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NURSING HOME CARE AND FACILITIES FOR VETERANS

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HEARINGS BEFORE THE COMMITTEE ON VETERANS' AFFAIRS OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE EIGHTY-EIGHTH CONGRESS FIRST AND SECOND SESSIONS ON H.R. 8009 AN ACT RELATING TO NURSING HOME CARE AND FACILITIES FOR VETERANS

NOVEMBER 20, DECEMBER 10, 1963; JANUARY 29,
FEBRUARY 25, MARCH 16 AND 30, 1964

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



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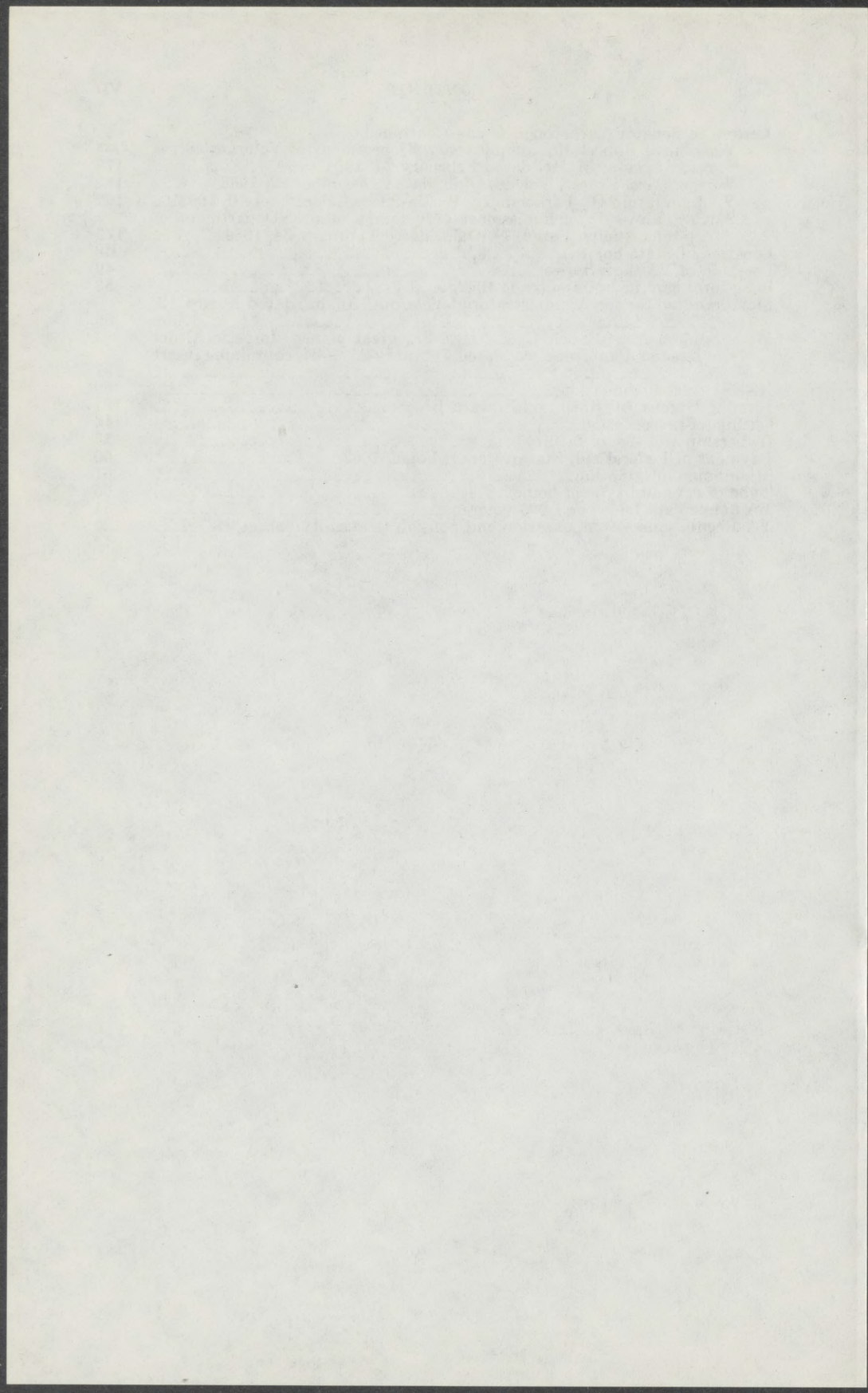
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NURSING HOME CARE AND FACILITIES FOR VETERANS

WEDNESDAY, NOVEMBER 20, 1963

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

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 4200, New Senate Office Building, Senator Ralph Yarborough (chairman of the subcommittee) presiding.

Present: Senators Yarborough (presiding) and Metcalf.

Committee staff members present: Stewart E. McClure, chief clerk; Charles Johnston, counsel, and John Strasburger, associate counsel of the subcommittee, and Raymond D. Hurley, associate minority counsel.

Senator YARBOROUGH. The Veterans' Subcommittee will come to order.

Gentlemen, we will have a new member of the committee and subcommittee with us later this morning. But due to the importance of this bill and the distance some of the witnesses have traveled, we will not wait until his arrival to begin with the testimony.

This morning we begin hearings on the very important measure, H.R. 8009, to amend title 38, United States Code, to provide certain veterans with nursing home care and nursing care facilities.

This bill has passed the House as we all know.

Briefly, it approaches this need for nursing home care for veterans in several manners; one, by authorizing the use of 2,000 additional nursing care beds in the Veterans' Administration system; by providing for limited care in private nursing homes for certain VA patients who have received maximum hospital benefits; three, by increasing aid to State homes by providing for 5-year programs of capital outlays on a matching basis and a larger per diem contribution for the care of nursing home patients in such homes; four, by encouraging veterans receiving aid and attendance pensions to reenter hospitals for brief stays, without the loss of their pension, thus preventing longer stays and more serious illnesses; five, by furnishing prosthetic appliances to certain aid and attendance pensioners on an outpatient basis of the type and variety required in their everyday lives, and which would be furnished if they were in the hospital; six, extending the completion of bed occupancy program to keep prospective nursing home care patients in their own homes and in their own environment as long as possible.

