to set up a community nursing home. Then the Hill-Burton grant mechanism also insures the standards of construction, so that they don't put up something that is substandard or nonfire resistant.

Mr. KORNEGAY. You are in favor of continuing both of these programs?

Dr. TEAGUE. Yes, sir; yes, indeed. I believe that in this bill under discussion here it transfers those funds in the loan feature from the HHFA to the Public Health Service. In my opinion, it ought to be in a health-oriented agency because you can use your nursing homes to improve the health care of the whole community if you have good nursing homes.

The funds for construction of health facilities are in my opinion best operated through the official health agency, although I have no bones to pick with HHFA. We have worked with these people. But, for the coordination through the State Hill-Burton authority from Public Health Service to the hospital and nursing home construction, it seems to me we should have the whole package rather than just part of it.

Mr. KORNEGAY. I see what you mean. Do you have any opinion with reference to which is needed worse, the hospital facilities or nursing home facilities?

Dr. TEAGUE. As I say in my statement, we have made real good progress in hospital construction. We are just getting off the ground on nursing homes. I would say nursing homes are needed all over the country. The population over 65 is increasing at a tremendous rate and of those between the ages of 65 and 70, about a fourth become ill and have to have nursing home care. There are many areas in the country that just do not have nursing homes at all.

In the eastern half of Kentucky, and just to use this as an example, there has not been a nonprofit home built in that whole area, not a single one in 44 counties.

Mr. KORNEGAY. If we had more nursing home facilities it would relieve some of the pressure that exists on the hospital facilities.

Dr. TEAGUE. Right. There are certain people who don't have to stay in the hospital and pay $38 per diem. They could be transferred to the nursing home for convalescent care, say on the third or fourth day, and in a few weeks they are ready to go home, even with chronic illnesses. Then by adding a home nursing program with physical therapists which is assisted by other grants this committee has authorized for the Public Health Service, we have the total picture and the patient can be placed in the facility where the care is most appropriate. The kind of care he needs he gets.

Mr. KORNEGAY. I believe you made some comment to my colleague, Mr. Hemphill, in connection with the Kerr-Mills legislation which you have in operation in Kentucky now.

Dr. TEAGUE. Yes, sir. It is in operation in about 46 States I believe at this time.

Mr. KORNEGAY. How soon after it was passed by Congress in 1960 did you implement it in Kentucky?

Dr. TEAGUE. Immediately. The Governor called a special session of the legislature the following week and appropriated matching funds to establish it by passing a special act. The law that the Congress passed, the present social welfare law, put the administration of all these programs in the welfare department of the State. This is a health program and it should be used to improve the health of the entire community.

I mean if you improve the nursing home you are not only doing it for the indigent and the aged; you are improving the nursing home for the whole community. We passed a law in Kentucky saying that the welfare department shall contract with the health department for the medical aspects of this program. That is how we implemented it and it went into effect the first week.

Mr. KORNEGAY. Do you have a medical care commission or any sort of medical State commission?

Dr. TEAGUE. Yes, the law creates a State advisory council on medical care. The health commissioner is a member, as is the welfare commissioner. Then there is one physician, one dentist, one nurse, one hospital administrator, one nursing home operator, one pharmacist, and four citizens at large who represent the community, the taxpayer.

This council meets every month and makes policy on the program or recommends policy to the two commissioners to me and the commissioner of welfare.

Mr. KORNEGAY. Let me see if I understand. Who actually administers the program? The welfare department?

Dr. TEAGUE. It is divided. He is responsible because the money goes to his department, and he does the social services. The social workers visit the homes and certify eligibility and the health department does the rest. We certify the bills; we inspect the facilities; we approve the bills for payment; and send them to the State treasury where the bills are paid. Really the function of the welfare department is one of social welfare, social services, and ours are the medical aspects.

We determine what drugs we pay for, what kind of services—comprehensive services—we pay for.

Mr. KORNEGAY. You are covering under this program two categories of people, aren't you? That is, the indigent, who have been on welfare all along and have gotten their medical treatment, and the medically indigent, who are not welfare cases but because of a catastrophic illness or accident are medically indigent?

Dr. TEAGUE. Medically indigent, over 65.

Mr. KORNEGAY. Who are unable to take care of their medical expense. They also come under this program, don't they?

Dr. TEAGUE. That is right.

Mr. KORNEGAY. Does the welfare department administer the total program?

Dr. TEAGUE. The eligibility part, the whole thing.

Mr. KORNEGAY. They make the recommendation and then they make the recommendations to your commission?

Dr. TEAGUE. Yes, sir.

Mr. KORNEGAY. How have you found that the program is working there?

Dr. TEAGUE. I think it works ideally.

Mr. KORNEGAY. Ideally?

Dr. TEAGUE. We started out slowly because we didn't want to overexpend and have to retrench, and in 3 years of operation our utilization has gone up. It is now costing us about $15 million a year, Federal and State money, for the entire program, the five categories of public assistance people, and under the Kerr-Mills program aged people who are medically indigent in addition to the old-age assistance.

I think we are meeting the needs of the people in that State.

Mr. KORNEGAY. I am delighted to hear that. The primary reason I asked you as much as I did about it is that my home State of North Carolina has been fussing and fuming with this thing for several years. They tried at one time to get a bill through the legislature and politics got into it and they didn't do anything. Then 2 years later they did get a bill through, which I understand from outstanding lawyers is a good bill. Now the welfare department and the medical care commission and all of the bureaucrats down there are fussing about it and they haven't done anything.

Dr. TEAGUE. I would like to suggest that Congress amend the Medical Care Act, the Kerr-Mills Act, to let the State decide what agency should administer the medical aspects of this program.

Mr. KORNEGAY. That is what I was getting to and I was going to ask you if you had any ideas about it that would help in States like my State. I am not being critical of any particular person or agency, because I don't know what is happening, except we do not have a program there. The State tells me the money is available for it if the administrators and bureaucrats would just get together and decide what they want to do.

Dr. TEAGUE. I went down to North Carolina at Raleigh just 2 months ago.

Mr. KORNEGAY. You may know more about it than I do.

Dr. TEAGUE. I spoke to to the North Carolina Public Health Association and the medical society that met jointly to discuss this very matter and I prescribed our program to them. There is a need to get the State health departments into this program. I believe that there was a bill to do this introduced last session by Mr. Baker called the Baker bill.

Dr. Hutcheson, the health officer of Tennessee, recommended it.

Mr. KORNEGAY. Mr. Howard Baker, now deceased.

Dr. TEAGUE. Yes, sir, and that bill hasn't pass, but it could be done with a small amendment to the Kerr-Mills Act. Let the Governor decide in each State which agency is best suited to administer certain parts of the program.

Mr. KORNEGAY. That is a very fine suggestion and I too want to join my colleagues and thank you for coming here and testifying, Dr. Teague.

Dr. TEAGUE. Thank you, sir.

Mr. KORNEGAY. That is all, Mr. Chairman.

Mr. STAGGERS. Mr. Curtin.

Mr. CURTIN. No questions, Mr. Chairman.

Mr. STAGGERS. Mr. Long?

Mr. LONG. Dr. Teague, my compliments to you on your fine statement. You indicate in your statement a feeling that the need for the

hospitals in rural areas to some extent has been satisfied and that now the question should be on building in urban areas and remodeling of existing facilities in large cities.

Dr. TEAGUE. Yes, sir.

Mr. LONG. Recognizing this is a matter of degree, as to which is pushed rather than the dropping completely of one of the projects and the starting up of another, from your experience in Kentucky, has the demand in the rural areas been pretty well satisfied?

Dr. TEAGUE. In my State it has. I was secretary of health in Pennsylvania and in that State also it is generally satisfied in the rural areas. The original philosophy in the Hill-Burton Act back in 1946 was that we start with these rural communities, hoping that we could attract doctors. Doctors are trained in hospitals and then when they went back to their hometown there was no hospital for them to work in. The original philosophy was to build them in rural communities, and in my State we have pretty well satisfied this aspect. We have three types of hospitals in my State—the big medical bases at Louisville and Lexington with a medical school and university hospital with a group of other big hospitals around this university center.

Then we have 14 regional hospitals which are large hospitals, in the neighborhood of 250 to 500 beds, located in cities like Paducah, Owensboro, Ashland, Bowling Green, and other cities of this size.

Then we have the small community hospital for obstetrics and medical treatment where pneumonia might be treated, or children with infectious diseases, and so forth. Many of these small community hospitals do not do surgery. Some of them do, but most of them do not. They refer patients to the regional hospital for the more expensive and sophisticated type of treatment. Each State, however, handles this in its planning agency. These agencies have been planning State by State and the situation varies from State to State.

In Louisiana you may have put more emphasis on your big cities and you need to continue with the communities in the rural area. I believe that part should be left to the communities. What we would like to see in this law is flexibility so each State which has a different problem can meet it.

The modernization money I would not like to be tied down so that you must use it for modernization, but that you could use it for construction if you don't have to modernize. Some States already have new hospitals and won't have to modernize many, so the flexibility left in the State planning agency is important, I believe.

Mr. LONG. Of course the formula in determining the amount of funds that go to each State has a bearing on this.

Dr. TEAGUE. Yes, sir.

Mr. LONG. Flexibility really is a good thing to have, but assuming a State doesn't need the program of modernization of existing facilities, and they are given the flexibility, unless the formula is in turn amended to make the additional money available to them, really the change in the flexibility is not going to give them very much advantage, as I would see it.

Dr. TEAGUE. That is right. I am a little concerned over the formula. I don't quite understand how the States will profit too much by this. If you give us the $150 million seed money and then in

addition give us an additional amount of money that can be used for modernization, but don't say it must be used for modernization, this is what I would like to see.

Mr. LONG. Of course all of us would like to get money with as little restriction imposed on us as possible.

Dr. TEAGUE. The only thing I am thinking of is that the situation differs from State to State. Big cities like Chicago, and New York, and San Francisco may need a lot of modernization, whereas in my State we have rebuilt practically every hospital in Louisville and Lexington. We don't need much modernization, but we could use it on new construction. In our State we have far, far more applicants than I can get to in the next 10 years, and I know that this is true in most States.

Mr. LONG. Your situation is very similar to that in the State of Louisiana. I talked this morning on long-distance telephone to the one of the most experienced men in the hospital field in the State of Louisiana. I was raising the question as to the application of the formula, also the flexibility allowed the States under the proposed legislation, and whether or not this was going to really help Louisiana. He said that the demand continued great for the construction of new facilities and for the availability of the Hill-Burton funds for construction of these new facilities. He raised the same point that you have just made, that most of the hospitals, and it is true I think generally in the South, have been constructed in the near recent past and consequently we don't have the need for remodeling that the others do. It was his point to me that anything we could do toward making more money available for construction rather than remodeling would in turn be of more benefit to Louisiana.

That is what I wanted your view on and I assume you share the general feeling in this regard.

Dr. TEAGUE. I share it completely.

Mr. LONG. Thank you, Mr. Chairman.

Mr. STAGGERS. Mr. Van Deerlin?

Mr. VAN DEERLIN. No questions.

Mr. STAGGERS. Mr. Pickle?

Mr. PICKLE. Doctor, I may have missed this question because I came in late and if so, pardon the duplication, but what is your position with regard to mortgage insurance presently operated now by the FHA? Do you think that should be kept with the FHA or transferred over to the Surgeon General?

Dr. TEAGUE. I think for nursing homes and hospitals it should be transferred to the Surgeon General.

Mr. PICKLE. You would agree with the bill.

Dr. TEAGUE. Yes, I agree. I think that the statewide planning, areawide planning, regional planning in the country for hospitals and nursing homes could be better coordinated if all agencies that finance them, such as the Hill-Burton program in the Public Health Service, and mortgage insurance, and others, could best be administered by the health agency.

Mr. PICKLE. Your statement is not in accord with all the gentlemen who have testified thus far.

Dr. TEAGUE. No; I don't object. I have no bones to pick with HHFA. We have gotten along fine with them, but it seems to me you

better coordinate your planning if the funds are administered by a health agency.

Mr. PICKLE. Don't you think this would create additional expense if you transferred this function over to the Surgeon General?

Dr. TEAGUE. I am sorry, I don't know.

Mr. PICKLE. You just have a "general" feeling that you would like to have it transferred over.

Dr. TEAGUE. When a person applies to HHFA and wants to build a nursing home in my State, we administer it in the health department at the State level. At least we approve the application to HHFA as a part of our overall plan, and it just seems to me that the people here who administer the nationwide Hill-Burton program could also have a part in these applications for mortgage insurance loans.

Mr. PICKLE. Do you think if it was transferred over to the Surgeon General that this would in effect give more Government control over the health problems and needs of the country?

Dr. TEAGUE. I don't think so. I just can't conceive of that. It is an insured loan. That is what it amounts to, and the advantage of borrowing it that way other than through some other mechanism, would be the low-interest rates, or the longer period of amortization.

Mr. KORNEGAY. Would the gentleman yield at that point?

Mr. PICKLE. Yes, sir; I yield.

Mr. KORNEGAY. Dr. Teague, of course they are going to have to meet certain standards and specifications, anyway, regardless of who has the authority to lend the money. Isn't that right?

Dr. TEAGUE. That is right.

Mr. KORNEGAY. So, from the standpoint of adequacy of the facility, and meeting the high standards that would be imposed, that would be carried out through the administrators at the State level?

Dr. TEAGUE. Yes, sir. By the way, may I make one comment on one section in this bill? It is the part that provides some money for State administration of this program. There is no Federal money that goes to the State health department for administering Hill-Burton. The States appropriated some money, back in 1946, to start these programs and in most States this has not increased since.

Meantime, the program has doubled, tripled, and quadrupled, including the amount of inspection services needed. I would certainly be very much for the portion of this bill that provides that up to 2 percent of the total funds might be used for administering the program, not to exceed $50,000 for any one State, and no State can cut back on the money they are now spending—this is over and above what they are now spending. Then, we would put on some very necessary staff people to help with the planning, and the programing, and inspection services, in the Hill-Burton and the nursing home program.

Mr. KORNEGAY. That is all.

Mr. PICKLE. I didn't understand your question. What was your question again?

Mr. KORNEGAY. He is talking about transferring the authority from the FHA over to the Surgeon General. My question was that the standards had to be met, and my point was the fact that it is

just like building a house. The contractor or the architect sets the standards, the design, and yet you go to the bank, or the building and loan, to get the money. If the architect was setting the price on it, or the amount of money to put in it, there just wouldn't be any ceiling on the thing.

That would be the point that would concern me about this transfer.

Mr. PICKLE. Yes. I share that view.

Mr. KORNEGAY. But you have a check and balance here when you have some banker in the picture.

Dr. TEAGUE. There is one thing about these standards that bothers us a little bit. The FHHA approves narrow corridors for homes for the aged, and we in the Hill-Burton program have different standards. I think that all health programs ought to be in a health-oriented agency, whether it is insuring a loan or what, because we do have something to say about the standards—much more to say about the standards if it is in a health agency than if it is in a financing agency.

What the Federal Government is really doing here is just insuring a loan at a certain rate of interest.

Mr. KORNEGAY. My point as this, Dr. Teague, and it is not to get on anybody at all: in anything, it is good to sort of have a check and a balance on it.

Dr. TEAGUE. Right.

Mr. KORNEGAY. And I am thinking about this. Take an architect who is an artist. He wants to make a creation here, he sets the amount of money that he is spending, and yet it isn't his money. Then, there is just no ceiling on where it is going. You see?

Dr. TEAGUE. Yes, sir.

Mr. KORNEGAY. As I look out the window to the right here, maybe we in Congress ought not to raise the point, but it is a point.

Mr. PICKLE. Thank you, Doctor. I wanted to get your views on it. That is all, Mr. Chairman.

Mr. STAGGERS. Any questions?

Mr. DINGELL. No questions, Mr. Chairman.

Mr. STAGGERS. Doctor, we certainly appreciate the fact that you come here from Kentucky to give us the benefit of your views in representing the American Public Health Association. I think, as I said to start with, they were very short, very concise, and very emphatic. Thank you, gentlemen.

Dr. TEAGUE. Our association appreciates the privilege and opportunity. Thank you.

Mr. STAGGERS. Fine. Have a nice trip back home.

Dr. TEAGUE. Thank you.

Mr. STAGGERS. At this time we will call on our colleague from Georgia, Charles Weltner, to introduce his constituent. I would like to say, in behalf of Chuck Weltner, that he is not only well liked and an able colleague of ours, but he is distinguished by one quality that to me is sorely needed in American life today, and that is the courage of his convictions.

Chuck, we are glad to have you with us, and if you would proceed to introduce your constituent we would be happy to have you do so.

FURTHER STATEMENT OF HON. CHARLES L. WELTNER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. WELTNER. Thank you, Mr. Chairman. Members of the committee, it is a pleasure to appear to introduce my constituent, Mr. Charles O. Emmerich, Jr., a resident of the Fifth District of Georgia, who is serving with distinction as chairman of the De Kalb County Board of Commissioners. Mr. Emmerich appears here today as chairman of the committee on health and education of the National Association of Counties, and he is the spokesman for that association. He is a man whose views have been called upon before by this committee.

Last year, I had the privilege of introducing him before Mr. Roberts' subcommittee, during the hearings held on the far-reaching mental health and retardation bills. I commend Mr. Emmerich's abilities and his views to this committee, and thank you for this opportunity.

Mr. STAGGERS. Thank you, Chuck. Mr. Emmerich, with that fine sendoff from our colleague, we will certainly be happy to hear from you and have your views. Will you state your name and position for the record.

STATEMENT OF CHARLES EMMERICH, COUNTY COMMISSIONER OF DE KALB COUNTY, GA.

Mr. EMMERICH. Mr. Charles O. Emmerich. Mr. Chairman, I would like to forgo the reading of this statement—you have copies—and let me just submit it for the record.

Mr. STAGGERS. That will be done. We would be glad to have your summary of your position.

Mr. EMMERICH. Thank you. I would like to summarize it right quickly. I think it would be almost foolish of me to spend a great deal of time expressing our feeling on the Hill-Burton program. This is one of the fine things that has come out of Washington and it is a fine program where the State, the Federal Government, and the local governments have played an important part in doing an excellent service to mankind. This I think is terribly important. I would like for a couple of seconds to refer back to my own State of Georgia where we are spending in the neighborhood of $18 million annually for critical, needed facilities and we are spending in the neighborhood of $100 million for facility services.

At the same time we still need about 5,000 additional beds—I am talking about general hospital beds—and we could use about 10,000 additional beds for the mentally ill and retarded, and about 12,000 beds for long-term care, including nursing homes. This list could be even lengthened. The fact is the list that we have on hand now runs about $76 million of needs at this time.

Georgia also has a deficit of about 80 percent in its both rehabilitation facilities and diagnostic treatment centers, which is extremely important to this whole health program. When you add this need to the other 49 States you can easily grasp the size of the program that we are talking about and the overwhelming needs.

I wouldn't try to dramatize this program. I don't think it could be overdramatized. The need is great in our country and I hope

that nothing will be said that will harm the program in general. This we would sponsor and agree with. The National Association of Counties which represents 3,043 counties in this country, have participated in this program. They have actually been a part of 2,224 Hill-Burton projects where the combined expenditures amounted to $1,645 million and the Federal share of this was $619 million. This seems to be a good investment from the standpoint of the Federal Government too.

This does not include another 164 projects where cities and counties worked together and had projects approved. The thing that I like about the new bill, which to me is very important, is, first, the funds provide for modernization. This is a longfelt need and we have realized for many years that something should be done about it. This is particularly true in the great metro areas throughout the country. You now have in the neighborhood of 212 such metropolitan complexes that are growing up and sometimes politically are not so strong statewide, but from the standpoint of population and need it is very obvious and very great and it is my hope that you will do everything to keep this part of the program in the program and, for that matter, strengthen it.

I believe of the three suggested bills that the bill we discuss this morning has the least amount in that area. We could actually probably have profitably gone up to a third of the money available in this new field because we are so far behind in our modernization program.

I think too that there are other parts of the program that are worth thinking about and one is the allocation of funds which has been discussed here this morning. We like the old formula that has been used for years as far as the new facilities are concerned, but when you get into this new program—this is a brand new program—while I like flexibility in administration I think that we ought to tie down some of this to be sure that we actually are going to get this new service in the area where it is needed.

It ought to lean in the direction I believe of the great cities that are being formed and I think this is important. Our organization has not taken a definite stand on this particular point, but I do quote here a part of a report which has not been printed, but we have had the privilege of reading, which was made by the Advisory Commission on Intergovernmental Relations and they come up with a stated policy which I think is good and one that is in my report there. We have actually sponsored the report itself, so I think I would be in keeping in saying that we would probably be responsible for this idea, and they are here saying when referring to equalization provisions that we should aim for a reasonable and uniform level of minimum program performance in every State; that uniformity in the mechanics of the equalization provisions is preferable over a variety; and that statutory specifications are preferable to administrative discretions.

This is a questionable item, but we feel it has merit and I hope you will consider this in your program.

These are the general remarks we would like to make. I know this is a very short period to appear here, but this program is so important to our country and its health that we wanted at least the chance to come here and say thank you that you are willing to take your time to listen to the public and thank you for the privilege of presenting the ideas as outlined in this record.

30-883—64——12

(The statement referred to follows:)

STATEMENT FOR THE NATIONAL ASSOCIATION OF COUNTIES ON H.R. 10041, HOSPITAL AND MEDICAL FACILITIES AMENDMENTS OF 1964 BY CHARLES EMMERICH, CHAIRMAN, BOARD OF COUNTY COMMISSIONERS, DE KALB COUNTY, GA.

Mr. Chairman and members of the committee, my name is Charles Emmerich and I am appearing here today on behalf of the National Association of Counties, an organization representing county government throughout the Nation. I am chairman of the board of county commissioners of De Kalb County, Ga., and serve in a similiar capacity for the committee on health and education of the National Association of Counties.

The success and continued need of the Hill-Burton program is well known to all persons associated with it. County government's experience particularly qualifies it to request an extension of the program and an accelerated pace.

You will note from the following table that county governments have sponsored 33 percent of all approved Hill-Burton projects. This percentage does not include the 164 joint city-county projects, built at a cost of $144 million. Counties have contributed in excess of $1 billion to these Hill-Burton projects in addition to the millions spent on other health facilities not associated with the program.

Hill-Burton projects, 1948–June 30, 1964

	Number of approved projects	Combined cost	Federal share
Total	6,810	$6,185,000,000	$1,963,000,000
County	2,224	1,645,000,000	619,000,000
City-county	164	144,000,000	56,000,000

MODERNIZATION

We feel the time is long overdue for this program to recognize more fully the need to modernize our large urban county and city hospitals. The need for modernization is not limited to those areas; however, they should receive a substantial percentage of the funds made available for modernization.

We appreciate the fact that H.R. 10041 provides considerable latitude in transferring funds from one category to another if such transfer will better carry out purposes of title, or if there has been no approvable application. Notwithstanding, we favor a larger dollar figure being specifically earmarked for modernization than does H.R. 10041.

PLANNING

We naturally support the concept of comprehensive planning for health facilities. It is interesting to note the trend in Federal legislation to encourage comprehensive planning, and oftentimes making it a requirement for Federal assistance.

In this respect, we suggest that comprehensive planning for health facilities should not be limited to a coordination of other health facilities. It should also consider the other factors inherent in comprehensive planning, such as transportation, water and sewage facilities, open space, etc. We suggest the committee consider the feasibility of having the planning envisioned in this proposal coordinated with other planning going on in the area, such as the 701 comprehensive planning program of the Housing and Home Finance Agency.

ALLOCATION OF FUNDS

As we understand H.R. 10041 and the draft bill submitted by the administration, the funds for modernization would be allocated to the States under a different formula than those funds allocated for new construction. Due to its relevance to this proposal, we should like to bring to the attention of the committee a recent report and accompanying recommendations adopted by the advisory commission on intergovernmental relations. As you know, this commission is composed of representatives from every level of Government and includes in its membership the secretary of the department administering this

program. The printed report will not be available until later this month; however, its recommendations have been released.

The report is on the role of equalization in the distribution of Federal grants-in-aid to State and local governments. The following two recommendations are the most pertinent to the situation at hand. However, they should ultimately be considered in the overall context of the other recommendations and the full report.

The commission concludes that equalization provisions, introduced through both allocation and matching requirements, should aim for a reasonable uniform level of minimum program performance in every State, that uniformity in the mechanics of the equalization provisions is preferred over variety, and that statutory specification is preferable to administrative discretion.

The commission believes that when the Congress determines that the national objectives sought by a grant-in-aid program require "equalization" (i.e., when it determines that the distribution of Federal funds among the States and the "matching" requirements shall take account of differences in the relative financial capabilities of the several States in terms of their own resources), the Congress should prescribe such "equalization" for all the funds distributed among the States for basic program support. The objective of "equalization" is needlessly limited when only part of program support funds are distributed on an "equalized" basis, while other parts are distributed in equal dollar amounts, or in proportion to population, caseload, etc.

Last year, the National Association of Counties supported legislation providing for community mental health centers. In effect, that program places a much greater burden on local governments by having them assume, in part, an activity traditionally handled by the States.

We supported this concept although it placed one more demand on our already strained local budgets. An increase in Federal funds is necessary if counties are to fulfill their responsibility in the field of community mental health centers and maintain an acceptable pace in the construction and modernization of other health facilities.

It is not my desire to overly dramatize the importance of the Hill-Burton participation in connection with the development of local health facilities. At the same time, this program has met such an overwhelming need that it is difficult to believe that this could be overly dramatized.

In my own State, there are approximately 4 million people covering a large geographical area that requires many types and levels of health-care services. To provide these services, a significant amount of money must be invested in the construction and operation of facility services. In an average year, approximately $18 million are being expended to meet critically needed medical facility construction in Georgia and about $100 million for the operation of facility services. The State health department and the Hill-Burton agency have a leadership role in encouraging objective planning for better geographic distribution of facilities or services based on population trends and to assure economic utilization of Federal and State grant funds, as well as local funds utilized for such purposes.

The planning problem for health-care facilities in Georgia is especially acute in the larger metropolitan areas with multiple facilities and expanded needs, due to the impact of industrialization, urbanization, and suburbanization trends. A considerable amount of funds are urgently needed for modernization and replacement of obsolete facilities in addition to the tremendous need for facilities to meet many areas of medical assistance that is, at the present time, near a void insofar as facilities are concerned.

Georgia does not have adequate health facilities to meet the pressing needs of communities and their citizens. Currently, Georgia needs about 5,000 additional general hospital beds, 10,000 additional beds for the mentally ill and retarded, and 12,000 beds for long-term care, including nursing homes. Furthermore, Georgia has an 80-percent deficit in both rehabilitation facilities and diagnostic treatment centers. In addition to current existing deficits in general hospital facilities, an additional 292 beds are needed annually to cover the increase in population and about 309 beds are needed annually to replace facilities that are becoming obsolete due to age and type of construction. This need is confirmed by effective demand for construction projects of all types.

As of December 1, 1963, the medical facilities service, Georgia Department of Public Health, listed the projects from counties and communities in Georgia, totaling 65 medical facility construction projects, with an estimated cost of $76,703,000.

The foregoing included 2,414 general hospital beds at an estimated cost of $53,198,000, and representing 33 projects; health centers with an estimated total cost of $1,176,000, and representing 11 projects; nursing homes with 812 beds at a cost of $7,554,000, representing 16 projects; and also 1 diagnostic and treatment center at $75,000; a chronic hospital unit with 50 beds at a cost of $1 million; and rehabilitation centers with 685 beds at a cost of $13,100,000 and representing 3 projects. This is, of course, 65 projects with 3,961 urgently needed beds at a cost of $76,703,000.

Gentlemen, I consider the needs outlined here for my own State of Georgia to have some relationship to the needs of other States of our Nation. In this one important field, there is a deficit in facilities of care that is alarming to our society. It is essential that local areas be given support in their attempt to climb in many cases from virtually no health facilities to a point of meeting minimum needs. The support of the Hill-Burton agency is an absolute essential to assist in providing for care of our citizens in the important field of general health.

It is my feeling that the areas of service of the Hill-Burton agency should be expanded to include renovation and repair of existing facilities also. There are facilities in some places in which expansion of those existing facilities and their renovation would be financially prudent and it would appear wise for the Hill-Burton agency to participate in such expansion and renovation.

Certainly, it would be impossible for me to appear before you today and fail to support the activities of the Hill-Burton agency to the fullest. The testimony which I have presented indicates to me an overwhelming need which must be met by all available interests and by all levels of government. The health of our people is one of our most urgent needs and I encourage, to the extent of my ability, the passage of H.R. 10041 and S. 2531.

Mr. STAGGERS. Does that conclude your statement?

Mr. EMMERICH. That is it.

Mr. STAGGERS. Thank you very kindly. Again I say we appreciate the fact that you would take time to come and give your views and to summarize them briefly here. I might say, of course, that they are very short, concise, and emphatic, too, and that you are in favor of the bill and we are happy to have your views.

Any questions, Mr. Dingell?

Mr. DINGELL. Mr. Chairman, I would just like to commend the witness for a very fine statement and tell him how highly we value his excellent Congressman, Charles Weltner. We think a great deal of him, and he has distinguished himself greatly by his ability and dedication to public service here, and I am sure you are as proud of him as we are.

Mr. EMMERICH. Yes; we are.

Mr. DINGELL. Thank you very much.

Mr. EMMERICH. Thank you.

Mr. STAGGERS. Mr. Schenck.

Mr. SCHENCK. Thank you, Mr. Chairman, I would like to associate myself with the comments of our colleague, Mr. Dingell, in response to your fine statement. Mr. Emmerich, you are chairman of a board of county commissioners in Georgia and you are also representing, as I understand, the National Association of Counties here.

Mr. EMMERICH. That is right.

Mr. SCHENCK. Mr. Emmerich, do you have in Georgia, or does your association have in general, difficulty in financing their county operations of various kinds?

Mr. EMMERICH. I guess all governments do, including our State, as probably you do. Yes; we have problems, but we appeared before you before, you remember, on mental health, where you were trying to outline a program where we would have local participation.

We agree with this. We agree this gives us a stronger program, and this, we think, is in the direction the thing should go. Yes; we have problems, but we still want to help face those problems.

Mr. SCHENCK. Mr. Emmerich, would you agree with us that the very same taxpayers that support your units of government, both county and State, also support the Federal Government?

Mr. EMMERICH. I would think so; yes.

Mr. SCHENCK. Do you know of any magic source of funds that the Federal Government has that is not also available to you?

Mr. EMMERICH. No, sir; I do not. If we did we would certainly look for them and do something about it.

Mr. SCHENCK. I am sure you would. Mr. Emmerich, since both the Federal Government and the counties, local and State units of government, are able to receive their operating money from the same sources—namely, all the taxpayers—when we spend more money than we have coming in, we have to borrow the money.

Mr. EMMERICH. Yes.

Mr. SCHENCK. The only sources of borrowing money is from the savings of the people or the institutions which manage their savings.

Mr. EMMERICH. I understand that clearly.

Mr. SCHENCK. Then how do you feel that the Federal Government ought to finance a great many different programs, increase the size and operation of the Federal Government, the national debt, the bureaucracy, and so on, which is frequently done at the expense of your own local operations?

Mr. EMMERICH. Mr. Congressman, this is a question that has been batted around now since the beginning our our great Federal Government, since the very beginning of time with us. I don't know the answers, but I do know that there are some programs that without the aid of the Federal Government we would not have made the progress we have now.

If you will consider for just a few moments the thousands of Hill-Burton hospitals that there are now throughout this country and the services they offer—and you have been a part of this—I think you would be proud of it. I think we needed this leadership. We needed this financial help.

As you know, the trend has been—and through our recent program in the area of retardation and mental illness—to let the local governments come in and participate. This is agreed with, but I don't think we are ready to walk yet. We are just crawling.

Mr. SCHENCK. Mr. Emmerich, I fully agree with you that there are many, many programs and developments which have tremendous merit and should be done for the benefit of people—and we here are very much interested in people as individuals.

Mr. EMMERICH. Right.

Mr. SCHENCK. The question of financing is an important matter, and the question I am questioning is the constant increase in the size of the Federal Government, the spreading bureaucracy and the controls which unavoidably go with spreading bureaucracy, which to me has a lot of interference with local operations of facilities and programs.

Mr. EMMERICH. Yes, sir.

Mr. SCHENCK. And I am wondering if the only reason for this is that it appears to be easier for the Federal Government to raise taxes from people than it is for local units of government to raise taxes of people because they are right smack up against and very close personally to the individuals whom they are asking to increase their taxes.

Mr. EMMERICH. Right. This is a great problem. I wish I knew the answer, but I do know there is a tremendous need from the standpoint of health as far as our people are concerned. I am talking about all of our people, and I don't think that there is any program now that the local governments could put over without aid from the State and National levels.

The new concept of bringing it nearer to the public we agree with and we are going as far as we can. In my county alone we spend over a million dollars each year for the indigent, and we are very proud of it. We are doing what we can, but I think this program is a must.

Now, my appearance here is to give you an attitude and speaking for the over 3,000 counties in this government of ours, and for my own, and for the State of Georgia, we need this program. We believe it should continue and we hope that it will.

Mr. SCHENCK. Mr. Emmerich, I am sure that most counties in the United States do spend a tremendous amount of money for indigent care and that it is very necessary and essential to do.

Mr. EMMERICH. Yes.

Mr. SCHENCK. However, would you have a feeling that it would be difficult to put a tax levy program or a bond issue program on in the individual counties to get this money to do this job?

Mr. EMMERICH. I don't think it is possible and do the other things we are doing. You build a Hill-Burton hospital and we have built several. We put up money. We actually have to float bonds, and in many cases we put up operating funds. We are operating two of them now. One of them is a 1,200-bed hospital which two counties operate together, and another one is a smaller, but a general hospital, we are doing, but I don't think we could have financed this alone. I think without the Hill-Burton funds this would not have been done and I think there would have been great suffering if it had not been done.

Mr. SCHENCK. Mr. Emmerich, I appreciate your frankness and your fine presentation. The fact still remains that with the Federal Government now reducing individual taxes this isn't going to help the individual very much if the local units of government also increase their taxes.

Mr. EMMERICH. Yes, sir. Of course, that is your viewpoint. I recognize that as being one. At the same time, I recognize that the people we are serving also are the same ones that paid these taxes, too; so it works two ways.

Mr. SCHENCK. That is very true. I think that it might be quite illuminating to you to look back over the statement put out in connection with the budget recommendation now for fiscal year 1965 and to know the cost to the Federal Government a few years ago as compared to the present time, and also the tremendous increase in the national debt of our Federal Government, which burden many are now apparently willing to pass on to our grandchildren and their grandchildren in order that we may have what we want at this point.

Mr. EMMERICH. Right. This is a great problem. I hope you find the answer.

Mr. SCHENCK. Thank you, Mr. Chairman.

Mr. DINGELL (presiding). Mr. Rogers?

Mr. ROGERS of Florida. Thank you, Mr. Chairman. Mr. Emmerich, I appreciate your testimony here on behalf of the National Association of Counties. I might say, too, it was certainly helpful to have your interest and support in the mental health and retardation program.

Mr. EMMERICH. Thank you. This is a wonderful program, Mr. Rogers.

Mr. ROGERS of Florida. We are anxious to see how that develops. It will take a little while, I am sure, to start moving, although here is a question now that has been in existence, as I understand it, since 1948. Isn't that true?

Mr. EMMERICH. Yes; yes, it has.

Mr. ROGERS of Florida. What this legislation contemplates is a continuation of the Hill-Burton program.

Mr. EMMERICH. Right.

Mr. ROGERS of Florida. Although I believe there is a new feature of modernization and I note that your organization puts a great deal of emphasis on this program of modernizing existing hospitals.

Mr. EMMERICH. Yes. We think the need is there. It has been there.

Mr. ROGERS of Florida. I was concerned somewhat by the testimony of HEW on the basis of allocation of moneys to the States for the program of modernization. From the testimony presented it was my understanding that the allocation to States for modernization would be based on a survey made in 1948 when the Hill-Burton program began, determining how many hospitals and hospital beds were available in the entire country. Each State made this, as I understand it.

Mr. EMMERICH. Right.

Mr. ROGERS of Florida. According to HEW they would take from the 1948 survey the number of hospitals then in existence in a State and compare that number to the total number in the United States and that percentage would then be the percentage to be allocated to the State for the modernization program now.

Mr. EMMERICH. That is tying it pretty close to need, isn't it?

Mr. ROGERS of Florida. Pardon me.

Mr. EMMERICH. That is tying it down pretty close to the need.

Mr. ROGERS of Florida. This is what I wondered and that is what I wanted to get your comment on. Now, later testimony from another witness—I have forgotten who it was right off—said that in 1956 there was a survey of actual need for modernization and this was done with that specifically in mind and they came up with a certain amount of, I think, a billion-dollar program.

Since then, in 1960, HEW conducted another survey on the need for modernization, and it comes out to be about $3.6 billion. If they have these programs and surveys based on need for modernization how do you feel as to the basis of allocation of funds going back to the 1948 survey? What would be your comment?

Mr. EMMERICH. I haven't studied the contrast of these two. You are talking about modernization mainly?

Mr. ROGERS of Florida. Yes, I am speaking only of the modernization feature of the program.

Mr. EMMERICH. I don't know as I would know the answer to that. I know from my own experience that usually most of these hospitals are in the great metropolitan areas and I have a feeling that the same formula we followed in the past, which actually I think helped more the rural areas, probably ought to be changed somewhat in favor of the metropolitan areas.

Mr. ROGERS of Florida. I think they plan to leave that within the discretion of the State.

Mr. EMMERICH. Yes, I understand that.

Mr. ROGERS of Florida. But I am speaking now of the allocation of the funds to the State for this particular program, if this is approved by this committee and the Congress. Is it wise for us to use as a basis the fact that just so many hospitals were in existence? Is this a reasonable basis for need?

Mr. EMMERICH. No.

Mr. ROGERS of Florida. Or should we go into a study that went into modernization specifically.

Mr. EMMERICH. It certainly ought to take into consideration the recent study. You would have to, I am sure.

Mr. ROGERS of Florida. I appreciate your comment on that. Also I notice that you have some concern about the equalization provisions and that you think this should be done by the Congress, by legislative fiat, rather than allowing it to administrative determination.

Mr. EMMERICH. That is correct. Still here referring mainly now to your remodeling program?

Mr. ROGERS of Florida. Still to the modernization program.