This is only a brief summary to cover some of the main points of the legislation.

We had expected the Veterans' Administration to submit reports on this bill prior to having this first hearing on the bill. However, we have been informed that the VA report is not yet completed. But due to the great interest in this bill over the country, and the time it will take to have the hearings, we have decided to get those hearings underway without waiting for the VA reports.

And so, this morning, we will begin the hearings. When the Veterans' Administration is ready to testify, we will hear them at that time.

I will order entered at this point in the record a copy of the bill and an explanation of the bill.

(H.R. 8009 and accompanying explanation follow:)

Union Calendar No. 287

88TH CONGRESS
1ST SESSION**H. R. 8009**

[Report No. 680]

IN THE HOUSE OF REPRESENTATIVES

AUGUST 8, 1963

Mr. TEAGUE of Texas introduced the following bill; which was referred to the Committee on Veterans' Affairs

AUGUST 14, 1963

Reported with amendments, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

[Omit the part struck through and insert the part printed in italic]

A BILL

To amend title 38, United States Code, to provide certain veterans with urgently needed nursing home care and nursing care facilities while reducing the cost to the United States of caring for such veterans, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 That subsection (a) of section 5001 of title 38, United States
4 Code, is amended (1) by inserting "(1)" immediately after
5 "(a)", (2) by redesignating clauses (1) and (2) thereof
6 as clauses (A) and (B), respectively, and (3) by adding at
7 the end thereof the following new paragraph:

8 "(2) The Administrator, subject to the approval of the
9 President, is authorized to establish and operate not more

2

1 than ~~four~~ two thousand additional beds for the furnishing of
2 nursing home care to eligible veterans in facilities over which
3 the Administrator has direct and exclusive jurisdiction."

4 SEC. 2. (a) Subchapter II of chapter 17 of title 38,
5 United States Code, is amended by adding at the end thereof
6 the following new section:

7 **"§ 620. Transfers for nursing home care**

8 "(a) Subject to subsection (b) of this section, the Ad-
9 ministrator may transfer any veteran, who has been furnished
10 care by the Administrator in a hospital under the direct and
11 exclusive jurisdiction of the Administrator, to any public
12 or private institution not under the jurisdiction of the Ad-
13 ministrator which furnishes nursing home care, for care at
14 the expense of the United States, if the Administrator deter-
15 mines that—

16 "(1) such veteran has received maximum benefits
17 from such care in such hospital, but will require a pro-
18 tracted period of nursing home care which can be fur-
19 nished in such institution, and

20 "(2) the cost of such nursing home care in such in-
21 stitution will not exceed one-third of the cost of care fur-
22 nished by the Veterans' Administration in a general
23 hospital under the direct and exclusive jurisdiction of the
24 Administrator, as such cost may be determined from
25 time to time by the Administrator.

3

1 Nursing home care may not be furnished pursuant to this
2 section at the expense of the United States for more than
3 six months in the aggregate in connection with any one
4 transfer, except where in the judgment of the Administrator
5 a longer period is warranted in the case of any veteran.

6 “(b) No veteran may be transferred to any institution
7 for nursing home care under this section, unless such institu-
8 tion is determined by the Chief Medical Director to meet such
9 standards as he may prescribe.”

10 (b) The analysis of chapter 17 of title 38, United States
11 Code, is amended by inserting immediately below

“619. Repair or replacement of certain prosthetic and other appliances.”
12 the following:

“620. Transfers for nursing home care.”

13 SEC. 3. (a) Section 641 of title 38, United States Code,
14 is amended to read as follows:

15 **“§ 641. Criteria for payment**

16 “The Administrator shall pay each State at the per
17 diem rate of \$2.50 for each veteran of any war receiving
18 hospitalization or domiciliary care in a State home in such
19 State if the veteran is eligible for hospitalization or domicil-
20 iary care in a Veterans’ Administration facility, and at the
21 per diem rate of \$3.50 for each veteran of any war receiving
22 nursing home care in a State home in such State, if such vet-
23 eran meets the requirements of paragraph (1), (2), or (3)
24 of section 610 (a) of this title, except that the requirement

1 in clause (B) of such paragraph (1) shall, for this purpose,
2 refer to the inability to defray the expenses of necessary
3 nursing home care; however, such payment shall not be more,
4 in any case, than one-half of the cost of the veteran's maintenance in such State home."

6 (b) No payment shall be made to any State home solely
7 by reason of the amendment made by this section on account
8 of nursing home care furnished any veteran except where
9 such care is furnished the veteran by the State home for the
10 first time after the effective date of this section.

11 (c) The amendment made by this section shall take
12 effect on January 1, 1964; except that subsection (b) of
13 section 641 of title 38, United States Code, as in effect immediately before such date, shall remain in effect with respect
14 to any amounts retained or collected by any State home before such date.

17 SEC. 4. (a) Chapter 81 of title 38, United States Code,
18 is amended by adding at the end thereof the following new
19 subchapter:

5

1 **"Subchapter III—State Home Facilities for Furnishing**
2 **Nursing Home Care**

3 **"§ 5031. Definitions**

4 "For the purpose of this subchapter—

5 “(a) The war veteran population of each State shall
6 be determined on the basis of the latest figures certified
7 by the Department of Commerce.

8 “(b) The term ‘State’ does not include any posses-
9 sion of the United States.

10 “(c) The term ‘construction’ means the construc-
11 tion of new buildings, the expansion, remodeling, modifi-
12 cation, or alteration of existing buildings, and the
13 providing of initial equipment for any such buildings.

14 “(d) The term ‘cost of construction’ means the
15 amount found by the Administrator to be necessary for
16 a project of construction of nursing home care facilities,
17 including architect fees, but not including the cost of
18 acquisition of land.