Mr. EMMERICH. Yes.

Mr. ROGERS of Florida. In other words, you think we should put down the necessary criteria of what constitutes need for modernization?

Mr. EMMERICH. Yes. I think if it is not you are going to lose it. It is going to be lost in the shuffle and we will continue to spend it the same way we did before, and I believe there is reason to think that you ought to ask for a different direction at this time and it ought to be set here.

This is what I think we are trying to say.

Mr. ROGERS of Florida. Thank you very much. I appreciate your testimony and the good work that your representatives here in Washington do in keeping us advised of the position of your organization. Thank you. Thank you, Mr. Chairman.

Mr. EMMERICH. Thank you.

Mr. DINGELL. Mr. Younger.

Mr. YOUNGER. Thank you, Mr. Chairman. Mr. Emmerich, you are aware of the changes that have been made in this bill compared to the previous bill?

Mr. EMMERICH. Yes, most of them, yes.

Mr. YOUNGER. In regard to the question of equal but separate facilities?

Mr. EMMERICH. I thought that had been settled already by the court; hasn't it?

Mr. YOUNGER. Will that change in the bill make any difference in your operation?

Mr. EMMERICH. I wouldn't think so.

Mr. YOUNGER. Both the hospitals that you operate under Hill-Burton are integrated?

Mr. EMMERICH. They are working on the old basis.

Mr. YOUNGER. They are integrated hospitals?

Mr. EMMERICH. Not all of them, no.

Mr. YOUNGER. Are the two Hill-Burton hospitals that you operate integrated?

Mr. EMMERICH. One is and one isn't.

Mr. YOUNGER. So you don't feel that this change in the bill will make any difference in your program?

Mr. EMMERICH. I am speaking as a representative of the national association.

Mr. YOUNGER. Yes.

Mr. EMMERICH. As a local I think my people would probably lean back to the old equal facilities, but I think speaking for the national association I would certainly have to hold out for the change you have made in it.

Mr. YOUNGER. But locally it might make some difference?

Mr. EMMERICH. It makes some, not as much as it would have a few years back.

Mr. YOUNGER. Once in a while we get a complaint from local governments asking that we discontinue passing bills all the time providing for matching funds, which is breaking them.

Have you had any experience like that in your county?

Mr. EMMERICH. I am sure we have, but we like the idea of a partnership affair. We do this in our own county and I think the counties as a whole like this. We are not opposed to it. This means that there must be enough interest at the local level to be willing to put up dollars, and this can assure you of something. We like this very much in our new mental bill and we feel it has a lot of merit.

Mr. YOUNGER. That is all, Mr. Chairman.

Mr. DINGELL. Mr. Kornegay.

Mr. KORNEGAY. Thank you, Mr. Chairman. Mr. Emmerich, let me ask you just one question. I notice in your statement you said that you thought that the bill ought to lean to the great cities.

Mr. EMMERICH. The large cities more than the rural counties and rural areas.

Mr. KORNEGAY. The interest is in the hospitals in the large metropolitan areas?

Mr. EMMERICH. Yes. You are talking about remodeling now?

Mr. KORNEGAY. Is it your thinking that it ought to be spelled out in the bill?

Mr. EMMERICH. Probably, yes.

Mr. KORNEGAY. Or be left up to the State authority, or that some definite standard ought to be set in the law?

Mr. EMMERICH. We haven't discussed this point in our group and I merely referred you here to the study which has just been completed by the Advisory Commission on Intergovernmental Relations, and this is what they have recommended and we did support this recommendation, so I assume I would be right in supporting this at this point.

Mr. KORNEGAY. I understand, but what I am trying to get at is, do you think it ought to be spelled out in the bill?

Mr. EMMERICH. Yes.

Mr. KORNEGAY. It should be?

Mr. EMMERICH. Yes.

Mr. KORNEGAY. By that you mean just the general policy that emphasis should be laid on the metropolitan areas, or maybe come up with a formula that so much money would have to go into cities of certain size?

Mr. EMMERICH. I think so.

Mr. KORNEGAY. What about States which don't have any large cities?

Mr. EMMERICH. Well, that would mean in population they don't have a great deal of population, too, so they wouldn't be affected.

Mr. KORNEGAY. I don't know now. My State of North Carolina has more people than your State of Georgia.

Mr. EMMERICH. That is right.

Mr. KORNEGAY. But at the same time we don't have any city which would even compare with Atlanta.

Mr. EMMERICH. But you have some wonderful urban areas which I would refer to as such in my statement.

Mr. KORNEGAY. I appreciate that, and, of course, I think so. But what I am getting at is that you have such varying degrees of composition of States throughout the Nation. You go out in the West, for example, and you find the same thing. You find large cities in certain States. So, wouldn't it actually be better to leave it up to the State authorities so they would make the survey and tell where that need is?

Mr. EMMERICH. In most cases I am sure that is right.

Mr. KORNEGAY. I live in the second largest city in North Carolina—Greensboro.

Mr. EMMERICH. Nice city.

Mr. KORNEGAY. We have recently built there three wonderful hospitals. One of them has a lot of Hill-Burton money in it, one of them has a little bit in it, and I don't know about the other. We are pretty well taken care of. It may be that we need more. I don't know. At the same time we have a lot of rural areas around there that might need some, too. But my point is that each State will vary, and wouldn't it be better really to leave it up to the State authority without putting a strict formula in the law itself?

Mr. EMMERICH. I only speak as an individual here; probably.

Mr. KORNEGAY. I am sure you know Mr. Hillenbrand of your association and you probably know my friend, Carson Bain.

Mr. EMMERICH. Mr. C. D. Ward is here now. I wish he would at least stand back there.

Mr. KORNEGAY. Yes, indeed. It is certainly nice to have you with us and we appreciate so much your coming from Atlanta to testify.

Mr. DINGELL. Mr. Van Deerlin.

Mr. VAN DEERLIN. Mr. Emmerich, in response to an earlier question, you said you didn't know of any sources of funds that are available to the Federal Government that are not available to the counties.

I was a little surprised by this answer, coming as it did from a veteran county official.

Mr. EMMERICH. I am not a veteran. I have only been in this business 3 years.

Mr. VAN DEERLIN. I have been here only 15 months, so you are a veteran. I just wondered, does the State of Georgia permit counties to impose income taxes?

Mr. EMMERICH. No, it does not.

Mr. VAN DEERLIN. Of course you don't have things like customs fees on foreign imports available to you.

Mr. EMMERICH. No, that is right.

Mr. VAN DEERLIN. You are not permitted to tax the great oil reserves of the Nation or anything like that.

Mr. EMMERICH. No.

Mr. VAN DEERLIN. I would imagine, then, that you might, if asked this question again, revise your answer.

Mr. EMMERICH. I didn't think I answered in that direction. I thought he said are there funds that we can't get. Of course there are funds we can't get. If it is, my answer is wrong; yes, I agree with you.

Mr. VAN DEERLIN. This does touch on a philosophical concept in this type of legislation because clearly there are sources of revenue available to the Federal Government——

Mr. EMMERICH. Right, to the Federal Government that are not to us.

Mr. VAN DEERLIN. Which is the reason for equalizing programs like this. The Federal Government can get the money where it is, and spend it where it is needed, and I guess my question was more rhetorical than seeking information.

Mr. EMMERICH. I appreciate that.

Mr. VAN DEERLIN. No further questions, Mr. Chairman.

Mr. DINGELL. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman. Mr. Emmerich, I would like to pursue the question that Mr. Kornegay had advanced to you, which is a matter of personal interest to me.

Now, I am speaking with reference to modernization. Your association here is the National Association of Counties. Am I to assume from this title that you represent more or less the rural segment of this hospital program, or do you consider yourself as representing at the same time the urban.

Mr. EMMERICH. As national chairman I represent all the counties, 3,043 of them, those that participate in our organization.

Mr. PICKLE. Would your association be primarily concerned about the rural construction—rural hospitals?

Mr. EMMERICH. We would be primarily concerned with all of them, both rural and urban.

Mr. PICKLE. You make no difference whether it is rural, urban, or anything else?

Mr. EMMERICH. No.

Mr. PICKLE. In your opinion have we, although there is always need for more modernization——

Mr. EMMERICH. The funds that have been used up to now I think have been very good.

Mr. PICKLE. Do you think, then, that the construction of hospitals in the regions or areas that you would call rural have been pretty well met?

Mr. EMMERICH. I don't think they have been well met; no. There is still a great need. I just think we were able to use funds in areas of remodeling many fine hospitals that really need the money.

You see, hospitals actually don't make money. They offer a service, and notoriously lose money. Somebody has to sponsor them, and this area has been neglected now for many years, and I am saying, since we are getting into this program, let's really stick in and stay with it, and put up about a third of this money for that purpose, because this would probably do more good dollarwise than any other way of spending money at this time.

Mr. PICKLE. Since you represent all counties, all hospitals, whether in the rural or the urban sections, then, your opinion is that we ought to put emphasis on the modernization of urban instead of the rural at this point—that the need is greater, about a third greater.

Mr. EMMERICH. We have suggested that about a third of the money go there for that direction; about a third of the money to be earmarked in that direction, or thereabouts.

Mr. PICKLE. Then, you are saying, in effect, that the need is greater there than it would be for similar work in the rural areas?

Mr. EMMERICH. I am saying this—and I am not trying to dodge the issue—that a third of the money that you are going to allocate, if it goes to that purpose, that you ought to make sure that we use it for that purpose and have a chance to. The others are in motion already.

When you start new programs, it takes a little while to get them underway, and we ought to be sure that funds can be made available in that area. This is varied in the three suggested bills, anywhere from $160 million on up to $500 million, and I would assume that probably a third of the money should go to that area. I think it would be well invested, if you did it.

Mr. PICKLE. Then you are saying, of the one-third that would go, the big portion of that should go to urban in the modernization program.

Mr. EMMERICH. Yes; that part of the program we are referring to.

Mr. PICKLE. Thank you very much. That is all, Mr. Chairman.

Mr. DINGELL. Gentlemen, thank you on behalf of the committee for a very fine statement this morning. Thank you.

Mr. EMMERICH. Thank you. I appreciate being here.

Mr. DINGELL. The next witness is Mr. Richard F. Taitano, Director of Territories, Department of the Interior, Washington, D.C. Mr. Taitano, the committee is happy to welcome you here this morning.

STATEMENT OF RICHARD F. TAITANO, DIRECTOR OF TERRITORIES, DEPARTMENT OF THE INTERIOR

Mr. TAITANO. Thank you very much, Mr. Chairman. I have a very short statement here. My name is Richard F. Taitano. I am from the Department of the Interior, presently the Director of the Office of Territories.

Mr. Chairman and members of the committee, I greatly appreciate the opportunity to appear before this committee and to represent the Department of the Interior. The Interior Department, through the Office of Territories, exercises overall supervision over the territories of the United States. We should like to comment, therefore, on those

parts of H.R. 10041 which affect the Virgin Islands, Guam, and American Samoa, and these Mr. Chairman, are the only three territories involved. We do not have Puerto Rico under our jurisdiction.

The bill provides for the allotment of funds among the several States, and the three territories, for assistance in the construction or modernization of various types of health facilities. It provides that sums allotted to the territories for a fiscal year remain available for obligation for the next 2 fiscal years, in addition to the sums allotted for each of those 2 fiscal years.

We believe this more generous treatment accorded the territories is fully justified in terms of the long leadtime which is required for the planning of construction, the ordering and delivery of materials, and construction itself in these relatively remote communities.

We believe that the opportunity so to accrue funds for 1 additional fiscal year is also of substantial importance to the territories in terms of the communities involved. Each territory is small geographically and, while clinics and dispensaries have their appropriate and important roles, frequently the major need is for a relatively large facility beyond the financial capacity of the local community, and equally beyond the assistance which has been available in the past. The new language in H.R. 10041 should help overcome this problem.

The legislation under consideration also provides that the formula allocation made to each of the territories may be increased to one-half the minimum allocated to the States, if the territory satisfies the Surgeon General, at such time prior to the beginning of such year as the Surgeon General may designate, that such allocation will be obligated in a timely manner.

Such larger allotments are needed, we believe, not only in terms of the nature of the geography of the area but because each territory is, or will be, visited by increasing numbers of travelers. In the Virgin Islands, in 1962, the hospital on St. Thomas provided inpatient services to nonresidents which represented more than one-third the total number of patient days in the hospital. Thus, under the existing Hill-Burton formula, at least one-third of the care is not covered.

A similar situation is likely to develop in American Samoa, where jet-plane service, and the development of hotel facilities, will increase the number of visitors in the territory for business or pleasure. Guam, too, is looking to transpacific travel as a growing element in its economy, and will likely be faced with providing medical and health services for transients.

The critical need is to provide the territories with minimum sums of money which can be used effectively. The provisions of the bill authorizing obligation of funds for two additional fiscal years, and the opportunity to qualify for one-half the minimum amounts allocated to the States, are, we believe, steps in this direction.

Mr. Chairman, I will be happy to answer whatever questions you and the members would raise, but let me say that I am not a doctor, and I have not been in this business of public health administration.

Mr. DINGELL. You have made a very fine statement, Mr. Taitano, and the chair will be happy to state to you that I have observed, over the years, that nondoctors are very often better qualified to discuss some questions of medical care than are members of the medical profession.

Mr. TAITANO. Thank you.

Mr. DINGELL. The chair is happy to recognize Mr. Younger.

Mr. YOUNGER. I have no questions.

Mr. DINGELL. Mr. Van Deerlin?

Mr. VAN DEERLIN. No thank you, Mr. Chairman.

Mr. DINGELL. Mr. Pickle?

Mr. PICKLE. I just want to ask you one question. In making a request for larger allotments you pointed out that in the Virgin Islands in 1962 this particular hospital on St. Thomas has provided inpatient service to nonresidents and this represented more than one-third of the inpatient days. Is this because of the visitors or tourists of which you spoke?

Mr. TAITANO. Yes, sir. In the same year, if I remember correctly, we had almost 300,000 visitors. I think the figure is 291,000. We only have a resident population on St. Thomas of 16,000.

On all the islands together we have about 32,000, 35,000. It is a tourist area.

Mr. PICKLE. Thank you. That is all, Mr. Chairman.

Mr. DINGELL. Mr. Taitano, the Chair has observed during the several days we have been conducting hearings on this legislation that we have no statement from any witnesses to the dollar amount of the needs of the several territories for different types of hospital construction nor have we received any statement as to the number of rooms needed or backlog of inpatient or outpatient care which exists in the several territories. I think a statement of this kind would be particularly helpful for the record. I recognize you may not be able to provide it this morning. If you so choose the Chair would be very happy to receive this additional information to perfect the record. I think it would be most helpful. I would urge upon you that you submit this information so that the committee may have the advantage of it in its consideration.

I am particularly interested in this because, as you know, we do provide for very substantial benefits to these territories in terms of Federal funds and I am sure we provide them on a very favorable basis, perhaps a good deal more so than the several States which will probably contribute the larger part of the benefits to be provided for the several territories and their residents, so I hope that you will extend to us some justification for this kind of participation by the territories in the benefits of this legislation.

Mr. TAITANO. I will be delighted to have that done, sir. For the moment let me say just in general terms what our needs are in the areas. Let me start with American Samoa. In American Samoa we have a hospital building there that was built by the Navy while they were in the territory. This is a frame structure. The building is just about ready to collapse. Let me say, however, Mr. Chairman, that we have gotten some money from Congress to totally replace the building. We do not anticipate help from the Hill-Burton funds to replace the existing hospital in American Samoa.

In the future we may need funds for clinics in the outlying areas. The number of clinics will be at a minimum, not more than three or four. In the Virgin Islands, sir, we have three hospitals, one on St. Thomas, about a 149-bed hospital; one in Christiantsed on St. Croix, a 60-bed hospital; and a 10-bed hospital in Frederiksted also on St. Croix.

Our latest survey of these three hospitals indicates that all of them are not only overloaded but obsolete in construction and design. The latest statement, which I still have not ascertained is true, is that on St. Thomas the occupancy is 104 percent. I just don't know what in medical parlance a statement like that means, 104 percent occupancy.

The statement goes on to say that the patients are overflowing into halls and corridors. The present plan of the government of the Virgin Islands is to replace all these three hospitals by the construction of two new hospitals in different locations, one on St. Thomas and only one for St. Croix.

I imagine that the new facilities will exceed over 200 beds. It may cost over $8 million. On the hospital at Guam, the civilian hospital for Guam—it is run by the government—is a 260-bed hospital, 200 beds for general service and about 60 beds for TB. Let me say at this point that in 1951 we built a TB hospital of over 200 beds. We have controlled the TB program to the extent that we have reduced it down to 60 beds at the present time. The hospital was devastated by the last two typhoons, one occurring in April of this year and one last November, which just almost totally destroyed it. The only thing that remained was the concrete structure.

Because of the application of the Federal Disaster Act we are presently getting assistance for the rebuilding of the existing facility. I understand that the recent invitation for bids indicated approximately over a million dollars that will go into the rebuilding of the structure.

The survey of this structure, however, by the Public Health Service indicated that it should have been replaced by another building. The amount, however, the minimum amount estimated to reconstruct a new building or to replace the hospital is anywhere between $8 to $10 million. This is just too much money for the community, a community whose average per capita income is about 50 percent of the national average here in the United States, so we decided that we can go along with the hospital for a little while, the existing building, anyway, for maybe a decade, if not more.

In Guam, however, there is a military hospital—Navy—but the hospital serves only their own personnel and their own civil service workers. Those, sir, in general, are the problems that we have in the territories.

Mr. DINGELL. I am sure they are very severe. I think it would be also useful, Mr. Taitano, if you were to submit to the committee some statistical evidence indicating the number of beds needed, and so forth. You might also choose to give the committee your comments with regard to per capita income of these areas which seems to be rather relatively small.

Mr. ROGERS of Florida. Would the gentleman yield?

Mr. DINGELL. Yes; be happy to.

Mr. ROGERS of Florida. What is the civilian population of Guam?

Mr. TAITANO. The civilian population is approximately 40,000.

Mr. ROGERS of Florida. Forty thousand.

Mr. TAITANO. Today.

Mr. ROGERS of Florida. And this is the only hospital then to serve them?

Mr. TAITANO. We have a clinic, a Catholic medical clinic, but it is not a hospital. I don't believe it has any beds.

Mr. ROGERS of Florida. Are there any other clinics.

Mr. TAITANO. There also is a smaller clinic run by the Seventh-day Adventists. These are the only two clinics that I know of, sir.

Mr. ROGERS of Florida. Could you let us know the extent of those clinics?

Mr. TAITANO. Yes, sir.

Mr. ROGERS of Florida. And on the Virgin Islands now on St. Thomas what is the civilian population?

Mr. TAITANO. The resident population for the island of St. Thomas is approximately 16,000, 17,000.

Mr. ROGERS of Florida. And St. Croix is, I guess, much smaller?

Mr. TAITANO. No; about the same.

Mr. ROGERS of Florida. About the same.

Mr. TAITANO. Yes.

Mr. ROGERS of Florida. St. John is the one that is less.

Mr. TAITANO. Yes; about a thousand.

Mr. ROGERS of Florida. They have to come from St. John to St. Thomas?

Mr. TAITANO. That is correct, sir.

Mr. ROGERS of Florida. Thank you very much.

Mr. DINGELL. Thank you, Mr. Taitano, for your testimony this morning.

Mr. TAITANO. Thank you very much, sir.

(The following information requested by the committee was later submitted by Mr. Taitano:)

DEPARTMENT OF THE INTERIOR,
OFFICE OF TERRITORIES,
Washington, D.C., April 7, 1964.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives,
Washington, D.C.

DEAR MR. HARRIS: As requested in the course of hearings on H.R. 10041, 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, the following information is furnished for the record.

On page 281 of the transcript of the hearings a question is noted as to the dollar needs of the several territories for different types of hospital construction. The following is submitted:

Guam

Project	*Estimated cost*
Sinajana Agana Heights	$45,000
Replacement of Inarajan Health Center	37,000
Catholic Medical Center, Inarajan Clinic (new facility)	100,000
Seventh-day Adventist Mission, diagnostic expansion (of existing facility)	125,000
Within 5 years a 30–50 bed hospital sanitorium combination	[1]

[1] Not available.

Rehabilitation of typhoon damage to the Guam Memorial Hospital with OEP funds will provide a total of 260 beds and supporting facilities. This number will be sufficient for approximately 2 to 3 years.

Virgin Islands

Existing facilities presently badly overcrowded with an average occupancy exceeding 90 percent. A rapid population increase is exected as is a substantial increase in nonresident transient population composed of tourists, resident alien workers, crews and passengers of ships in port, and

military personnel on leave. The problem of providing adequate medical facilities is compounded by high construction cost and some duplication required by distance between main islands of St. Thomas and St. Croix.

Estimated long-range total dollar needs:	
Hospitals (500 beds at $30,000 per bed)	$15,000,000
Long-term care (200 beds at $10,000 per bed)	2,000,000
Resident quarters	400,000
Research centers	800,000
Public health and diagnostic centers	550,000

Samoa

Adequate facilities planned for construction. Such facilities to be financed through direct appropriation.

On page 282 of the transcript reference is made to what justification exists for participation by the territories in this particular Federal assistance program.

With respect to American Samoa, we would note that Samoa does not now participate and, at least for the foreseeable future does not intend to request such assistance, since upon adequate justification funds are made available to the Government through direct appropriations in the forms of grants.

However, Guam and the Virgin Islands are not provided for in this fashion. These territories have reached a degree of development which largely obviates the need for direct appropriations or grants. There does exist Federal subsidization, of course, in the form of retention of internal revenue proceeds in both Guam and the Virgin Islands, and, in the case of the Virgin Islands, a substantial return of taxes collected on Virgin Islands products imported into the United States. Since these revenues together with local revenues must be used to finance the entire governmental activity of these territories, and are in fact barely adequate in the face of an ever-expanding population and need for services, it is important for both Guam and the Virgin Islands to participate in Federal programs such as Hill-Burton aid.

On page 285 of the transcript information is requested as to per capita income. The following figures, based principally on the 1960 census, may be of assistance in demonstrating both the small population base, and the generally low income.

	Population	Mean family income
Guam	[1] 34,726	$3,368
American Samoa	20,000	687
Virgin Islands	32,400	2,243

[1] Does not include approximately 30,000 military personnel and dependents utilizing separate medical facilities.

Finally, on page 286 of the transcript information is requested in connection with the two private clinics in Guam.

The Catholic Medical Center has an outpatient program in Agana (the principal urban center) and employs six qualified doctors. These doctors have medical staff privileges at the Guam Memorial Hospital and admit patients on a private basis. During calendar year the outpatient visits totaled 32,015. Outpatient treatments have increased rapidly. In 1959 the visits totaled 16,797. There are no private medical facilities south of Agana and one of the new facilities contemplated is a second Catholic clinic in Inarajan.

The second private clinic is the Far Eastern Island Mission Medical Clinic, operated under the auspices of the Seventh Day Adventist Mission, at Agana Heights. This clinic employs two doctors having the same privileges as the doctors of the Catholic clinic. Outpatient visits for 1963 totaled 30,000, again a substantial increase over the 14,040 visits in 1959. This clinic also proposed an expansion program in the form of a diagnostic center and ultimately a 30-50 bed hospital and sanitorium.

Neither American Samoa nor the Virgin Islands have any private clinics.

It is hoped that the foregoing adequately responds to your several questions.

Sincerely yours,

RICHARD F. TAITANO, *Director.*

Mr. DINGELL. The committee will now hear from Robert N. Barr, executive officer and secretary, State department of health, from Minneapolis, Minn.

Dr. Barr, the committee is happy to receive your testimony.

STATEMENT OF DR. ROBERT N. BARR, EXECUTIVE OFFICER AND SECRETARY, STATE DEPARTMENT OF HEALTH, MINNEAPOLIS, MINN.

Dr. BARR. I think they have copies for you, Mr. Chairman, and they will bring them right in.

Mr. Chairman, if you find yourself trapped at any time, it would be perfectly all right with me to call a halt to this. I could come back tomorrow if it is necessary. I am going to be in town tomorrow as well.

Mr. DINGELL. The Chair will try to hear you out if it will be possible, Doctor.

Dr. BARR. Mr. Chairman and members of the committee, my name is Dr. Robert N. Barr. I am secretary and executive officer of the Minnesota State Board of Health. I am appearing before you today to present the views of the Association of State and Territorial Health Officers on the proposals to improve the public health through revising, consolidating, and improving the hospital and other medical facilities provisions of the Public Health Service Act.

I am sure that you recognize that this program is of extreme importance to the total public health programs of our respective States. It has always been strongly supported by our association, and the public recognition of its great value has steadily increased since its inception.

The fact that subsequent health legislative acts, such as mental health, mental retardation, have embodied the basic principles included in the Hospital and Medical Facilities Construction Act is mute testimony to the national acceptance and endorsement of its accomplishments and recognition of its keystone position in public health. These basic principles include:

1. Coordinated planning for facilities at the local, State, and National levels.
2. Continuous revision and documentation of such planning.
3. Guidance and assistance in the planning of as well as specific financial aid in the construction of hospitals and related facilities based on a priority schedule of needs.
4. The provision of minimum standards for facilities and services.

It is obvious that as this program has progressed over the past 16 years many changes as to recognized needs will have developed. The following seven recommendations of the Association of State and Territorial Health Officers embody the principles and needs as thoroughly discussed and approved over the last few years. It is believed that these would receive essentially unanimous support by all agencies and groups interested in the health of the public.

(*a*) That the Hospital and Medical Facilities Act be extended through 1969.

(*b*) That planning grants be made available on a continuing basis to survey the need for modernization, expansion, replacement, and new construction of facilities.

(*c*) Provide consultation and assistance to local planning agencies to develop and implement areawide plans for hospital and medical facilities, such funds to be made available to the States so as to stimulate and analyze local and areawide planning.

(*d*) Provide increased financial assistance through special project grants for the development of areawide comprehensive and coordinated plans for needed facilities and services.

(*e*) That Federal funds be made available, over and above the sums now authorized by the Hill-Burton Act, to provide assistance in the modernization, expansion, replacement, and new construction of facilities with special consideration to the more urban areas of the various States.

(*f*) That Federal financial assistance be provided to help cover the cost of administering the State hospital and medical facilities program and that such funds be over and above existing State appropriations.

(*g*) That State hospital construction authorities develop long-range plans and projections relative to the need for facilities and beds as well as personnel.

The following information is submitted in support of the principles enunciated in each of the above recommendations of the association of State and territorial health officers.

It is well recognized by the State authorities that each State and local or areawide plan must be tailored to meet specific needs. Therefore, it is essential that this legislation retain maximum flexibility. The legislation should also allow for long-range areawide planning which will permit the complex integration of all health and health-related plans, facilities, and services in the community.

(*a*) That the Hospital and Medical Facilities Act be extended through 1969.

The hospital and medical facilities program we believe to be an outstanding and highly successful cooperative effort resulting in the provision of needed health facilities and improved health services.

The emphasis to date has been on general hospitals in the rural areas. More than one-half of the population of this country now resides in metropolitan and urban centers. These areas represent the greatest need in many States. The Public Health Service recently collected information from all States regarding the projects which could be approved under the Hill-Burton program if there were no limitation of Federal funds.

Undoubtedly this information has or will be made available to this committee. On November 15, 1963, Minnesota reported a total of 100 such projects for fiscal years 1965 and 1966 involving a total estimated cost of $105 million and a total Federal share of almost $40 million, and this is if there were unlimited amounts.

Total hospital construction in Minnesota completed or under construction as of January 1, 1963, was $377,017,332. If estimated cost of those facilities in the planning stage are included this total would approximate $560 million, and by January 1, 1964, this estimate would approximate $600 million.

Hill-Burton allotments to Minnesota through fiscal year 1964 total $46,882,970. This amount has for the past several years consistently represented only slightly in excess of 11 percent of the total construction cost completed and underway since 1948.

The Association of State and Territorial Health Officers thus recommends that the act be extended through 1969 and that the appropriations for construction be not less than the amounts authorized.

(*b*) That planning grants be made available on a continuing basis to survey the need for modernization, expansion, replacement and new construction of facilities.

Many of the older and larger hospitals are deficient in space requirements for administrative areas; for laboratory, X-ray and therapy services; for kitchen and dietary departments; for laundry and storage space. The functional relationships of the services are frequently such as to produce a very inefficient operation, thereby reducing the level of service to patients. Financial support is needed on a continuing basis for the careful evaluation of the complex needs for modernization and expansion versus replacement as well as for the need for the construction of new facilities in areas of rapid population growth.

Adding to the complexity is the importance of these larger hospitals as centers of medical research and professional training. Only a few of these large hospitals should provide the highly complex and specialized services developing as a result of modern medical research.

(*c*) Provide consultation and assistance to local planning agencies to develop and implement areawide plans for hospitals and medical facilities, such funds to be made available to the States so as to stimulate and analyze local and areawide planning.

It is essential that all States stimulate the development of voluntary planning agencies and provide assistance and coordination to those already in existence. Present limitations in Hill-Burton agency staffs do not permit adequate studies to meet the needs or the requests for assistance in planning in the metropolitan areas, the rapidly growing suburbs or the larger urban centers.

Millions of dollars are or will be involved in new construction, modernization, and expansion as well as in conversion. Consultation and advice should be available for the development of a sound program of planning and projection for all types of care facilities and services. Every possible consideration must be given toward making the best use of the limited numbers of trained personnel in the health field, avoiding needless expenditures and conserving community resources.

Public interest and support in health matters and recognition of the needs for the study and planning to provide comprehensive services is at a high level today. We believe that much of this stems from the public's actual participation in developing hospitals and related facilities and services through the Hill-Burton Act.

Hospital planning councils increasingly recognize the value of total health planning and will no doubt be expanding their scope or combining their planning with that of other health planning agencies, such as, I would add, Mr. Chairman, the Community Chest and these types of agencies.

The individual citizen today recognizes his stake in such planning and development. It would be almost criminal on the part of public health and community leaders today to fail to support in every way possible the fruition of such interest.

Federal assistance at the State and local levels for metropolitan and areawide hospital planning will do much to channel such interest into reality. It will also provide solution to many of the complicating problems that besiege this and similar programs. Examples of such problems include: overbuilding, maldistribution, underutilization, understaffing and poor services, undue criticism of high costs, and shortages of trained personnel.

Good planning at the local and State levels could very well negate the need for franchise or legislative controls to prevent overbuilding, fragmentation and duplication of facilities and services. I might add that there have been several proposals made that either the State or some of the agencies make provisions to control the construction of hospitals and related facilities by law either by a franchise or, as you know in Michigan, the question came up whether or not Blue Cross should pay for the care of patients in a hospital and a hospital was built over the objections of the hospital planning council and they were upheld, not because of this, but because of their authority as an agency to contract with any fit hospital or facility in the State to provide such services.

We are concerned and many of us are somewhat frightened about placing this kind of authority in a State agency or in any kind of another agency providing service which says, "You may not build a hospital in such and such place and if you do nobody will provide any of the care, or the dollars for the care."

Mr. DINGELL. You are critical of this idea then of Blue Cross?

Dr. BARR. Yes. I think we should have moral pressures, but I don't believe we ought to have this much power centered in any one organization. I think it is dangerous, sir.

(*d*) Provide increased financial assistance through special project grants for the development of areawide comprehensive and coordinated plans for needed facilities and services.

It is highly important that communities be encouraged to develop areawide planning bodies on a continuing basis, that they determine and establish priorities of relative need, and that individual facilities define and carry out their objectives and projected roles in accordance with an areawide plan.

The State agency, in turn, should stimulate and expedite local efforts, analyze local planning and determine the validity and reasonableness of incorporating areawide plans in whole or in part as integral parts of the overall State plans for hospital and related medical facilities construction.

(*e*) That Federal funds be made available, over and above the sums now authorized by the Hill-Burton Act, to provide assistance in the modernization, expansion, replacement, and new construction of facilities with special consideration to the more urban areas of the various States.

The existing program has enabled many communities to provide new and needed facilities and to expand some existing hospitals. However, it has not been possible to provide a construction program

sufficient in scope to enable existing hospitals to overcome functional obsolescence through modernization and replacement.

This is a serious matter in the hospital and medical field where scientific and technical advances are progressing rapidly. The problem is most severe in the more densely populated areas of the States. This is a most pressing need and, also, it can be the Hill-Burton program's new opportunity for service.

(*f*) That Federal financial assistance be provided to help cover the cost of administering the State hospital and medical facilities program and that such funds be over and above existing State appropriations.

The role of the State Hill-Burton agency has become increasingly important in the total picture of health facilities and services, particularly in the areas of chronic illness, aging, mental health, mental retardation, and rehabilitation.

Considerable time is involved in discussing the role as well as the need for facilities constructed under FHA, HHFA, and the Public Works Acceleration Act. Increasing requests for assistance and guidance in solving local and statewide problems is evidence of the real service rendered.

Impetus must be given to planning and projection in order to keep abreast of the rapid developments in all areas of care facilities and services. Unless solutions are found to provide some relief, the potential and effectiveness of the program will suffer.

All projects, whether Hill-Burton funds are provided or not, have the same need for assistance in planning and in the review of architectural plans for improving functional design in the interests of efficiency of operation.

Similarly, the same assistance should be available to all licensed care facilities in improving quality of services, avoiding unnecessary duplication and fragmentation or gaps in services and promoting coordination with other services in the community.

Minnesota probably has an average number of personnel for administration of the Hill-Burton program. Even though other Health Department staff assist and special demonstration projects have been developed, the staff is far from adequate to accomplish what most of us believe to be a good job.

Today's program should include not only assistance in planning and construction but licensure of all institutions, the improvement of patient care services, recruitment and refresher training activities and integration with related programs at the State and local levels. These include chronic illness and aging, vocational rehabilitation and mental health and mental retardation, and the numerous community out-of-hospital services.

(*g*) That State hospital construction authorities develop long-range plans and projects relative to the need for facilities and beds as well as personnel.

With the increasing complexity of our needs and the magnitude of resources which will be expanded to serve a growing population, continuous planning and projections are essential to assure proper use of all funds expended.

There is a need to develop long-range plans which include coordination between contiguous States and which will assure the develop-

ment and coordination of hospital and related facilities and services and all other health activities in order to best meet the public need and utilize the health-care dollar most efficiently.

Mr. Chairman, may I add that it should be brought to your attention that with the acceleration under public works, and FHA and HHFA, our work in the hospital field was almost doubled in the number of plans that were required to be reviewed and our work with people. We found at first in this program a resistance by the State to doing the same kind of assistance and planning with the hospital that was not receiving Hill-Burton aid, because, as you know, the act under Hill-Burton provided for the administration of this at the State level.

Now we believe that the community which is building a hospital on its own should have every bit of assistance that every other has. When it comes to the question of whether or not a community should build a hospital, and we have said in the plan that we don't feel that they should in a specific area, and we will not provide Hill-Burton aid to this community because they are within 13 to 15 miles of another one that has a good hospital, but if you do provide a hospital, if you put up your own money and build one, we will give you every bit of assistance to see to it that it is efficiently and effectively planned and see to it that it is staffed, because we license this hospital.

Unless it comes up to good standards we will not license it as a hospital. I think it has been an effective way to reduce some of the overbuilding in some communities that feel a hospital is terribly important as an economic factor or it is important for recognition. They believe they must have one to prevent their town from disappearing in these farm, rural areas.

I also recognize that there is a variable problem in this modernization and replacement in many States. Some of us have built base hospitals, regional hospitals, at the same time and at the same rate that we have built rural hospitals, and we have been able to take care of some of this need. On the other hand with the rapid development and movement of populations we have seen the growth of new private hospitals. Los Angeles is a good example, Chicago, and some of the eastern States. These are operated for profit; they are substandard in that they are not providing all the services they ought to and they are using up a great many of the technical personnel. This is bad and something ought to be done to prevent this.

One of the items that has come up in discussion is a central community hospital building, plus another as a satellite. A large one, out in the suburbs of a large city. We have one example in a hospital that was built at Southdale—that is the Dayton Shopping Center in Minneapolis—where the Fairview Hospital Board is building a 225-bed hospital with some Hill-Burton assistance and having the same board, but separate staffs.

A 225-bed hospital will take care of a large area in that particular portion of town and the financing is best there. I think in reference to the questions that have been raised about financing I would add that in Minnesota the problems of borrowing money seem not to be too great a problem. On the question of HHFA, which may provide financing assistance only, as I recall it, in the construction of homes for the aged, the law provides that these may not be used as nursing

homes, any portion thereof. This has negated against the development of this kind of facility in the more rural farm areas because you build a home of 100 beds for the aged and in a matter of 4 or 5 or 6 years you find that from one-third to one-half of those people really need nursing home care. Unless it is developed so this can be converted that means tearing people out by the roots and moving them someplace else.

We think this should be changed. As to HHFA and their standards, they should not cut their corridors down, as previously testified, or narrow their doors, because in so doing they make a poor home for the aged facility. In homes for the aged they need room for wheelchairs and crutches for these people. They need to be able to take care of people who have partial disabilities. I think the important thing as far as States are concerned is that they should be in a position to do needed studies, and help and provide assistance, and plan, and to do this, means more staffing and more work.

If we can do so, I am sure you will find a better use of the dollars we have.

When it comes to nursing homes, my particular State is interesting because we have more nursing home beds in Minnesota than we have hospital beds and we still have a greater need for them. I think this is because we had an old-age assistance program and the categorical aids were unlimited. Medical, hospital, and nursing home care was provided for these people since the inception of the program so we have actually had a Kerr-Mills program in a way because people were transferred from old-age assistance, if they had any, when they needed medical care and couldn't afford it.

We only recently passed Kerr-Mills. It goes into effect this July. The estimates are that we will not have a great increase in the need for beds. To give an example, I might say that our State will be spending under old-age assistance, medical care, as they classify it, primarily in hospital and nursing homes, drugs, and all of these things, about $32 million this year for something like 14,000 patients who will be receiving medical care out of the 40,000-some that are on old-age assistance.

Mr. DINGELL. The Chair desires to commend you, Doctor, for a very fine statement and I express the gratitude of the committee for your appearance this morning and for your very helpful testimony.

The Chair adjourns the committee until tomorrow morning at 10 o'clock.

(Whereupon, at 12:20 p.m., the committee adjourned until Thursday, March 12, 1964, at 10 a.m.)