1 **"§ 5032. Declaration of purpose**

2 "The purpose of this subchapter is to assist the several
3 States to construct State home facilities for furnishing
4 nursing home care to war veterans.

5 **"§ 5033. Authorization of appropriations**

6 "(a) There is hereby authorized to be appropriated
7 \$5,000,000 for the fiscal year ending June 30, 1964, and a
8 like sum for each of the four succeeding fiscal years. Sums
9 appropriated pursuant to this section shall be used for mak-
10 ing grants to States which have submitted, and have had
11 approved by the Administrator, applications for carrying
12 out the purposes of section 5032 of this title.

13 "(b) Sums appropriated pursuant to subsection (a) of
14 this section shall remain available until the end of the second
15 fiscal year following the fiscal year for which they are ap-
16 propriated.

17 "(c) Not more than 10 per centum of the funds appro-
18 priated pursuant to subsection (a) of this section for any
19 fiscal year shall be used to assist in the construction of nurs-
20 ing home care facilities in any one State.

21 **"§ 5034. General regulations**

22 "Within six months after the date of enactment of this
23 subchapter, the Administrator shall prescribe the following
24 by regulation:

25 "(1) The number of beds required to provide ade-

1 quate nursing home care to war veterans residing in each
2 State, which number shall not exceed one-half bed per
3 thousand war veteran population in the case of any State.

4 “(2) General standards of construction, repairs,
5 modernization, alteration, and equipment for facilities
6 for furnishing nursing home care which are constructed
7 with assistance received under this subchapter.

8 **“§ 5035. Applications with respect to projects; payments**

9 “(a) After regulations have been prescribed by the
10 Administrator under section 5034 of this title, any State
11 desiring to receive assistance for a project for construction
12 of State home facilities for furnishing nursing home care must
13 submit to the Administrator an application. Such applica-
14 tion shall set forth—

15 “(1) the amount of the grant requested with respect
16 to such project which may not exceed 50 per centum of
17 the estimated cost of construction of such project,

18 “(2) a description of the site for such project,

19 “(3) plans and specifications for such project in
20 accordance with regulations prescribed by the Adminis-
21 trator pursuant to section 5034 (2) of this title,

22 “(4) reasonable assurance that upon completion of
23 such project the facilities will be used principally to
24 furnish nursing home care to war veterans and that not
25 more than 10 per centum of the bed occupancy at any

1 one time will consist of patients who are not receiving
2 nursing home care as war veterans,

3 “(5) reasonable assurance that title to such site is or
4 will be vested solely in the applicant, a State home, or
5 another agency or instrumentality of the State,

6 “(6) reasonable assurance that adequate financial
7 support will be available for the construction of the
8 project and for its maintenance and operation when
9 complete,

10 “(7) reasonable assurance that the State will
11 make such reports in such form and containing such
12 information as the Administrator may from time to time
13 reasonably require, and give the Administrator, upon
14 demand, access to the records upon which such informa-
15 tion is based, and

16 “(8) reasonable assurance that the rates of pay for
17 laborers and mechanics engaged in construction of the
18 project will be not less than the prevailing local wage
19 rates for similar work as determined in accordance with
20 sections 276a through 276a-5 of title 40 (known as
21 the Davis-Bacon Act).

22 “(b) The Administrator shall approve any such appli-
23 cation if he finds that—

24 “(1) there are sufficient funds available to make the
25 grant requested with respect to such project,

9

1 “(2) such grant does not exceed 50 per centum of
2 the estimated cost of construction of such project,

3 “(3) that such a grant would not result in more
4 than 10 per centum of the funds appropriated for any
5 fiscal year pursuant to section 5033 (a) of this title being
6 used to assist the construction of facilities in any one
7 State,

8 “(4) the application contains such reasonable as-
9 surance as to use, title, financial support, reports and
10 access to records, and payment of prevailing rates of
11 wages, as the Administrator may determine to be neces-
12 sary, and

13 “(5) the plans and specifications for such project
14 are in accord with regulations prescribed pursuant to
15 section 5034 (2) of this title and that the construction of
16 such project, together with other projects under construc-
17 tion and other facilities, will not result in more than
18 the number of beds prescribed by the Administrator
19 pursuant to section 5034 (1) of this title for the State
20 in which such project is located being available for fur-
21 nishing nursing home care to war veterans in such
22 State.

23 “(c) No application submitted to the Administrator un-
24 der this section shall be disapproved until the Administrator
25 has afforded the applicant an opportunity for a hearing.

10

1 “(d) Upon approving an application under this section,
2 the Administrator shall certify to the Secretary of the Treas-
3 ury the amount of the grant requested with respect to such
4 project in such application, but in no event an amount greater
5 than 50 per centum of the estimated cost of construction of
6 the project, and shall designate the appropriation from which
7 it shall be paid. Such certification shall provide for payment
8 to the applicant or, if designated by the applicant, the State
9 home for which such project is being constructed or any
10 other agency or instrumentality of the applicant. Such
11 amount shall be paid, in advance or by way of reimburse-
12 ment, and in such installments consistent with the progress
13 of construction as the Administrator may determine and
14 certify for payment to the Secretary of the Treasury. Funds
15 paid under this section for the construction of an approved
16 project shall be used solely for carrying out such project as so
17 approved.

18 “(e) Any amendment of any approved application shall
19 be subject to approval in the same manner as an original
20 application.

21 **“§ 5036. Recapture provisions**

22 “If, within twenty years after completion of any proj-
23 ect for construction of facilities for furnishing nursing home
24 care with respect to which a grant has been made under
25 this subchapter, such facilities cease to be operated by a

11

1 State, a State home, or an agency or instrumentality of a
2 State principally for furnishing nursing home care to war
3 veterans, the United States shall be entitled to recover
4 from the State which was the recipient of the grant under
5 this subchapter, or from the then owner of such facilities, 50
6 per centum of the then value of such facilities, as determined
7 by agreement of the parties or by action brought in the dis-
8 trict court of the United States for the district in which such
9 facilities are situated.