EXTENSION AND REVISION OF HILL-BURTON HOSPITAL CONSTRUCTION PROGRAM

THURSDAY, MARCH 12, 1964

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

The committee met at 10 a.m., pursuant to recess, in room 1334, Longworth Building, Hon. Oren Harris (chairman of the committee) presiding.

The CHAIRMAN. The committee will come to order.

Today, as we continue the hearings on the revision and extension of the Hospital Construction Act, H.R. 10041, we are pleased to welcome as our first witness, Dr. Percy E. Hopkins, chairman of the board of trustees, the American Medical Association.

Dr. Hopkins, on behalf of the committee, I want to welcome you and your associates here this morning. I observe that you have with you Dr. Willard A. Wright, chairman of the American Medical Association Council on Medical Services, and Dr. Francis C. Coleman, chairman of the American Medical Association's Council on Legislative Activities.

We are glad to have all three of you and I want to say now, since I have another commitment with the leadership and another committee has requested my presence, that I will not be able to stay for your entire presentation. I want to say that I appreciate your taking the time from your busy life to come before the committee and give us the benefit of your thinking and the views of your organizations on this very important and worthwhile, and in my judgment, imperative program in the interest of the health and welfare of our people.

Now, having said this on my own, Doctor, I want to also say that one of my lifelong friends and important constituent, whose friendship I have cherished for over many years, being an associate of yours as a member of the board of trustees, Dr. R. B. Robbins, of Camden, Ark., has prewarned me, I should say, of your appearance here. I do not know why, unless it is the fact that he has known me so long, that he would attempt to admonish me to be kind to you. [Laughter.]

I do not want anyone to get any image of me that I am unkind to witnesses that come before this committee. If so, I want to dispel that now and forevermore.

But, seriously, Dr. Robbins did want me to know that he was associated with you during your work together and I know that he joins you in the serious effort to get this revision and extension of the hospital construction program enacted.

I have just been reminded that the House will also go in session at 11 o'clock, so that is going to make it more difficult and even more necessary that you proceed with your statement and we get along with it with the least possible delay.

So, you may proceed then, without further ado.

STATEMENTS OF DR. PERCY E. HOPKINS, CHAIRMAN, BOARD OF TRUSTEES; DR. WILLARD A. WRIGHT, CHAIRMAN, COUNCIL ON MEDICAL SERVICE; AND DR. FRANCIS C. COLEMAN, CHAIRMAN, COUNCIL ON LEGISLATIVE ACTIVITIES, AMERICAN MEDICAL ASSOCIATION

Dr. HOPKINS. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, the American Medical Association is grateful for this opportunity to express its views on H.R. 10041, 88th Congress. This is a subject in which the medical profession has a deep and continuing interest. The association hopes that you will find its comments helpful to your committee's discussions and deliberations.

I am Dr. Percy E. Hopkins, a practicing surgeon from Chicago, Ill., and the chairman of the board of trustees of the American Medical Association. With me are Dr. Francis C. Coleman, who is engaged in medical practice in Des Moines, Iowa, and chairman of the American Medical Association's Council on Legislative Activities, and Dr. Willard A. Wright, who is in the practice of general surgery in Williston, N. Dak. Dr. Wright is chairman of the AMA Council on Medical Service.

The American Medical Association heartily approves of the concern and interest in the improvement of the public health and in the provision of adequate health facilities expressed by the chairman and members of this committee. We have shared this concern with the Congress over a period of many years, and the AMA is pleased to have the opportunity of again expressing its views on a matter so vital to the health interests of the American people.

The councils of the American Medical Association which are most directly interested in Federal programs and legislation pertaining to the development of hospital and other medical facilities are the council on medical service and the council on legislative activities. The physicians who are here with me today, as chairmen of these councils, are well qualified through longstanding experience to present the views of the American Medical Association.

With your permission, Mr. Chairman, I would like to ask Dr. Willard A. Wright to begin our comments on H.R. 10041. At the end of his remarks, Dr. Francis C. Coleman will conclude our statement by presenting further comments with respect to the pending legislation. We shall then be pleased to attempt to answer any questions which may be directed to you by members of the committee.

Mr. STAGGERS (presiding). Dr. Hopkins, I think that is satisfactory. We will save the questions until you have all finished your statements.

Dr. Wright.

Dr. WRIGHT. Thank you, sir. I am Willard Wright.

Mr. Chairman and members of the committee, it is our recommendation that the Hill-Burton program be continued. We agree that some of its objectives should be redefined and some changes made in the program in order to make it more effective.

We believe that, with few exceptions, the Hill-Burton construction program has been administered effectively and in the interest of the public, and while we further believe that the objectives of the original legislation have, for the most part, been achieved, we agree that with a shift in emphasis toward modernization, and some modifications in the existing program, continuation of Hill-Burton is warranted for a period of time.

Our support of this type of legislation is longstanding. The American Medical Association has on numerous occasions gone on record as approving the principle of hospital construction by the use of grants-in-aid. In 1940, the AMA House of Delegates supported President Roosevelt's plan for the construction of hospitals with Federal funds, and, in 1945, endorsed the AMA board of trustees's support of the original Hill-Burton bill, saying:

> This action of the board of trustees is within the [AMA] program of constructive action toward improving the health of the American people.

On a number of occasions, AMA representatives have appeared before committees of Congress to give the views of the association with respect to legislative proposals to extend and to amend the Hill-Burton Act. We have been aware of our obligation to provide the Congress with information and expert opinion which could add additional substance to its discussions and deliberations. And while we have, in the main, approved the Hill-Burton program, we have also from time to time offered what we have believed to be constructive criticism. We hope to do so again today.

Specifically, the American Medical Association supports the principle of matching grants for the construction and modernization of hospitals. We further support what appears to be a shift in emphasis toward grants for the modernization of hospital and related facilities, the combining of cateogrical grants, and the principle of Federal support of construction through guaranteed mortgages. In these areas and in others we support H.R. 10041. However, we shall note also where amendment to the provisions of H.R. 10041 would, in our opinion, establish a more effective program.

We believe that the immediate major emphasis of Hill-Burton should be directed toward the improvement and effective use of existing facilities. It appears to us that the greatest need is for modernization and renovation programs.

According to the State Hill-Burton agencies, as of January 1, 1963, there were 338,170 unacceptable beds which represented approximately 19 percent of existing beds. Between 1957 and 1963, the number of inpatient beds increased from 1,505,695 to 1,786,461, which is an increase of 19 percent. During this same period, the number of unacceptable beds, according to the State Hill-Burton agencies, increased from 285,149 to 338,170, also an increase of 19 percent. Accordingly, in spite of construction during this period of time, the percentage of existing beds which are unacceptable remained the same.

Another study, in 1956 by the American Hospital Association indicated that almost one-half, 48 percent, of all hospitals in the coun-

try needed some form of modernization of existing buildings at an estimated total cost of about $1 billion. Approximately 80 percent of the responding hospitals reporting a need for modernization stated that major repairs were needed in buildings and plants at an average cost of $126,000 per hospital. Approximately the same proportion of hospitals reported a need for modernization of their equipment and mechanical systems, averaging $99,000 per hospital. Finally, one more study, in 1960 sponsored by the Public Health Service in cooperation with the State Hill-Burton agencies, indicated that it would cost $3.6 billion to modernize or replace obsolete facilities without adding any additional beds.

The conclusion that the need is for renovation and modernization appears justified in the light of these statistics.

We concur with the intent to combine the categories of chronic disease hospitals and nursing homes into one category called long-term care facilities. However, in order to grant the States greater freedom in the allocation of funds, the association has long recommended the elimination of all categorical grants. In 1958, after an exhaustive study of the Hill-Burton program, the AMA Council on Medical Service recommended:

> That all categorical grants be eliminated (thereby) permitting the States to allocate funds to the various types of hospitals and medical facilities according to their needs. These categorical grants as provided under the 1954 amendment to the act, have not improved the effectiveness of the program and are unnecessary.

With regard to our support of the principle of Federal guarantee of mortgages, or as termed in the bill, "mortgage insurance," the Surgeon General, as we understand it, would be authorized to insure, on behalf of the United States, any mortgage financing the cost of construction or modernization of a private nonprofit hospital or other specified medical facility, or proprietary nursing home.

The use of the guaranteed mortgage mechanism offers an incentive to local nonprofit organizations to construct and improve needed medical facilities. We wholeheartedly support this voluntary method which utilizes available local funds and encourages maximum community participation in the projects. However, while we fully support the principle and urge its enactment, we suggest that part B be deleted from H.R. 10041 and be separately considered and acted upon by the Congress.

The Federal Housing Adiministration has conducted an insured loan program for construction of proprietary nursing homes. Its experience in the area of guaranteeing loans on the construction of improvements to real property is not matched by any other Federal agency. Accordingly, it appears to us to be wise to continue this activity, which is essentially a business and administration technique, in the FHA. Further recognizing the obvious advantages of encouraging the use of private funds in the construction of the private nonprofit facilities included in H.R. 10041, we recommend that a separate bill which would extend to the FHA authority to guarantee mortgage loans for the construction and modernization of such facilities be submitted to the Congress for consideration by the appropriate committees.

Mr. Chairman, with your permission, Dr. Coleman will now continue with our statement and will express the AMA's comments with respect to other provisions of the legislation before you.

Mr. STAGGERS. Thank you, Dr. Wright. Dr. Coleman, we will be glad to hear from you.

Dr. COLEMAN. Thank you, sir.

Mr. Chairman and members of the committee, Dr. Wright has presented our overall views on the pending legislation. He has related the American Medical Association's longstanding support of the Hill-Burton principle of grants for the construction of needed hospitals. And he has told you of our agreement that the emphasis of the program can now very well be placed on the modernization of existing facilities rather than on the continued construction of new facilities.

H.R. 10041 would provide that the funds appropriated for the construction and modernization of new hospitals and public health centers be used entirely for construction during fiscal 1965. In the succeeding 4 years, by far the major portion of the appropriated funds would be designated for construction.

We believe that the purposes of the program would best be served if the enactment of H.R. 10041 encouraged the use, from the outset, of funds for modernization. Accordingly, we suggest that section 602 under "State allotments" be amended to permit, for modernization purposes, an immediate and greater use of the allotted funds.

Part C of H.R. 10041 proposed to increase the membership of the Federal Hospital Council from 8 to 12 members. In the 18 years since the enactment of the Hill-Burton law, only two physicians representing medicine have served on the Council, and such representation has not been granted recently.

It is in the best interests of the American public that at least two physicians be included as members of this vital Council. Since the American Medical Association represents over 200,000 physicians, it seems appropriate that the representatives from medicine be selected from a panel submitted by the association. We believe that the objectives encompassed in H.R. 10041 can be best accomplished with the support and counsel of representatives of organized medicine on the Federal Hospital Council.

With respect to "diagnostic and treatment centers," we urge that they be deleted as facilities eligible to participate in the program. There is little evidence of demand for these facilities since their inclusion in 1954. Moreover, the definition of the term "diagnostic or treatment center" is vague and confusing.

As of June 30, 1963, approval has been given to 551 diagnostic and treatment center projects. According to the reports from the various Hill-Burton agencies, as of June 30, 1963, only four States estimated total needs in excess of the Federal formula of one diagnostic and treatment center per 10,000 population. On the other hand, 34 States estimated that their total needs were less than one-half of the number allowed under the Federal formula. This, we feel, indicates the lack of demand and the lack of local interest in financing such facilities. Even so, some of the "demand" may be artificial in that physicians' offices, clinics, private laboratories, et cetera, are not included in the count of existing facilities.

Furthermore, most such facilities have been constructed as outpatient departments of hospitals. We believe that other provisions of H.R. 10041 permit such facilities to be financed without the necessity of maintaining a separate category.

With regard to "public health centers," as defined under section 645 of the bill, we recommend that the definition be amended so as to identify public health centers as those facilities which are operated by an official public health department.

The American Medical Association urges that the traditional local determination of need and local administration of the Hill-Burton program be continued. The success enjoyed by the program testifies to the effectiveness of this approach.

The association further urges that areawide planning for hospitals and related health facilities remain on a voluntary basis. Further, with respect to regulations that may be promulgated pursuant to the enactment of the provisions regarding area planning, it is our belief that the success of each project would be enhanced if the efforts of the local agency and the local medical society could be joined when planning the location or improvement of facilities.

Mr. Chairman, before concluding our testimony, we would like to urge an amendment which would clearly express the intent of this committee and the Congress with respect to the acceptance of funds under the proposed law. We are confident that it has always been the intention of Congress that the nongovernmental character of a hospital would not be affected by its participation in the Hill-Burton program. This attitude is reiterated in section 643 of H.R. 10041, which provides:

> 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.

We believe that this congressional statement of intent would be strengthened by the inclusion of the following clause at the end of section 643:

> Nor shall the acceptance of funds by a private facility under this title be construed as making that facility a public institution.

Mr. Chairman, although we have had a limited time to review H.R. 10041, we are impressed with the depth and impact of the measure. We regret that we have been unable to develop in greater detail our views with respect to the bill. However, Dr. Hopkins, Dr. Wright, and I shall be pleased to attempt to answer any questions the committee may have.

In behalf of Dr. Hopkins and Dr. Wright, and in behalf of the American Medical Association, I wish to express our appreciation for the privilege of presenting this association's comments on H.R. 10041, and for the consideration you will give to our views.

Mr. STAGGERS. Thank you Dr. Coleman.

I wish to thank you and Dr. Hopkins and Dr. Wright all, for taking the time to come to give us your views, although you say they were brief—they were brief—they were concise, and I think very emphatic. One thing I was impressed by was the phrase in Dr. Wright's state-

ment that you were here to give constructive criticism. So many times we do not have that from the witnesses.

On behalf of the committee, I wish to thank all of you for taking the time to come and give us the benefit of your views.

Do you have any questions, Mr. Hemphill?

Mr. HEMPHILL. Thank you. I want to join the chairman in thanking you gentlemen for your time and coming here.

We have a companion bill which has been introduced by the chairman of our committee which is 10042, proposed legislation endeavoring to provide facilities for and training of personnel who would be employed in the hospitals of our Nation; I asked a witness yesterday, and I do not want to belabor the point, but does the American Medical Association have any views on the question of whether or not, if we put the brick and mortar into effect, as we have done in Hill-Burton, that we are really not accomplishing anything unless we do something about the lack of personnel. Would you care to comment on that, please?

Dr. COLEMAN. Yes, Congressman. We have been unable to review the bill in question because of the short time that has elapsed since the introduction of the bill. We do plan, however, to review it in the very near future. At that time, we will probably have some views which we could transmit to you.

Mr. HEMPHILL. I might ask you this. Is the American Medical Association aware of the critical shortage of trained nurses in the hospitals of this Nation?

Dr. COLEMAN. Yes, I think we are quite aware of the shortage of trained personnel in the health field. This actually goes beyond nurses and includes other personnel as well.

Mr. HEMPHILL. And I might ask you whether or not the American Medical Association has ever considered the problem of nurses pay and salaries which seems to be one of the deterrents in this age, up until this time, to people who might otherwise seek nursing as a career.

Has your association gone into that at all?

Dr. COLEMAN. We have a liaison committee with the American Nurses Association that has discussed a number of things. I am not prepared today to give you a detailed report of these discussions, but I would be pleased to present to you and to the committee any comments that we might have on this issue for the record.

Mr. HEMPHILL. I would certainly thank you. I have been very much concerned because in my particular district, which I assume is no different than most of the nonurban—I do not have the figures—districts in America, we have a number of wonderful Hill-Burton hospitals, the finest facilities, but our problem has been getting the trained personnel who are not only competent but trained to do the necessary treatment, perform the necessary treatment, including the use and administration of narcotics, and shots, and other medications which I am sure the American Medical Association would want a trained person to have charge of.

It seems to me that as good as this legislation is, and as strong an advocate of Hill-Burton principles as I am, that we are going to have to recognize that the other problem exists and that the two go hand in hand. I would hope that the American Medical Association feels that they do go hand in hand.

Would you say that they did, sir?

Dr. COLEMAN. Yes; there is no question about that.

Mr. HEMPHILL. I certainly thank you again for answering my questions and coming today. Thank you very much.

Mr. STAGGERS. Mr. Younger?

Mr. YOUNGER. Thank you, very much. I, too, wish to thank the doctors of the American Medical Association for appearing and giving us the benefit of their experience in this field.

I am inclined to agree with you in regard to the insurance of mortgages, that they be left with the Housing and Home Finance Agency, but it will present some problems. In other words, you have a problem with the nonprofit hospitals wherein you might have a grant from the Federal Government and they might also be eligible for an insured mortgage. We are going to have to work out some kind of a combination on the part of the Department of Health, Education, and Welfare, and of Housing and Home Finance in order to cover that.

There is another phase I think I would like to have your advice on. In the bill the propietary hospital, for instance, can get an insured loan up to 90 percent, yet we may have a problem where you have a hospital that is greatly needed in the community, where the State has already used up all of its funds for grants, and it is a nonprofit institution.

And certainly, in my opinion, a nonprofit institution should not be penalized and be limited to 75 percent when the propietary institution can get an insured mortgage for 90 percent.

What would your comment be on that?

Dr. WRIGHT. We have taken no position on that. I would be inclined to agree with you. Our experience is only with the FHA loan guarantees which have been given to proprietary nursing homes. Our experience has been that it is a very satisfactory program. We would like to see it continued.

We also approve the principle of mortgage insurance for nonprofit hospitals. We believe that such guarantees should be provided by the FHA, which has much experience in the field, and that this authority should not be transferred to another Federal agency.

Mr. YOUNGER. As I understand it at present their authority exists only in nursing homes.

Dr. WRIGHT. That is correct, sir.

Mr. YOUNGER. And if we are going to extend it to hospitals then we must include both the proprietary hospital or a nonprofit hospital?

Dr. WRIGHT. Yes, sir.

Mr. YOUNGER. One other question. We all received a circular which was given to us to encourage us to vote for the salary bill today, and in that it says a recent nationwide survey showed that dentists averaged more than $75,000 a year in earnings and doctors in excess of $100,000. I would like to know if in your opinion that is correct. [Laughter.]

Dr. WRIGHT. I wish I were one of them.

Dr. HOPKINS. Mr. Chairman, I have been in the practice of medicine for 48 years and longer. There are very, very few men, even in very highly specialized areas of medicine, who have incomes that great from the practice of medicine.

It is my recollection, although it may not be correct, that the average income of physicians is somewhere around $22,000 a year.

Mr. YOUNGER. One of the Members of the House, a doctor, told me yesterday that his recollection was that the average earnings of the physician in general practice in the United States in the last survey was something like $16,500.

Dr. HOPKINS. That may be more accurate, sir.

Dr. WRIGHT. That is the last survey, sir; that is correct.

Mr. HEMPHILL (presiding). Mr. Dingell, do you have a question?

Mr. DINGELL. I wonder if you would like to give the committee your definition of socialized medicine.

Dr. COLEMAN. Well, Congressman, this subject of socialized medicine is certainly one that has been discussed for a long time. The words "socialized medicine" mean many things to many people.

Mr. DINGELL. You are speaking on behalf of the American Medical Association today, supposing you tell us what it means to the American Medical Association.

Dr. COLEMAN. I do not believe, Congressman, that the American Medical Association has a specific definition for socialized medicine which it is using at the present time.

Mr. DINGELL. They use it on anything that comes along they don't like, is that it?

Dr. COLEMAN. I don't believe that, sir.

Mr. DINGELL. Supposing you tell us that socialized medicine is Government expenditures for health?

Dr. COLEMAN. No, sir, that would——

Mr. DINGELL. You in the AMA have called the OASI amendments of 1950 socialized medicine, which provided for medical care for old-age assistance. You called grants to States and for tuberculosis care and for medical care for expectant mothers and for child health benefits socialized medicine. You called the original Dingell-Murray-Wagner bill socialized medcine.

All of these things were Government expenditures for purposes of bettering the health or authorized expenditures of Federal funds for meeting health problems of the American people. You called those things socialized medicine.

Now, would you like to particularize your definition in the light of that question a little bit?

Dr. COLEMAN. In the first place, Congressman, the things that you have cited are things that happened several years ago, and I am not prepared today to state what the official position of the American Medical Association was on these issues.

Mr. DINGELL. Assuming first of all, and this happens to be a fact, that these things were denominated as socialized medicine by the AMA, would it follow then that they are not socialized medicine today or would it follow they were socialized medicine today if they were so denominated by the AMA?

For example, workmen's compensation was originally characterized as socialized medicine by the AMA. Would it follow that it is socialized medicine? The Social Security Act was characterized as socialized medicine by the AMA. Is it socialized medicine today or was not in the past, or was socialized medicine in the past?

I am trying to find out from you good gentlemen down here whether this bill is socialized medicine or not.

Dr. COLEMAN. Congressman, as I stated earlier, I am in no position today to identify specifically actions that the American Medical Association has taken on issues in the past.

Mr. DINGELL. All I am asking you to tell me is what is socialized medicine?

Dr. COLEMAN. I think we can say based upon our statement today that we are supporting the continuation of the Hill-Burton program. The issue of socialized medicine——

Mr. DINGELL. You are aware of the fact that the Hill-Burton program on which you are testifying today was originally a page in the Dingell-Murray-Wagner bill which was ripped bodily out of that bill by Hill and Burton and was enacted into law. It was opposed when it was part of the Dingell-Murray-Wagner bill by the AMA and subsequently was endorsed by your organization. That is why I am trying to find out what is socialized medicine.

I assume you people are experts on socialized medicine, you use the word with great frequency.

Dr. COLEMAN. In our statement today, Congressman, we pointed out that we have supported the Hill-Burton program ever since it was first introduced in 1946.

Mr. DINGELL. I pointed out to you that you opposed it in 1944 and in 1946, and it was part of another piece of legislation where it was before it ever was introduced by either Hill or Burton.

Dr. COLEMAN. Congressman, I am sorry not to be able to discuss this past history with you, but my memory is not good enough to identify happenings of that long ago at this time.

Mr. DINGELL. Well, you have one thing here in your statement that concerns me, and that is that it is the position of the AMA that we should have the following amendments to section 643:

> Nor shall the acceptance of funds by a private facility under this title be construed as making that facility a public institution.

Now, what is the function of that particular language?

Dr. COLEMAN. The purpose of that particular language, Congressman, is simply to reiterate what we believe to have been the attitude and position of Congress since the inception of the Hill-Burton program; namely, that the acceptance of grants would not convert a private institution to a public institution. We are simply restating what we believe to have been the position of Congress ever since 1946.

Mr. DINGELL. Are you aware of the decision in the *Moses Cone* case?

Dr. COLEMAN. Yes.

Mr. DINGELL. That was a decision that held that hospitals that received grants under this were public institutions and accordingly discrimination was not allowed in their institution.

Dr. COLEMAN. I have general knowledge of the *Moses Cone* case. I have not read the Court decision in the case, but I know in general terms what it is.

Mr. DINGELL. What this is then is an attempt to legislatively override the *Moses Cone* decision under the image of the AMA?

Dr. COLEMAN. No, sir, you are not correct.

Mr. DINGELL. If this amendment has the effect of overriding the *Moses Cone* decision, do you change your position in view of that?

Dr. COLEMAN. Well, it is our opinion that it does not override the *Moses Cone* decision.

Mr. DINGELL. Well, I will put into the record, then, appropriate sections of the *Moses Cone* decision to make it abundantly plain that this does override and plainly seeks on the part of your organization to override the *Moses Cone* decision, because that was bottomed on the fact that acceptance of grants and participation in a State program constituted governmental action within the prescribed action of the 14th amendment. If that be so, then it is very plain that this is an attempt to override the *Moses Cone* decision, is it not?

Dr. COLEMAN. Congressman, this is not our interpretation, and this is not our purpose in suggesting this amendment. We have no desire to override the decision in the *Moses Cone* case.

Mr. DINGELL. Thank you, Mr. Chairman.

Mr. HEMPHILL. Is there objection to Mr. Dingell inserting in the record such remarks as he feels desirable?

Without objection, it is so ordered.

(The statement to be furnished follows:)

In the Supreme Court of the United States

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No. 776. MOSES H. CONE MEMORIAL HOSPITAL et al., Petitioners, v. G. C. SIMKINS et al.

March 2, 1964. Petition for writ of certiorari to the United States Court of Appeals for the Fourth Circuit denied.

In the Court of Appeals for the Fourth Circuit

G. C. SIMKINS, Jr., A. W. Blount, Jr., et al., Plaintiffs, and United States of America, Intervenor, Appellants,

v.

The MOSES H. CONE MEMORIAL HOSPITAL, a Corporation, Harold Bettis, Director of The Moses H. Cone Memorial Hospital, and Wesley Long Community Hospital, a Corporation, and A. O. Smith, Administrator of the Wesley Long Community Hospital, Appellees.

No. 8908.

United States Court of Appeals, Fourth Circuit.

Argued April 1, 1963.

Decided Nov. 1, 1963.

Action by Negro physicians, dentists and patients suing on behalf of themselves and other Negro citizens for declaratory and injunctive relief against defendant hospitals and their administrators and directors for discrimination because of their race. The United States District Court for the Middle District of North Carolina, at Greensboro, Edwin M. Stanley, Chief Judge, entered judgment adverse to plaintiffs and they appealed. The Court of Appeals, Sobeloff, Chief Judge, held that portion of Hill-Burton Hospital Survey and Construction Act tolerating "separate-but-equal" facilities for separate population groups and relevant regulations implementing that passage in statute are unconstitutional under the due process clause of the Fifth Amendment and the equal protection clause of the Fourteenth Amendment and that plaintiffs were entitled to relief.

Reversed and remanded.

Haynsworth and Boreman, Circuit Judges, dissented.

1. Constitutional Law 215

Private hospitals which participated in Hill-Burton joint federal and state program for allocating aid to hospital facilities were sufficiently involved with state, including federal, action to be within Fifth and Fourteenth Amendment prohibitions against racial discrimination. U.S.C.A. Const. Amends. 5, 14; Hospital Survey and Construction Act, § 622(f), 42 U.S.C.A. § 291e(f).

2. Constitutional Law 213

When state function or responsibilty is being exercised, it matters not for Fourteenth Amendment purposes that institution actually chosen would otherwise be private: the equal protection guarantee applies. U.S.C.A.Const. Amend. 14.

3. Constitutional Law 213

Governmental sanction need not reach level of compulsion to clothe what is otherwise private discrimination with state action. U.S.C.A.Const. Amend. 14.

4. Constitutional Law 215, 253
Hospitals 1

Portion of Hill-Burton Hospital Survey and Construction Act tolerating "separate-but-equal" facilities for separate population groups and relevant regulations implementing that passage in statute are unconstitutional under the due process clause of the Fifth Amendment and the equal protection clause of the Fourteenth Amendment. U.S.C.A.Const. Amends. 5, 14; Hospital Survey and Construction Act, § 622(f), 42 U.S.C.A. § 291e(f).

Jack Greenberg, New York City (James M. Nabrit, III, New York City, Michael Meltsner, New York City, and Conrad O. Pearson, Durham, N.C., on brief), for appellants other than the United States.

Harold H. Greene, Dept. of Justice (Burke Marshall, Asst. Atty. Gen. William H. Murdock, U.S. Atty., St. John Barrett and Howard A. Glickstein, Attys., Dept. of Justice, on brief), for the United States, intervenor, appellant.

Charles E. Roth, Greensboro, N.C. (Herbert S. Falk, Greensboro, N.C., on brief), for The Moses H. Cone Memorial Hospital and Harold Bettis, its Director, appellees.

Thornton H. Brooks, Greensboro, N.C. (Thomas O. More, Jr., and McLendon, Brim, Holderness & Brooks, Greensboro, N.C., on brief), for Wesley Long Community Hospital, Inc., and A. O. Smith, appellees.

Before SOBELOFF, Chief Judge, and HAYNSWORTH, BOREMAN, BRYAN and J. SPENCER BELL, Circuit Judges, sitting en banc.

SOBELOFF, Chief Judge.

The threshold question in this appeal is whether the activities of the two defendants, Moses H. Cone Memorial Hospital and Wesley Long Community Hospital, of Greensboro, North Carolina, which participated in the Hill-Burton program, are sufficiently imbued with "state action" to bring them within the Fifth and Fourteenth Amendment prohibitions against racial discrimination. Beyond this initial inquiry lies the question of the constitutionality of a portion of the Hill-Burton Act (Hospital Survey and Construction Act), 60 Stat. 1041 (1946), as amended, 42 U.S.C.A. § 291e(f),[1] and a regulation pursuant thereto,

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[1] 42 U.S.C.A. § 291e(f) provides:

"291e. General regulations. Within six months after August 13, 1946 [the enactment of this title], the Surgeon General, with the approval of the Federal Hospital Council and the Secretary [of Health, Education, and Welfare], shall by general regulation prescribe—

* * * * * * *

"(f) That the State plan shall provide for adequate hospital facilities for the people residing in a State, without discrimination on account of race, creed, or color, and shall provide for adequate hospital facilities for persons unable to pay therefor. Such regulation may require that before approval of any application for a hospital or addition to a hospital is recommended by a State agency, assurance shall be received by the State from the applicant that (1) such hospital or addition to a hospital will be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed, or color, but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group; and (2) there will be made available in each such hospital or addition to a hospital a reasonable volume of hospital services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial standpoint."

42 C.F.R. § 53.112,[2] 21 Fed. Reg. 9841 (December 12, 1956). Because of the importance of these questions the court, on its own motion, has heard the appeal en banc.

The plaintiffs are Negro physicians, dentists and patients suing on behalf of themselves and other Negro citizens similarly situated. Their complaint seeks declaratory and injunctive relief against the defendant hospitals and their respective administrators and directors. The basis of their complaint is that the defendants have discriminated and continue to discriminate, against them because of their race in violation of the Fifth and Fourteenth Amendments to the United States Constitution. The plaintiffs seek an injunction restraining the defendants from continuing to deny Negro physicians and dentists the use of staff facilities on the ground of race; an injunction restraining the defendants from continuing to deny and abridge admission of patients on the basis of race, and refusing on that basis to permit patients to be treated by their own physicians and dentists at the defendant hospitals; and a judgment declaring unconstitutional 42 U.S.C.A. § 291e(f) and 42 C.F.R. § 53.112, which authorize the construction of hospital facilities and the promotion of hospital services with funds of the United States on a "separate-but-equal" basis.

Since this proceeding is one in which "the constitutionality of * * * [an] Act of Congress affecting the public interest * * * [has been] drawn in question, "the United States, pursuant to 28 U.S.C.A. § 2403 and Rule 24(a), Fed. R. Civ. P., moved to intervene. Its motion for intervention was granted and throughout the proceedings the Government, unusually enough, has joined the plaintiffs in this attack on the Congressional Act and the regulation made pursuant thereto.

The present appeal is from a final order of the District Court, entered December 17, 1962, granting the defendants' Motion to Dismiss for lack of jurisdiction on the ground that no "state action" was proved and denying the motions by the plaintiffs and the United States for summary judgment.[3] The plaintiffs and the United States appealed.

As the District Court concluded, there is no material issue of fact. Moreover, extensive and well-supported findings of fact were made by that court.[4] We will not undertake to repeat these findings which are to be deemed incorporated in our opinion by reference. We set forth only such facts as are necessary for the development of the discussion.

FACTUAL BACKGROUND

Six of the plaintiffs are physicians and three are dentists, and all of them are duly licensed and practice their professions in Greensboro. Before filing the complaint they sought staff privileges at the defendant hospitals which were denied them because of racial exclusionary policies. Two of the plaintiffs are persons in need of medical treatment who desire to enter either of the defendant hospitals which, they contend, possess the most complete medical equipment and the best facilities available in the Greensboro area. They also desire to be treated by their personal physicians who are Negroes. The Long Hospital, however, completely excludes Negro patients and professionals. The Cone Hospital, on the other hand, excludes all but a select few Negro patients, who are admitted on special conditions not applied to whites; and, when the complaint was filed, this hospital did not admit Negro doctors and dentists to staff privileges.[5]

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[2] 42 C.F.R. § 53.112 provides:
"53.112 Nondiscrimination. Before a construction application is recommended by a State agency for approval, the State agency shall obtain assurance from the applicant that the facilities to be built with aid under the Act will be made available without discrimination on account of race, creed, or color, to all persons residing in the area to be served by that facility. However, in any area where separate hospital, diagnostic or treatment center, rehabilitation or nursing home facilities, are provided for separate population groups, the State agency may waive the requirement of assurance from the construction applicant if (a) it finds that the plan otherwise makes equitable provision on the basis of need for facilities and services of like quality for each such population group in the area, and (b) such finding is subsequently approved by the Surgeon General. Facilities provided under the Federal Act will be considered as making equitable provision for separate population groups when the facilities to be built for the group less well provided for heretofore are equal to the proportion of such group in the total population of the area, except that the State plan shall not program facilities for a separate population group for construction beyond the level of adequacy for such group."

[3] Simkins v. Moses H. Cone Memorial Hospital, 211 F. Supp. 628 (M.D.N.C. 1962).

[4] Id. 211 F. Supp. at 630–634.

[5] On the day following the order dismissing the case, Cone Hospital advised the plaintiffs, and publicly announced, that it would consider staff applications from Negroes. The policy with respect to Negro patients, however, was not changed.

The claims of racial discrimination were, as the District Court found, "clearly established." In fact the hospitals' applications for Federal grants for construction projects openly stated, as was permitted by statute, 42 U.S.C. § 291e(f), and regulations, 42 C.F.R. § 53.112, that "certain persons in the area will be denied admission to the proposed facilities as patients because of race, creed or color." These applications were approved by the North Carolina Medical Care Commission, a state agency, and the Surgeon General of the United States under his statutory authorization.

Both Cone and Long are nonprofit hospitals owned and governed by boards of trustees, and under state law they are duly constituted charitable corporations. The Long Hospital is governed by a self-perpetuating board of twelve trustees. The Cone Hospital, however, is governed by fifteen trustees, five of whom are selected by various state agencies, and one is appointed by a "public agency" as the District Court assumed for the purpose of its decision. Neither hospital's charter contains any explicit or implicit authorization or requirement for the exclusion of Negro professionals or patients.

By far the most significant governmental contact of these two hospitals is their participation in the federally assisted Hill-Burton hospital system. As a result of their involvement in the Hill-Burton hospital construction program both hospitals have received large amounts of public funds, paid by the United States to the State of North Carolina and in turn by North Carolina, through its Treasurer, to the hospitals. They received these funds as part of a "state plan" for hospital construction, which allocates available resources for hospitals within the state and contemplates and authorizes the defendants to exclude Negroes.

When this action was commenced, the United States had appropriated $1,269,950.00 to the Cone Hospital and $1,948,800.00 to the Long Hospital. Cone had already received these funds which amounted to about 15% of the total construction expenses involved in its two projects. Long had received most of the funds appropriated to it (over $1,500,000.00 already paid) which constitute about 50% of the total cost of its three projects.[6] These appropriations for the most part were after the Supreme Court's landmark decisions in Brown v. Board of Education, 347 U.S. 483, 74 S. Ct. 686, 98 L. Ed. 873 (1954) and 349 U.S. 294, 75 S. Ct. 753, 99 L. Ed. 1083 (1955).

The Hill-Burton program requires that states wishing to participate must inventory existing facilities to determine hospital construction needs and to develop construction priorities under federal standards. State agencies are designated to perform this function and to adopt state-wide plans to be submitted for the approval of the Surgeon General of the United States. The designated North Carolina agency is the North Carolina Medical Care Commission. The Act pro-

[6] See the following:

CONE HOSPITAL

Project No. and year approved	Purpose	Federal funds appropriated May 8, 1962	Total cost of project	Federal percent of cost
NC-86 (1954)	General Hospital construction	$462,000	$5,277,023.32	
NC-330 (1960).	Diagnostic and treatment center; general hospital construction.	807,950	2,090,000.00	
Total		1,269,950	7,367,023.32	*17.2

LONG HOSPITAL

NC-311 (1959).	New hospital construction	$1,617,150	$3,314,749.40	
NC-353 (1961).	Laundry	66,000	120,000.00	
NC-358 (1961).	Hospital nurses training school	265,000	492,636.00	
Total		1,948,800	3,927,385.40	*49.6

*The court found "approximately" 15 percent for Cone and "approximately" 50 percent for long.

vides for grants of federal funds for construction of new or additional facilities for governmentally owned hospitals and voluntary nonprofit hospitals.[7]

The allocation of federal funds among the states is determined by a mathematical formula based on population and per capita income. 42 U.S.C.A. § 291g. The "federal share" of costs of particular projects within a state is governed by federally approved state plans. 42 U.S.C.A. § 291e(f). North Carolina's current plan programs general hospital facilities based on a "federal share" of 55%. Through January 31, 1963, a total of 350 Hill-Burton projects was approved by the State of North Carolina. This involved 10,210 inpatient beds and 106 health units. The total cost of these projects was approximately $180,866,000.00 and the "federal share" amounted to approximately $77,854,000.00. Of these projects 325 were already in operation. They included 8496 inpatient beds and 100 health units. The total cost of these facilities was $139,650,000.00 and the "federal share" was $58,621,000.00.[8]

Participation in the Hill-Burton program subjects hospitals to an elaborate and intricate pattern of governmental regulations, both state and federal, of which the following categories are most significant for present purposes:

(1) The Act provides that if within 20 years after completion of a project a hospital is sold to anyone who is not qualified to file an application thereunder or is not approved by the state agency, or if the hospital ceases to be "nonprofit," the United States can recover a proportionate share of its grant to the hospital. 42 U.S.C.A. § 291h(e). The state agency is required to give notice of any such changes of status. 42 C.F.R. § 53.130.

(2) On its fact the Act indicates that participating institutions, correlative to their right to receive monetary assistance, are obligated to render hospital services pursuant to specified "minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of hospitals which receive Federal aid * * *." 42 U.S.C.A. § 291f(a)(7). And no federal grants are to be allocated to any state which does not enact legislation requiring compliance with the minimum standards. 42 U.S. C. A. § 291f(d). Within a year after the passage of the Hill-Burton Act, North Carolina, to meet its requirements, enacted a "Hospital Licensing Act" in 1947, N.C.Gen.Stat. § 131–126.1 et seq (1958), authorizing the adoption of detailed regulations governing hospital maintenance and operation. The federal authorities prescribed and North Carolina adopted "Rules and Regulations for Hospital Licensure." These provide in detail for the management of hospitals under general headings such as administration, clinical services, auxiliary services, nursing service, and food service.