10 **“§ 5037. State control of operations**

11 “Except as otherwise specifically provided, nothing in
12 this subchapter shall be construed as conferring on any Fed-
13 eral officer or employee the right to exercise any supervision
14 or control over the administration, personnel, maintenance,
15 or operation of any State home for which facilities are
16 constructed with assistance received under this subchapter.”

17 (b) The analysis of chapter 81 of title 38, United States
18 Code, is amended by adding at the end thereof the following:

“SUBCHAPTER III—STATE HOME FACILITIES FOR FURNISHING NURSING
HOME CARE

“5031. Definitions.

“5032. Declaration of purpose.

“5033. Authorization of appropriations.

“5034. General regulations.

“5035. Applications with respect to projects; Payments.

“5036. Recapture provisions.

“5037. State control of operations.”

19 (c) Paragraph (19) of section 101 of title 38, United
20 States Code, is amended by adding at the end thereof the

1 following: "Such term also includes such a home which fur-
2 nishes nursing home care for veterans of any war."

3 (d) Section 101 of title 38, United States Code, is
4 amended by adding at the end thereof the following new
5 paragraph:

6 "(28) The term 'nursing home care' means the accom-
7 modation of convalescents or other persons who are not
8 acutely ill and not in need of hospital care, but who require
9 skilled nursing care and related medical services, if such
10 nursing care and medical services are prescribed by, or are
11 performed under the general direction of, persons duly li-
12 censed to provide such care. The term includes intensive care
13 where the nursing service is under the supervision of a reg-
14 istered professional nurse."

15 SEC. 5. (a) Section 3203 (f) of title 38, United States
16 Code, is amended to read as follows:

17 "(f) Where any veteran in receipt of an aid and
18 attendance allowance described in section 314 (r) of this
19 title is hospitalized at Government expense, such allowance
20 shall be discontinued from the first day of the second calendar
21 month which begins after the date of his admission for such
22 hospitalization for so long as such hospitalization continues.
23 Any discontinuance required by administrative regulation,
24 during hospitalization of a veteran by the Veterans' Admin-
25 istration, of increased pension based on need of regular aid

13

1 and attendance or additional compensation based on need of
2 regular aid and attendance as described in subsection (l)
3 or (m) of section 314 of this title, shall not be effective
4 earlier than the first day of the second calendar month which
5 begins after the date of the veteran's admission for hos-
6 pitalization. In case a veteran affected by this subsection
7 leaves a hospital against medical advice and is thereafter
8 admitted to hospitalization, such allowance, increased pen-
9 sion, or additional compensation, as the case may be, shall be
10 discontinued from the date of such readmission for so long
11 as such hospitalization continues."

12 (b) The amendment made by this section shall apply
13 only with respect to compensation or pension based upon
14 need of regular aid and attendance in the case of veterans
15 admitted for hospitalization on or after the first day of the
16 second calendar month which begins after the date of enact-
17 ment of this Act.

18 SEC. 6. (a) Section 617 of title 38, United States Code,
19 is amended by inserting "(a)" immediately before "The Ad-
20 ministrator" and by adding at the end thereof the following
21 new subsection:

22 "(b) The Administrator may furnish any type of thera-
23 peutic or rehabilitative device, as well as other medical equip-
24 ment and supplies (excluding medicines), if medically in-
25 dicated, to any veteran who is eligible to receive an invalid

14

1 lift under subsection (a) of this section, or who would be so
2 eligible, but for the fact that he has such a lift."

3 (b) The analysis of chapter 17 of title 38, United States
4 Code, is amended by striking out

"617. Invalid lift for pensioners."

5 and inserting in lieu thereof the following:

"617. Invalid lifts and other devices for pensioners."

6 (c) *The heading of section 617 of title 38, United States*
7 *Code, is amended to read as follows:*

8 "§ 617. *Invalid lifts and other devices for pensioners*".

9 SEC. 7. Section 612 of title 38, United States Code,
10 is amended by adding at the end thereof the following:

11 "(g) Where any veteran is in receipt of pension under
12 chapter 15 of this title based on the need of regular aid and
13 attendance or of an aid and attendance allowance received
14 under section 314 or 334 of this title, or who, but for the
15 receipt of retired pay, would be in receipt of such pension
16 or such an allowance, and—

17 "(1) has received care for not less than one year
18 under paragraph (2) of subsection (f) of this section;
19 and

20 "(2) is suffering from (A) cardiovascular-renal
21 disease, including hypertension, (B) endocrinopathies,

15

- 1 (C) diabetes mellitus, (D) cancer, or (E) a neuro-
- 2 psychiatric disorder, (F) *tuberculosis*;
- 3 then the Administrator may furnish the veteran such further
- 4 care as is reasonably necessary for such disease or disorder."

EXPLANATION OF H.R. 8009

Section 1 of the bill provides that the Administrator of Veterans' Affairs may, subject to the approval of the President, establish and operate not more than 2,000 additional nursing home care beds for veterans eligible for such care in facilities over which the Administrator has direct and exclusive jurisdiction, whether or not the 2,000 beds are within or without the 125,000 administrative ceiling which was established during the Eisenhower administration, or whether or not the beds are included in the domiciliary allotment (which is not governed by any ceiling other than availability of funds).

Such nursing home beds may be based on renovation or modernization of existing Veterans' Administration facilities or it may be new construction along the lines of the long-term chronic care facilities.

Section 2 authorizes the Administrator to transfer any long-term patient in a Veterans' Administration Hospital who has received maximum hospital benefits, and who will require nursing home care, to other facilities outside the control of the Veterans' Administration, but at the expense of the agency, so long as the per diem cost does not exceed one-third of the cost applicable to a general hospital operated by the Veterans' Administration. The per diem cost of care in a VA general hospital at present is approximately \$27. Such nursing home care is not to be furnished for a period longer than 6 months in the aggregate in connection with any one transfer except where the judgment of the Administrator a longer period is warranted. The Chief Medical Director is authorized to prescribe and establish such standards for nursing home care facilities in privately operated facilities as he may determine. The 6-month limitation prescribed is the same period of time as that advocated by the Administration in its medical care program. Any nursing home in which a veteran would be placed would be in conjunction with the general Veterans' Administration hospital nearest to the institution.