(3) The Act provides for federal decision as to the number of general hospital beds and other facilities required to provide "adequate service" in a state, for general methods of distribution in areas of a state, and for the general manner in which a state agency shall determine priorities of projects based on relative need. 42 U.S.C.A. § 291e(a), (b) (c), (d). State allowances in terms of number of beds per thousand population have been fixed by regulation. 42 C.F.R. § 53.11, as have the methods to be used by state agencies in distributing hospitals in a state. 42 C.F.R. §§ 53.12, 53.13. In addition the "separate-but-equal" provisions stipulate that facilities for separate population groups shall not be programmed for construction "beyond the level of adequacy for such group." 42 C.F.R. § 53.112. And federal standards governing the state agencies' determination of the priority of projects are set out in 42 C.F.R. §§ 53.71 to 53.80. See also 42 C.F.R. § 53.127(b) and 42 C.F.R. § 53.127(d) (6).

(4) A state, to participate in the Hill-Burton program, is required to submit for approval by the Surgeon General a state plan setting forth a "hospital construction program" which, among other things, "meets the requirements as to lack of discrimination on account of race, creed, or color, and for furnishing needed hospital services to persons unable to pay therefor, required by regulations prescribed under section 291e(f). * * *" 42 U.S.C.A. § 291f(a)(4).

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[7] In the first fifteen years of the program (1947–1961) approximately $1.55 billion of federal funds were approved for such projects. Slightly more than half of the total went to voluntary nonprofit hospital projects. In the same period state and local funds (governmental and nongovernmental) totaled about $3.38 billion; thus, the federal share of Hill-Burton projects was slightly more than 30% of their total cost. See "Hill-Burton Program—Progress Report, July 1, 1947–June 30, 1961." United States Department of Health, Education, and Welfare, Public Health Service Publication No. 880 (1961).

[8] See "Hill-Burton Project Register: Hospital and Medical Facility Projects Approved During January, 1963." United States Department of Health, Education, and Welfare, Public Health Service-Division of Hospital and Medical Facilities (1963).

Both state plans, 42 U.S.C.A. § 291f(a)(4)(D); 42 C.F.R. § 53.111, and project applications, 42 U.S.C.A. § 291h(a); 42 C.F.R. § 53.127(d)(4), are subject to this general nondiscrimination requirement. However, the Act, 42 U.S.C.A. § 291e(f), authorizes the Surgeon General to make a regulation to provide an exception to the general racial nondiscrimination rule by making "equitable provision" for separate hospitals for separate population groups. Thus, by statute and regulation the states may meet the nondiscrimination requirement "in any area where separate hospital, diagnostic or treatment center, rehabilitation or nursing home facilities and services of like quality for each such population group in the area, and * * * such finding is subsequently approved by the Surgeon General." 42 C.F.R. § 53.112.

Where a "separate-but-equal" plan is in operation, the individual applicant for aid need not given any assurance that it will not discriminate and, in fact, may expressly indicate on its application form, as did each of the defendant hospitals, that "certain persons in this area will be denied admission to the proposed facilities as patients because of race, creed, or color." The arrangement to extend aid is formally concluded by a memorandum of agreement, signed by representatives of the applicant, the state agency and the Surgeon General.

Where a state seeks to meet the nondiscrimination requirement by programming separate facilities for different population groups, it is required to submit to the Surgean General a "Non-Discrimination Report" (Form PHS–8). The preparation of this report requires the state agency specifically to enumerate the number of hospital beds available for each racial group. According to the record, the North Carolina Medical Care Commission submitted such a "Non-Discrimination Report" on January 3, 1962. It lists the L. Richardson Memorial Hospital as having 91 acceptable beds for "non-white" patients and none for "white"; Wesley Long Community Hospital as having none for "non-white" patients and 220 for "white"; and Moses H. Cone Hospital as having none for "non-white" and 482 for "white" patients.

Significant duties are imposed on the Surgeon General with respect to the "Non-Discrimination Report." 42 C.F.R. § 53.112 provides that a state agency's findings must be approved by the Surgeon General. Consequently, the Surgeon General has the duty of determining whether the state agency has properly applied the "separate-but-equal" formula, *i.e.*, whether the state's plan actually makes "equitable provision" for all population groups. The "Non-Discrimination Report" submitted by the North Carolina Medical Care Commission on January 3, 1962, was approved by the Surgeon General on January 22, 1962.

The point of present interest is not the equality or lack of equality in "separate-but-equal," but the degree of participation by the national and state governments in the geographical proration of hospital facilities throughout the state.[9]

THE LEGAL ISSUE

Upon this factual foundation the District Court formulated the question for determination as follows: "[W]hether the defendants have been shown to be so impressed with a public interest as to render them instrumentalities of government, and thus within the reach of the Fifth and Fourteenth Amendments to the Constitution of the United States." After first examining separately each of the above and other points of governmental contact, the court concluded that none was sufficient to impress the hospitals with the necessary "public interest." Then, considering the various factors together, the court agreed with the defendants that "zero [the quantum of each separate factor] multiplied by any number would still equal zero." Having found no "state action" the court declined to pass upon the constitutionality of 42 U.S.C.A. § 291e(f) and 42 C.F.R. § 53.112 since such a declaratory ruling was no longer necessary to the decision of the case and would therefore constitute a forbidden "advisory opinion."

Although the District Judge earnestly faced and sought to make a reasoned analysis of the problems presented, it is our conclusion that the case was wrongly decided. In the first place we would formulate the initial question differently to avoid the erroneous view that for an otherwise private body to be subject to the antidiscrimination requirements of the Fifth and the Fourteenth Amendments it must actually be "render[ed an] instrumentalit[y] of government * * *." In our view the initial question is, rather, whether the state or

[9] As an aside, it is to be noted that in "Equal Protection of the Laws in North Carolina," a Report of the North Carolina Advisory Committee to the United States Commission on Civil Rights (1962) (pamphlet), a special study group fuond that facilities available to nonwhites were both inferior to those available to whites and more limited.

the federal government, or both, have become so involved in the conduct of these otherwise private bodies that their activities are also the activities of these governments and performed under their aegis without the private body necessarily become either their instrumentality or their agent in a strict sense. As the Supreme Court recently said in Burton v. Wilmington Parking Authority, 365 U.S. 715, 721–722, 81 S.Ct. 856, 859–860, 6 L.Ed.2d 45 (1961), a case involving racial discrimination by a privately owned restaurant operating on government property:

> "The Civil Rights Cases, 109 U.S. 3 [3 S.Ct. 18, 27 L.Ed. 835] (1883), 'embedded in our constitutional law' the principle 'that the action inhibited by the first section [Equal Protection Clause] of the Fourteenth Amendment is only such action as may fairly be said to be that of the States. That Amendment erects no shield against merely private conduct, however discriminatory or wrongful.' Chief Justice Vinson in Shelley v. Kraemer, 334 U.S. 1, 13 [68 S.Ct. 836, 842, 92 L.Ed. 1161] (1948). It was language in the opinion in the Civil Rights Cases, supra, that phrased the broad test of state responsibility under the Fourteenth Amendment, predicating its consequence upon 'State action of every kind * * * which denies * * * the equal protection of the laws.' At p. 11 [of 109 U.S. at p. 21 of 3 S.Ct. 27 L.Ed. 835]. And only two Terms ago, some 75 years later, the same concept of state responsibility was interpreted as necessarily following upon 'state participation through any arrangement, management, funds or property.' Cooper v. Aaron, 358 U.S. 1, 4 [78 S.Ct. 1401, 1402–1403, 3 L.Ed.2d 5] (1958). It is clear, as it always has been since the Civil Rights Cases, supra, that 'Individual invasion of individual rights is not the subject-matter of the amendment,' [109 U.S.] at p. 11 [3 S.Ct. at p. 21, 27 L. Ed. 835], and that private conduct abridging individual rights does no violence to the Equal Protection Clause *unless to some significant extent the State in any of its manifestations has been found to have become involved in it.* Because the virtue of the right to equal protection of the laws could lie only in the breadth of its application, its constitutional assurance was reserved in terms whose imprecision was necessary if the right were to be enjoyed in the variety of individual-state relationships which the Amendment was designed to embrace. For the same reason, to fashion and apply a precise formula for recognition of state responsibility under the Equal Protection Clause is an 'impossible task' which 'This Court has never attempted.' [Citation omitted.] *Only by sifting facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance.*" (Emphasis added.)

Weighing the circumstances we are of the opinion that this case is controlled by Burton, where the Court held that the "activities, obligations and responsibilities of the [Parking] Authority, the benefits mutually conferred, together with the obvious fact that the restaurant is operated as an integral part of a public building devoted to a public parking service, indicates that degree of state participation and involvement in discriminatory action which it was the design of the Fourteenth Amendment to condemn." 365 U.S. at 724, 81 S. Ct. at 864, 6 L. Ed. 2d 45.[10]

[1] Here the most significant contacts compel the conclusion that the necessary "degree of state [in the broad sense, including federal] participation and involvement" is present as a result of the participation by the defendants in the Hill-Burton program. The massive use of public funds[11] and extensive state-federal sharing in the common plan are all relevant factors. We deal here with the appropriation of millions of dollars of public monies pursuant to comprehensive governmental plans.[12] But we emphasize that this is not merely a

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[10] Accord, Smith v. Holiday Inns of America, 220 F. Supp. 1 (M.D. Tenn. 1963); see also Garner v. Louisiana, 368 U.S. 157, 183, 82 S. Ct. 248, 7 L. Ed. 2d 207 (1961) (Mr. Justice Douglas concurring); Public Utilities Comm. v. Pollak, 343 U.S. 451, 462, 72 S. Ct. 813, 96 L. Ed. 1068 (1952).

[11] In Cooper v. Aaron, 358 U.S. 1, 78 S. Ct. 1401, 3 L. Ed. 2d 5 (1958), the Court explained its decision in Brown v. Board of Education, 347 U.S. 483, 74 S. Ct. 686, 98 L. Ed. 873 (1954), as follows:

> "That holding was that the Fourteenth Amendment forbids States to use their governmental powers to bar children on racial grounds from attending schools where there is *state participation through any arrangement, management, funds or property.*" 358 U.S. at 4, 78 S. Ct. at 1402–1403, 3 L. Ed. 2d 5. (Emphasis added.)

[12] Contrast the case at hand with Eaton v. Board of Managers of James Walker Mem. Hospital, 261 F. 2d 521 (4th Cir.), cert. denied, 359 U.S. 984, 79 S. Ct. 941, 3 L. Ed. 2d 934 (1958), where the total authorities by contract for care of indigents paid the hospital less than 4½% of its budget.

controversy over a sum of money. Viewed from the plaintiff's standpoint it is an effort by a group of citizens to escape the consequences of discrimination in a concern touching health and life itself. As the case affects the defendants it raises the question of whether they may escape constitutional responsibilities for the equal treatment of citizens, arising from participation in a joint federal and state program allocating aid to hospital facilities throughout the state.

Not every subvention by the federal or state government automatically involves the beneficiary in "state action," and it is not necessary or appropriate in this case to undertake a precise delineation of the legal rule as it may operate in circumstances not now before the court. Prudence and established judicial practice counsel against such an attempt at needlessly broad adjudication. Our concern is with the Hill-Burton program, and examination of its functioning leads to the conclusion that we have state action here. Just as the Court in the Parking Authority case attached major significance to "the obvious fact that the restaurant is operated as an integral part of a public building devoted to a public parking service," 365 U.S. at 724, 81 S. Ct. at 864, 6 L. Ed. 2d 45, we find it significant here that the defendant hospitals operate as integral parts of comprehensive joint or intermeshing state and federal plans or programs designed to effect a proper allocation of available medical and hospital resources for the best possible promotion and maintenance of public health.[13] Such involvement in discriminatory action "it was the design of the Fourteenth Amendment to condemn." 365 US. at 724,[14] 81 S. Ct. at 864, 6 L. Ed. 2d 45.

Two additional theories presented by the plaintiffs and the Government are worthy of note.

[2] As the Government argued in its brief, the Hill-Burton Act itself and its legislative history reveal "emphasis on the creation of a State-wide system of hospitals for the provision of hospital service to all the people of the State [which] indicates that the Hill-Burton program was not limited to the granting of financial aid to individual *hospitals*. It shows, rather, a congressional design to induce the States, upon joining the program, to undertake the supervision of the construction and maintenance of adequate hospital facilities throughout their territory. Upon joining the program a participating State in effect assumes, as a State function, the obligation of planning for adequate hospital care. And it is, of course, clear that when a State function or responsibility is being exercised, it matters not for Fourteenth Amendment purposes that the * * * [institution actually chosen] would otherwise be private: the equal protection guarantee applies." [15]

[3] Moreover, the Government's argument stresses the fact that the challenged discrimination has been affirmatively sanctioned by both the state and the federal government pursuant to federal law and regulation. 42 U.S.C.A. § 291e(f); 42 C.F.R. § 53.112. It is settled that governmental sanction need not reach the level of compulsion to clothe what is otherwise private discrimination with "state action." [16]

It remains to discuss the case of Eaton v. Board of Managers of James Walker Mem. Hospital, 261 F. 2d 521 (4th Cir.), cert. denied, 359 U.S. 984, 79 S. Ct. 941, 3 L. Ed. 2d 934 (1958). Not only the defendants but also the District Court relied on this as a precedent in apparent conflict with the present decision. This court held, upon consideration of certain sums paid by the City of Wilmington and the County of New Hanover, North Carolina, that the defendant hospital was not so impressed with "state action" as to require injunction under the Four-

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[13] See 42 U.S.C.A. § 291 (a), (b), (c) ("Declaration of purpose with respect to construction of hospitals").

[14] Accord, Peterson v. City of Greenville, 373 U.S. 244, 247, 83 S. Ct. 1119, 10 L. Ed. 2d 323 (1963).

[15] Terry v. Adams, 345 U.S. 461, 73 S. Ct. 809, 97 L. Ed. 1152 (1953); Marsh v. Alabama, 326 U.S. 501, 66 S. Ct. 276, 90 L. Ed. 265 (1946); Smith v. Allwright, 321 U.S. 649, 64 S. Ct. 757, 88 L. Ed. 987 (1944); Nixon v. Condon, 286 U.S. 73, 52 S. Ct. 484, 76 L. Ed. 984 (1932); Guillory v. Administrators of Tulane Univ. of Louisiana, 212 F. Supp. 674 (E.D. La. 1962).

[16] See McCabe v. Atchison, T. & S.F.R. Co., 235 U.S. 151, 161, 35 S. Ct. 69, 59 L. Ed. 169 (1914); cf. Lombard v. Louisiana, 373 U.S. 267, 83 S. Ct. 1122, 10 L. Ed. 2d 338 (1963); Peterson v. City of Greenville, 373 U.S. 244, 83 S. Ct. 1119, 10 L. Ed. 2d 323 Edgerton, JJ. dissenting).

See also Gantt v. Clemson Agricultural College, 320 F. 2d 611 (4th Cir. 1963), a school segregation case, where the court said: "The distinction drawn between prohibition and discouragement is a novel one in legal literature, and we must hold it unacceptable. Under the Constitution of the United States a state may no more pursue a policy of discouraging and impeding admission to its educational institutions on the ground of race than it may maintain a policy of strictly prohibiting admissions on account of race."

teenth Amendment against its racially discriminatory practices. Initially we note that Eaton was decided before the Supreme Court's decision in Burton v. Wilmington Parking Authority, 365 U.S. 715, 81 S. Ct. 856, 6 L. Ed. 2d 45 (1961). In light of Burton doubt is cast upon Eaton's continued value as a precedent.[17] And we hold that the District Court erred in its attempt to distinguish the Burton decision. The Supreme Court's language and holding is not to be limited to cases involving lessees of public property. Also significant is the fact that the Eaton case did not involve any consideration of the Hill-Burton program, with its massive financial aid and comprehensive plans.[18] Moreover, no argument was presented in Eaton as to possible fulfillment by a private body of a "state" function pursuant to an extensive state plan.[19] And finally, the Eaton case did not consider what effect overt state and federal approval would have on otherwise purely private discrimination.

Having found the requisite "state action," necessarily we must remand to the District Court with directions to grant the requested injunctive relief.[20] We agree with the plaintiffs and the Government that adjudication of the statute's constitutionality is not advisory merely and that the plaintiffs have standing to challenge the constitutionality of 42 U.S.C.A. § 291e(f) and 42 C.F.R. § 53.112 which promote federally assisted and approved hospital facilities. To make any relief effective it becomes necessary to pass upon the validity of the statute and the regulation, because they contain an affirmative sanction of the unconstitutional practice.

[4] These federal provisions undertaking to authorize segregation by state-connected institutions are unconstitutional.[21] The rest of section 291e(f), providing for hospital facilities without discrimination, however, remains in effect. The basic and overriding purpose of the Hill-Burton Act was to permit the states to develop programs of hospital construction that would provide adequate services "to all their people."[22] 42 U.S.C.A. § 291(a). It serves the dominant congressional purpose best to prune from the statutory provision only that language which adopted what is now known to be an unconstitutional means of accomplishing a constitutional end. The general prohibition against discrimination stands; only the exception tolerating "separate-but-equal" fails. Accordingly, we declare invalid only that portion of 42 U.S.C.A. § 291e(f) which reads:

> "* * * but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group; * * *."

Unconstitutional as well under the Due Process Clause of the Fifth Amendment and the Equal Protection Clause of the Fourteenth are the relevant regulations implementing this passage in the statute.

This court does not overlook the hospitals' contention that they accepted government grants without warning that they would thereby subject themselves to restrictions on their racial policies. Indeed they are being required to do what the Government assured them they would not have to do. But in this regard the defendants, owners of publicly assisted facilities, can stand no better than the collective body of Southern voters who approved school bond issues before the

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[17] See Hampton v. City of Jacksonville, 304 F. 2d 320, 323 (5th Cir. 1962) (Eaton questioned in the light of Burton). See also n. 12, supra. True, the opinion of the Fifth Circuit stresses the reverter feature in Eaton as the equivalent of the lease in the Burton case; but there is also in the present case, as we have seen, a reverter provision in the event of a sale of the hospital to an unqualified owner within 20 years after completion of a project. 42 U.S.C.A. § 291h(e); 42 C.F.R. § 53.130.

[18] It is now advanced as an argument against our conclusion that the Walker Hospital, like the hospitals here, received construction subsidies of federal origin at some stage of its history after the erection of the building at the expense of the initial private donor. The opinion of this court does not deal with this and indeed shows no awareness of it; nor was this argued to the court. Certainly the decision can scarcely be relied on as authority for a proposition not considered.

[19] See, e.g., Terry v. Adams, 345 U.S. 461, 73 S. Ct. 809, 97 L. Ed. 1152 (1953); Marsh v. Alabama, 326 U.S. 501, 66 S. Ct. 276, 90 L. Ed. 275 (1946); Smith v. Allwright, 321 U.S. 649, 64 S. Ct. 757, 88 L. Ed. 987 (1944).

[20] The District Court's opinion states that the defendants conceded that if the hospitals were found to embody the necessary "state action," "the plaintiffs were entitled to the injunctive relief sought."

[21] See, e.g., Bolling v. Sharpe, 347 U.S. 497, 500, 74 S. Ct. 693, 98 L. Ed. 884 (1954); cf. Brown v. Board of Education, 347 U.S. 483, 74 S. Ct. 686, 98 L. Ed. 473 (1954); Steele v. Louisville & N. R. Co., 323 U.S. 192, 65 S. Ct. 226, 89 L. Ed. 173 (1944).

[22] Senator Hill, co-author of the Hill-Burton Act, stated that it was intended to assist the states in preparing "a Statewide program for new construction so that all the people of the State may have adequate health and hospital facilities." Hearings before Senate Committee on Education and Labor on S. 191, 79th Cong., 1st Sess., p. 8.

Brown decision or the private entrepreneur who outfitted his restaurant business in the Wilmington Parking Garage before the Burton decision. The voters might not have approved some of the bond issues if they had known that the schools would be compelled to abandon their historic practice of separation of the races, and the restaurateur might have been unwilling to venture his capital in a business on the premises of the Wilmington Parking Authority if he had anticipated the imposition of a requirement for desegregated service. What was said by the Supreme Court in Burton in regard to the leases there in question is pertinent here:

"[W]hen a State leases public property in the manner and for the purpose shown to have been the case here, the proscriptions of the Fourteenth Amendment must be complied with by the lessee as certainly as though they were *binding covenants written into the agreement itself.*" (Emphasis added.) 365 U.S. at p. 726, 81 S. Ct. at p. 862, 6 L. Ed. 2d 45.

We accord full weight to the argument of the defendants, but it cannot prevail. Not only does the Constitution stand in the way of the claimed immunity but there are powerful countervailing equities in favor of the plaintiffs. Racial discrimination by hospitals visits severe consequences upon Negro physicians and their patients.[23]

Giving recognition to its responsibilities for public health, the state elected not to build publicly owned hospitals, which concededly could not have avoided a legal requirement against discrimination. Instead it adopted and the defendants participated in a plan for meeting those responsibilities by permitting its share of Hill-Burton funds to go to existing private institutions. The appropriation of such funds to the Cone and Long Hospitals effectively limits Hill-Burton funds available in the future to create non-segregated facilities in the Greensboro area. In these circumstances, the plaintiffs can have no effective remedy unless the constitutional discrimination complained of is forbidden.[24]

The order of the District Court is reversed and the case is remanded for the entry of an order in conformity with the opinion of this court.

Reversed and remanded.

HAYNSWORTH, Circuit Judge, with who BOREMAN, Circuit Judge, joins (dissenting).

Believing the conclusion of the majority both unprecedented and unwarranted, I respectfully dissent.

If it is not made plain in the opinion of the majority, it should be clearly understood that neither of these hospitals came into existence under the promptings of federal or state officials, or because of the lure of large governmental subsidies.

Moses H. Cone Memorial Hospital was first organized in 1911. Mrs. Bertha Cone, the widow of Moses H. Cone, provided large sums of money for the purpose of establishing and constructing a nonprofit hospital in Greensboro, North Carolina. The corporation which she caused to be organized in 1911 has since successfully operated a large hospital in Greensboro providing a wide variety of medical services. It owned and operated facilities having a depreciated cost value of many millions of dollars, and, in addtion, it had a substantial endowment. It was not until 1954 that the Cone Hospital, contemplating an addition to cost $5,277,023.32, made application for Hill-Burton funds in the amount of $462,000. In 1960, it filed a second application for Hill-Burton funds in the amount of $807,950 in connection with the construction of a diagnostic and treatment center and a further addition to its general facilities, costing in the aggregate $2,090,000.

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[23] Cf. Sweatt v. Painter, 339 U.S. 629, 70 S. Ct. 848, 94 L. Ed. 114 (1950).

Racial discrimination in medical facilities is at least partly responsible for the fact that in North Carolina the rate of Negro infant mortality is twice the rate for whites and maternal deaths are five times greater. See "Equal Protection of the Laws Concerning Medical Care in North Carolina," Appendix K (Subcommittee on Medical Care of the North Carolina Advisory Committee to the United States Commission on Civil Rights (mimeographed)).

Exclusion of Negro physicians from practice in hospitals on account of their race denies them opportunities for professional improvement and has discouraged Negro physicians from practicing in the cities of the South. Reitzes, Negroes and Medicine, 272, 295, 316 (1958).

[24] Raised in a preliminary motion in the District Court not pressed on appeal, was the question whether, since the complaint challenged the constitutionality of an act of Congress, a three-judge district court was required. See 28 U.S.C.A. § 2282. If there is state action, as we hold, the validity of the statute is no longer debatable, the recent decisions of the Supreme Court having clearly and uniformly decided against such distinctions as the statute permits. When the substantive issue has become so academic, the convening of a three-judge court is not required. See Bailey v. Patterson, 369 U.S. 31, 82 S. Ct. 549, 7 L. Ed. 2d 512 (1962).

Both of these applications were approved, with the result that the Cone Hospital has received a total of $1,269,950 in Hill-Burton funds in connection with additions costing $7,367,023.32. As the majority opinion points out, the subsidies Cone received amounted to a little more than seventeen per cent of the cost of the 1954 and 1960 additions, but the subsidies amounted to a very much smaller proportion of the total cost of all of its facilities.

The facilities of the small 78-bed Wesley Long Hospital in Greensboro were antiquated. In 1959 and 1961, it filed three applications for Hill-Burton funds in aid of reconstruction and expansion projects designed to replace its antiquated facilities with modern ones and to enlarge its capacity to 150 beds. These applications were approved in the aggregate amount of $1,948,100, being approximately fifty per cent of the total cost of the construction programs undertaken in 1959 and 1961. The proportion of subsidy to the total value of all of its facilities does not appear.

It is against this background that we must approach the question of whether or not the present operation of these hospitals is "state action" in a constitutional sense, so that their operation is subject to the requirements of the Fourteenth Amendment.

The plaintiffs contended that state action should be found to have arisen out of the "totality" of the circumstances that a minority of the members of the Board of Trustees of the Cone Hospital are appointed by designated public officials, that Cone voluntarily cooperates with two state supported colleges in a program for the training of student nurses, and, with respect to both hospitals, that they are licensed by the state, as doctors, lawyers and restaurants are, that they enjoy a tax exemption, as every eleemosynary corporation in North Carolina does, and that they received Hill-Burton funds. Since the majority rests its opinion solely upon the receipt of Hill-Burton funds, we may dismiss the other suggested governmental contracts upon which the plaintiffs would rely, being unwilling to rely upon the Hill-Burton contention alone. The United States, as intervenor, readily conceeds that the receipt of governmental subsidy alone would not make the subsequent operation of a hospital state action, but it finds in the Hill-Burton Act and the North Carolina statutes passed in compliance with it such regulation and power of control as to convert the operation of the hospitals into state action in a constitutional sense. This theory, adopted by the majority, distorts the Hill-Burton Act, its purposes and its operation in practice.

The Hill-Burton Act[25] was enacted in 1944 in recognition of the fact that throughout the country construction of hospital facilities had lagged behind the growing needs of our growing population. The country had only recently passed through the long, deep depression of the 1930's and was then still heavily engaged in the second world war. The avowed purposes of the Act were to assist the states in surveying the need for new hospital facilities and developing programs for the construction of needed facilities, and, secondly, to assist in the construction of "public and other nonprofit hospitals" in accordance with the state programs. Memory is not so dim, of course, that it cannot be recalled that, at the time, it was very politic to utilize state agencies wherever possible in the administration of federal programs of grants in aid and of assistance.

That the Congress intended the enactment of no regulatory scheme plainly appears from the provisions of the Act[26] that, "[e]xcept as otherwise specifically provided," nothing in the Act should be construed as giving any federal officer or employee any right of supervision or control over any hospital receiving grants in aid under the Act. The exception encompasses only the powers of the Surgeon General of the United States to approve or disapprove state plans and specific applications for grants in aid. It is thus clear that the Congress intended that receipt by a private, nonprofit hospital of a grant in aid should not result in a continuing right of control by the Surgeon General or by any other official of the United States. In short, subsequent operation of a hospital which had received a grant in aid of a construction program was not to be federal action.

This is substantiated by the legislative history. In the hearings before the Senate Committee on Education and Labor, Dr. Donald M. Smeltzer, President of the American Hospital Association, made it plain that, once a grant had been paid to a private hospital, the money would belong to the hospital; the grant was a gift.[27] Dr. Parran, Surgeon General of the United States, testified that

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[25] 42 U.S.C.A. § 291 et seq.
[26] 42 U.S.C.A. § 291m.
[27] Hearings before the Senate Committee on Education and Labor on S. 191, 79th Cong., 1st Sess. p. 22.

the purpose was to assist the states "to fill out the missing pieces in the present hospital pattern, and that the hospitals continue to be under local government and voluntary management as they are now." [28]

The donee of such a gift does not become an arm of the donor.

In 1945, North Carolina adopted a statute,[29] as contemplated by the Hill-Burton Act, authorizing the North Carolina Medical Care Commission to survey and determine the need for hospital facilities and what, if any, state assistance was needed by public and private nonprofit hospitals in financing their construction programs. The statute, of course, authorizes the Commission to receive funds from the United States and such funds as might be appropriated by North Carolina, out of which it was authorized to make grants in aid to public and private nonprofit hospitals for construction projects. The statute goes no further than to authorize the Commission to perform those administrative functions in cooperation with the Surgeon General, as are contemplated by the Hill-Burton Act. There is nothing in it which suggests that the Commission was empowered to exercise regulatory or supervisory functions over the operation of private nonprofit hospitals, whether or not their operators had been the recipients of grants in aid of construction projects. The Attorney General of North Carolina, rendered an opinion on February 10, 1962, in which he stated that the Commission had no regulatory or supervisory powers in connection with the operation of these hospitals or of their administrative and professional staffs, and the Executive Secretary of the Commission filed an affidavit in which he disclaimed the existence of any such power. Indeed, the record is barren of any suggestion that the state statute contemplated exercise by the Commission of any such power or that the Commission ever undertook the exercise of any such power.[30]

The Hill-Burton Act and the North Carolina statute complementing it thus provided the machinery by which a hospital, owned and supported by a subdivision of North Carolina or by a private nonprofit corporation, might apply for a grant in aid of a contemplated construction program. Such an application would be granted only, if, based upon the Commission's survey, it was found that there was a need for the contemplated facilities, and those of greater need were to be approved before those of lesser need. There is no suggestion whatever, however, that North Carolina undertook in any other way, as a function of the state, the provision of adequate hospital facilities throughout the state for the benefit of all of its people. The state does provide medical facilities of a specialized nature, as for the care of the insane, but the statutes do not empower the Medical Care Commission to provide general hospital facilities in a locality in default of cooperative efforts by local governmental bodies or citizens for the provision of such facilities. The role of the Commission is strictly limited, as is the role of the United States, to providing grants in aid of local effort, and the Commission is empowered to do nothing in the absence of such local effort. The assertion of the United States that North Carolina had undertaken a duty to provide local hospital services, where none were otherwise provided, is without any support whatever.

In this aspect of the case, the so-called "state plan" is no more than a survey of existing facilities to be utilized as a basis for judgment as to the relative need of such additional facilities as might be proposed by local governmental bodies or private nonprofit corporations or groups. In this scheme of things, these two hospitals played the same role in the same way before they applied for and received grants in aid of construction programs as they did afterwards. The facilities they operated before necessarily were taken into account and were highly relevant to any determination of the need of additional facilities in Greensboro. Afterwards, in exactly the same way, their expanded facilities entered into the survey and were highly relevant to a determination of any

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[28] Ibid. p. 60.

[29] General Statutes of North Carolina § 131–120.

[30] Under a separate statute, no hospital may be operated in North Carolina without a license from the Commission. § 131–126 et seq. No such license may be obtained or renewed unless the hospital meets certain maintenance and operational standards as prescribed by the Commission. The licensure statute, however, applies to every hospital in North Carolina, whether or not it ever received Hill-Burton funds. It is altogether comparable to statutes which require licenses for the practice of medicine and of law and which prescribe minimal standards of training and of competence. It is comparable to restaurant licensing statutes which prescribe minimal sanitary standards. All of such statutes are designed to protect the public from gross professional incompetence or slovenliness.

It bears repeating, however, that the licensing statute applies to all hospitals, those which have received no Hill-Burton funds as well as to those which have.

need for additional facilities in the area.[21] Whether the expansion and improvement of these hospitals were accomplished with or without grants in aid, they would have affected the "plan" in precisely the same way. If then, the operation of these hospitals was not state action before their receipt of the grants in aid, a determination that their operation is now state action depends wholly upon the fact that they received the grants in aid. The parties in the controversy are agreed that receipt of the grants, alone, does not permit a conclusion that subsequent operation of the hospitals is state action. Certainly no court has yet held that the private operation of any endeavor becomes state action merely because its construction or operation has been subsidized by Government. But that is all there is in this case.

Here it should be noted that as to North Carolina the first of the stated purposes of the Hill-Burton Act was largely accomplished in 1945, or soon thereafter, when North Carolina enacted a statute within the contemplation of the Act, created its Medical Care Commission, and that Commission made the survey and adopted regulations meeting Hill-Burton's requirements. Indeed, North Carolina had conducted its hospital survey before Hill-Burton's enactment in 1944. When the first of these grants in aid was approved in 1954, approximately nine years after the first of the stated purposes of Hill-Burton had been accomplished, it was clearly in furtherance of the second of its stated purposes, to assist in the construction of "public and other nonprofit hospitals." From this, one cannot reasonably infer that an "other" than public nonprofit hospital, the construction of which was thus assisted, became public because of the assistance.

The majority appears to make much of the fact that, as authorized by the statutes, the Surgeon General and the North Carolina Medical Care Commission require certain minimal construction standards as a condition of the approval of grants in aid, but it does not follow from such requirements that the United States or North Carolina has so reached into the operation of the hospitals as to make that function a governmental one. Inevitably, when Government subsidizes, it requires assurance that its subsidy will be used for the intended purpose. Applications for grants in aid for construction programs which are not needed are not to be approved, nor should they be approved if the proposed facilities will not serve the intended purpose. The minimal construction standards are provided only for the purpose of assuring that the facilities actually constructed with the help of a grant in aid will adequately serve the need which prompted the allowance of the grant. Anything short of that would be a profligate and irresponsible waste of public money; anything more than that cannot be spun out of this record.[22]

Finally, reference is made to the fact that there is a right to recapture a proportionate part of a grant in aid in the event that the constructed facilities are abandoned for hospital purposes or transferred to an unqualified operator within twenty years. That provision, however, creates no interest in the facilities. It is not comparable to a right of reverter retained by a public body. It simply creates a limited and declining personal right of action against the recipient of the grant in aid if it deserts the purpose it represented it had when it obtained the grant. Again, this is no more than a necessary provision for the protection of public moneys against unreasonable profligacy.

Any system of governmental subsidization necessarily carries with it the terms or conditions which must be met if the subsidy is to be obtained by a particular applicant. The tobacco farmer cannot obtain price supports if he does not comply

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[21] I find no warrant for the majority's statement that "the defendant hospitals operate as integral parts of comprehensive joint or intermeshing state and federal plans or programs designed to effect a proper allocation of available medical and hospital resources for the best possible promotion and maintenance of public health." The fact that these hospitals exist and operate must be taken into account in determining what, if any, additional hospital facilities are needed in the Greensboro area. Their "operation" is no part, much less integral, of someone else's plan to assist in providing additional hospital facilities in the areas of greatest need. Neither those of us who are well fed nor those of us who are underfed may be said reasonably to "operate as integral parts" of a governmental plan to make surplus foods available to indigents. A determination of those of us who are indigent is an essential part of the plan, but those whose heads are counted are neither integrally nor otherwise a part of the plan, though those on one side of the dividing line are its beneficiaries.

[22] Minimal operational and maintenance standards are prescribed as a condition of licensing, but the licensing statutes apply to all hospitals without regard to the receipt of Hill-Burton funds. See fn. 6, supra.

with the quota requirements. A farmer cannot obtain a soil bank payment if he devotes his land to an unallowable use. A private, nonprofit college cannot obtain from the Small Business Administration a grant in aid of research unless it agrees to devote the money to a research project calculated to be of assistance to small businesses and which merits the approval of the Small Business Administration. The imposition of such conditions upon the receipt of subsidies is not, in a legal sense, the exercise of such control or the assumption of such authority as to make the subsequent operations of the recipient state action in a constitutional sense. The tobacco farmer harvesting his inquota tobacco or another farmer planting trees on his soil bank land is performing no function of state or nation, though his work, as all legitimate, productive work, contributes to the economic health of the nation.

Here, it is apparent that a private operator of a nonprofit hospital must meet the conditions upon which grants in aid are made available if it wants to obtain the grant, but, having done so, its subsequent operation is not made thereby a governmental function. We may extract from the statutes such words as "plans," "surveys" and "programs," but magnification of the extracted words cannot convert the conditions of the grant in aid program into an authoritative regulatory program which the Congress specifically proscribed and which the State of North Carolina disavows. The truth is plain. This scheme for grants in aid to hospitals differs neither in kind nor degree from any other provision for grants in aid of private endeavor.

The question should be regarded as foreclosed in this Circuit by our decision in Eaton v. Board of Managers of The James Walker Memorial Hospital, 4 Cir., 261 F. 2d 521. There, it appeared the municipality conveyed the original site to the hospital, reserving to itself a right of reverter in the event the land ceased to be used for hospital purposes. Public officials selected the original board of trustees, but the original facilities were constructed with the private funds of Mr. Walker. That occurred shortly after the turn of the century. Much later, other land was acquired in fee and additional facilities were built. The complaint, as the records of this court disclose, alleged that the hospital "received large grants of money from the Federal Government" for its expansion project, an allegation which was admitted by the motion upon which the case was decided. In addition, it appeared that the city and county made annual payments to current operating revenues under contracts providing for the care of indigent patients. During the six years, 1952 through 1957, these annual contributions to operating revenues amounted to more than $277,000. These contributions to operating funds, as the majority points out, amounted, on the average, to approximately four per cent of the operating budget, but they were far from inconsequential, and the fact is that the hospital had also received construction subsidies of federal origin, just as had the hospitals here.

It is true that, in holding that the Walker Memorial Hospital "was not an instrumentality of the State but a corporation managed and operated by an independent board free from State control," our attention was concentrated upon the annual contributions to operating funds rather than upon the contributions to capital funds, but the case is quite indistinguishable in its facts. Indeed, the cases here are stronger for the defense, for these hospitals are not shown to have been the recipients of any contributions toward operating revenues, and the land of neither is subject to any right of reverter in favor of any governmental body.

I find no reason for thinking that our decision in Eaton was overruled or weakened, as applied to the facts here, by the decision of the United States Supreme Court in Burton v. Wilmington Parking Authority, 365 U.S. 715, 81 S.Ct. 856, 6 L.Ed.2d 45. There, Wilmington Parking Authority, an agency of the State of Delaware, constructed a parking facility, of which a restaurant was an integral part. It leased the restaurant area to a restaurant operator. Under the lease, the Authority supplied to the restaurant heat and fuel, and the Authority maintained exterior surfaces and had the right to place directional signs upon them. Fixtures placed in the leased area by the lessee became the property of the Authority and were not subject to taxation. The entire building, however, and this is the point of Burton, was a public building owned by a public authority and serving a public purpose. It was conceived and constructed as an entity, the restaurant being a necessary or an appropriate adjunct to the other services offered in the building. That the Authority chose to operate the restaurant through a lessee did not destroy the public character of the restaurant which it inevitably acquired from the building. Concessionaires and lessees in governmental buildings such as capitols and courthouses take on the character of the

buildings and of the primary functions they serve. They necessarily are understood to be serving a public purpose and discharging a public function.