One of the principal purposes of section 2 is to aid the veteran and his family in making the transition from a hospital to his eventual place in the community.

After the Civil War many States established old soldiers' homes which ultimately were enlarged and their functions changed until today we have 33 such homes in 28 States. Under existing law the Administrator of Veterans' Affairs is authorized to pay not more than \$2.50 for each day of care given any veteran in any one of these State homes if the veteran is entitled to receive hospital or domiciliary care in a VA facility. Section 3 contains this \$2.50 per day rate for those veterans who are currently in the home but establishes a new rate of \$3.50 per day for any veteran who is admitted to the home after the date of enactment of this bill for the first time and who receives nursing home care there. It is estimated that approximately 70 percent of those now in the homes are receiving domiciliary care.

Today a veteran may be admitted for hospital or domiciliary reasons and is thereafter maintained if he develops into a nursing-care case but he cannot be admitted in the later category for the first time and have the VA pay any of the per diem cost. Section 3 would permit the VA to pay this cost.

Section 3 also repeals the so-called offset provisions in the law today which permits a reduction by one-half of any amount which is retained by the home from any payments of pensions or compensation made to such veteran and, unless wives or widows of veterans are admitted and maintained by such home, by any amounts collected in any manner from such veteran and used for the support of such State home.

Section 4 authorizes, on a matching basis, \$5 million, for each of the next 5 fiscal years to assist the States in the construction of new buildings or the expansion, remodeling, modification, or alteration of existing structures in order to provide nursing home beds in their State homes. Appropriate authority is granted the Administrator of Veterans' Affairs to prescribe standards governing such construction.

This grant provision is not restricted to States with existing State homes, but rather applies to all States whether or not they at the present time operate a State home. A 10-percent limitation applies on the funds that may be granted to any State for construction of nursing home facilities. All the funds must be used for the construction of nursing home care facilities and not to enlarge or increase existing facilities for hospital or domiciliary care. Facilities would be constructed on the basis of the war veteran population in each State but not to exceed facilities to provide in excess of one-half bed per 1,000 war veterans in the case of any State.

Section 5 provides that any veteran who is in receipt of the aid and attendance pension or compensation shall not have his pension reduced on account of the aid and attendance allowance earlier than the first day of the second calendar month which begins after the date of the veteran's admission for hospitalization by the Veterans' Administration. This provision is identical in purpose to section 2 of Public Law 87-645, which provides the same sort of arrangement for veterans receiving the maximum rate of compensation for service-connected disabilities.

Section 6 authorizes the Administrator of Veterans' Affairs to furnish any type of therapeutic, rehabilitative, and medical equipment and supplies, if medically indicated and the veteran is eligible for an invalid lift or would be so eligible if it were not for the fact that he has one. The invalid lift was authorized as a section of Public Law 86-211, effective July 1, 1960. The use of this device has not been widespread—only 270 such lifts have been furnished. This experience indicates the possible use of the authority contained in section 6.

Section 7 relates to the CBOC program—completion of bed occupancy. Section 612(b), title 38, United States Code, added Public Law 86-639, provides that where a veteran reaches a condition in his medical treatment such as to warrant no further medical care in a Veterans' Administration hospital, he may be placed in the CBOC program and in effect be cared for on an outpatient basis to round out the hospital care. Administratively this has been limited to a period not to exceed 1 year. Section 7 would remove this administrative time limit of the CBOC program in the case as to six specific diseases from which many of our older veterans are suffering: (1) Cardiovascular—renal disease, including hypertension, (2) endocrinopathies, (3) diabetes mellitus, (4) cancer, (5) neuropsychiatric disorders, and (6) tuberculosis. Care could be given so long as medical judgment dictated such action.

Senator YARBOROUGH. The first witness this morning is Mr. Clarence H. Olson, Director of the National Legislative Commission of the American Legion.

You have been with the American Legion here in Washington, I believe, longer than 12 years, which is about double the length of time I have been with the Senate here.

And, with your position you have had much legislative experience with the Congress.

Prior to coming here, I believe, were you not the department commander of the department of Montana of the American Legion?

Mr. OLSON. Yes, sir; I was.

Senator YARBOROUGH. You have other witnesses with you?

Mr. OLSON. Yes, sir.

Senator YARBOROUGH. Who is that—Bob McCurdy, of Pasadena, and Mr. Horton, of Gulf Shores, Ala.; Mr. John Corcoran of the Washington office of the American Legion.

I believe also you brought Dr. Brick with you—Dr. Irving B. Brick, senior medical consultant for the American Legion; and professor of medicine at Georgetown University Medical School.

Would you like all of those accompanying you and your aids to come around, Mr. Olson, and be with you?

I want to welcome all of you here, and ask that you proceed in your own manner, Captain Olson.

STATEMENT OF CLARENCE H. OLSON, DIRECTOR OF THE LEGISLATIVE COMMISSION OF THE AMERICAN LEGION

Mr. OLSON. Mr. Chairman, we of the American Legion are grateful to you and your subcommittee for the opportunity to be heard this morning in support of H.R. 8009, a bill that we consider to be one of the most important veterans measures to be under consideration by the Congress in many years.

I am very pleased to have the privilege of presenting our principal witnesses. I am sure you will be interested in learning something of their qualifications, which I shall briefly cite at this time.

Mr. Robert M. McCurdy is the chairman of our national rehabilitation commission. His home is in Pasadena. His home address is 1096 North Holliston Avenue.

Mr. McCurdy, on March 1, 1961, retired as assistant city manager of Pasadena, Calif., a position he had held since 1948. His service with the city of Pasadena dates to March 1, 1931.