Here, in contrast, these hospitals are not publicly owned. They serve no public purposes, except that their operation contributes to public health, just as it did before their receipt of Hill-Burton funds. The state has an interest in public health, but identity of interest does not convert a private organization into a public body. That a private organization's operations are compatible with governmental purposes is a cause of satisfaction, but, when a private organization operates on its own premises, in its own way, free of governmental supervision and control, its operations cannot be said to be state action.[33]

The suggestion of the majority that the Court of Appeals for the Fifth Circuit in Hampton v. City of Jacksonville, 5 Cir. 304 F.2d 320, questioned our decision in Eaton in the light of the Supreme Court's decision in Burton v. Wilmington Parking Authority is wholly unwarranted in this context. Chief Judge Tuttle, in his opinion, thought that, in the circumstances of the transfer of the golf course by the City, reservation of the right of reverter was comparable to a lease arrangement such as that involved in Burton v. Wilmington Parking Authority. Thinking so, he suggested that Eaton might have been otherwise decided had it come before us after Burton, but only because of the presence in Eaton of the right of reverter in favor of the municipality. There is present here no right of reverter in favor of any governmental authority, and the question posed by Chief Judge Tuttle in Hampton is wholly inapposite here. There is nothing in his opinion even obliquely critical of Eaton in the context with which we are now concerned.

Interestingly, Judge Jones concurred in Hampton upon a very limited ground having no bearing upon the authority of Eaton in any context, while Judge Gewin dissented. Judge Gewin found Eaton persuasive after Burton v. Wilmington Parking Authority even in the specific context of the reserved right of reverter in favor of the municipality.

The specific question with which we deal, the effect of the receipt of Hill-Burton funds upon the operation of an otherwise private, nonprofit hospital, has been considered by other courts. They have been unanimous in their conclusion that the operation of such hospitals is not state action so as to make applicable to them the provisions of the Fourteenth Amendment. The Supreme Court of Appeals of Virginia considered the question in Khoury v. Community Memorial Hospital, Incorporated, 203 Va. 236, 123 S.E. 2d 533. Judge Michie, of the Western District of Virginia, dealt with it in Wood v. Hogan, 215 F.Supp. 53. Finally, Eaton, who brought the earlier case against the Board of Managers of Walker Memorial Hospital before us, filed a new action against the Board of Managers of that hospital, seeking a readjudication based upon an attempt to more particularize the facts and upon a contention that the decision of the Supreme Court in Burton v. Wilmington Parking Authority changed the legal climate. Judge Butler held against the plaintiff and dismissed the complaint. Eaton v. Grubbs, E.D.N.C., 216 F.Supp. 465.[34]

Recent measures in the Congress may bear upon governmental understanding of what was undertaken by the Hill-Burton Act and the state statutes enacted in order to qualify hospitals within the states for the grants in aid. On August 7, 1963, the Senate rejected a proposal that henceforth grants in aid to hospitals under the Hill-Burton Act be restricted to hospitals which are desegregated and which practice no discrimination on account of race.[35] Other broader proposals for the elimination of racial discrimination in broad categories of institutions and businesses, to be applied prospectively, are now pending before the Congress. These proposals lend some emphasis to what is so clearly apparent from the original Hill-Burton Act that the Congress had no idea that grants in aid authorized through cooperative state agencies would convert the subsequent operation of recipient private hospitals into state action so as to bring them un-

[33] Of course, when public facilities are nominally transferred to private interests in order to escape constitutional commands and with the intention that the facilities will continue to be devoted to public use as in the past, they are not private. Hall v. St. Helena Parish School Board, E. D. La., (Three Judge Court) 197 F. Supp. 649; Hampton v. City of Jacksonville, 5 Cir., 304 F. 2d 320; and see Griffin v. Board of Supervisors of Prince Edward County, 4 Cir., 322 F. 2d 332; cf. City of Greensboro v. Simkins, 4 Cir., 246 F. 2d 425.

[34] See also such cases as Norris v. Mayor and City Council of Baltimore, D. Md., 78 F. Supp. 451, and Mitchell v. Boys Club of Metropolitan Police, D.C., D.D.C., 157 F. Supp. 101.

[35] Vol. 10 Southern School News No. 3, p. 5.

der the Fourteenth Amendment. The Congress may properly reconsider this matter, and, undoubtedly, it has the power, if it chooses to exercise it, to condition future grants of Hill-Burton funds to the execution of nondiscrimination agreements. Under these circumstances, it seems to me particularly inappropriate for us to now hold that the Congress, unbeknownst to itself, in 1944 had done what it now has under consideration for prospective operation only.

For the foregoing reasons, I would affirm the judgment.

Mr. HEMPHILL. Mr. Curtin.

Mr. CURTIN. Thank you, Mr. Chairman.

Dr. Wright, in your statement you speak of the fact that there are 338,170 unacceptable beds in the hospitals. What is your definition of an unacceptable bed?

Dr. WRIGHT. We accept the definition used by a State agency under the Hill-Burton law. A State agency within certain prescribed criteria, decides what is and what is not an acceptable bed; we are simply quoting figures supplied by the various State agencies.

Mr. CURTIN. But what is the accepted standard which decides whether a bed is an acceptable bed or a nonacceptable bed?

Dr. WRIGHT. Standards are different in certain areas, but in general, they have to do with fire hazards, with the square footage allowed to each bed, with general sanitation and things of that nature—that is the physical part of the hospital.

Mr. CURTIN. Doctor, could you tell me how many hospital beds there are in the United States? Would you have that information?

Dr. WRIGHT. I believe, 1,786,461.

Mr. CURTIN. Excuse me, how many was that?

Dr. WRIGHT. 1,786,461.

Mr. CURTIN. Does this number of beds—1,786,461—include these unacceptable beds that you have mentioned, or is that total over and above the unacceptable beds?

Dr. WRIGHT. They are included in that figure.

Mr. CURTIN. Secretary Celebrezze said that there are 133,000 additional new beds needed in order to continue the services. Is that in conformity with your understanding?

Dr. WRIGHT. This is based on what the State authorities call unmet needs, and we would have to accept, under present criteria, the statement of the State authorities that there still are these unmet needs. However, there are a great many factors in estimating unmet needs which are not taken into account under the original Hill-Burton formula.

You must know that the use of hospitals, the trend from the rural to the urban areas, back to the suburbs, and now I understand back again to the urban areas, has made the question of distribution of hospital beds extremely complex. Any statement that there are so many thousands needed beds requires a good deal of qualification. However, I would agree that that is a statement of fact according to the criteria now being used.

Mr. CURTIN. Doctor, apparently the Secretary did not differentiate between types of beds in the number of beds that he mentioned, because he says there are only 133,000 new beds needed, which are, of course, far less than the 338,170 unacceptable beds that you have mentioned in your statements.

So, under those figures, do you say that what are really needed now are 133,000 beds, plus the 338,170 beds which you say are unacceptable?

Dr. WRIGHT. Our position would simply be that, first of all, you should work to make these unacceptable beds acceptable by modernization and renovation programs.

Mr. CURTIN. That is all, thank you, Mr. Chairman.

Mr. HEMPHILL. Mr. Healey?

Hr. HEALEY. No questions.

Mr. HEMPHILL. Mr. Brotzman?

Mr. BROTZMAN. Thank you, Mr. Chairman.

What makes a bed unacceptable according to your testimony or what standards were employed by the various State Hill-Burton agencies in determining that these beds were, in fact, unacceptable?

Dr. WRIGHT. First of all, the State Hill-Burton agency surveys the hospital as a whole: Is it fireproof? Does it have adequate corridor space? Does it have adequate kitchen facilities? Does it have a proper operating room? Does it have an X-ray machine? Does it have all the things a hospital should have?

Next, they survey it specifically as to the number of square feet allowed for each bed. Is there enough lighting in each room? All of these are physical factors, and little or no attention is paid to the use of the bed. It is merely the presence of that bed and the conditions under which that bed is present. These are the criteria that are used.

Mr. BROTZMAN. My next question is more specifically to the point. You have mentioned certain criteria or standards. Are these set in each of the various States making the determination or is there a national standard that would indicate that the bed was acceptable or unacceptable?

Dr. WRIGHT. I think this is mainly a national standard. However, there is some latitude and difference of opinion in certain States. I would not be competent to answer that adequately, but I am sure the Surgeon General could answer that, sir.

Mr. BROTZMAN. If there is a national standard, would that be set by the Surgeon General?

Dr. WRIGHT. Oh, yes.

Mr. BROTZMAN. So if we wanted to ascertain what it was, we would have to get that information from him?

Dr. WRIGHT. That is correct.

Mr. BROTZMAN. But you think there is some flexibility at the State level on the determination?

Dr. WRIGHT. Yes.

Mr. BROTZMAN. I have been interested in one particular factor and I think it is a question that we in Congress have to determine as a matter of policy, relative to the amount of money that is available for the health needs of this country, the big question is, In this area should we be spending it for new construction? Should we be spending it for modernization? Or is there a correct ratio between these two things that would best assist the health needs of the country?

Now, it seems to me that most of the witnesses that have appeared here have been emphasizing very heavily this modernization factor. This is a final conclusion that you have arrived at, I assume, after very careful consideration.

Dr. WRIGHT. Yes, we would agree with that completely, sir. The great need at the present time is for modernization of existing facili-

ties. There is always some need for new construction, and our position does not preclude new construction.

Mr. BROTZMAN. Just looking at these figures here very quickly, as brought out by my colleague from Pennsylvania, it does not seem like we are gaining on the problem very much. It seems like the beds are becoming unacceptable about as fast as we are building beds. Would that be a fair surmise from this testimony?

Dr. WRIGHT. That is correct. I think if I built a hospital and got it all in operation, 3 days later some of it would be unacceptable. Things move that quickly. It is discouraging, isn't it?

Mr. BROTZMAN. Well, I see a lot of things that are discouraging up here, Doctor, but I wonder, is the allocation of moneys correct between the Federal and the local effort in this area?

Dr. WRIGHT. Do you mean the Federal formula under which this money is given to the States?

Mr. BROTZMAN. Yes. I am wondering if the local effort could be more toward, shall we say, maintaining the local structure and modernizing, with perhaps the Federal going more for the new construction.

Dr. WRIGHT. I will have to answer that a little obliquely. We are all in favor of the maximum local effort and the minimum Federal. I am sure we are all in favor of the maximum being provided locally. As to how you divide that up, I am not prepared to say.

Do you want to comment on that, Dr. Coleman?

Dr. COLEMAN. Yes, I would like to comment very briefly, if I may, Congressman.

The need for modernization versus new construction varies a great deal from one geographic location to another. For example, in those areas in this country where there are rapid population increases, the maximum need might well be for new construction. In those parts where the population is relatively stable, or where the area has been populated for a long time, the greatest need might be for modernization.

Our position is that the program should be flexible enough to take care of the need that exists in each particular area. It is our belief that if the State agency administering the program has enough flexibility and identifies the needs in that State or in the various parts of the State, then it can come up with a better solution than could be obtained if a policy were adopted that would be applicable to the entire country.

I would like to make one additional comment about the modernization issue and cite the example of obstetrical beds in hospitals that have been built under the Hill-Burton program. There are certain areas in this country that have hospitals constructed under the Hill-Burton program back in the late forties, we will say, when the birth rate in the area was such that they needed a certain number of obstetrical beds.

There have been some population shifts in this country since the late 1940's, which in many areas, at least, resulted in the younger people in the area moving to other parts of the State or other parts of the country. This, plus a decrease in the birth rate which has manifested itself in the last 2 or 3 years, makes the need for obstetrical beds in this particular area not nearly so great as it was a few years ago.

Yet the method of construction of hospitals is to isolate the obstetrical beds in order to protect the mother and the newborn baby from the rest of the patients in the hospital for the purpose of preventing infection and so forth. So in many instances you have an obstetrical unit of 8, 10, 12, or even 15 beds in a smaller hospital, where the daily census shows only 1 or 2 obstetrical patients.

Now, there is a need, in order to provide for effective use of those beds, to convert or modernize them, so that they can be used for other types of patients. This is one of the things that Dr. Wright was getting at.

Mr. BROTZMAN. Thank you very much for your statement. This is my last question.

It is your position that maximum flexibility should be maintained at the State level in order to make a determination between modernization versus construction? This is where you believe that determination could best be made, is that right?

Dr. COLEMAN. Yes, sir; that is right. Dr. Wright?

Dr. WRIGHT. Yes, sir.

Mr. HEMPHILL. The bells are ringing and that means that we are going to have to go over and answer to our names.

Many of the members of the committee have indicated to me that they would like to ask you questions. Unfortunately, I am neither chairman of the committee nor chairman of the Subcommittee on Health and Safety, and I have no authority except the gavel for the purpose of conducting this particular hearing.

I am wondering if the committee were to schedule hearings again in the morning, are you going to be in town?

Dr. WRIGHT. No, sir; we are not.

Mr. HEMPHILL. Off the record.

(Discussion off the record.)

Mr. HEMPHILL. I want to thank you again for coming and we are sorry the session was cut short because of reasons beyond our control.

(The following letters were later received for the record:)

AMERICAN MEDICAL ASSOCIATION,
Washington, D.C., March 17, 1964.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. HARRIS: After I talked with you about the American Medical Association's position on amendment and extension of the Hill-Burton Act, it occurred to me that I should make more clear the organization's views on which agency should administer mortgage insurance.

Following are the main reasons why our association opposes the transfer from the Federal Housing Administration to the Public Health Service of authority to insure mortgages for construction of proprietary nursing homes.

The first reason is the obvious experience of the Federal Housing Administration, which has been operating this program since 1959. In the first 5 years of its operation, some 7,000 nursing home beds have been constructed. Eleven thousand additional beds are currently under construction and it has been estimated that the FHA program will produce, in the next 5 years, 100,000 new beds.

The second reason is that the FHA law provides what we believe to be adequate and competent State supervision of the program. The State Hill-Burton agency is required to certify to the Federal Housing Administrator that there is a need for the nursing home for which a mortgage insurance application has been filed and that there are in force in the State minimum standards for licensure and methods of operation for such facilities. We believe that H.R. 10041 brings the Federal Government unnecessarily further into the picture by requiring

that the Surgeon General have the final say as to whether the insurance would be granted.

Third, we do not believe that this program needs to be administered by a health-oriented organization. It is essentially a financial and administrative problem. As noted above, the State Hill-Burton agency can provide the necessary guidance from a health standpoint.

It is for these reasons that we also believe that mortgage insurance for nonprofit hospitals and other nonprofit facilities included under H.R. 10041 should be provided solely by the Federal Housing Administration.

We believe that the FHA is also the proper agency to use for providing additional financing of both construction and modernization of hospitals and other medical facilities—by additional, I mean where such facilities need more construction dollars than the grant program affords or where financing without mortgage guarantees is neither available nor sufficient.

In any event, we certainly agree with you that any effort to move the responsibility for hospital and health facility construction away from Government subsidy and toward the repaid loan concept is desirable.

Sincerely yours,

CECIL B. DICKSON.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., March 26, 1964.

HON. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. HARRIS: At the time the witnesses for the American Medical Association appeared before the Interstate and Foreign Commerce Committee to present the association's comments on H.R. 10041, Mr. Dingell questioned the intent of the association's suggestion that section 643 of H.R. 10041 be amended to include the following clause: "Nor shall the acceptance of funds by a private facility under this title be construed as making that facility a public institution."

Congressman Dingell asked if the suggested amendment is "an attempt to legislatively override the *Moses Cone* decision" (p. 326 of Report of Proceedings, Mar. 12, 1964). Dr. Coleman, the AMA witness, said that it was the association's opinion that the suggested amendment would not have the effect of overriding the decision in *Simkins* v. *Moses H. Cone Memorial Hospital* (323 F. 2d 959).

At the outset the position of the AMA may be summarized as follows:

(1) It is abundantly clear that the Hill-Burton law was not intended to convert private hospitals into Federal or State instrumentalities.

(2) Unless an affirmation of intent is made by Congress following the *Cone* decision, the narrow holding of the court's decision might be extended by further judicial action with the result that private hospitals may be judicially determined to be State or Federal instrumentalities because of their acceptance of Hill-Burton funds.

(3) The American Medical Association does not seek to reverse or overrule the *Cone* decision as to the specific holding that the "separate but equal" provision of the Hill-Burton law is unconstitutional.

(4) The American Medical Association is deeply concerned about the possibility that this doctrine might be further extended to affect matters other than those involved in the *Cone* case, and accordingly urges a reaffirmation of congressional intent that the participation of a private hospital in the Hill-Burton program does not in any way change the private character of the hospital in any respect other than outlawing discriminaion based on race, creed, or color.

SIMKINS V. CONE

The facts of the *Simkins* v. *Cone* case are well known to this committee. Briefly stated, they are: A group of physicians, dentists and patients, all Negro, instituted an action in the U.S. District Court for the Middle District of North Carolina, seeking to enjoin the Cone and Long Hospitals from continuing to deny the admission of physicians and dentists to hospital staff privileges, and the admission of patients to hospital facilities, on the basis of race. The petitioners also sought a declaratory judgment finding unconstitutional the section of the Hospital Survey and Construction Act (Hill-Burton Act) which would require that

the facility be available to all persons without discrimination on account of race, creed, or color, with an exception, however, if separate but equal facilities are provided for separate population groups. A similar judgment was sought in regard to a regulation promulgated pursuant to that section of the Hill-Burton Act.

From a judgment of the district court dismissing the complaint, the petitioners appealed to the U.S. Court of Appeals for the Fourth Circuit. The appeals court, on November 1, 1963, in a 3-to-2 decision reversed the decision of the district court. The Supreme Court subsequently denied the petition of the hospitals for a writ of certiorari.

AMA'S SUPPORT OF HILL-BURTON

The American Medical Association has reviewed, with understandable interest, the decision of the circuit court of appeals. From the inception of the Hill-Burton program the AMA has participated in discussions, hearings, and programs concerning it. Dr. Willard Wright, in our testimony of March 12, recounted some of the occasions on which the association has gone on record as approving the principle of hospital construction by the use of grants-in-aid. He spoke of the support of President Roosevelt's plan voted by our House of Delegates in 1940, and of the AMA Board of Trustees' endorsement of the original Hill-Burton bill in 1945. The support of the program has further been evidenced by the studies and other activities conducted by the AMA Council on Medical Education and Hospitals.

Undoubtedly, the AMA position of support for the Hill-Burton program was arrived at after due consideration of a number of factors, including our understanding that the acceptance of Federal funds would not, in itself, establish the recipient as a public instrumentality. The understanding resulted from all the oral and written testimony presented at the hearings. That this conclusion was justified may be seen from a review of the legislative history of the adoption of the Hill-Burton bill in the 79th Congress.

LEGISLATIVE HISTORY OF HILL-BURTON

For example, in hearings before the Senate Committee on Education and Labor on S. 191, 79th Congress, the Surgeon General said: "From the above concept, it should be clear that I am not recommending a system of federally operated hospitals. On the contrary, what I am suggesting and what Senate bill 191 would provide is that the Federal Government help the States to fill out the missing pieces in the present hospital pattern and that the hospitals continue to be under local government and voluntary management as they are now."

At another time, Senator Taft, on the subject of private hospitals remaining private, asked: "And then the Surgeon General may grant that Federal grant directly, we will say, for the enlargement of the private hospital, and when that money is gone that is owned by the private hospital, is it not?"

The answer was, "Yes, sir."

COURT'S DECISION RESTRICTED TO "SEPARATE BUT EQUAL"

That the Court does not intend its decision to go beyond the question before it is stated in its discussion of the "legal issue":

"Not every subvention by the Federal or State Government automatically involves the beneficiary in 'State action,' and it is not necessary or appropriate in this case to undertake a precise delineation of the legal rule as it may operate in circumstances not now before the Court."

The Court affirms that its decision is limited to a finding that the separate-but-equal provision of Hill-Burton is unconstitutional, when it says: "Accordingly, we declare invalid *only* that portion of 42 U.S.C.A. sec. 291e(f) which reads '* * * but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group * * *'" [Emphasis added.]

The American Medical Association was not a party to the *Simkins* v. *Cone* case. Because the matter relates to health care facilities, and because of AMA's historical participation in the Hill-Burton programs, our interest, as we have said before, is understandable. But contrary to Mr. Dingell's allegation, our interest is not to attempt to "override" the Court's decision. Such an allegation is without merit.

COURT DOES NOT INTEND TO CONVERT PRIVATE HOSPITAL

The Court confined its decision to the quoted portion of the Hill-Burton Act. As we read the opinion, the Court does not intend that the acceptance of Federal funds shall make the facility a Government instrumentality for any purposes other than the antidiscrimination provision and the separate-but-equal doctrine. If it would be otherwise, then the Court should have struck section 291m (42 U.S.C.A.), which provides that nothing in the act 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 subchapter."

SUGGESTED AMENDMENT IN ACCORD WITH INTENT OF CONGRESS

It is our belief that it was the intent of the 79th Congress, and it remains the intent of this Congress, that the Hill-Burton Act, in iself, shall not transform a privae facility into a publicly operated, maintained, and controlled institution. The Court's decision relates to discrimination with respect to race, creed, or color. We believe that an expression in H.R. 10041, in the nature of our suggested amendment to section 643, would be in accord with the intent of the appeals court—restricting the judgment to the discrimination question and discouraging unwarranted interpretations to the effect that the private Hill-Burton hospital, for other purposes and effect, has now become a Government operated, maintained, and controlled institution.

NOT A GOVERNMENT INSTRUMENTALITY IN "STRICT SENSE"

The Court, in reaching its conclusion, stated the initial question to be whether the activities of these otherwise private bodies are also the activities of these governments and performed under their aegis without the private body necessarily becoming either their instrumentality or their agent in the strict sense. The use of the phrase "strict sense" shows the Court's intent to be that the facility has not become an instrumentality of the State or Federal Government for other purposes. It seems clear that the Court intended to permit the private hospital to remain a private facility except for the Court's decision relating to discrimination based on race, creed, or color. Our suggested amendment to section 643 of H.R. 10041 appears to us to be in full accord with the Court's decision, and does not, as Mr. Dingell alleges, attempt to override any Federal court decision.

In view of the question propounded by Congressman Dingell, we are very grateful for this opportunity to clarify the proposed amendment. I would appreciate it if these additional remarks could be inserted in the record at page 327 in the report of proceedings, or at the place following Mr. Dingell's supplementary remarks to be inserted in support of his interpretation of the purpose of our suggested amendment.

Sincerely,

F. J. L. BLASINGAME, M.D.

Mr. HEMPHILL. We had another witness scheduled, Mr. Andrew J. Biemiller, director, department of legislation, AFL-CIO, who is represented by Mr. Clinton Fair and Miss Lizbeth Bamberger, assistant director of the social security department.

I would be glad to have you submit your statement at this time, but would you submit it tenatively pending the call of the Chair for you to come back for implementation of that statement?

Mr. FAIR. Mr. Chairman, we appreciate that very much. I think that is a good suggestion and we appreciate it.

(Mr. Biemiller's statement follows:)

STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR & CONGRESS OF INDUSTRIAL ORGANIZATIONS, ON H.R. 10041, A BILL TO REVISE AND EXTEND THE HILL-BURTON HOSPITAL CONSTRUCTION ACT

Mr. Chairman, my name is Andrew J. Biemiller. I am director of the department of legislation of the AFL–CIO and I am appearing here today on behalf of that organization. I am accompanied by Miss Lisbeth Bamberger, assistant director of the social security department.

The longstanding and vigorous support of the AFL–CIO for the Federal hospital and medical facilities construction program is well known to this committee. Both the AFL and the CIO urged the enactment of the Hill-Burton program in 1946. Our two organizations, and since merger, the AFL–CIO, have appeared before this committe on numerous occasions to urge the broadening and further extension of the program when such revisions seemed to be necessary. We regularly appear before the Appropriations Committee to support the adequate financing of the program. Persons closely connected with the labor movement have served as members of the Federal Hospital Council, to advise on the administration of the program.

As representatives of the consumers of hospital services we recognize the enormous contribution of the Hill-Burton program to the improved health of all Americans. There are many ways that we in this country have fallen behind other Western nations in our provisions for the organization and financing of medical care. In hospital and medical facilities construction we are unquestionably ahead of most other nations. This fact is due almost entirely to the existence and successful operation of the Hill-Burton program.

Today we come before you to support what is probably the most basic revision of the Hill-Burton Act that has yet been proposed. We believe that changes in the act, along the lines proposed by the administration and contained in the Harris bill, H.R. 10041, will be of great value and significance in improving the health services available to the American people. Enactment of these changes will keep the Hill-Burton program responsive to new needs and new opportunities.

MODERNIZATION

This committee is as aware as we are that the greatest impact of the Hill-Burton program so far has been in rural areas and small communities. These, of course, are the areas that had the greatest deficiencies in hospitals and other facilities at the time that the Federal Government began to make Hill-Burton funds available. As a result of the great success of the Hill-Burton program this picture has radically changed. The great deficiencies in medical care facilities today are no longer almost exclusively in sparsely populated areas. They tend to be concentrated in the cores of our big cities. And the deficiencies we find today are not limited to an absence of hospitals and a lack of hospital beds. Today's deficiencies are more likely to be the result of inadequate, obsolete, inefficient, and sometimes hazardous physical plants. This means that the criteria by which money was allocated under initial Hill-Burton legislation can no longer be relied on, operating by itself, to insure that the Federal funds will go where they are most needed. New criteria must be established, not to substitute for, but to supplement the existing methods of allocation.

We, therefore, endorse wholeheartedly the earmarking of funds to be used for the renovation, replacement, and modernization of existing facilities. These funds would be allocated in a different way from the funds that will continue to be used for the construction of new facilities. Although we are inclined to believe that essential modernization and renovation can best be accomplished through the enactment of the formula proposed by the Department of Health, Education, and Welfare, we would support any formula that will provide adequate funds for this purpose.

PLANNING GRANTS

In early 1963 the Executive Council of the AFL–CIO developed a broad policy statement on community hospitals. Included in this statement was a section endorsing the principle of regional planning. The council stated that—

"No hospital should be built, enlarged, or relocated except in accord with a systematic plan of estimated present and future needs for hospitals and allied agencies; a plan prepared by a representative nonprofit agency, enlisting the services of impartial experts should be understood to include not only physical facilities, but also services. Every proposal for expansion, brought forward by individual hospitals or others should be evaluated according to the needs defined in the plan—needs not only for beds for acutely ill patients, but also for facilities for long-term patients, for nursing homes, for home care, for ambulatory facilities, for rehabilitative facilities, for facilities for research and education of professional and technical personnel.

"Our communities, their surrounding areas and their needs have become so large and complex, and the cost of medical facilities have become so high, that we cannot afford the inefficiencies and the costs of unbridled individual autonomy. Persons and institutions have an obligation to discipline their autonomy in terms of their obligations to their community."

The provision in section 318 of H.R. 10041 providing special project grants for assisting in the areawide planning of health and related facilities will make possible the kind of rational planning that is required, and we strongly support its enactment.

LONG-TERM CARE FACILITIES

The increase in the authorization for the construction of public or other nonprofit facilities for long-term care contained in H.R. 10041 is crucial. There is hardly a family in the country that has not had the experience of trying to find a decent nursing home or chronic disease facility for an aged relative or friend, and been shocked and dismayed at the miserable inadequacy of the vast majority of facilities currently available. The proposed increase in the authorization for financing long-term care facilities would do much to remedy the shameful inadequacies of the facilities available for the care of the chronically ill today.

OUTPATIENT DIAGNOSIS FACILITIES

We fully support the provision in H.R. 10041 that would delete the requirement now in the Hill-Burton Act that a private nonprofit diagnostic or treatment center must be sponsored by a corporation or association which owns and operates a nonprofit hospital in order to be eligible for assistance. The proposed change is entirely consistent with the need to provide organized high quality care on an outpatient as well as an inpatient basis.

MORTGAGE GUARANTEES

We support the principle of adding a program of mortgage guarantees to the Hill-Burton Act. We would suggest, however, that the committee consider raising the ceiling on the amount that may be secured by the guaranteed mortgage from 50 to 90 percent of the value of the facility. This change would eliminate the anomaly of more favorable treatment, so far as mortgage guarantees are concerned, provided to proprietary facilities compared to nonprofit facilities.

ELIMINATION OF RACIAL DISCRIMINATION

The Fourth Constitutional Convention of the AFL–CIO called upon the Congress to make certain that Hill-Burton aided facilities "are available to all the citizens of the land without regard to race, color, or creed." As recently as February 18, the AFL–CIO executive council stated that "the administration, in its efforts to improve health and eliminate poverty, must assume a leadership role in eliminating racial discrimination in the provision of health services."

Now the courts have spoken on this issue. We agree with you, Mr. Chairman, that in the light of *Simkins* v. *Moses H. Cone Memorial Hospital* (323 F. (2d) 959, 4th Cir. 1963; certiorari denied, 32 U.S. Law Week, 3304, Feb. 25, 1964) the law on this matter is now quite clear. We have examined the statement of the Secretary of Health, Education, and Welfare outlining his plans for the administration of the Hill-Burton program in order to make it consistent with the court decision. We believe that the Secretary is fully meeting his responsibilities in this regard. We were extremely gratified to note that he is also providing his personal leadership and that of his Department in order to bring about a smooth transition and adjustment to the requirements of the law, that facilities aided under the Hill-Burton program not discriminate in providing patient care or staff privileges.

We believe that whatever language will facilitate the successful and efficient administration of these provisions should be written into the bill. We trust that this committee and the Department of Health, Education, and Welfare will find some mutually acceptable language to accomplish this purpose.

In conclusion, Mr. Chairman, we congratulate you and this committee on the leadership you have exercised in the past to bring to the people of this country the splendid hospital and medical facilities we now have, and trust that you will continue this tradition into the future. We urge that this committee and the House act promptly and favorably on H.R. 10041 in order that the Federal Government will remain in the position of providing the assistance to the States and local communities that is required if we are to reach our goal of making the best of modern medical care available to all Americans.

Mr. HEMPHILL. The record will remain open for 10 days and the committee is recessed subject to the call of the Chair.

(Whereupon, at 11:10, the committee adjourned subject to call of the Chair.)

EXTENSION AND REVISION OF HILL-BURTON HOSPITAL CONSTRUCTION PROGRAM

TUESDAY, MARCH 24, 1964

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

The committee met at 10 a.m., pursuant to recess, in room 1334, Longworth Building, Hon. Oren Harris (chairman of the committee) presiding.

Mr. ROBERTS (presiding). The committee will please be in order.

This is a continuation of the hearings on H.R. 10041, introduced by the distinguished chairman of the committee, Mr. Harris, for revision and extension of the Hill-Burton Hospital Construction Act.

We are very happy to have Dr. Terry and his associates with us today. I am glad to see you, Dr. Terry. After having observed the fine work you did on behalf of our country at Geneva, I thought you did an outstanding job. I was privileged to represent our committee as an adviser and to sit in with you on some very important meetings.

I want to personally commend you, and I think that goes for the gentleman from Minnesota, Mr. Nelsen, who was also an adviser. We are glad to see you again and you may proceed with your statement.

STATEMENT OF DR. LUTHER TERRY, SURGEON GENERAL, PUBLIC HEALTH SERVICE; ACCOMPANIED BY DR. HARALD GRANING, CHIEF, DIVISION OF HOSPITAL AND MEDICAL FACILITIES, PUBLIC HEALTH SERVICE; AND WILLIAM B. BURLEIGH, SPECIAL ASSISTANT TO CHIEF, DIVISION OF HOSPITAL AND MEDICAL FACILITIES, PUBLIC HEALTH SERVICE

Dr. TERRY. Thank you, Mr. Roberts. If I may, before I begin talking about the legislation, I would like to say as the Chief of our U.S. delegation to the U.S. World Health Assembly, I speak for the entire delegation in saying how fortunate we feel we were in having you and Mr. Nelsen from this committee as our congressional advisers.

I think you were tremendously helpful and supportive to us in arriving at many of the decisions that have to be made after one reaches the scene, so to speak, of such an international assembly. I believe it is the first time that we have had members of this committee as congressional advisers, at least for a long period of time, and I personally thought that it was most appropriate that we have representa-

tives from this committee to serve in this capacity. All of us are very appreciative for all that you and Mr. Nelsen did.

Mr. ROBERTS. Thank you, Doctor.

Dr. TERRY. Mr. Roberts, I have with me, Dr. Harald Graning, who is chief of our hospital facilities construction program, and then Mr. William Burleigh, who is special assistant in that program area.

Inasmuch as Mr. Celebrezze has presented to the committee a summarization of our position on these bills, and particularly what we might call the Harris bill, which is before you, I have not made any other formal preparation. I am merely here this morning, Mr. Roberts, to support that position and am anxious to help in clarifying any questions that the members of the committee might have to ask.

Mr. ROBERTS. Frankly, Dr. Terry, I have not thoroughly gone through the bill. I have not had an opportunity to go through the bill. I know generally about the subject. I am particularly interested in bringing up one phase that has been considered by a good many Members of Congress, and that is section 605 on page 19, which has to do with approval of projects for construction or modernization.

I think if you or your associates would cover that section and tell us generally how it would work and explain the need for it and how much money would be available for this section, it would be helpful. I would like to know if you have not already some authority for approval of projects for modernization.

So, with that as a form of reference, I would like to have your testimony on that part.

Dr. TERRY. Yes, sir. If I may begin at the last regarding existing authorization, we do have some authorization and it has been used to a limited extent in terms of remodeling, renovating, and modernizing existing medical care facilities. One of our basic problems has been that the program has been so heavily directed toward the creation of new beds, which have been badly needed, admittedly, that over a period of time a relatively small proportion of the funds has gone into modernization.

As a result, we are finding that in many of our areas—this is particularly true in the metropolitan areas and the urban complexes, but also true in some of the lesser metropolitan areas, too—there is a gradual increase in the number of beds involved in these institutions but that such hospitals really need modernization in order to keep up the satisfactory use of these facilities.

It is for this reason that we felt that special attention should be paid in the legislation to the need for modernization; by pointing it out as a high-priority need and in setting aside a special category of funds for this purpose.

With regard to the provisions in H.R. 10041, the Harris bill, for 1965, there are no funds allocated for this purpose in this bill. The following year, 1966, there is $20 million, increasing to $35, $50, and finally $55 million in 1969.

Mr. BENNETT. Doctor, may I interrupt to ask you why you haven't asked for any funds for this program for this year?

Dr. TERRY. As a matter of fact, the administration proposal did propose funds for 1965.

Mr. BENNETT. The bill we are considering does not provide any funds for this year?

Dr. TERRY. That is right, sir; 10041 does not provide funds for 1965.

Mr. BENNETT. That is our chairman's bill?

Dr. TERRY. Mr. Harris' bill; yes, sir.

The CHAIRMAN. Would the gentleman yield?

Mr. BENNETT. Yes; I just wanted to get that cleared up.

The CHAIRMAN. As was thoroughly brought out during the course of the hearings when Secretary Celebrezze was here. When the administration sent up their bill first, it provided $150 million authorization for the total program. This amount was included in the budget.

Under the original proposal, $100 million was to go into the current Hill-Burton program, and $50 million was to be diverted to the new program for the modernization of facilities. Senator Hill objected strenuously to reducing the amount for the current Hill-Burton program. As it was developed during the course of the hearings with Secretary Celebrezze, I had what I thought was an understanding with Dr. Terry's organization that for the year 1965 we would carry the same program forward under the Hill-Burton program, and the total amount would be used for that purpose.

The following year, 1966, the total amount in the Hill-Burton program would be reduced and an amount set aside for the modernization. For 1967, more reduction in Hill-Burton and more for modernization, and 1968 and 1969 the same. For that reason, when the bill was introduced, it did not carry with it the transfer of $50 million for modernization for 1965 to be taken away from the Hill-Burton formula.

Whether it has been brought out again this morning or not, I do not know, but I would say to the gentleman that under part of the bill providing for the continuation of the Hill-Burton program one formula is used for the allocation of funds. Under the new formula for the modernization program to be authorized, a different formula would be used, and the different formula would lean toward the urban areas more so than would the formula under Hill-Burton.

That is the reason that the change was made when the bill was introduced. I might say that I thought we had an understanding with the agency that the program set out in my bill would be acceptable. But when the Secretary came here, he brought his statement up in which he urged the committee to adopt the original recommendation that was made.

I took it up with him in the hearings to find out if we did have an understanding, and it developed that we did not have. He felt compelled to give the original program since that was submitted by the President and approved by the Bureau of the Budget and became the administration bill.

I hope that explains the situation. I still think that what is proposed in this bill would be satisfactory, too. Senator Hill had a different idea altogether and he didn't want to go along with the proposed new modernization program. He introduced the bill with a different kind of approach than we did here.

Dr. TERRY. That is correct. As a matter of fact, there is a provision in the bill introduced by Senator Hill whereby the State may

upon election, transfer up to a third of the new construction funds to modernization. In other words, there would be none specifically allocated for this purpose.

Mr. BENNETT. The money under Mr. Harris' bill for 1966 would go under a formula to the various States?

Dr. TERRY. Yes, sir.

Mr. BENNETT. Does a State not needing money for modernization have the opportunity to build a hospital?

Dr. TERRY. In Mr. Harris' bill there is a provision that if sufficiently high-priority modernization projects are not submitted to the State Hill-Burton agency, it could transfer modernization funds to the general funds for initial new hospital construction.

Mr. BENNETT. Who makes that decision?

Dr. TERRY. The State Hill-Burton agency makes the decision.

Mr. BENNETT. As to whether they want to use it for modernization or whether they want to use it for new construction?

Dr. TERRY. Yes, sir. Basically it would be allocated to them for modernization, but if they felt that they did not have a sufficient number of projects for modernization of a sufficiently high priority, the funds could be transferred to the general construction program.

The CHAIRMAN. Would the gentleman yield further on that point for further clarification?

Mr. BENNETT. Yes.

The CHAIRMAN. The approach under this bill is to provide that the States may at their election have a total authorization for new construction up to $150 million each year. That is the way the gradual transfer would work.

Mr. BENNETT. I think it would be unfair to delegate a State money for modernization and upon finding they didn't need the money for modernization, they would have to give it back when they did need it for new construction. I am glad that is clarified.

Mr. ROBERTS. The gentleman from Michigan, Mr. Bennett.

Mr. BENNETT. I wanted to say, Dr. Terry, at the outset that I have always supported the Hill-Burton program, ever since I have been here and I think it was enacted in the term prior to my coming here, and I would like to support it again, and intend to support it again.

But I do have some questions to ask you in reference to the scope of the program, but also in reference to some of the new phases of the program that you have suggested we enact. As I understand it, this bill calls for an overall authorization of $1,385 million for 5 years. That is the Harris bill.

Dr. TERRY. I believe, if I may, the total of the Harris bill for 5 years is $1,397,500,000.

Mr. BENNETT. In the last 15 years, is it correct that we have spent under Hill-Burton $1,900 million?

Dr. TERRY. That is roughly correct. I believe it is $1 billion 8 hundred-odd million.

Mr. BENNETT. How much have we spent in the Hill-Burton program in the last 5 years?

Dr. TERRY. I would have to total that, but I can give it to you by years, if you like, sir. In 1964, $220 million; 1963, $220 million; 1962, $209.728 million; 1961, $185 million; 1960, $185 million. So that the scale has been from $185 million in 1960 up to a total of $220 million available in each of the last 2 years.

Mr. BENNETT. This authorization doesn't include any money that has been provided for under H.R. 12?

Dr. TERRY. No, sir.

Mr. BENNETT. Nor under the mental health?

Dr. TERRY. That is correct.

Mr. BENNETT. When he was testifying here, Dr. Wright of the American Medical Association, said in his opinion the original objective of the Hill-Burton Act was mostly achieved. What is your opinion about that?

Dr. TERRY. I think we have made substantial progress, Mr. Bennett. If one looks back in terms of the estimated need and what was actually available, we have risen over the past few years in the general hospital bed category to about 83 percent of the general hospital beds needed today. That compares with meeting only 59.4 percent in 1948. We have made some real progress—1948 was the first year of the actual operation of the Hill-Burton program.

Mr. BENNETT. If 83 percent of the needs have been met, why do you need the same amount of money for the next 5-year period?

Dr. TERRY. There are several factors that are involved. In the first place, even though 83 percent of the need is met at the present time, the remaining 17 percent consists of a very large number of beds. In addition to that the expanding population requires an increase in the number of general hospital beds.

Mr. BENNETT. When do you anticipate the need will be met 100 percent? Do you anticipate that time will ever come?

Dr. TERRY. I wonder if we will ever reach the 100-percent stage. Certainly it is not anticipated that we will be at that level within the authorization proposed in this bill for the next 5 years.

Mr. BENNETT. You have three new parts to the program that have been added. Two other parts have been combined. I want to ask you a question about those.

Dr. TERRY. Yes, sir.

Mr. BENNETT. As I understand it, the chronic disease hospitals and nursing homes under the proposed legislation have been combined in a category called long-term facilities.

Dr. TERRY. Yes, sir.

Mr. BENNETT. You are going to spend the same amount of money for the program but just giving it a different name?

Dr. TERRY. No, sir; that is not correct. The proposal is that the amount of money would be greater than the combined nursing home and chronic disease hospital authorization for this year. In other words, the present authorization is $20 million for nursing homes and $20 million for chronic disease hospitals. The proposal here is that we combine these into one category called long-term care facilities and increase the ceiling to $70 million. This would be an increase of $30 million above the present $40 million authorization.

Mr. BENNETT. That is almost doubling the present rate of spending. What is the reason for that?

Dr. TERRY. Our problem is this: Our program has over the years supplied larger numbers of general hospital beds than chronic disease or long-term care facilities. In addition, every year a larger proportion of our population is getting into the elderly group which requires the long-term care type of facilities.

We are much less adequately prepared in this area than we are with general hospital beds. Consequently, it is our feeling that we need to place great emphasis on the construction of long-term care beds and facilities.

Mr. BENNETT. This legislation also provides for loans to profitmaking or proprietary type nursing homes, does it not?

Dr. TERRY. That is right, sir. It provides for the transfer of this program, which is in existence in HHFA at the present time to the Public Health Service.

Mr. BENNETT. Does that also include chronic-disease type hospitals?

Dr. TERRY. Yes, sir.

Mr. BENNETT. I mean under the loan provision.

Dr. TERRY. It is not in the $70 million that I was talking about. This is a proposed grant program.

Mr. BENNETT. I understand that. I understand you are going to spend $70 million in grants. That is for nonprofit public type nursing homes and chronic disease centers.

Dr. TERRY. That is right.

Mr. BENNETT. In addition to that there is also a program to make loans to profitmaking nursing homes. I don't know whether that goes to chronic disease centers or not.

Dr. TERRY. Actually, the character of those beds would be what we would refer to as long-term care beds. It is a separate program, as you indicated, and would be supported from our standpoint on a guaranteed loan basis rather than a grant.

Mr. BENNETT. It is financed in a different way, but it is the same type of facility once constructed.

Dr. TERRY. That is right.

Mr. BENNETT. It fulfills the same need.

Dr. TERRY. That is right, sir.

Mr. BENNETT. In spite of authorizing loans to proprietary profitmaking organizations to build nursing homes, you are almost doubling the amount you have heretofore spent on grants. Do you think that is justifiable?

Dr. TERRY. I have no question in my mind but that it is justifiable. I think this is one of the greatest needs in the whole facilities program, that is, in the construction of adequate facilities to care for the long-term patient. I think this is particularly true, Mr. Bennett, when you take into consideration the heavy needs that exist and the ones that are going to accumulate, so to speak, over a period of time. If we don't make provisions for such facilities we are going to get into a situation where many of our more expensively constructed and expensively operated hospital beds will have to be used for the long-term care patients who could be cared for in chronic disease facilities.

The States report as of this time, a combined report from the State agencies, that there is an additional need for 530,000 beds in this category.

Mr. BENNETT. You gave us the percentage of the need that has been met in hospital construction. Do you have the percentage of the need to be met in nursing home construction?

Dr. TERRY. Yes, sir. We estimated that as of 1963, we were meeting 34.5 percent of the existing need for long-term care beds.

Mr. BENNETT. What about now? Is that a year ago?

Dr. TERRY. Yes, sir. Those are the latest figures we have. It is based on reports from the States in terms of the number of facilities in existence and what they felt they needed at that time.

Mr. BENNETT. You anticipate with this expanded program of grants for nursing homes, plus the loan program, that there will be some overlapping and duplication of these types of facilities in communities. What plans do you have in that regard.

Dr. TERRY. No, sir. As a matter of fact, I think this legislation does two things to help prevent that, Mr. Bennett. One is a provision in the bill to encourage and to support areawide planning, which would include all types of facilities in a given area.

The second thing that I think is important is that in bringing this guaranteed loan provision for the proprietary or profitmaking nursing home in the same shop in the Public Health Service, so to speak, with the nonprofit nursing home program, and working through the State agencies we will get the best coordination possible.

I think both of these provisions will actually result in some improvement in this respect.

Mr. BENNETT. You already have the loan program in part?

Dr. TERRY. We have a loan program at the present time where loans can be made available by the State if the institution does not wish to accept a grant. A loan may be made in lieu of that grant.

Mr. BENNETT. What authority do you have in having the loan approved?

Dr. TERRY. I am not sure I understand that question.

Mr. BENNETT. Do you have some control or some jurisdiction over the loan program for nursing homes? What kind of jurisdiction is that?

Dr. TERRY. We do not have any jurisdiction over the present proprietary loan program which is administered in HHFA. We do consult with them in overall terms, but we have no real jurisdiction.

Mr. BENNETT. If the Public Health Service objects to a loan for a nursing home, can the HHFA make a loan anyway?

Dr. TERRY. Actually, we do not review the individual projects that come to HHFA. It is on a broader basis that we consult with them—in terms of standards, needs, and so forth.

Mr. BENNETT. I understand that they insure the loan and not make the loan. I understand that to be the case. I misspoke in saying that the Government is making the loan. Actually, as a practical matter they are making the loan when they guarantee up to 100 percent because they are responsible for it if the borrower doesn't pay.

My concern is mainly why did the Public Health Service get itself involved in a strictly financing of loan-type program that is already, I think, adequately administered by the type of agency that is well suited for that purpose?

Dr. TERRY. Mr. Bennett, in the first place you should take into consideration that this bill also provides for guaranteed loans to be made to nonprofit health institutions and facilities. I think it is perfectly natural and realistic, whether the Federal Government is loaning money or guaranteeing loans of money to proprietary or to nonprofit institutions in the field of health and medicine, that the two should be

pulled together in order that they may be operated hand-in-hand through the State agencies.

Mr. BENNETT. Has the HHFA been doing an ineffective job in your opinion?

Dr. TERRY. From all of the evidence I have, sir, they have been doing a satisfactory job. I am not suggesting it be moved from that agency because it was unsatisfactorily administered. It is merely a question of pulling a program into what we consider its proper sphere of program activity and responsibility, and also pulling it in in such a way that it can be more closely coordinated with all other hospital facility construction.

The CHAIRMAN. Would the gentleman yield at that point?

Mr. BENNETT. Yes.

The CHAIRMAN. Doctor, you were not here during the course of the hearings, but it developed that there is a jurisdictional problem. We run into those problems up here quite often. The Banking and Currency Committee has had jurisdiction over the mortgage guarantee loan program, and this is a part of their program.

That committee through its subcommittee, chairmaned by Mr. Albert Rains, has raised some questions as to the wisdom and advisability of interfering with that program. What would be your comment with reference to leaving the authority on loans for proprietary institutions where it is, and if any extension is made, applying it only to the nonprofit institutions?

Dr. TERRY. My recommendation is what makes sense to me from a program standpoint—and I have no ability or right to comment on the question of jurisdictional matters at the congressional level, looking at the program content it makes sense to carry these programs along together, that is the nonprofit and the proprietary nursing homes.

Secondly, I think in the long run, if the two were carried along together, Mr. Harris, that it would probably be more economical for the Federal Government in terms of administration.

The CHAIRMAN. I understand your problem.

Mr. BENNETT. Once you start transferring authority to loan money or to guarantee loans from an established financial agency like Federal Housing to HEW, you are setting a precedent for doing it for any number of other type agencies. I can't name them at the moment or suggest what they might be, but I am pretty sure of this, that there are a number of other programs that HHFA deals with that other agencies have some relationship to and could very well come in and ask Congress for the transfer of loan authority to them. I look with considerable apprehension on this type of thing myself.

Dr. TERRY. I think it should be pointed out, Mr. Bennett, that HHFA has agreed to the proposal to transfer this program to the Public Health Service.

Mr. BENNETT. Even so, I still look at it with considerable doubt and apprehension. I am going to hurry along because I know other members have questions and I don't want to monopolize the time, but I did have these questions in my mind that I would like to clarify.

With reference to the diagnostic center, as I understand the proposed legislation provides the same kind of program you have had.

Dr. TERRY. That is right, at the same level.

Mr. BENNETT. I want to ask what the diagnostic center consists of. I don't know that we have any in my district. I believe they are associated with a sort of outpatient department, if we have them. My first question is this: Are these diagnostic centers usually attached to an existing general hospital and operated more or less like an outpatient department, or are they separate-type institutions, and if so, who operates them?

Dr. TERRY. Mr. Bennett, Dr. Graning can give you a great deal more detail on this and if I may, I would like to have him answer this question.

Dr. GRANING. Mr. Bennett, you are quite right in thinking that diagnostic treatment centers have been associated with hospitals. This is because the enabling legislation for this program stipulated that a diagnostic treatment center had to be in connection with a hospital unless it is owned by a public agency. In the legislation before you we are asking for permission to build diagnostic and treatment centers owned by nonprofit sponsors even though there is no ownership of a hospital.

We cited previously a situation in Texas that was illustrative of the need for this type of permissiveness in the legislation. There are situations in which it is to the public interest to have a diagnostic treatment facility specifically directed to a problem.

In Fort Worth, Tex., for instance, six community agencies, all interested in children, have an excellent staff, and wanted to get together to save in terms of the expenditures involved and to provide a better and a more coordinated service. The community wanted to do this, the State agency was interested in supporting it, we were interested in it.

Everyone who looked at it thought well of it. But because of the existing regulation that nonprofit diagnostic centers have to be owned by a hospital, we could not support it. In all other respects this legislation is the same as that under which we have been operating heretofore.

Mr. BENNETT. Has the program been generally satisfactory or has it been unsatisfactory? Have you had many instances of the type you now mention around the country where it would be more desirable to have it apart from a hospital?

Dr. GRANING. It will still be true that in most instances the community will elect to make the diagnostic treatment portion the outpatient section of their hospital. But there will be instances, as I have cited, and there have been others as well, in which it would have been in the public interest to permit construction of a facility apart from the hospital.

Mr. BENNETT. Would the new authority you are asking for permit you to make loans to diagnostic centers to groups of doctors who jointly practice together?

Dr. GRANING. I would think not, sir.

Mr. BENNETT. If they operated a facility on a nonprofit basis, would they be eligible?

Dr. GRANING. If a group of physicians were employed by a nonprofit agency, but physicians getting together to use these funds to build offices; no, sir.

Mr. BENNETT. Even if a community sponsored the project, they would have to get a group of doctors in there to actually operate it.

Dr. GRANING. Yes.

Mr. BENNETT. My point is this. Would this facilitate or help the medical profession in the group practice area?

Dr. GRANING. This was not the intent of the request, sir.

Mr. BENNETT. How widespread are your requests for separate type facilities? Do you have a great number of them on hand?

Dr. GRANING. Initially when this legislation was first proposed back in 1952 or 1953, I believe, it had been the thought that diagnostic treatment centers might serve in satellite areas that were not sufficiently large to support a hospital. There are different licensing requirements for hospitals. When the legislation was passed, this specific restriction regarding hospital ownership was written into it.

Since then, in terms of our operating experience, we have suggested that it would be in the public interest to make it possible for the Surgeon General—and we would intend to be very careful about instances in which this would be approved—to approve facilities when in his opinion such approval was merited.

Mr. BENNETT. Whether they are connected with a hospital or whether they are not, in effect they really perform the same function as the outpatient department of a regular general hospital does. Is that a fair statement?

Dr. GRANING. In the Fort Worth situation they would not.

Dr. TERRY. Generally speaking they would be outpatient facilities though they might be limited to a particular disease category or something of that sort. In general, they would be an outpatient department of a hospital.

Mr. BENNETT. Is it your intent, Dr. Terry, to depart from the general hospitals and build them mainly as separate institutions?

Dr. TERRY. It is not our intention at all to do that. The only thing it is our intention to do on the basis of a few examples, such as the one that Dr. Graning just cited to you, is to construct such facilities if such action conforms with the public interest. It would be well to have this authority to use on occasion.

Mr. BENNETT. But you are not planning any radical change in the program as it was administered in the past?

Dr. TERRY. That is right, sir.

Mr. BENNETT. What about the need for the areawide planning part of this legislation that is going to cost $45 million? How do you justify that, and how is that going to work?

Dr. TERRY. I think this is one of the more important parts of this legislation. Under our existing authority for research and demonstration we have been able to support a few areawide planning projects over the past few years.

Each of these we feel—and the people in the community feel—has been a tremendous asset to the community in terms of having a formalized program and staff to look at the needs of the community areawide and to propose and develop plans for the future.

Mr. BENNETT. How do you describe an area?

Dr. TERRY. Generally speaking, you run into as many as 10 or 15 separate political jurisdictions within a city in the overall complexes. The overall complex to us would be a metropolitan area even though

it is spread out into one or two adjacent counties or into two or three additional cities.

I would expect and probably even hope that we would not have a rigid definition of a "metropolitan area" because I think this would limit the usefulness of the program and in certain areas might definitely restrict it.

Mr. BENNETT. What about rural areas?

Dr. TERRY. Yes, projects could be approved for areawide planning for rural as well as metropolitan areas.

Mr. BENNETT. Would it be if this bill passes?

Dr. TERRY. Yes, sir; this would be acceptable to us, providing the projects were approved by the State agency.

Mr. BENNETT. Who would control this money? Would it be your agency that would give the money direct to certain areas, or would you give it to a State agency and let them allocate it to areas as they defined the areas?

Dr. TERRY. A proposal from a given community or area would pass through the State agency and would have to have the recommendation of the State agency.

Mr. BENNETT. Suppose I wanted to make my congressional district an areawide planning area, how would I go about that?

Dr. TERRY. If this made sense to your State Hill-Burton agency, this would be an acceptable approach.

Mr. BENNETT. If it doesn't make sense to them, if you are going to have areawide planning, it seems to me you would have to have it all over. In other words, you do have at the present time, a system of planning since the Hill-Burton Act was passed. Each State has to come up with a State plan.

Dr. TERRY. That is right.

Mr. BENNETT. That is supposed to be based on criteria that the Surgeon General has laid down for the States to follow, how they formulate their plans, and how they establish eligibility for locality for different types of facilities, and so forth. That has been going on ever since the program was started.

Dr. TERRY. That is right.

Mr. BENNETT. In what respect is this going to be different than what we have now and why is what we have now not adequate?

Dr. TERRY. The way it is going to be different is this. Within the general regulations and guidelines which have been laid down by us for guidance of the States they have done broad general planning within the State. But, admittedly, they have not gotten into the detail of planning for specific rural or metropolitan areas in the same degree which they would like to and which we would like to have them do.

So, basically, what it means, Mr. Bennett, is that planning would be more specifically pinpointed for a particular medical practice area.

Mr. BENNETT. You would still have your State plans?

Dr. TERRY. That is right. It is quite obvious that these area plans would have to fit into the overall State plan.

Mr. BENNETT. This would be superimposed on the State plan, or it would be something in addition to the State plan?

Dr. TERRY. They would be a part of the State plan.

Mr. BENNETT. Would an area plan finally become merged with a State plan before it became effective?

Dr. TERRY. It would be part of the State plan or the Hill-Burton agency would not approve it.

Mr. BENNETT. Suppose I get my congressional district designated as an eligible area of planning. Does that mean that this money would be available to appoint a group of experts who would go over my whole district and decide where adidtional beds were needed and where a diagnostic center might be needed or where a nursing home might be needed, and then recommend that to the State agency?

Dr. TERRY. Just a moment.

Dr. GRANING. Mr. Bennett, in that event the people of your community who are interested in a coordinated approach to planning for the health needs of your congressional district would establish a committee that would be made up of outstanding people in the community—both consumers and people who are in the health field.

They would make an application for a grant, the purpose of which would be to consider the relative needs for various kinds of health facilities within your congressional area. This would include general hospitals, long-term care facilities, nursing homes, and the need for rehabilitation services; in short, a coordinated plan for health service for your area.

They would propose in their request that money be granted to employ planning people, who would be on their payroll. Their proposal would be processed by the State agency, acted upon by the Federal Hospital Council, and the grant given directly to the group in your community. They would then develop coordinated plans for your area.

The Division of Hospital Facilities has supported this to a limited scale through our research and demonstration program. Where it has been going on—as for instance in the State of New York where there have been some regional planning groups that have been supported with funds from the Division—the State agency has found these planning groups very useful, because the people who are most involved, the people on the boards of trustees of hospitals, get together and think through what their collective needs are.

Kansas City, Mo., has had a very fine experience in terms of this same approach. It is an effort to get the health leaders and the principal industrial people in the community together on planning in a coordinated way for their specific health needs.

Mr. BENNETT. Can't they do that same thing now and are they not doing it in large measure?

Dr. GRANING. There has been no financial support for this other than the very modest support the Division has given out of research and demonstration funds in an effort to get this program underway.

Mr. BENNETT. If an area wants Federal money and it is available for different type programs, do you think it is necessary in addition to the State constituted boards we already have acting under criteria that you have already set up for these programs and planning, to superimpose on that another spending program for localities themselves to get Federal grants so that they can engage in planning activity themselves that may be inconsistent with the State plan or have nothing to do with it and would be a pure waste of money?

Dr. GRANING. Before we will give grants to a community, there has to be real evidence of local interest and support. They have to put up

some of the money themselves. The act provides that they put up 33⅓ percent.

Mr. BENNETT. And you put up 66⅔ percent?

Dr. GRANING. It is proposed in the legislation that this be done.

Mr. BENNETT. Do you deal this out directly from here?

Dr. GRANING. Yes.

Mr. BENNETT. You don't allocate this to the States?

Dr. GRANING. No, sir. This would be on a project grant basis. This has the collective support of the American Hospital Association, the American Medical Association, and everyone believes that this would be money very well invested.

Mr. BENNETT. But you could spend 50 percent of the money in two or three States. My point is this, if it is needed—and I have some doubts myself as to the great need for it—you are going to have a widespread demand for getting grants, especially if the Federal Government comes in with 66⅔ percent.

The one that gets the area plan in first would get the money. The State itself would not have any protection.

Dr. GRANING. Mr. Bennett, the Federal Hospital Council has indicated that in terms of its interest in supporting projects, it does not have any intention whatsoever of supporting areawide planning grants on a continuing basis and it has recently taken action along the same lines.

Mr. BENNETT. If you are going to do this, why don't you let the States have the money and let the State agency allocate it or expand its own agency?

Dr. GRANING. These are modest project grants in size and they are phased out. We get out of supporting them in a matter of 3 or 4 years. We have no interest in continuing to support areawide planning activities. We are asking for this in order to get these programs underway.

Mr. BENNETT. Once you set up an area planning group and you give them the money and they come forth with a plan, can you give them money from here or do they have to go to the State to get their money?

Dr. GRANING. They have to go to the State and the State agencies are very supportive of this whole concept.

Mr. BENNETT. You might have within a State a dozen people, all with their own plans.

Dr. GRANING. With $5 million available for the country as a whole, there is going to be relatively few projects supported. We could not support many in each State.

Mr. BENNETT. You have another provision to give 2-percent grants to the States to be used for administration expenses. Is that 2 percent of the allocation they get from the Federal Government, or 2 percent of what?

Dr. TERRY. Mr. Bennett, the provision there is 2 percent or not to exceed $50,000, whichever is less. The wordage of the bill is written in such a way that the individual State would continue to have to put in as much money as it had spent on administration in 1964, so that there would not be a substitution of Federal for State funds.

Mr. BENNETT. Has there been a showing that States are not able to pay the administrative cost of their own planning agencies under this act?

Dr. TERRY. I think one of the real deficiencies we have had in this program thus far has been the fact that the States have not been able to develop the sort of staff for the State Hill-Burton agency they need to do the best job for that State and for us. Therefore, with this conviction, it is our feeling that we should assist the States in improving their staff and improving their administrative ability.

Mr. BENNETT. In our State we have a very good State agency. In fact, we always have had as far as my experience goes. I have never heard anything from them about being short of funds and making plans. As a matter of fact, with the staff they have now they come up with more projects than the Federal Government has money to give them to take care of them.

So, if you give them more staff they would probably get more plans, but where are you going to get the money to carry them out?

Dr. TERRY. Mr. Bennett, it is a qualitative, not a quantitative thing. This is essentially true in every State that there are more proposals than funds available. Actually, with regard to the Michigan situation——

Mr. BENNETT. Do you think if you give them 2 percent of the money they will come up with better projects?

Dr. TERRY. Yes, sir. I have no question in my mind that this is true. Certainly the Michigan agency has been very fine. But repeatedly over the years, the representatives of the State Hill-Burton agencies have asked for this assistance, in recognition that they are not doing the best job that they can do.

Mr. BENNETT. I disagree with them from time to time on priorities and thought they were not dealing as fairly with my district people as some other district. I must say, by and large, I think they have acted in good faith and have operated very efficiently. I suppose that same thing is true of most other States. It is hard for me to see why the Federal Government should be dishing out money to pay part of their administrative expenses. I think the States are well equipped to do it.

Dr. TERRY. I would say that not all of the States have an agency as good as Michigan. Furthermore, I think in terms of costs the thing that you should appreciate is that this is an elective thing—the State elects whether or not to take this administrative support out of its overall allotments.

It would not increase the overall cost of the program.

Mr. BENNETT. That is all, Mr. Chairman. I am sorry I have taken so much time.

The CHAIRMAN (presiding). Mr. Springer.

Mr. SPRINGER. Dr. Terry, do you have a record of all 50 States and of the money they received last year?

Dr. TERRY. Yes. It is right here, sir. I believe the last year we have immediately at hand is 1964.

Mr. SPRINGER. Take the year 1962.

Dr. GRANING. We have 1964.

Mr. SPRINGER. You haven't spent the money for 1964.

Dr. TERRY. The allotments have been determined.

Mr. SPRINGER. Everything has been made?

Dr. TERRY. The allotments have been determined. I am not sure they have all been completed.

Mr. SPRINGER. Fiscal 1964?

Dr. TERRY. Yes, sir.

Mr. SPRINGER. You are not at the end of 1964 yet. Let us go back to 1963.

Dr. GRANING. Are you talking about expenditures or allotments?

Mr. SPRINGER. I am talking about money expended.

Dr. TERRY. I don't think we have the previous years here.

Mr. SPRINGER. Let us take 1964 and see if we can work it out.

Dr. TERRY. Yes, sir.

Mr. SPRINGER. How many States have at present times unexhausted money?

Mr. BURLEIGH. Mr. Springer, actually we don't have the figures here. But over the life of the program less than one-half of 1 percent of the total construction funds allotted to the States have reverted and gone back to the Treasury.

Mr. SPRINGER. Will you repeat that?

Mr. BURLEIGH. Less than one-half of 1 percent of the total construction funds appropriated by the Congress have reverted.

Mr. SPRINGER. Let me put this question another way. Actually in every year since the program has been founded, in better than 9 out of 10 States, the funds have been more than exhausted, have they not?

Mr. BURLEIGH. Yes, sir.

Mr. SPRINGER. Now, I come back to Dr. Terry. What was the purpose of the Hill-Burton Act when we started?

Dr. TERRY. The purpose of the Hill-Burton Act was to improve in terms of quantity and quality the facilities for the care of patients.

Mr. SPRINGER. It was to build hospitals, is that true?

Dr. TERRY. Basically, in its beginning.

Mr. SPRINGER. To be truthful that is why we created the act; to build hospitals in places where they didn't have any hospitals.

Dr. TERRY. Or to build additions in areas where they didn't have enough hospital beds.

Mr. SPRINGER. I will accept that qualification. I will take mine because it fits me. Both of these have been done. There has not been a single year, so I am advised by Springfield, wherein they have had enough money to fulfill all of the requests that legitimately should have been fulfilled in the State of Illinois.

Does anyone have any evidence that is not correct?

Dr. TERRY. No, sir. This is, generally speaking, true throughout the Nation.

Mr. SPRINGER. They have exhausted all of the fund in each and every year for the State of Illinois given them to build hospitals. That is all we have been doing, building hospitals, is it not? You can come to conclusions whether you can improve it. That is all we have done in the State of Illinois, is to build hospitals or additions.

Dr. TERRY. I don't have the details on Illinois, but in most of the States we have built considerable numbers of other medical facilities, including clinics, diagnostic treatment facilities, rehabilitation facilities, and others. I am not sure of the exact circumstances in Illinois.

Mr. SPRINGER. I will wager in the State of Illinois less than 5 percent of the money has been devoted to that purpose. Ninety-five percent has been devoted to building hospitals. Would that be a fair statement?

Dr. TERRY. General hospitals?

Mr. SPRINGER. Hospitals or additions to hospitals.

Dr. TERRY. This may be true.

Mr. SPRINGER. Now, you are proposing to make a substantial change in the program, are you not?

Dr. TERRY. There are several changes in the program.

Mr. SPRINGER. Let us stay with the hospitals.

Dr. TERRY. Yes, sir.

Mr. SPRINGER. You are proposing to make a substantial change in how that money shall be spent, is that not correct?

Dr. TERRY. I think that is correct, sir.

Mr. SPRINGER. Actually, if you took the program suggested by the Secretary, you are making in essence a two-thirds change in the program, are you not, or a possibility of being as much as two-thirds of a change, to be more accurate?

Dr. TERRY. If you are speaking of the major change, the modernization provision in the administration proposal, it would be one-third. It would be $50 of the $150 million that would be devoted to modernization.

Mr. SPRINGER. But it would be a 66⅔ change in program, wouldn't it, under the Secretary's bill?

Dr. TERRY. I don't know how you arrive at that figure.

Mr. SPRINGER. It reduces the appropriation authorization for new hospitals beginning with the fiscal year from 150 to 100 and adds a new 5-year program with 50 million in the first year, 60 million in the second year, 70 million in the third year, and 80 million in the fourth and fifth years.

It is my mistake, it is a little less, 60 percent when you reach the ultimate; 60 percent, isn't that right? Eighty million out of one hundred and fifty million? That is a change in the program.

Dr. TERRY. Yes, sir.

Mr. SPRINGER. Then, in fact, what you do have here, Dr. Terry, is not one program but two programs, don't you?

Dr. TERRY. I think it is all part of a complex.

Mr. SPRINGER. First of all, you are going to continue to build hospitals.

Dr. TERRY. Yes, sir. New hospitals and additions to old ones.

Mr. SPRINGER. Now you are going to have a new program in which you are going to rehabilitate and renovate and also supply with equipment, isn't that correct?

Dr. TERRY. We have been doing some rehabilitation and modernization under the existing program, sir.

Mr. SPRINGER. Under what authority?

Dr. TERRY. The general authority of the act. I can't cite the particular portion.

Dr. GRANING. Sir, I had the privilege of working in the regional office in Chicago and we served the State of Illinois for seven and a half years. I am personally conversant with the fine work that the State health department has done and the work of its advisory hospital council. The decisions in the State of Illinois in terms of who gets funds have had to be related to the basic tenet of the Hill-Burton Act; namely, that hospitals shall be built in areas and communities that can demonstrate a need for beds.

Once a community has demonstrated a need for beds, there is nothing whatsoever that precludes renovation of the hospital, additions to the hospital, or modernizing the hospital—as long as you can reach the hospital on a bed-need basis. The State of Illinois has been able under the existing program to modernize many of the hospitals that it has helped expand.

The basic purpose of the modernization category is simply to give the State of Illinois the right to allocate some of the money on a straight modernization-need basis. Some community hospitals whose bed needs are currently met but who may have an obsolete operating room or an inadequate obstetrical unit may then obtain some funds to modernize that particular hospital.

Mr. SPRINGER. Where do you find that in the act?

Dr. TERRY. Section 631 of the Public Health Service Act.

Mr. SPRINGER. Are you reading from the Hill-Burton Act now?

Dr. TERRY. Yes, sir; section 631(h). The term "construction" includes construction of new buildings, expansion, remodeling and alternation of existing buildings and initial equipment of any such buildings.

Mr. SPRINGER. Is that the language contained in this act?

Dr. TERRY. That is the exact language, sir.

Mr. SPRINGER. Then what you are in effect doing, if not a new program, you are expanding on that program, is that correct? You are expanding on that language?

Dr. TERRY. We are expanding on this language and pointing up a particular priority for greater needs in the direction of moderization.

Mr. SPRINGER. Actually, you had had all the funds expended for the building of hospitals. That is essentially what you have been doing, is that not correct?

Dr. TERRY. In large part; yes, sir.

Mr. SPRINGER. Has that purpose been exhausted?

Dr. TERRY. No, sir. As I indicated, our best estimate today in terms of general hospital beds is that we are at approximately 83 percent of our overall national need. So it has not been met.

Mr. SPRINGER. It has not been met. Let us just give an example What do you mean by being met?

Dr. TERRY. I mean on the basis of a State studying the number of beds that it feels it needs to care for its population and comparing this to the number of beds actually in existence.

Mr. SPRINGER. Actually, there is a sort of rule that you don't want anything less than a 50-bed hospital, is that right?

Dr. TERRY. Generally speaking, we approve—or we favor, I should say—hospitals of that size or larger, sir.

Mr. SPRINGER. That is where you have been putting your money, isn't it?

Dr. TERRY. Not necessarily. There have been many hospitals that are much smaller than that, sir.

Mr. SPRINGER. This is the general rule, Dr. Terry, that the hospital association wants followed at the present time, isn't it?

Dr. TERRY. I am not sure about the hospital association on this, sir. I believe they concur.

Mr. SPRINGER. At the present time you are proposing here, if you follow this bill, to give 60 percent of this in the fourth and fifth years

to renovation, if they want it, in spite of the fact that all the funds which are allotted to the States are more than subscribed for or asked for, for the building of hospitals at the present time.

Dr. TERRY. That is correct, sir.

Mr. SPRINGER. Now, let us go to nursing homes.

Dr. TERRY. Yes, sir.

Mr. SPRINGER. Has any survey been made on nursing homes to determine what the supply of nursing homes has been in the last few years?

Dr. TERRY. Yes, sir; there have been State surveys which have been reported to us. In our figures we have them in terms of long-term-care beds which would include chronic-disease beds, as well as nursing home beds.

Mr. SPRINGER. Let us take Illinois.

Dr. TERRY. I don't have Illinois. I don't have them broken down by State. I have the total for each year in terms of the total beds needed as estimated by the State, the existing beds and the report of the additional beds needed.

Mr. SPRINGER. Doctor, I don't understand. I just visited three new ones in my district, very substantial ones, within the last 3 or 4 months. These are large ones, brand new. Not luxurious, but I would say pretty close to it. At a very substantial cost, too, $20 a day.

But it seems to me that in my particular area they are building more private-care nursing homes than hospital beds. This is why I question this large figure. How much of the need is undermet, 83 percent, for chronic patients?

Dr. TERRY. It is estimated in terms of the need for general hospital beds in this country that today we are meeting 83 percent of that need.

Mr. SPRINGER. You had a figure there a moment ago in answer to Mr. Bennett of the unmet chronic-disease beds.

Dr. TERRY. It is estimated at the present time at 532,000.

Mr. SPRINGER. People?

Dr. TERRY. No, of the additional beds needed in the long-term-care category.

Mr. SPRINGER. This is a half million that is needed?

Dr. TERRY. That is right, sir. A little over.

Mr. SPRINGER. Let me ask you this, Doctor. Suppose that this next year you have this program set up and you still have these hospitals that want to be built coming in and requesting funds. Are you going to make this allotment between those that want to build a new hospital and those that want to renovate?

Dr. TERRY. This will largely be done on a State basis, sir.

Mr. SPRINGER. Isn't the very purpose of what you are trying to do here to get away from the idea of building hospitals and to renovating old hospitals?

Dr. TERRY. No, sir; this is not true.

Mr. SPRINGER. You are asking $80 million out of the $150 million. What else can we expect?

Dr. TERRY. The thing we want to do is to put increased emphasis over the coming years in renovating beds which are becoming obsolete.

Mr. SPRINGER. Dr. Terry, almost all the testimony we have had here from Mr. Cellebrezze on down is the emphasis on this whole question of city, which has never been brought up before. We have

never had this before the committee for anything else than building hospitals.

Now, we come to the question that yon don't want to build hospitals, in fact, the testimony has been that that has been taken care of. There is certainly one fundamental conflict between all the testimony and the figures here, that in every State of the Union the funds are exhausted for building hospitals.

Now you ask that we shift the funds for renovating when the evidence is very clear and conclusive that all the funds are being used and there is not enough to build hospitals.

Dr. TERRY. There is not enough. It is a question of making some priority decision in terms of the limited funds that will be available.

Mr. SPRINGER. Why not make this fundamental decision and come to the conclusion where the emphasis ought to be? We will build hospitals, but it shall be the duty of the local communities to keep them up. Wouldn't that be a fundamental approach to this thing, that if we help build hospitals they keep them up?

You are shifting into an entirely new field and taking an entirely different emphasis. When you will not have enough money in this program to build hospitals, you are asking for money to build new beds to take the community load off the people who ought to be taking care of their own hospitals and saying to them, we are not going to build any hospitals in these communities but we will shift the money over to make it a little easier for the community to renovate a hospital.

It seems to me this is a fundamental approach to this bill and I have serious doubts whether or not this should be done. If there was a lot of surplus money coming here that would be a different thing. If you take all the money here, my best information is that if you take all the applications for new hospitals, more than this amount of money is going to be needed.

This is a decision which I think this committee has to make this year. I am not convinced that emphasis ought to be shifted away from building hospitals and creating new beds to going back and renovating old hospitals for communities merely because they don't get out and keep those hospitals up.

I am very frank with the people who are writing to me in my own district that I simply cannot go along with the idea that communities cannot keep up their own hospitals. In my estimation, it ought to be put in those places where there will be new beds created where there is a general wide need for new hospital facilities.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Rogers?

Mr. ROGERS of Florida. No questions.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. Thank you, Mr. Chairman.

Dr. Terry, in regard to the criteria for allocation of funds, I am wondering whether the criteria we had before for the Hill-Burton adequately takes care of a State where you have a shift in population. For instance, in California where we have a great influx of retired people whose income is below the average and brings the average down, but adds materially to the need for hospital beds and especially for the long-term use of beds.

Does this formula we have adequately take care of States like Florida and California?

Dr. TERRY. I think it does. At least we have not been able to devise anything better in this respect. Each year you work out the allotment on the basis of this formula, which takes into consideration the population plus the per capita income. We feel that this is the best basis that we can devise.

It seemed to us over the years, even in States where there is a change in population, that it has worked out reasonably well. We have not been able to devise anything better.

Mr. YOUNGER. It seems to me that a State which has pretty much a static pouplation, but where the retired people move out and move into the Southern States like Florida and our own, and leave that State, that they have an increasing per capita income where we would have a decreasing per capita income.

Dr. TERRY. At the same time they are losing population, too.

Mr. YOUNGER. No, they are pretty much static. I don't know of any State except one that has lost population, according to the last census. That is Arkansas. All the rest have gained some. They have not lost population, but they have lost the population which after retirement might decrease the per capita income figure.

Mr. KORNEGAY. Would the gentleman yield?

Mr. YOUNGER. Yes, sir.

Mr. KORNEGAY. A lot of them lose their population in Congress.

Mr. YOUNGER. Yes. They lose their representation. I am not sure of the formula which you have. I am not sure it does justice to States like Florida and California.

Dr. TERRY. As I indicated previously, Mr. Younger, we have not been able to devise a better formula. Overall we have felt it has been equitable to each and all of the States.

Mr. YOUNGER. You had no complaint from any of the States?

Dr. TERRY. I don't know of any specific complaint. It would be amazing if we haven't, because I can't think of very many questions in the world about which there has not been some complaint. I don't recall any specific complaint and it certainly has not been an outstanding problem.

Dr. YOUNGER. When the Secretary was here I asked him the question whether the funds provided in this bill were in the budget, and he said, "Yes, all of them were."