He is a past president and life director of the Pasadena Tournament of Roses Association, and has been active in many civic associations over the years. He is a member of the Park and Recreation Commission of Los Angeles County, and a vice president of the California Board of Pharmacy.

In his Legion career, Bob McCurdy has filled many positions in the post, district and State organizations of the American Legion. He has served on the National Rehabilitation Commission continuously since 1942, and has been chairman, with the exception of one year, since 1948.

Senator YARBOROUGH. Pardon me, may I interrupt you 1 minute?

I have known Bob McCurdy for some years, heard of him for a long time before that, thought I knew him fairly well. But I didn't know of his long park and conservation record in addition to his work with the veterans.

I want to congratulate you on that, too. I am interested in those subjects, also. I now have two bills pending in Congress, one to create a national park, another to create a national monument, a third to create a State park.

I didn't realize the scope of your activities had covered so broad a phase of human endeavor in southern California and in the Nation. Congratulations.

Mr. OLSON. Mr. C. C. Horton is the chairman of our national legislative commission. His home address is Gulf Shores, Ala. His mailing address is Box 216, at Gulf Shores.

Mr. Horton has recently retired as State director of the Department of Veterans' Affairs of the State of Alabama. He presently serves on the Governor's staff as consultant in State veterans' affairs.

During his long Legion service, he has enjoyed many recognitions from his department, including that of State commander, and has also been engaged in many civic enterprises throughout his State.

Prior to becoming national chairman of the legislative commission, he served for 15 years on the National Rehabilitation Commission of the American Legion, some of these as vice chairman, and for many years he worked shoulder to shoulder with Bob McCurdy in their many activities in behalf of veterans' affairs.

He is a past president of the National Association of State Directors of Veterans' Affairs.

Mr. Horton has journeyed here, as has Bob, to lend his support and strength to the legislation under consideration.

Mr. John J. Corcoran is the director of the rehabilitation commission, serving under Bob McCurdy. He has a staff of some 80 people under his jurisdiction, and has been in the position of director for the past 5 or 6 years. He has been associated with the American Legion

in rehabilitation work since his release from the service in 1945. We feel that he is doing an excellent job and is well qualified as a witness.

Senator YARBOROUGH. I have been a dues paying member of the American Legion since I have got back from overseas from World War II, and now I see where those dues went. I see you have been pretty active with them. You really have a working staff.

Mr. OLSON. Yes, sir.

Before proceeding with the testimony, I would like for the record to show, also, that we are accompanied this morning by Mr. Bernard McLeish, of Bayport, Mich., who is vice chairman of our national legislative commission. And, of course—

Senator YARBOROUGH. We welcome you, Mr. McLeish. If you want to add anything in the way of testimony—you may come up to the table, if you wish.

Mr. OLSON. Mr. McLeish is not to testify this morning. I think he is going to try to make an appointment with you for a later date.

You have taken note of the fact that Dr. Brick, our chief medical consultant, is with us.

Now, with your permission, Mr. Chairman, we would like to proceed with our testimony as follows:

Mr. Corcoran will read our prepared statement, and then will be followed by supplemental testimony from Messrs. Horton and McCurdy.

Now, it is likely that Dr. Brick will be called upon for an appropriate comment, and if so I would be pleased if Mr. Corcoran would read into the record his qualifications.

If it is now agreeable, Mr. Chairman, Mr. Corcoran will proceed with the prepared statement.

Senator YARBOROUGH. Yes, it certainly is.

Mr. Corcoran, you may proceed with the prepared statement.

STATEMENT OF JOHN C. CORCORAN, DIRECTOR, NATIONAL REHABILITATION COMMISSION OF THE AMERICAN LEGION

Mr. CORCORAN. Thank you, sir.

Mr. Chairman, and members of the subcommittee, may I begin by expressing the gratitude of the American Legion for the opportunity to appear before your subcommittee at this time. We believe we are somewhat aware of the demands made upon the time of the Members of the Senate; and, in the light of the extraordinary conditions now facing the Congress, we are doubly appreciative of the action you have taken in scheduling hearings on H.R. 8009.

As you know, H.R. 8009 is an act " * * to provide certain veterans with urgently needed nursing home care and nursing care facilities while reducing the cost to the United States of caring for such veterans, and for other purposes."

We consider H.R. 8009 as the most important substantive legislation, in the field of veterans' affairs, since the Congress included veterans of the Korean conflict in veterans' benefits legislation.

In general, it may be said that literature on problems of the aging is staggering in the aggregate. Even confining discussion to the special field of problems of the aging war veterans, there is a definite lack of opportunity to cover all phases of the subject within the limits of

this presentation. We have attempted, therefore, to determine what selections should be made to conserve your time and attention, and at the same time adequately express our approach to the subject.

Since 1955, the governing bodies of the American Legion have approved at least 72 national resolutions directly dealing with the subject of legislation to meet some phase of the problems facing the aged war veteran. At times, we have been dismayed at the lack of progress that has been made. It is in this light that we consider H.R. 8009 and related developments within the period of this session as being so important.

Who is the veteran covered in H.R. 8009?

In this age of the computer, with its attendant flow of statistics, we have sometimes observed a tendency to overlook the individual. It is desirable to contemplate the type of patient comprehended by H.R. 8009, to understand his plight, and to sympathize with his problems. One eminent authority, former Chief Medical Director of the Veterans' Administration, Dr. William S. Middleton, gave the following picture in testifying before the House Appropriations Subcommittee:

A nursing home is a proper residence for an individual who has ill, who cannot take care of himself, who does not need continued attention but he is past the point where there can be medical gain in his care.

Dr. Middleton then discussed the four classes of possible patients that might receive care from the Veterans' Administration. Category three was the nursing home patient.