Dr. TERRY. That is correct.

Mr. YOUNGER. I understand that you have a figure in there that says that you are depending on supplemental appropriations.

Dr. TERRY. That is right. You see, this was submitted as a part of the President's overall budget, but dependent upon legislation being extended because the legislation is due to expire June 30. It was presented as part of the President's budget for later submission.

Mr. YOUNGER. I know, but if this bill passes and the funds authorized by this legislation are provided through appropriations, then it would come through a supplemental appropriation and would increase the deficit of the present budget for 1965, is that true?

Dr. TERRY. It would still be within the President's budget as he submitted it to Congress.

Mr. YOUNGER. For 1965?

Dr. TERRY. Yes, sir.

Mr. YOUNGER. And for 1966. The estimated budget for 1966?

Dr. TERRY. Yes, sir; in 1966, too.

Mr. YOUNGER. There is no contemplation at all in this program for supplemental appropriations?

Dr. TERRY. No, sir; that is not correct. There will obviously have to be supplemental appropriations to take care of the program next year, because the Appropriations Committee can't act on this now since there is no authorization to support it.

Mr. YOUNGER. Doctor, there are a lot of things which can be put into a budget that are not authorized?

Dr. TERRY. That is exactly what the President did for later submission on this particular program. He included it in his budget for later submission.

Mr. YOUNGER. What is it?

Dr. TERRY. $270 million for 1965.

Mr. YOUNGER. That is all provided for in the budget?

Dr. TERRY. That is right, sir.

Mr. YOUNGER. There seems to be some question that we have not been able to work out. We have some other information on it. I will look into that afterward.

Mr. ROGERS of Florida. If the gentleman would yield, I would like to ask a question on the formula since you are talking about formulas on modernization.

You use as the basis for determining the need for facilities your survey in 1948 and how many hospital beds they had at that time.

Dr. TERRY. How many hospital beds; yes sir.

Mr. ROGERS of Florida. As of 1948?

Dr. TERRY. Yes, sir.

Mr. ROGERS of Florida. It was my understanding from later testimony that there have been two surveys since then on actual needs for modernization, one made in 1956 and brought up to date in 1960. I wonder why you didn't want to use this basis rather than go back to 1948 when there was no specific survey taken with this in mind?

Dr. GRANING. Mr. Rogers, the figures cited to demonstrate the present need for modernization were used to support the validity of the request. The data that is provided by the State agencies on modernization need was obtained on a statistically valid sample.

Mr. ROGERS of Florida. That was in 1960?

Dr. GRANING. Yes, sir.

Mr. ROGERS of Florida. What about 1956?

Dr. GRANING. There was no effort by the State agencies to try to appraise for each individual hospital its specific modernization need. The 1948 bed census data is used simply as an index of the initial distribution of that portion of the modernization category that is going to relate to need.

As we discussed before you last time, the State agency will have to make decisions in terms of where this money would go, and a hospital built in 1952 may have a greater need for obsolescence assistance than one built in 1940.

Mr. ROGERS of Florida. I understand this. But the testimony was that the Public Health Service along with the cooperation of the States and the American hospital group made a survey in 1956 specifically with modernization in mind.

Dr. GRANING. The Public Health Service has never made a survey.

Mr. ROGERS of Florida. Never has?

Dr. GRANING. Never has, sir. We are talking about what the State agencies have reported to us as their need.

Mr. ROGERS of Florida. What was the 1956 survey, just a report by the State agencies?

Dr. GRANING. I recall only the 1960 survey that we reported in our testimony.

Dr. TERRY. Apparently there has been some misunderstanding, Mr. Rogers, because Mr. Burleigh, who has been in the program for many years, tells me that there was no such study or reporting in 1956.

Mr. ROGERS of Florida. I think it was in the testimony from the American Hospital Association. We had some discussion on this at the time and they said then you had made a sample survey again in 1960, but a very thorough survey in 1956, in which the modernization needs were something like a billion or a billion and a half in 1956—in 1960 it was somewhere up to 3 or 4 billion. I have this statement here, and the statement contains this [reading]:

> In 1956 the association conducted a survey in collaboration with the U.S. Public Health Service * * *.

That is your service, isn't it?

Dr. TERRY. Yes, sir; it is.

Mr. ROGERS of Florida (continues reading):

> * * * of the modernization needs of hospitals. This study indicated at that time a total need of well over $1 billion. Of the 2,634 hospitals covered by this survey, 435, or one-sixth were more than 50 years of age.
>
> In 1960, the Public Health Service in a further effort to determine the magnitude of the problem of modernization undertook a nationwide study in cooperation with the State hospital construction agencies and metropolitan planning bodies. Direct reports were obtained from 25 metropolitan areas.

That is the sample you speak of in 1960?

Dr. TERRY. Yes, sir.

Mr. ROGERS of Florida. According to the testimony, the 1956 survey was a rather detailed survey and quite specific.

Dr. TERRY. I must admit I am not acquainted with that survey.

Mr. ROGERS of Florida. If there were such a survey made, don't you think it would be better to use that as a basis for determining need rather than going back to 1948 where there is no basis at all for modernization but simply a census of hospital beds? Or don't you think this should be considered before you make a determination as to the exact basis you will use?

Mr. BURLEIGH. One of the difficulties is that the survey that you allude to back in 1956 which involved $1 billion worth of modernization needs obviously was not a complete survey of this problem, because only 4 years later we come up with reports from State agencies that total $3.6 billion.

Mr. ROGERS of Florida. I don't know that is a proper assumption because the survey was conducted in connection with the U.S. Public Health Service in 1956, to determine what the needs are.

Mr. BURLEIGH. If I could speak to this problem just a minute, it is more than just a reporting problem. You can get general estimates as to what the needs are in a particular urban area or a particular community. But to determine the needs of a particular hospital the authorities in the field have given a great deal of study to this problem and have decided that the only way to do it is for a team of engineers and architects and possibly hospital consultants or physicians to visit each hospital and spend as much as 2 to 3 days going through that facility and examining its structural soundness and whether or not the functional layout is now obsolete and requires modernization.

It is a very complex problem. We do not think that the study we made—the $3.6 billion study that the Public Health Service made on the basis of reports from State agencies—gives us sufficient detail on which to project the modernization needs of the individual States.

We think it is a good national estimate but does not represent figures that can stand for particular States.

Mr. ROGERS of Florida. How about the 1956 survey?

Mr. BURLEIGH. I must confess ignorance to the 1956 survey.

Mr. ROGERS of Florida. I think it might be interesting for us—I don't know what validity it has either—to get that report and look at it and get familiar with it because it may help answer this problem.

Mr. BURLEIGH. May I say one further thing, sir?

Mr. ROGERS of Florida. Yes.

Mr. BURLEIGH. The reason we made the survey in 1960 was the fact that we had no reasonable estimates as to the magnitude of the modernization problem in the United States.

Mr. ROGERS of Florida. I though you had in 1956. You had a billion dollars there. That is a better indication than the number of beds in 1948, isn't it?

Mr. BURLEIGH. I would say the $3.6 billion in 1960 is a better indication than the study of 1956.

Mr. ROGERS of Florida. I am not sure. You just did some spot checking in 1960. I think it would be well to look at the survey and see how thorough it was in 1956. Let us consider it. Perhaps it is not a proper basis. I would feel a little better about approaching this problem.

In other words, what is the point of spending money for surveys to determine need, and then ignoring the surveys? There is no point spending this money if you are going to ignore these surveys.

Dr. TERRY. We will certainly look into this. I am not sure of the details.

Mr. ROGERS of Florida. I think you should study it.

Dr. TERRY. We will be glad to look into it and report to the committee if the chairman would like.

Mr. ROGERS of Florida. I think this would be helpful. I would like to see a report, if I may.

Dr. TERRY. Yes, sir.

Mr. ROGERS of Florida. Thank you, Mr. Chairman.

Mr. BENNETT. I have just one question for information. Doctor, would you submit for the record the most recent surveys that have been made by the States, showing by State the number of nursing beds that are needed? That is No. 1.

Dr. TERRY. Yes, sir.

Mr. BENNETT. And No. 2, the number of approved applications by States which have been approved by the State for nursing homes but for which no funds are available.

Dr. TERRY. I am not sure that we would be able to provide that because the States do not, I believe, submit to us those applications for which they do not have funds to back up.

Mr. BENNETT. Could you get that information? I think it would be very helpful. Can you get it from the State agencies?

Mr. BURLEIGH. We can submit to you a statement which State agencies give to us before appropriation hearings each year which shows the total number of projects which they could approve within each State if there was no limitation on Federal funds.

This may well give you an indication of the magnitude of the problem. We would be glad to submit that for the record.

(The information requested follows:)

INFORMATION REGARDING 1956 STUDY OF HOSPITAL MODERNIZATION

In June 1954, the AHA board of trustees directed two of its councils to study the desirability of a proposal "for the rehabilitation and/or construction of new hospital facilities under any public works program which might become necessary because of depressed economic conditions." The joint committee of the two councils decided "that rehabilitation and remodeling of existing hospitals offered the most practical and helpful activity during a period of recession."

In January 1956 a questionnaire developed with the assistance of the Public Health Service was mailed to all non-Federal member hospitals of the AHA. Returns were received from slightly more than 2,600 hospitals—54 percent of the total sent out. These represented all sizes, types, and ownership groups as well as all geographical regions in the country. The cost of reported modernization needs amounted to about $400 million. A national projection of survey results indicated that almost one-half of all hospitals in the country needed some form of modernization at a total estimated cost of about $1 billion.

The survey was well planned and developed, and the resulting national projection of modernization costs was considered useful and valid for the intended purpose at that time. However, the survey was limited in scope since it did not reflect the cost of replacing obsolete facilities which were beyond the possibility of modernization work.

Because of the early date and limitations of the 1956 survey, the Public Health Service, in cooperation with Hill-Burton State agencies, make a study in 1960 of the backlog of modernization work, including the replacement of obsolete facilities. This study showed that replacement costs comprised a substantial portion of the total modernization and replacement requirements of $3.6 billion.

Summary of anticipated construction of hospitals and other medical facilities (under title VI of the Public Health Service Act) if there were no limitation on Federal assistance, United States and territories, for fiscal years 1965 and 1966

State and program year	Number of projects			Beds or units added, by type of project										Estimated cost (thousands)					
				Part C					Part G					Total program		Part C		Part G	
	Total	Part C	Part G	General hospital	Mental hospital	Chronic hospital	TB hospital	Health center (units)	Diagnostic or treatment (units)	Chronic hospital	Rehabilitation facilities (units)	Nursing homes		Total cost	Federal share	Total cost	Federal share	Total cost	Federal share
Total	1,821	1,234	587	81,975	9,724	995	276	87	113	3,391	66	22,879		$2,855,811	$1,213,693	$2,436,977	$1,034,162	$418,834	$179,531
1965	1,165	770	395	51,081	6,931	710	200	52	87	1,880	53	14,185		1,731,109	688,400	1,449,921	573,422	281,188	114,978
1966	656	464	192	30,894	2,793	285	76	35	26	1,511	13	8,694		1,124,702	525,293	987,056	460,740	137,646	64,553
Alabama	41	33	8	1,276				8				240		20,140	13,350	17,791	11,784	2,349	1,566
1965	23	18	5	507				4				150		8,154	5,426	6,705	4,460	1,449	966
1966	18	15	3	769				4				90		11,986	7,924	11,086	7,324	900	600
Alaska	13	5	8	115	252				3		3	34		16,786	7,114	12,776	5,110	4,010	2,004
1965	6	2	4	103					2		1	14		7,026	2,950	5,616	2,246	1,410	704
1966	7	3	4	12	252				1		2	20		9,760	4,164	7,160	2,864	2,600	1,300
Arizona	19	12	7	1,510				1	3	40	2	25		34,813	17,406	30,393	15,196	4,420	2,210
1965	17	11	6	1,510					3		2	25		33,813	16,906	30,193	15,096	3,620	1,810
1966	2	1	1					1		40				1,000	500	200	100	800	400
Arkansas	41	26	15	570	315			3		70	1	395		19,175	10,108	15,050	7,475	4,125	2,633
1965	23	14	9	335	100			1		70	1	205		10,465	5,518	7,750	3,825	2,715	1,693
1966	18	12	6	235	215			2				190		8,710	4,590	7,300	3,650	1,410	940
California	42	33	9	3,066	104		259		3	84	3	100		117,409	35,639	108,212	33,388	9,197	2,251
1965	32	24	8	2,110	104		200		3	50	3	100		91,223	27,163	82,605	25,105	8,618	2,058
1966	10	9	1	956			59			34				26,186	8,474	25,607	8,283	579	193
Colorado	44	33	11	2,127	500	10		1	5		2	138		53,279	23,995	50,262	22,587	3,017	1,408
1965	44	33	11	2,127	500	10		1	5		2	138		53,279	11,997	50,262	11,293	3,017	704
1966															11,998		11,294		704

Connecticut	16	11	5	571				1	1		2	60	24,799	8,267	22,296	7,432	2,503	835
1965	13	8	5	416					1		2	60	22,849	7,617	20,346	6,782	2,503	835
1966	3	3		155				1					1,950	650	1,950	650		
Delaware	5	3	2	55	110			1	1			75	5,140	2,138	2,597	866	2,543	1,272
1965	5	3	2	55	110			1	1			75	5,140	2,138	2,597	866	2,543	1,272
1966																		
District of Columbia	4		4						3		1		22,800	1,350			22,800	1,350
1965	4		4						3		1		22,800	1,350			22,800	1,350
1966																		
Florida	75	49	26	3,420	638			7	9	120	4	845	73,049	34,624	59,774	27,985	13,275	6,639
1965	75	49	26	3,420	638			7	9	120	4	845	73,049	30,280	59,774	23,641	13,275	6,639
1966														4,344		4,344		
Georgia	65	44	21	2,339	75			11	1	50	3	812	76,703	34,159	54,974	21,986	21,729	12,173
1965	36	28	8	1,373	75			11	1	50	3	92	50,498	23,016	35,390	14,153	15,108	8,863
1966	29	16	13	966								720	26,205	11,143	19,584	7,833	6,621	3,310
Hawaii	22	17	5	267	174			4	2	30	1	50	26,516	12,723	23,516	11,283	3,000	1,440
1965	12	9	3	100	114			3	1		1	50	5,692	2,728	3,692	1,768	2,000	960
1966	10	8	2	167	60			1	1	30			20,824	9,995	19,824	9,515	1,000	480
Idaho	8	4	4	107					1			114	4,525	2,132	3,150	1,445	1,375	687
1965	5	1	4	82					1			114	3,375	1,557	2,000	870	1,375	687
1966	3	3		25									1,150	575	1,150	575		
Illinois	52	36	16	3,333	860				3	100		910	151,910	69,286	139,910	63,990	12,000	5,296
1965	24	14	10	1,021	860				3			610	71,710	34,585	63,710	30,916	8,000	3,669
1966	28	22	6	2,312						100		300	80,200	34,701	76,200	33,074	4,000	1,627
Indiana	25	18	7	3,237					3	100	1	85	86,633	27,770	80,813	25,978	5,820	1,783
1965	21	14	7	2,898					3	100	1	85	76,948	24,543	71,128	22,760	5,820	1,783
1966	4	4		339									9,685	3,227	9,685	3,227		
Iowa	46	34	12	1,973	100	180			1	486	2		72,080	24,200	63,050	20,990	9,030	3,210
1965	28	20	8	1,147	100	100			1	306	1		37,505	12,575	31,775	10,565	5,730	2,010
1966	18	14	4	826		80				180	1		34,575	11,625	31,275	10,425	3,300	1,200

Summary of anticipated construction of hospitals and other medical facilities (under title VI of the Public Health Service Act) if there were no limitation on Federal assistance, United States and territories, for fiscal years 1965 and 1966—Continued

State and program year	Number of projects			Beds or units added, by type of project									Estimated cost (thousands)					
				Part C					Part G				Total program		Part C		Part G	
	Total	Part C	Part G	General hospital	Mental hospital	Chronic hospital	TB hospital	Health center (units)	Diagnostic or treatment (units)	Chronic hospital	Rehabilitation facilities (units)	Nursing homes	Total cost	Federal share	Total cost	Federal share	Total cost	Federal share
Kansas	28	19	9	907							2	575	$61,638	$30,809	$53,138	$26,559	$8,500	$4,250
1965	4	2	2	100								190	5,646	2,813	4,146	2,063	1,500	750
1966	24	17	7	807							2	385	55,992	27,996	48,992	24,496	7,000	3,500
Kentucky	21	21		1,079				1					27,725	14,046	27,725	13,907		139
1965	11	11		599									13,765	6,616	13,765	6,477		139
1966	10	10		480				1					13,960	7,430	13,960	7,430		
Louisiana	41	28	13	2,940	2,100				3	190	2	485	94,400	47,200	87,800	43,900	6,600	3,300
1965	24	15	9	2,250	1,000				2	100	1	435	60,300	30,150	55,300	27,650	5,000	2,500
1966	17	13	4	690	1,100				1	90	1	50	34,100	17,050	32,500	16,250	1,600	800
Maine	25	13	12	263			17		1	145	1	208	15,038	7,519	8,680	4,340	6,358	3,179
1965	14	8	6	183					1		1	90	8,868	4,434	6,880	3,440	1,988	994
1966	11	5	6	80			17			145		118	6,170	3,085	1,800	900	4,370	2,185
Maryland	30	24	6	2,030	1,022			1		66	1	115	112,159	46,046	106,459	42,962	5,700	3,084
1965	18	14	4	835	772			1		16	1	90	53,999	26,566	48,659	23,662	5,340	2,904
1966	12	10	2	1,195	250					50		25	58,160	19,480	57,800	19,300	360	180
Massachusetts	53	40	13	2,653				1	8	80		250	90,494	36,198	82,610	33,044	7,884	3,154
1965	22	17	5	987					5				28,399	11,360	27,524	11,010	875	350
1966	31	23	8	1,666				1	3	80		250	62,095	24,838	55,086	22,034	7,009	2,804

Michigan	29	22	7	1,600				2				765	55,300	21,519	47,500	17,619	7,800	3,900
1965	29	22	7	1,600				2				765	55,300	21,519	47,500	17,619	7,800	3,900
1966																		
Minnesota	100	31	69	2,342					1		3	3,572	104,716	38,312	72,485	23,808	32,231	14,504
1965	66	20	46	1,521					1		2	2,477	76,132	24,282	53,088	13,912	23,044	10,370
1966	34	11	23	821							1	1,095	28,584	14,030	19,397	9,896	9,187	4,134
Mississippi	13	13		865	46								18,120	12,080	18,120	12,080		
1965	13	13		865	46								18,120	12,080	18,120	12,080		
1966																		
Missouri	43	28	15	775	410	419			2		1	1,460	62,644	31,322	49,712	24,856	12,932	6,466
1965	23	14	9	215	365	224			2			1,170	40,248	20,124	31,166	15,583	9,082	4,541
1966	20	14	6	560	45	195					1	290	22,396	11,198	18,546	9,273	3,850	1,925
Montana	13	8	5	354	16						1	127	11,512	4,564	9,340	3,696	2,172	868
1965	13	8	5	354	16						1	127	11,512	2,377	9,340	1,907	2,172	470
1966														2,187		1,789		398
Nebraska	26	15	11	1,264					2	150	2	324	41,127	16,889	32,265	13,385	8,862	3,504
1965	16	9	7	478						150	1	124	13,104	5,680	10,329	4,611	2,775	1,069
1966	10	6	4	786					2		1	200	28,023	11,209	21,936	8,774	6,087	2,435
Nevada	14	8	6	180					2			64	7,980	3,612	5,600	2,422	2,380	1,190
1965	7	3	4	40					2			44	3,480	1,689	2,200	1,049	1,280	640
1966	7	5	2	140								20	4,500	1,923	3,400	1,373	1,100	550
New Hampshire	15	7	8	290					6		1	60	9,100	3,383	6,700	2,233	2,400	1,150
1965	14	6	8	190					6		1	60	6,400	1,633	4,000	883	2,400	750
1966	1	1		100									2,700	1,750	2,700	1,350		400
New Jersey	30	21	9	1,769				2	2	25	4	215	40,975	14,343	33,285	11,651	7,690	2,692
1965	23	18	5	1,498				1	2		3		30,491	10,673	27,091	9,483	3,400	1,190
1966	7	3	4	271				1		25	1	215	10,484	3,670	6,194	2,168	4,290	1,502
New Mexico	28	19	9	972	110			8	2	40	1	390	23,667	11,832	20,985	10,491	2,682	1,341
1965	17	10	7	502	110			4	1	40	1	270	12,487	6,243	10,585	5,292	1,902	951
1966	11	9	2	470				4	1			120	11,180	5,589	10,400	5,199	780	390

Summary of anticipated construction of hospitals and other medical facilities (under title VI of the Public Health Service Act) if there were no limitation on Federal assistance, United States and territories, for fiscal years 1965 and 1966—Continued

State and program year	Number of projects			Beds or units added, by type of project									Estimated cost (thousands)					
				Part C					Part G				Total program		Part C		Part G	
	Total	Part C	Part G	General hospital	Mental hospital	Chronic hospital	TB hospital	Health center (units)	Diagnostic or treatment (units)	Chronic hospital	Rehabilitation facilities (units)	Nursing homes	Total cost	Federal share	Total cost	Federal share	Total cost	Federal share
New York	92	60	32	6,867	975			2		174	5	1,819	$294,332	$98,106	$255,772	$85,254	$38,560	$12,852
1965	47	32	15	3,587	870					70	3	541	131,832	43,940	119,522	39,838	12,310	4,102
1966	45	28	17	3,280	105			2		104	2	1,278	162,500	54,166	136,250	45,416	26,250	8,750
North Carolina	35	27	8	2,095					4	150			62,975	39,946	55,375	34,778	7,600	5,168
1965	15	11	4	625					2	75			26,425	19,843	20,125	15,390	6,300	4,453
1966	20	16	4	1,470					2	75			36,550	20,103	35,250	19,388	1,300	715
North Dakota	10	6	4	189	25							350	9,153	3,792	5,653	1,883	3,500	1,909
1965	6	4	2	164								150	5,323	1,810	3,823	821	1,500	989
1966	4	2	2	25	25							200	3,830	1,982	1,830	1,062	2,000	920
Ohio	92	69	23	5,702	91	206		3	6		5	874	171,330	54,512	151,675	48,728	19,655	5,784
1965	63	44	19	3,693	77	206		1	6		5	610	123,900	39,702	106,895	34,801	17,005	4,901
1966	29	25	4	2,009	14			2				264	47,430	14,810	44,780	13,927	2,650	883
Oklahoma	26	18	8	1,790					4	95			54,750	27,350	52,700	26,325	2,050	1,025
1965	15	11	4	480						95			11,450	4,700	10,700	4,325	750	375
1966	11	7	4	1,310					4				43,300	22,650	42,000	22,000	1,300	650
Oregon	14	11	3	435								90	12,679	4,226	11,629	3,876	1,050	350
1965	5	4	1	142								20	2,244	748	2,034	678	210	70
1966	9	7	2	293								70	10,435	3,478	9,595	3,198	840	280

Pennsylvania	62	43	19	2,202	87				2	364		834	87,004	29,578	70,908	23,744	16,096	5,834
1965	47	38	9	1,789	87				2			566	60,264	20,631	52,379	17,567	7,885	3,064
1966	15	5	10	413						364		268	26,740	8,947	18,529	6,177	8,211	2,770
Rhode Island	5	3	2		8				2				17,473	7,835	8,846	3,522	8,627	4,313
1965	3	3	2		8				2				17,473	3,988	8,846	1,808	8,627	2,180
1966														3,847		1,714		2,133
South Carolina	38	26	12	2,105					5		1	400	54,870	36,580	46,920	31,280	7,950	5,300
1965	16	10	6	924					3		1	150	26,910	13,940	22,710	11,140	4,200	2,800
1966	22	16	6	1,181					2			250	27,960	22,640	24,210	20,140	3,750	2,500
South Dakota	24	19	5	282	17							163	12,234	5,413	10,334	4,463	1,900	950
1965	14	11	3	199								84	7,554	3,073	6,554	2,573	1,000	500
1966	10	8	2	83	17							79	4,680	2,340	3,780	1,890	900	450
Tennessee	13	12	1	539								100	8,749	4,548	7,749	4,028	1,000	520
1965	13	12	1	539								100	8,749	4,548	7,749	4,028	1,000	520
1966																		
Texas	114	81	33	4,740	1,482	30		7	3	142	4	3,133	140,984	63,697	116,673	51,542	24,311	12,155
1965	73	50	23	3,636	822	30		2	3	98	4	1,588	102,451	39,780	87,426	32,268	15,025	7,512
1966	41	31	10	1,104	660			5		44		1,545	38,533	23,917	29,247	19,274	9,286	4,643
Utah	28	24	4	1,263		80		4				150	37,150	16,524	35,700	15,799	1,450	725
1965	16	12	4	235		80		2				150	11,400	4,912	9,950	4,187	1,450	725
1966	12	12		1,028				2					25,750	11,612	25,750	11,612		
Vermont	8	4	4	290					2	15		25	7,516	2,862	6,075	2,141	1,441	721
1965	8	4	4	290					2	15		25	7,516	1,630	6,075	1,154	1,441	476
1966														1,232		987		245
Virginia	19	12	7	1,287						225		290	33,921	20,518	28,661	17,658	5,260	2,860
1965	12	6	6	652						225		140	18,621	11,453	14,161	9,033	4,460	2,420
1966	7	6	1	635								150	15,300	9,065	14,500	8,625	800	440
Washington	33	28	5	1,662				10	2		1	100	53,737	21,494	51,565	20,625	2,172	869
1965	25	21	4	1,412				6	2		1	50	42,517	14,806	40,695	14,077	1,822	729
1966	8	7	1	250				4				50	11,220	6,688	10,870	6,548	350	140

Summary of anticipated construction of hospitals and other medical facilities (under title VI of the Public Health Service Act) if there were no limitation on Federal assistance, United States and territories, for fiscal years 1965 and 1966—Continued

State and program year	Number of projects			Beds or units added, by type of project									Estimated cost (thousands)					
				Part C					Part G				Total program		Part C		Part G	
	Total	Part C	Part G	General hospital	Mental hospital	Chronic hospital	TB hospital	Health center (units)	Diagnostic or treatment (units)	Chronic hospital	Rehabilitation facilities (units)	Nursing homes	Total cost	Federal share	Total cost	Federal share	Total cost	Federal share
West Virginia	32	29	3	955	45	70	----	7	1	----	----	175	32,370	16,175	28,970	14,475	3,400	1,700
1965	19	16	3	590	45	60	----	3	1	----	----	175	22,890	11,436	19,490	9,736	3,400	1,700
1966	13	13	----	365	----	10	----	4	----	----	----	----	9,480	4,739	9,480	4,739	----	----
Wisconsin	86	42	44	3,162	162	----	----	1	6	450	6	1,480	125,343	50,105	95,460	38,152	29,883	11,953
1965	51	23	28	1,318	112	----	----	1	2	300	5	1,028	55,931	22,342	37,964	15,154	17,967	7,188
1966	35	19	16	1,844	50	----	----	----	4	150	1	452	69,412	27,763	57,496	22,998	11,916	4,765
Wyoming	15	6	9	229	----	----	----	----	1	----	----	253	6,345	2,530	3,525	1,120	2,820	1,410
1965	15	6	9	229	----	----	----	----	1	----	----	253	6,345	1,410	3,525	510	2,820	900
1966	----	----	----	----	----	----	----	----	----	----	----	----	----	1,120	----	610	----	510
Guam	1	1	----	----	----	----	----	1	----	----	----	----	36	24	36	24	----	----
1965	1	1	----	----	----	----	----	1	----	----	----	----	36	24	36	24	----	----
1966	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----
Puerto Rico	47	38	9	1,932	----	----	----	----	7	----	----	150	50,508	43,943	45,783	40,288	4,725	3,655
1965	17	13	4	1,156	----	----	----	----	2	----	----	150	29,501	25,096	26,026	23,243	3,475	1,853
1966	30	25	5	776	----	----	----	----	5	----	----	----	21,007	18,847	19,757	17,045	1,250	1,802
Virgin Islands [1]	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

[1] Data not available.

Source: State agency reports to the Public Health Service.

Mr. YOUNGER. Doctor, will you turn to page 15 of the bill, please?

Dr. TERRY. Yes, sir.

Mr. YOUNGER. On line 16, after "and," I propose to submit an amendment as follows, "and a majority comprised of representatives of consumers." In other words, let the consumers majority control that decision. Have you any reaction to that?

Dr. TERRY. At the moment, I don't see any objection to it, Mr. Younger. I have not had a chance to study it thoroughly but I don't see any objection immediately.

Mr. YOUNGER. Then a number of places where we have the proprietary views, to say proprietary or private, nonprofit, and include those both in the same category.

Dr. TERRY. No, sir. Private nonprofit and proprietary could not be included in the same category. When we speak of proprietary we speak of profit or potentially profitmaking organizations.

Mr. YOUNGER. This is in regard to the mortgage insurance.

Dr. TERRY. Yes, sir. But you could not put nonprofit institutions in with profitmaking institutions.

Mr. YOUNGER. Here is the theory. Unfortunately, it seems to me in this bill the proprietary hospitals and other facilities are given the privilege of having insured mortgages up to 90 percent.

Dr. TERRY. This is only nursing homes.

Mr. YOUNGER. Nursing homes and on hospitals also, they get insurance.

Dr. TERRY. They get insurance?

Mr. YOUNGER. Seventy-five.

Dr. TERRY. Not proprietary hospitals.

Mr. YOUNGER. You mean no insurance at all for them?

Dr. TERRY. That is right, sir.

Mr. YOUNGER. In nursing homes, why should a nonprofit nursing home, if there are no funds available within the State, be denied the same rights that a proprietary nursing home receives?

Dr. TERRY. The program for proprietary nursing homes guarantees loans up to the 90-percent level. However, we feel that in a community project, whether it be a nursing home or hospital sponsored by a nonprofit type of organization, whether it is public or privately owned, that there should be enough support in the community to supply at least up to 25 percent of the total cost.

Mr. YOUNGER. That would be true, but if you have a nonprofit institution, and there are no funds available, there are no grants available, the funds have all been exhausted, why should they be denied insurance on the same basis that a proprietary nursing can secure?

Dr. TERRY. I think, basically, the problem arises here that you are dealing with different types of institutions in terms of your nonprofit as contracted with your proprietary.

Mr. YOUNGER. Certainly you are. But here is a nonprofit nursing home, for instance, that would be approved by your State agency, but the funds are all exhausted. However, they would like to build and get their mortgage insured. Why should they be limited to a degree more than the proprietary institutions?

Dr. TERRY. I think the question here is that if a nonprofit type of facility is to be built in a community and you can't get more support than that for it, it is in a very hazardous fiscal circumstance, in my

opinion, in terms of its long-range outlook. This is a community project in contrast to an individual or group business project.

Mr. YOUNGER. You are announcing a theory there, Doctor, that brings to my mind the reason why we should not shift this insurance from where it is at the present time to your Department. What you are saying is that if a proprietary group comes in and wants insurance, you give them insurance up to 90 percent, and that is all right.

They only have to furnish 10 percent. That is a perfectly good basis on which to insure. But if it is a nonprofit institution, then we have to have a whole lot larger basis in order to insure its continuance than a proprietary institution. Why?

Dr. GRANING. With Dr. Terry's permission, I would like to make two points in this connection, sir. The present 90-percent loan guarantee program of FHA is not a matter over which the Department of Health Education, and Welfare had any voice. We did not recommend a 90-percent level for the Federal Government to give a loan guarantee to proprietary nursing homes.

We know that this is now an operating program at the 90-percent level. When one builds a hospital, for instance, we know in just 26 months the operating cost of the hospital tends to equal the cost of construction. If it is true that with reference to a nonprofit facility there cannot be marshaled enough community interest to put up 25 percent of the cost of building the facility, we do not believe it is in the public interest to encourage that area to build a facility.

We also do not think it is in the public interest for an institution to start operating with a very large indebtedness that has to be written off over a period of time. Our experience in hospital construction has led us to the conviction that when there is enough community support to put up their share the people feel involved in it and they want to make it successful, and this is why, sir, we have suggested that the maximum grant and loan to a nonprofit facility be 75 percent.

Dr. TERRY. Another point that might be mentioned in that respect, Mr. Younger, is that, in many of these instances where loans are involved for nonprofit institutions, there will also be grants involved for a portion of that 75 percent.

Mr. YOUNGER. I am giving you an example where there is no grant and there are no funds available, but it is an institution that is approved by the State. To go back to your argument, you have already testified that the program of insurance up to 90 percent which is now going forward with the FHA has been successful.

You have already testified to that. Now are you saying that it is not successful?

Dr. TERRY. No, sir. To be exact, Mr. Younger, the thing I said related to the administration of the program in FHA. Insofar as I knew the administration had been satisfactory. That was the term I used.

Mr. YOUNGER. That is right. As far as you know there have been no claims made on the Government as far as the insurance is concerned.

Dr. TERRY. I am not sure about that at all. I don't know.

Mr. YOUNGER. You don't know.

Dr. TERRY. I don't know positively or negatively on that question.

Mr. YOUNGER. That is all, Mr. Chairman.

The CHAIRMAN. Mr. Pickle.

Mr. PICKLE. Doctor, section 644 of this bill provides grants in the field of research, experimentation, and design of hospitals. It further provides that no one grant would exceed $500,000, or in some instances not to exceed over 50 percent. I am assuming that wherever there has been a grant made by a previous Congress, or where a program is underway for the design of a hospital, you don't intend to cut that out.

To be more specific, there was an appropriation made last year for the design of a new hospital at Georgetown University. This has been advanced to a point where I think they are getting underway now.

Dr. TERRY. This would certainly not affect obligations which have already been made under current law.

Mr. PICKLE. It would not affect that?

Dr. TERRY. It would not affect that.

Mr. PICKLE. In other words, you would accept language that would exclude grants already made by the Congress?

Dr. TERRY. Yes, sir. I would doubt that the language is even necessary, but if the committee felt that it was, I would see no objection to it.

Mr. PICKLE. That is the only question I have now.

The CHAIRMAN. Mr. Long.

Mr. LONG. I have no questions, Mr. Chairman.

The CHAIRMAN. Does anyone else have any questions?

If not, Doctor, thank you very much for your appearance here this morning. Doctor, we brought you back, and your associates with you that were here before with Mr. Celebrezze, in order to get as fully acquainted with the proposed program as possible. We just have a different quarterback this morning.

Mr. LONG. Mr. Chairman, I think it might be in order to compliment the associates that Dr. Terry has with him on their ability to furnish him information rapidly and unobtrusively.

Dr. TERRY. The Surgeon General of the Public Health Service, with the multitude of responsibilities he has, would be a dead duck if he did not have a fine staff backing him.

Mr. LONG. You certainly do.

The CHAIRMAN. They should be all good, because they have had practice before. This is the second round within recent days.

This will conclude the hearings, and we will permit 5 days for any additional information to be filed. Now, we did the same thing when we concluded the hearings before and announced at that time that it was our intention to try to get this bill considered by the committee prior to the Easter recess, and then these other developments occurred.

In doing so, I did inquire, Doctor, of your group about the record, and I learned that the transcript had not been returned and we did not even have a galley proof. I know you have a lot of work just like we do here. All of us have a lot of work. We will be unable to take this up until we do get all the record together.

Mr. BENNETT. I hope, Mr. Chairman, that we will be able to have the record printed before we take the bill up in executive session.

The CHAIRMAN. We will proceed with the record just as fast as we can and getting it printed, as we always do. It is going to be my intention to call the committee together in executive session on this the week of April 13. That should give plenty of time for everybody to get their material in and get the record printed.

Mr. BENNETT. If you give them 5 days from now, it will be plenty of time between then and the 13th to get the record printed.

Dr. TERRY. Mr. Chairman, I was not aware that this transcript was not back. It is in the Department, if it has not been sent back, and I shall certainly see that this gets right back.

The CHAIRMAN. It may have gotten back in the last day or two. At the same time there was to be supplied certain information, and one was a comparison of the costs in table form.

I want copies of that table for each member of the committee. I am trying to outline to you something of our problem. We need the information enough in advance to be able to study it to help us decide what to do. I am trying to announce a schedule far enough in advance so that everyone can prepare for it and be ready.

This is going to be another record this morning. It would be very helpful to the staff in getting the record together and to the Printer for printing, if you could have someone get this back just as soon as your time and convenience will permit.

Dr. TERRY. Mr. Chairman, after your pointed remarks, I can assure you there will be no delay in getting the copy back to you.

The CHAIRMAN. Thank you very much. Again, we are glad to have you back with the committee. I hope you enjoyed your experience in Geneva with the World Health Organization, and I am sure you contributed a lot to it as well as got a lot out of it.

Dr. TERRY. I did, Mr. Chairman. Before you came in, I remarked to the members of the committee about how happy we were to have two members of this committee as our congressional advisers this year. I think they did an outstanding job and we were grateful to have them.

The CHAIRMAN. I am glad two members of the committee could be with you. We already have had some reports from them and we expect more.

This will conclude the hearings on this bill as announced.

Thank you very much.

Dr. TERRY. Thank you, sir.

(The following material was submitted for the record:)

TESTIMONY OF THE BLUE CROSS ASSOCIATION ON H.R. 10041 HOSPITAL AND MEDICAL FACILITIES AMENDMENT OF 1964

My name is Walter J. McNerney. I am president of the Blue Cross Association. The following statement is made on behalf of the member plans of the association which together provide health benefits to approximately 59 million citizens.

Blue Cross plans feel that the Hospital Survey and Construction Act, built on Federal, State, and local cooperation, has served several useful purposes. It introduced on a broad scale a concept of areawide planning and it stimulated the growth of needed facilities and programs. This stimulation was and is important. The public will not and should not have to tolerate unwarranted delays in the translation of advances in medical sciences into concrete and reasonably available services.

Blue Cross feels that the act should be extended, but wishes to underscore several considerations. In conjunction with construction and programing emanating entirely from voluntary sources, the act has involved the Government in

the construction of beds based on varying concepts of need; it has contributed in some part, through focus on acute inpatient facilities, to the imbalance existing among preventive, acute, subacute, and rehabilitative services; and it has put at times excessive emphasis on small hospital construction in areas where fewer and larger hospitals, with the existence of ever-improving transportation, would be more productive.