At this point, I would like to quote from another authority, to describe the type of patient comprehended by H.R. 8009. In testifying before the Subcommittee on Intermediate Care in the House, Dr. Jack C. Haldeman, Assistant Surgeon General of the Department of Health, Education, and Welfare, described the characteristics of the nursing home patient as follows:

Certain basic facts regarding the characteristics of patients in nursing homes can be obtained from studies in this area. The very elderly predominate among nursing home patients. Their average age is in the neighborhood of 80 years. The majority have some heart or circulatory condition, and a significant proportion have had fractures, in most cases of the hips. Two out of every 10 are confined in bed, and only 5 out of 10 can walk alone, sometimes helped by a cane or a crutch. More than half have periods in which they are mentally confused. In general, they have been patients in the home for a year or longer.

What is the proper location for the nursing home?

It is generally recognized that those domiciled in nursing homes have reached that stage in life where they should have ready access to medical care. This view is supported by testimony of Dr. Jack C. Haldeman, Assistant Surgeon General (Report of hearings, House Subcommittee on Intermediate Care, May 16, 1963, p. 1178):

We feel very strongly that nursing homes should have an affiliation with a hospital regardless of where it is located. About half of our projects, as I say, have been sponsored by a hospital, and usually they are located on the grounds of the hospital.

What is the situation in the VA?

We will now describe, in general terms, the network of VA facilities. The justifiable pride of the VA Department of Medicine and Surgery lies in the fact that, in the years since World War II, its appropriately located hospitals, and newly constructed facilities, have been identified with the medical colleges of the Nation. In this sense, they are termed

teaching hospitals. This has produced a high type of general medical and surgical hospitals operating at standards comparing favorably with the best non-VA hospitals.

The VA Department of Medicine and Surgery also operates a system of domiciliaries. These are a development of post-Civil War days. Although these were once classified as soldiers' homes, there has been no overall policy to modernize them with anything like the degree that has applied to the operation of the U.S. Soldiers' Home for retired soldiers located within the District of Columbia.

Further, the VA has one operating restoration center and one about to come into operation. In his appearance before the House Appropriations Subcommittee, the Administrator of Veterans' Affairs stated briefly that there are plans for 42 of these facilities, though the present schedule of preparation is limited to the 2 already mentioned. These appear to be a part of the domiciliary program.

There are, also, State veterans' homes, partially supported by VA, providing domiciliary, nursing home, and hospital care.

There is one new 200-bed hospital at Kecoughtan, Va., designed for chronic care patients.

In Wood, Wis., and at Los Angeles, there are special programs having as their objectives, among other things, the return of long-term patients and members to employment status.

The Veterans' Administration has an authorized hospital bed strength of 125,000 and 18,000-member domiciliary system. The number of hospital and domiciliary facilities operating is approximately 122,000 hospital beds, and facilities for 16,000-plus domiciliary members.

In the House report of hearings on intermediate care, page 492, the following statement is used:

The Veterans' Administration is providing hospital space for at least 11,000 nursing-home-type cases in our general medical and surgical hospitals and domiciliaries. To this figure could be added at least a like number who are receiving only custodial care in our NP hospitals.

In practice, therefore, the VA has a considerable volume of experience in dealing with the nursing home type of patient. The American Legion has not examined in detail the many research projects in medicine operated by the Veterans' Administration. We assume that at least a part of this research activity is devoted to the major medical problems of the aged.

There is a continuously operating intense program within the VA geared to preparing long-term chronic patients for transfer to foster home and nursing home care, in non-VA facilities. This activity is limited in effectiveness due to the lack of income of those in this class presently cared for in the hospital and domiciliary beds.

Additionally, the VA is adding to the number of veterans who may be cared for through the prebed and postbed outpatient care program authorized by the Congress.

Thus far it is shown that, in practice, the Veterans' Administration is operating a nursing home program, and one that is closely allied with the hospital program.

The Veterans' Administration General Counsel, in his opinion submitted to the Administrator of Veterans' Affairs, May 7, 1963, established the legal authority of the Veterans' Administration to provide

nursing care for veterans. The broad range of service covered in this opinion fully supports all sections of H.R. 8009.

For example, in paragraph 6, the General Counsel stated:

In an opinion to the Chief Medical Director of April 9, 1962, dealing with a somewhat related problem involving recognition of State homes, we stated the view that nursing-home-type patients receiving only incidental medical treatment could be regarded administratively as receiving a form of domiciliary nature.

In the broad sweep of this opinion, the General Counsel stated that there was authority for VA to treat the nursing care patient:

* * * providing the regulations are changed to authorize the admission into the domiciliaries of veterans requiring such care.

The memorandum for the Administrator of Veterans' Affairs, issued by the President, August 12, 1963, acknowledges the authority and the primary necessity of providing nursing care within the entire medical program of the Veterans' Administration. This memorandum establishes the Executive recognition of the Veterans' Administration problems presently existing. In the sense that the memorandum provides an additional 2,000 beds which may be used to establish a formal type of nursing care program in the Veterans' Administration, there is substantial agreement with the principles enunciated in H.R. 8009.

We can, therefore, summarize the present situation, namely:

(1) The Veterans' Administration is, in practice, giving some type of nursing attention to approximately 22,000 patients in the general medical and surgical and mental type hospitals.

(2) Since these 22,000 patients have no place to go because of financial and other factors, they are using 22,000 beds that could better be used for those on the waiting list applying for hospitalization for causes remedial by acute medical care.

(3) The Presidential memorandum of August 12, 1963, recognizes the need for a program such as that provided in H.R. 8009.

(4) The General Counsel's opinion of May 7, 1963, establishes that the Veterans' Administration may, with full legal authority, change its regulations to accept a nursing-type care program. The establishment of the President's program calls for such changes in the regulations.

(5) The prebed and postbed programs under which the Veterans' Administration is enabled to make greater use of existing hospital beds is another instance of providing care in the community, at lower patient cost.

Why we think H.R. 8009 is desirable and a reasonable approach to the care of the aging war veteran.

We will now discuss in general terms the various provisions of the act.

(1) Authorizing the use of 2,000 additional nursing care beds in the existing Veterans' Administration system.

Senator YARBOROUGH. Mr. Corcoran, could you suspend for just a minute?