These rough spots are to be expected in programs that blaze new trails. It is important, however, to correct them on the basis of experience.

A matter of prime importance is the development of better planning criteria. In some sections of the country bed-need formulas call for almost twice as many acute beds per thousand population as in other sections. The proportioning of resources among types of facilities and services, such as general and special hospitals, nursing homes, and ambulatory services, varies greatly also. Whereas the needs of the public differ somewhat by area, a broad range in measurement cannot be defended.

Also of major importance is the need for discipline in the modernizing of or expansion of old facilities and in the building of new facilities. Throughout the country there should be planning agencies that develop construction programs, based on the best information available, and that proceed, in every way possible, to relate major building changes or new building to areawide plans. Presently a few urban areas through voluntary planning councils are doing a highly commendable job backed up by State agencies; some State agencies, limited largely by the influence of Government money, are attempting to promote continuity of care through a concept of regionalization; but, in fact, many areas of the country, while they might have paper plans, have little more. Ways must be found to increase the number of metropolitan planning councils, to enlarge their geographical scope, and to tie them together into State or, where appropriate, multi-State units. The council should concern themselves not only with acute general hospital care, but also with a broad range of health services. It is an established fact that once a hospital bed is provided there is a strong tendency for it to get used and, as a result, to increase the community health bill. On top of initial capital costs follow years of operating costs. Given the growing costs of hospital and other health care and the growing percentage of personal consumption expenditures needed for proper health care, effective action should not be delayed.

Amendments to the Hospital Survey and Construction Act should make firm provision for the development of planning criteria so that concepts of need are not so widely variable. Strong support should be given to the development of voluntary planning organizations on market trading area and State levels. These should work in cooperation with State agencies and provision should be made for experimentation with several patterns. Also funds should be conditioned on responses to planning needs to a greater degree. Without the checks and balances of coordinated planning, which should involve the public extensively, as well as providers of care, the degrees of Federal and State participation should not be uncritically liberalized.

Recognizing that the way money is spent affects the quality and effectiveness of care, our stress, in essence, is upon the need to assure the consumer that the provision of care is related to need not only in total amount but in kind.

Blue Cross shares with the American Hospital Association and other groups grave reservations about including proprietary nursing institutions in an act which utilizes public funds in the implementation of community programs.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
OFFICE OF THE MAJORITY LEADER,
Washington, D.C., April 1, 1964.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: There is enclosed a copy of a letter which I have received from the Oklahoma Hospital Association, Inc., stating its views and recommendations with respect to H.R. 10041, the Hospital and Medical Facilities Amendment of 1964. It will be appreciated if this can be made a part of the record. The association's major complaint, of course, has to do with the modest

authorization which will allow only limited progress in hospital modernization in view of present-day costs. I will appreciate, and I know the Oklahoma Hospital Association also will be grateful for, any consideration which may be given their suggestions.

Sincerely,

CARL ALBERT,
Member of Congress.

OKLAHOMA HOSPITAL ASSOCIATION, INC.,
Tulsa, Okla, March 26, 1964.

Hon. CARL ALBERT,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ALBERT: The Oklahoma Hospital Association has reviewed H.R. 10041, Hospital and Medical Facilities Amendment of 1964, with representatives of the American Hospital Association.

We are greatly pleased that the Federal Congress has seen fit to assist in the modernization of the older hospitals, but were distressed that the Congress authorized only $160 million for the 5-year period. We sincerely believe that this is not a realistic figure considering the great number of our larger hospitals, particularly the medical centers, most pressing needs for modernization. We further believe that this money should be allocated for modernization purposes only, as this is the most pressing need, rather than new beds.

We also question the advisability of transferring the present mortgage insurance for proprietary nursing homes from the Federal Housng Administration to the Public Health Service.

We noted that the rate of interest on short loans is available to health facilities for 6½ percent. We believe this woudl be prohibitive to nonprofit health facilities as they would not be able to retire the principal and pay the interest without a substantial increase in their charges to their patients. Since the sick patients will be paying this interest, we think it would be justifiable for the program to offer long-term, low-interest, direct Federal loans.

We would greatly appreciate your taking time to study this important piece of legislation and consider our suggestions.

Again, we would like to thank you for your splendid cooperation with the Oklahoma hospitals.

Sincerely,

CLEVELAND RODGERS,
Executive Director.

STATEMENT OF THE AMERICAN OSTEOPATHIC ASSOCIATION, BY CARL E. MORRISON, D.O., CHAIRMAN, COUNCIL ON FEDERAL HEALTH PROGRAMS, WASHINGTON, D.C.

The American Osteopathic Association appreciates this opportunity for comment on H.R. 10041, 88th Congress, a bill revising and extending the Hill-Burton program for an additional 5 years to June 30, 1969.

The American Osteopathic Association is a nonprofit, tax-exempt federation of divisional societies of osteopathic physicians and surgeons, the first objective of which, as set forth in its constitution is "to promote the public health."

Our support of a national hospital program of Federal assistance for building new hospitals and providing additional beds in existing hospitals, in accordance with State plans, to increase the availability of hospital care, particularly in rural areas, dates back to 1940, S. 3230, 76th Congress, and has continued throughout the years.

On May 30, 1940, a national hospital bill, S. 3230, passed the Senate. It included provision for a National Advisory Hospital Council to consist of eight members to "be selected from leading medical, osteopathic, or scientific authorities who are outstanding in matters pertaining to hospitals and other public services."

When the Hill-Burton bill was finally adopted in 1946, the areas for appointment to an eight-member Federal Hospital Council were couched in general terms. The act of October 31, 1963, Public Law 88–164, increased the membership of the Federal Hospital Council to 12 members and in so doing reverted to particularity of some of the fields to be represented. H.R. 10041 retains the increase to 12 members and since no authority in the field of the osteopathic profession and hospitals has been appointed to the Council, we feel that such an appointment is long overdue.

Section 2 of H.R. 10041 authorizes $45 million for special project grants to assist public and nonprofit agencies in areawide planning of health and related facilities. A report of the Joint Committee of the American Hospital Association and the Public Health Service (PHS publication No. 855) on "Areawide Planning for Hospitals and Related Health Facilities" points out that planning agencies may find it advisable to—

"refuse to recommend projects for Federal or State assistance and discourage actively the use of capital funds from any source for construction which is not consonant with the plan."

Manifestly, the osteopathic profession is vitally interested and should have a voice in the resolution of such planning problems as duplication of facilities, maldistribution, underutilization, understaffing, and shortage of trained personnel. We hope the legislative history will make clear the desirability of osteopathic representation wherever available on the areawide planning agencies assisted in this program.

The following statistics for the year 1962, the latest available, were prepared by the American Osteopathic Hospital Association, an affiliate of the American Osteopathic Association:

Number of osteopathic hospitals	330
Number of beds	14,115
Number of newborn bassinets	2,390
Number of admissions	531,263
Number of live births	81,260
Total expenses	$126,440,594
Average daily census	10,190
Average daily census—newborn	890
Cost per patient-day	$34.75

All hospitals included in the above statistics are professionally directed by osteopathic physicians and surgeons. Ninety-five percent of the beds are in hospitals accredited by the Bureau of Hospitals of the American Osteopathic Association. Accreditation standards relating to professional staff include, among others, the following provisions:

"The hospitals must be able to show evidence of maintaing a qualified and well-organized professional staff.

"(*a*) There must be a minimum of there organized professional departments as follows:

"(1) Osteopathic medicine.

"(2) Obstetrics and gynecology.

"(3) Surgery.

(*b*) "Radiology and pathology services must be provided.

"The staff must be composed of licensed osteopathic physicians who are members in good standing of their national and divisional associations, and local associations where such exist.

"Courtesy staff privileges may be accorded, other licensed physicians and dentists who are members in good standing of the American Medical Association, American Institute of Homeopathy, American Dental Association, and their respective component societies, each in his proper category." (Excerpted from "Requirements for the Training of Interns and/or Residents as approved by the American Osteopathic Association.")

Since the inception of the Hill-Burton program, 65 osteopathic projects have been approved involving a total construction cost of $51,387,242, including the Federal share of $17,514,198. These projects provided 3,096 beds, of which 1,379 or 44.5 percent were in new hospitals. Categories represented include 51 general hospitals, 7 diagnostic and treatment centers, 4 nursing homes, 2 chronic disease facilities, and 1 rehabilitation facility.

We are pleased that the bill includes a new program of grants for modernization of hospitals and other medical facilities. In our presentation to this committee in 1958 we requested that the program be expanded in this respect. We stated:

"Ninety of the hospitals containing 40 percent of the beds are located in cities of over 100,000 population. A substantial number of these need to replace obsolete beds, but they are prevented from Hill-Burton participation for the purpose due to the operation of a priority system that has become unrealistic in this respect."

The bill also authorizes a new program of mortgage insurance for construction and modernization of hospitals and other medical facilities. The insured loan could not exceed 50 percent of the value of the facility after completion

of the project, and could not, when added to the amount of any Federal grant for the project, exceed 75 percent of the value of the facility after completion. The insured loan could not exceed 40 years and must be completely amortized by periodic payments. The interest rate could not exceed 6 percent. The program would apply to nonprofit hospitals and medical facilities and to proprietary nursing homes. Insofar as it applies to nonprofit facilities, we urge that the loans be made directly by the Federal Government and that the interest rate be equated with the going Federal rate for numerous other programs.

MINNEAPOLIS, MINN., *March 5, 1964.*

HON. ANCHER NELSEN,
House of Representatives,
New House Office Building, Washington, D.C.:

The Minnesota Hospital Association has heard that House bill 10041 will be heard on Monday or Tuesday of next week. It is our understanding that this bill would make the bulk of Hill-Burton money available for the building of new hospitals. This might be desirable in some States, but Minnesota now has a hospital within 20 miles of almost everyone in the State. Any moneys available to Minnesota should be for renovation or improvement of present facilities. Good medical care would be served better if we could enlarge present units or renovate and improve the equipment in present units. We hope that any bills that might be promoted in this area, you will keep this viewpoint in mind.

GLEN TAYLOR,
Executive Secretary, Minnesota Hospital Association.

WASHINGTON, D.C., *March 20, 1964.*

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
Washington, D.C.:

The National Association for the Advancement of Colored People urges that the present nondiscrimination clause in the Hill-Burton Act be retained with the deletion of its "separate but equal" provision when the act is amended by H.R. 10041 now being considered by your committee. Experience has shown that Federal agencies are reluctant to act against discrimination in the programs they administer without a clear congressional mandate. Moreover, failure to enact a nondiscrimination clause in clear terms would represent a retreat by Congress from its original action when it passed the Hill-Burton Act. We, therefore, ask the Committee on Interstate and Foreign Commerce to amend H.R. 10041 in order that the nondiscrimination provision of the act (42 U.S.C. 291E(f)) be retained and applied to all provisions of the amended act with the deletion of the following language: "But an exception shall be made in all cases where separate hospital facilities are provided for separate population groups if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group." We request that this telegram be made part of the record of the hearing on H.R. 10041.

CLARENCE MITCHELL,
Director, Washington Bureau, NAACP.

NATIONAL ASSOCIATION FOR THE
ADVANCEMENT OF COLORED PEOPLE,
New York, N.Y., March 31, 1964.

HON. JOHN D. DINGELL,
U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN DINGELL: Reference is made to my telegram of March 20 to Congressman Oren Harris, chairman of the Interstate and Foreign Commerce Committee, on H.R. 10041, a copy of which was sent to you.

We wish to reiterate the necessity of strong clear prohibitions against racial discrimination being written into any bill extending and amending the Hill-Burton hospital program. Our experience with the Department of Health, Education, and Welfare indicates that its officials are reluctant to act to implement the nondiscrimination provision even against hospitals that have contractually committed themselves to a program of nondiscrimination. It is our belief that this reluc-

tance can be overcome only by a congressional mandate couched in the strongest possible language.

We have been advised that the American Medical Association in testifying on H.R. 10041 requested an amendment declaring that the acceptance of funds by a hospital will not be construed as making a private facility a public institution.

We oppose this proposed amendment. We view it as an attempt to circumvent the effect of the decision in *Simkins* v. *Cone Memorial Hospital*, 325 F. 2d 959, cert. den., 32 U.S. L.W. 3304. The decision in this case held the "separate but equal" provision of the Hill-Burton Act to be unconstitutional and held that hospitals receiving assistance under the act were involved in State action within the meaning of the 14th amendment.

Since there was no occasion to raise the issue of the effect of the act on private hospitals prior to the decision in the *Simkins* case, we believe the only purpose in raising it now is to undermine the effect of that decision. We urge you to oppose this and any other attempts to revert to the "separate but equal" practice.

Sincerely yours,

CLARENCE MITCHELL,
Director, Washington Bureau.

UNITED STATES CONFERENCE OF MAYORS,
Washington, D.C., March 18, 1964.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The United States Conference of Mayors and the American Municipal Association have supported the Hill-Burton program of grants for the construction of hospital facilities since its inception. We are pleased at this time to advise you of our support for a 5-year extension of the program as provided for in your bill, H.R. 10041, the Hospital and Medical Facilities Act of 1964.

The basis of our support is embodied in the attached resolution approved by the membership of the United States Conference of Mayors in May of 1963 and by the attached policy statement adopted by the membership of the American Municipal Association at its annual meeting in August of 1963.

You will also note in reviewing the resolution and the policy statement that in addition to supporting the extension of the Hill-Burton program both organizations most strongly urge the enactment of amendments to the basic legislation which will provide Federal assistance for modernization and renovation of existing hospital facilities.

As administration witnesses have testified, the backlog of need for reconstruction and modernization of hospital facilities amounts to approximately $4 billion and this backlog is growing.

It has been conservatively estimated that it will take at least $150 million a year in grants for renovation and modernization purposes over a 10-year period to make any significant inroads into this serious deficiency. Even a program of this size would not provide for the additional urban hospital demands which grow out of population growth and accelerated urbanization.

We therefore urge your committee to approve your bill, H.R. 10041, as introduced, with an amendment authorizing $150 million a year for renovation and modernization programs, which would be in addition to the authorization of a minimum $225 million annually for the traditional new construction programs.

In conclusion, Mr. Chairman, we emphasize the urgency of the need for assistance to the Nation's major medical complexes, which are for the most part located in our metropolitan areas. These hospital centers serve as a training ground for nearly all of the Nation's practicing doctors and nurses, and in addition, provide highly specialized treatment and facilities which are available to and used by all the people of the Nation.

Respectfully,

JOHN J. GUNTHER,
Executive Director, United States Conference of Mayors.
PATRICK HEALY, Jr.,
Executive Director, American Municipal Association.

P.S.—We would greatly appreciate your including this letter, along with the attachments, as part of the record of the public hearings on H.R. 10041.

Enclosures.

RESOLUTION ADOPTED, 30TH ANNUAL CONFERENCE OF MAYORS, UNITED STATES CONFERENCE OF MAYORS, HONOLULU, HAWAII

HOSPITAL FACILITIES

Whereas the construction and operation of hospitals and other health facilities involve substantial investments of funds by private groups and local, State, and Federal governments, and every effort should be made to insure that (1) existing health facilities and services are well coordinated and are utilized fully, effectively, and economically; (2) additional health facilities are constructed where—and only where—they are needed; (3) expensive services, facilities, and equipment are not unnecessarily duplicated; and

Whereas the current deficit of quality nursing homes will become more serious as our aged population continues to increase, and the construction of additional long-term care facilities in a community will relieve some of the pressure for the more expensive general hospital beds and facilities; and

Whereas the Public Health Service determined through a study made in cooperation with State agencies that the cost of modernizing and replacing health facilities throughout the country amounts to more than $3.6 billion, and hospital and community leaders agree that (1) many of the quality-care hospitals located in the more densely populated areas of each State are structurally or functionally obsolete, and can no longer provide efficient and economic service; (2) smaller rural and suburban hospitals must depend on the larger facilities located in urban centers for specialized services and care; (3) facilities located in our urban centers cannot receive effective financial aid from the Hill-Burton program because of the limited funds available and the priority accorded projects which provide additional beds in rural and suburban areas; and

Whereas the Hill-Burton program—now due to expire on June 30, 1964—has proved to be an effective stimulant to the construction of sorely needed hospitals, public health centers, nursing homes, diagnostic and treatment centers, and rehabilitation facilities, and States and communities report that the need and demand for additional facilities continue unabated; now, therefore, be it

Resolved, That the United States Conference of Mayors urge amendments of the Hill-Burton legislation to—

(1) Authorize special project grants to stimulate the activation and operation of planning bodies in communities, areas, regions, and States for the purpose of developing comprehensive plans for the construction, utilization, and coordination of all types of health facilities.

(2) Increase the annual appropriation ceiling for construction of nursing homes from $20 million to a higher figure more commensurate with needs.

(3) Authorize a grant program designed to assist the States and communities in modernizing and replacing hospitals and other health facilities throughout the country, giving special consideration to those located in the more densely populated areas.

(4) Extend the life of the Hill-Burton program for 5 years beyond the expiration date of June 30, 1964.

NATIONAL MUNICIPAL POLICY OF THE AMERICAN MUNICIPAL ASSOCIATION

HOSPITAL CONSTRUCTION

The provisions of the Hill-Burton Act have probably accounted for the greatest single contribution to the health of this Nation in recent years. Properly directed toward providing hospitals in rural and smaller population areas, the results have more than justified the vision of the sponsors.

However, while the Hill-Burton program has accomplished a great deal to improve the Nation's hospital plant, it has done so primarily in terms of new construction and has left virtually untouched a serious and rapidly growing need for renovation and modernization of our older hospital facilities. The channeling of the bulk of Hill-Burton funds into new construction rather than renovation, together with the emphasis which that program places on rural areas, has produced in many cases a pattern of modern and efficient small hospitals in regions surrounding metropolitan areas, while the metropolitan areas themselves are served by institutions many of which are far from being either modern, efficient, or fire safe. The plight of these urban hospitals and the growing deficiency of their physical plant are important to the total health picture.

A recent survey conducted by the U.S. Public Health Service has estimated that the cost for needed hospital modernization and replacement in the Nation's metropolitan areas exceeds $3.5 billion. On the basis of the reported assets of $15.5 billion of all U.S. hospitals (as reported by the American Hospital Association) the bill for obsolescence is about 20 percent of assets.

In addition to this, urban communities are in a state of social flux around the hospital doors; neighborhoods are being transformed by superhighways, by industry and commerce, and by the movement of people to the suburbs. All of these factors create new pressures requiring that special attention be devoted to urban modernization and replacement, including the relocation of some facilities to other sites.

We therefore recommend that the Congress, in addition to continuing the Hill-Burton Program at the present authorization, modify the act to create a new program, either for Federal matching grants or long-term low-interest loans, for modernization and renovation of facilities in our urban areas and that funds in the amount of $150 million per year be authorized for this program. Under such an approach the orderly development of the Nation's hospital system is assured. New hospitals can be built where they are most needed, and existing hospitals can be renovated, restoring them to modern efficiency and acceptable standards of safety.

We recommend that the Congress support the development of urban planning programs for hospital facilities.

STATEMENT OF DR. IMRE WEITZNER, PRESIDENT, PHYSICIANS CHAPTER, AMERICAN JEWISH CONGRESS, ON H.R. 10041

This statement is submitted on behalf of the Physicians Chapter of the American Jewish Congress. As members of the American Jewish Congress, we are committed to the principle that the destinies of all Americans are indissolubly linked and that any act which injures one group necessarily injures all groups. Believing as we do that Jewish interests are inseparable from the interests of justice and the well-being of all Americans, we are concerned with all issues raising questions of discrimination, humilitation, or sacrifice inflicted because of race, religion, or national origin. As doctors we are particularly concerned that the physical and mental well-being of all persons in the United States be advanced and that improved medical facilities be made available to all persons. We therefore welcome this opportunity to present our views at these hearings on the Harris-Hill bill (H.R. 10041).

In general, we approve of Federal financing of the construction of medical facilities within the various States and support this revision of the 1946 Hill-Burton Act providing for the improvement of public health through the consolidation and expansion of hospital and other medical facilities.

Our basic concern in this testimony is with the aspects of the Harris-Hill bill relating to the use of the medical facilities by all citizens without discrimination on the basis of race or religion. Our fundamental principle is that no physician, patient, or paid employees of a hospital receiving Government funds shall be discriminated against or suffer any disadvantage by reason of his race, religion, national origin, or ancestry. We believe this principle consonant with the public policy of this country and with the general dictates of fairness. Further, we think it required by the mandate of equality imposed on the State and Federal Governments by the 5th and 14th amendments to the U.S. Constitution.

We are therefore gratified that the present bill omits the section of the Hill-Burton Act (291e(f)) which permitted segregated facilities for separate population groups. It had, of course, been clear for many years that this section was unconstitutional. Obviously, the mere retention of this provision on the Federal statute books violated the constitutional obligations of the Congress itself. Further, an estimated $600 million of Federal funds had gone into the construction of over 2,000 medical facilities in Southern States since 1946 and in practically all of these "separate but equal" faciilties Negroes were discriminated against in one way or another. In short, under the Hill-Burton Act, Congress sanctioned by a patently unconstitutional provision the discriminatory use of tax-raised moneys amounting to one-third of the total funds allocated under the act.

The gross injustice of this situation will, we trust, be rectified by the passage of the present bill, and funds obtained by the compulsory taxation of all persons without regard to race, will be used for the benefit of all persons—at least in their capacity as patients—equally without regard to race.

We are not certain, however, that under the present formulation other forms of discrimination on the basis of race, religion, national origin, or ancestry are as clearly barred. As will be recalled, section 291e(f) of the 1946 Hill-Burton Act provided that the State plans would "provide for adequate hospital facilities for the people residing in a State, without discrimination on account of race, creed, or color * * *" with an exception permitting segregated facilities. The Harris-Hill bill substitutes for this provision a paragraph (sec. 603(e)) stating that "the State plan shall provide for adequate hospitals and other facilities * * * for all persons residing within the State. * * *" We assume that this language is intended to encompass the broad antidiscrimination provision of the original act so as to bar discrimination on the basis of religion, national origin, or ancestry as well as discrimination on the basis of race.

It is conceivable, however, that the language of the bill will be construed as applying only to patients, and not as requiring nondiscriminatory employment practices, or nondiscriminatory use of the facility by doctors and other medical staff. Further, it is possible for hospitals to evade even their statutory obligation toward patients by various administrative practices which tend to discourage use of the facility by minority groups.

To avoid this emasculation of the broad principle favoring equal use of the facility by "all persons residing in the State" we urge the inclusion of statutory language covering the following points:

1. "No patient otherwise qualified shall be denied admission to or be discriminated against in use of the facilities of the hospital because of his race, religion, national origin, or ancestry. Patients shall not be segregated on the basis of race, national origin, or ancestry, nor, without their consent, on the basis of religion."

An exception is made in the case of religion to the absolute prohibition of segregation. In many instances it may be permissible and even desirable to place a patient in a room or ward with his coreligionists, since religious symbols in a room, which might be offensive to some, may offer comfort to others. However, even in these cases it should not be done against the will of the patient or of the person whose consent is required for the patient's admission to the hospital.

2. "No otherwise qualified physician or applicant for a position as a member of the regularly paid nursing, administrative or other staff of the hospital shall be discriminated against on the ground of race, religion, national origin, or ancestry, or because he or she practices or advises medical treatment which is not unlawful and which accords with medical standards, or is a member of an organization which practices or advises such treatment."

This provision will make clear that in general nondiscriminatory employment practices are a condition of Federal assistance. We recognize that many denominational hospitals are staffed in whole or in part by persons who are members of religious orders that impose vows of poverty and that these persons do not receive regular payment for their services. It is possible that a denominational hospital should be permitted to select such persons in preference to lay employees. However, if the hospital does engage lay employees, it should not be permitted to practice racial or religious discrimination in its selection of such employees.

The second clause of this provision recognizes that certain medical practices are forbidden by the dictates of some religions, but are nevertheless lawful and considered acceptable by the medical profession generally. A physician who engages in such a practice or is a member of an association that counsels it should not be denied employment by the hospital or access to its facilities, if he is otherwise qualified, merely because these practices are forbidden by the religious dictates of the hospital management. Such denial clearly constitutes discrimination on grounds of religion.

3. "The facilities of the federally assisted medical institution shall not be refused for any operation or medical treatment which is lawful and which accords with accepted medical practice. Further, while no member of the medical, nursing, or other staff of the hospital shall be required to participate in any treatment which violates his religious beliefs, the hospital shall be required to provide qualified medical assistance by persons whose religious beliefs are not violated by participation in the treatment."

We believe that the refusal to allow medical treatment which is not unlawful and which is approved by general medical practice because it is contrary to the religious convictions of the management of the hospital is in effect a denial

of facilities to a patient needing such treatment solely on the grounds of religion. The denial imposes upon the patient the dogmas and doctrines of a religion which he does not profess. Whatever the justification for such a procedure on the part of the private hospital which receives no Government assistance, this practice is without justification in the case of a hospital receiving Government funds. If we accept the premise that denominational hospitals may receive Government funds, it is probably neither realistic nor practical to require that persons managing the hospital either relinquish their religious convictions or forgo the acceptance of Federal moneys. Since it is necessary to find an adjustment for the conflicting considerations, we suggest a provision permitting personal nonparticipation by individual members of the hospital staff, providing competent and adequate substitutes are supplied.

4. "If chapel facilities are available to patients of one faith, there shall be acceptable and equivalent facilities for patients of all faiths." (This may be accomplished by separate chapels for Protestants, Catholics, and Jews, or a single chapel which can be used as needed by each of the faiths consistent with the specific requirements of the faith.)

5. "There shall be no religious symbols or statues in the public or common parts of the hospital. Religious symbols and statues may be placed in the rooms and wards of those patients requesting them."

Persons of some religions consider it sinful to enter premises in which religious statues or symbols are publicly exhibited, and it is clear that the exhibition of such statues or symbols effectively bars these persons from availing themselves of the hospital's facilities. This is, in effect, an act of discrimination. We recognize that many patients desire to be in a room having religous symbols and statues and note that compliance with this desire does not infringe upon the rights of others. The question of religious symbols and statues in wards of patients of various religions can be left to the sound discretion of the hospital management. Wherever practicable, the patients could be distributed so as to minimize as far as possible any sense of religious embarrassment or discomfort.

6. "Services of clergymen shall be available to all patients on equal terms. No pressure shall be exerted on any patient to avail himself of such services, but the hospital shall make every effort to provide such services and shall inform all patients of their availability."

We are convinced as doctors that patients have the right to the best medical care available without discrimination based on such irrelevant factors as race, religion, national origin, or ancestry. We believe that hospitals and other institutions receiving substantial aid from the Government, Federal, or State, should be barred from engaging in discrimination in the selection of staff or in the treatment of patients. We believe that these objectives can best be assured by including in the bill these specific conditions for receiving Federal funds.

STATEMENT OF AMERICAN NURSES' ASSOCIATION ON H.R. 10041, THE HOSPITAL AND MEDICAL FACILITIES AMENDMENTS OF 1964

The American Nurses' Association, the national organization of registered professional nurses, wishes to record its support of H.R. 10041, the bill to improve the public health through revising, consolidating, and improving the hospital and other medical facilities provisions of the Public Health Service Act. On several occasions, the association has commented critically on the existing law, but has always supported the intent of the Hospital and Medical Facilities Survey and Construction Act to provide the necessary number of hospital beds needed for all of our citizens.

Our major concern and the one which has caused the most anxiety was the continuing appropriations for construction without an associated plan for staffing the facilities. In order to assure high standards of care, hospitals need qualified health personnel. Many of the installations are located in rural areas where the nurse population is very limited or in communities that could not attract nurses. Action by the Congress in authorizing traineeships for graduate nurses and a stepped up program for improving and expanding the training of practical nurses has eased the situation somewhat. But the needs are still overwhelming, particularly in the small isolated hospitals, the large public hospitals, and in the nursing homes of this country.

Should the Congress act favorably on H.R. 10042, which proposes to amend the Public Health Service Act to increase the opportunities for training pro-

fessional nursing personnel, and which is now pending before your committee, a start will be made toward overcoming the chasm between facilities and the number of nurses of quality to staff them.

We agree that there is an urgent need to rehabilitate and/or replace many of the metropolitan or urban hospitals. Improvement and modernization of existing physical plants can have a direct effect on the quality of service that the institution provides. Workers can be recruited to and retrained in a structure which makes efficient and safe care possible.

A bill provides that a plan for construction must guarantee that there will be sufficient funds to maintain and operate the facilities. We would recommend that the plan demonstrate financial ability to employ the requisite number of qualified personnel deemed necessary to maintain at least a minimum of safety for the patient. Our constituent State nurses associations can be called upon to give valuable assistance in planning for adequate staff and can supply information on salary and standards of employment.

For many years the American Nurses' Association has questioned the provision in the original Hospital and Medical Facilities Survey and Construction Act known as the "separate but equal clause." In formulating its policies on civil rights legislation in 1956, the American Nurses' Association said, "Health and welfare programs supported by tax funds should promote and protect the physical, mental, and social well-being of all citizens regardless of race, creed, color, or national origin." On a number of occasions the American Nurses' Association has called on the Congress and the administration to eliminate the clause from the law. We are pleased to observe that the proposed revision of the law provides that facilities be available to all in the area where the institution is constructed. We heartily support this change.

We hope the committee will give serious consideration to the views of the American Nurses' Association expressed in this statement.

MICHIGAN DEPARTMENT OF HEALTH,
Lansing, Mich., March 10, 1964.

Hon. OREN HARRIS,
Chairman, House Committee on Interstate and Foreign Commerce,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN HARRIS: We are writing you in support of H.R. 10041, which amends the Hill-Burton Act, and should like to offer the following comments for the consideration of your committee:

1. Extension of the Hill-Burton Act through 1969 is essential to provide adequate health facilities for our people.

In making needed facilities available by underwriting a portion of the cost, the Hill-Burton program has also greatly contributed to orderly planning for health care and the proper design of facilities.

While $74 million has been allocated to projects in Michigan since the beginning of the Hill-Burton program, population growth plus obsolescence of present facilities resulting from changes in medical practice and passage of time have resulted in no lessening of justifiable requests for assistance in provision of needed health facilities.

2. The extensive needs of the older hospitals in urban centers point up the need for special attention to a modernization program and we are in full support of the additional authorization for this purpose. It is our belief, however, that a modernization program should not be rigidly established as a separate category, but that the legislation would have sufficient flexibility to enable a State to develop the best arrangement possible in terms of both administrative and planning considerations.

3. With the growing complexity of the health facilities system, areawide planning becomes increasingly significant to assure wise expenditure of public funds.

The authorization for special project grants makes it possible to undertake more extensive areawide planning at the State level and to develop viable local planning agencies which are indicated. We are particularly appreciative of the provision requiring prior approval of State agencies for grant applications.

4. We are wholeheartedly in support of the carefully drafted provision for making available to the States limited funds to underwrite administrative costs. While the Michigan Legislature has been relatively generous in providing ad-

ministrative staff for the Hill-Burton program, even so, my associates in this program are able to keep up with the increasing workload only by working an excessive amount of overtime. Many States are woefully understaffed. Yet our State staffs are the very keystone to the effective administration of this significant program. Providing this financial underpinning, as has been customary in other grant-in-aid programs, is long overdue. As additional responsibilities are given to the State agencies, such as in last year's accelerated public works program and the new mental facility construction program, and as greater insistence is placed on more effective planning and analysis of need, the necessity for more adequate staffing becomes imperative. This provision most effectively covers State agency requirements for staff to survey facility needs, to provide consultation and assistance to local planning agencies, and to carry out the growing administrative responsibilities.

Thank you and your committee very much for your consideration of our views.

Sincerely,

ALBERT E. HEUSTIS, M.D., *Commissioner.*

HOSPITAL REVIEW AND PLANNING COUNCIL OF SOUTHERN NEW YORK, INC.,
New York, N.Y., March 10, 1964.

Hon. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: Since its enactment in 1946, the Hospital Survey and Construction Act has been a major force in developing and improving hospital facilities throughout the Nation. However, despite the outstanding success of this program, it has had limited influence in meeting the mounting backlog of construction and modernization needs in metropolitan areas of the Nation.

In 1957 a study by the Hospital Council of Greater New York, the predecessor agency of the reconstituted Hospital Review and Planning Council of Southern New York, revealed that an expenditure of approximately $180 million was required at that time to improve or replace inadequate facilities housing existing voluntary hospital programs and another $47 million to establish new programs in New York City alone. Since then, the situation has worsened and perhaps $250 to $300 million is necessary to accomplish what the $180 million would have accomplished 7 years ago.

The advances of modern medicine have rendered many hospital plants completely inadequate to carry out the new demands being placed upon them. Many plants were constructed at the turn of the century when medicine and hospital practices were less complex. Many such facilities are not only inefficient and inadequate to maintain and operate, but in some instances do not conform to modern safety standards. In the past local funds have been inadequate to meet the competing demands of hospitals to correct such deficiencies and there is no indication that the situation will appreciably improve in the future. In the opinion of the board of directors of the Hospital Review and Planning Council of Southern New York, only by an extension of Hill-Burton activities into this field can needs of aging hospitals in metropolitan areas be met.

The board of directors of this council further urges the enactment of legislation authorizing Federal special project grant funds to assist in the support of areawide hospital planning agencies. The intelligent use and distribution of Federal funds for hospitals requires strong areawide planning activities, on an organized and continuing basis.

Your support in these matters would be most encouraging.

Sincerely yours,

JACK C. HALDEMAN, M.D., *President.*

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: The American Nursing Home Association wishes to have its position known to the members of your committee concerning H.R. 10041, the Hospital and Medical Amendments of 1964. This association represents approximately 4,400 nursing homes throughout the country. Approximately 15 percent of our membership are nonprofit homes. Each nursing

home member is also a member of their local State nursing home association.

We wholeheartedly support the purposes of the bill except two parts thereof, one of which would transfer the FHA mortgage insurance program to the Surgeon General. Many of our members have constructed new and additional facilities under the FHA program. We have worked closely to aid that program. We believe that the program has been well administered and has given great impetus to the construction of new and more modern facilities throughout the United States.

Although the FHA program has only been in existence since 1959, as of January 31, 1964, it was aiding the construction of over 425 homes with 40,000 beds, with a total mortgage value of $264 million. The FHA has had countless experience in the mortgage insurance field generally. On the other hand, the U.S. Public Health Service has not had such experience, which leads us to believe that the transfer of this program would not be an easy and smooth transition. In addition, it would result in the establishment of another section or division whose responsibilities would not be concerned with the primary purpose of the Public Health Service or the Hill-Burton program, both of which relate to public, nonprofit facilities.

If the congressional policy is to concentrate the supervision of the construction of all medical care facilities in the Public Health Service, then it would be only logical to transfer to the Public Health Service that portion of the program of the Small Business Administration and of the Area Redevelopment Agency of the Department of Commerce which relate to the construction of nursing homes.

If this were done it would appear that programs logically belonging in other agencies were being transferred to an agency whose purpose was other than in the construction or mortgage financing field.

We question the wisdom of transferring only the most successful of these programs to the Public Health Service.

Under section 603(e) of the bill, which authorizes "general regulations" by the Secretary of Health, Education, and Welfare, it is provided (p. 14, line 14) that these regulations "may" also require new nonprofit facilities to make available (lines 21, 23, subsec. (2)) "a reasonable volume of services to persons unable to pay therefor." We have had continuing complaints from our member State associations where nonprofit homes constructed with public funds refused to take indigent or public assistance patients. It seems to us only fair and reasonable that nursing homes constructed with public funds should be required to take a certain percentage of "indigent" or public assistance patients.

Accordingly, we suggest that the word "may" on line 14, page 14, be stricken and the word "must" be substituted therefor. This would require such homes to take a "reasonable volume" of indigent and/or public assistance cases, which is certainly fair and equitable.

As it is now, certain homes constructed with public funds refuse to take "indigent" or public assistance patients with the result that extreme pressure is exerted on proprietary homes to take far more than their fair share of these patients.

If we can be of any assistance to the committee, or supply you with any additional information, kindly let us know.

Respectfully yours,

WILLIAM E. BEAUMONT, JR.,
President, North American Nursing Home Association.

HOSPITAL ASSOCIATION OF HAWAII,
Honolulu, Hawaii, March 30, 1964.

Subject: H.R. 10041, Hospital and Medical Facilities Amendment of 1964.

Hon. HIRAM L. FONG,
U.S. Senate,
Washington, D.C.

SIR: The subject proposed legislation makes several substantial changes in the existing Hill-Burton Act. We ask your consideration and assistance on two categories in the bill.

The bill calls for a new category to assist in the modernization of the older hospitals mostly in urban areas. The administration had requested that $340 million be authorized and earmarked for this purpose over a 5-year period.

H.R. 10041 authorizes only $160 million for the same period. It also permits States to transfer funds into new bed construction and may well, therefore, nullify its effectiveness.

We urge that $50 million of modernization funds be authorized for the first year, $70 million for the second year, and $100 million for the 3 remaining years of the program. This making a total of $420 million over the 5 years' extension of the Hill-Burton program, as requested by the administration. We feel that it is absolutely necessary that this amount of money be authorized if an impact is to be made in assisting the older hospitals in their renovation endeavors. Also, the amounts recommended should be specifically allocated for modernization purposes only.

The other category relates to a new program of mortgage insurance on loans for construction or modernization of private, nonprofit hospitals, nursing homes, and other medical facilities. Also, the bill contains a recommendation transferring the present program of mortgage insurance for proprietary nursing homes from the Federal Housing Administration to the Public Health Service. We oppose this transfer.

We feel that the rate of interest which in the bill can run to 6½ percent would be so high that nonprofit health facilities would not be able to retire the principal and pay the interest without a substantial increase in bed-patient per day cost. Therefore, we urge a program of long-term, low-interest direct Federal loans.

There is a great need for a major program of modernization of older hospital facilities in Hawaii. Great numbers of hospitals here have been anxiously awaiting a program of Federal assistance. As an example, some sections of the Queen's Hospital were originally constructed in 1904, and while these and other sections of the hospital have been renovated to some degree over the years, much needs to be done to modernize parts of this facility to meet today's medical care requirements. This example is true of many other facilities throughout the State of Hawaii.

Your kokua is most sincerely requested in order that older hospitals in Hawaii may be assisted in vitally needed modernization programs.

Aloha,

FRANK E. KEIFER,
Executive Director, the Hospital Association of Hawaii.

(Whereupon, at 12:15 p.m., the committee adjourned.)

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