Gentlemen, I welcome at this time the new Member of the Subcommittee on Veterans' Affairs, Senator Lee Metcalf of Montana. He has been very active in the Senate, and has just been assigned to this subcommittee. Senator Metcalf was a former associate justice of the Supreme Court of Montana, after a distinguished career there

as a lawyer, and as a Member of the House of Representatives for the 83d and 86th Congresses—as well as service here in the Senate since November 3, 1960. He brings to this subcommittee a wealth of legislative, judicial, and legal experience that will benefit not merely this subcommittee in its work, but all the veterans of the country.

Senator Metcalf, we have long watched your service to the people of Montana, and while you were in the House, we here on the Senate side regarded you as one of the most able Members of the House of Representatives of the United States. I feel honored that this subcommittee had added to it a man of the ability and drive, a working Senator, like Senator Metcalf.

I see here that Captain Olson keeps on smiling about having added to the subcommittee, someone not only with the broad experience, but somebody else from Montana, since Captain Olson here is a former department commander for the American Legion, Department of Montana.

Senator Metcalf, we welcome you to the first meeting of the Veterans' Affairs Subcommittee since you have joined our subcommittee.

Mr. OLSON. Senator Yarborough, may I say I am personally very pleased to see my Senator here. I would like the subcommittee and the people present to know that over the years it has been my pleasure to work with Senator Metcalf, when he was a Representative, in veterans activities, and I am also pleased to say that we have met with some degree of success.

Glad to see you here, Lee.

Senator METCALF. Thank you, Mr. Chairman. I am delighted, of course, to be back on the Labor and Welfare Committee. That was the first committee to which I was assigned when I came to the House. I am especially pleased to be able to be on your subcommittee, Mr. Chairman, because I have had an interest in veterans' affairs ever since I came to Congress, as would be necessary if you have such a constituent who is interested in this as Captain Olson.

I am looking forward to serving with you.

I certainly apologize for being late this morning, but I had to make an appearance, myself, before the Interior Committee on an Indian bill. And between Indians and veterans, we Montanans are pretty busy.

Senator YARBOROUGH. Thank you, Senator Metcalf.

We are now in the midst of the testimony of Mr. Corcoran, director of the rehabilitation commission of the American Legion. You have that before you. It has been reduced to writing, and it is a very concise statement, with much very valuable information. You may continue.

Mr. CORCORAN. Thank you, Senator. Turning now to the various provisions of 8009:

(1) Authorizing the use of 2,000 additional nursing care beds in the existing Veterans' Administration system.

As stated above, the President's memorandum of August 12, 1963, recognizes the worth of this action. The General Counsel's opinion of May 7, 1963, establishes the legal authority for such an action within the Veterans' Administration.

Statements of the Bureau of the Budget representative and of officials of the Veterans' Administration opposing such action were

prepared and delivered prior to the issuance of the President's memorandum to the Administrator of Veterans' Affairs. In the absence of information about statements from such authorities to your subcommittee, it is assumed there would be some revision of the opponent's position so that divergent expressions will not be placed before your subcommittee as representing the viewpoint of the administration.

While it is not, at this time, practicable to present a detailed comment on the viewpoint of the Administrator of Veterans' Affairs and of the representative of the Bureau of the Budget, limited comment follows. In the event opposing statements issue from these sources in subsequent hearings scheduled by your subcommittee, it is hoped we would have an opportunity to file an additional statement.

The following comment is in relation to the testimony of Philip S. Hughes, Assistant Director for Legislative Reference of the Bureau of the Budget, before the House Subcommittee on Intermediate Care for Veterans.

Mr. Hughes at that time made the statement that one-half the hospital care being provided for veterans without service-connected disabilities is provided at Government expense. The 1957 survey to which Mr. Hughes made reference equated stay in non-VA hospitals with that in VA hospitals. At the time the survey was made, the so-called short-term patients occupied VA beds on the order of three to four times as long as short-term patients in non-VA hospitals. And, apparently, the chronic care patient beds in VA hospitals with a considerable percentage occupying beds for more than a year, were compared on a basis with the short-term patients in non-VA hospitals. In the past 2 years, the VA has been making a new study of this question but, so far as the American Legion knows, nothing has been made public to correct the errors of the 1957 study.

In general, Mr. Hughes' statement is in keeping with the attacks on the structure of veterans benefits as contained in the two Hoover reports, and the subsequent reports of the President's Commission on Veterans Pensions, the Bradley Commission.

Insofar as veterans affairs are concerned, the Congress has thus far not accepted the recommendations of either of the Hoover Commissions, or of the Bradley Commission.

At one point, Mr. Hughes states:

* * * since veterans as a group are better educated, have better jobs, and higher incomes than nonveterans, there is no economic justification for singling them out for additional special benefits.

Such a statement overlooks the fact that the improvements sought for veterans through H.R. 8009 do not include those who are in superior economic status. The class being considered are those who haven't the income to provide a place to go. This is the group symbolized by the 22,000 who are in general medical and surgical and mental hospitals in the VA who can't leave because they have no homes of their own to go to and they can't go to nursing homes because they haven't the income to pay for such care.

At another point Mr. Hughes makes the statement that—

any proposals which might lead to the provision of nursing care for millions of our older veterans should likewise be considered in the context of the nature and scope of the problems of the aged people in general and from the viewpoint of the existing and proposed programs to assist them.

We are not considering millions of our older veterans. Nor have the VA hospitals and domiciliaries ever provided care for millions of veterans. Currently, there are approximately 700,000 admissions and discharges from the VA hospitals in any given year, and these may represent no more than 350,000 different veterans. Specifically, H.R. 8009 is considering limited attention to the long-term 22,000 patients occupying VA beds. These patients have no other place to go.

Mr. Hughes statement overlooks the fact that, to the extent Veterans' Administration cares for needy aging war veterans, the cost to social security for the proposed King-Anderson legislation will be offset.

Under existing pension legislation administered by the VA, we have seen how liberalization of the OASDI payments under social security has had the effect of reducing, or in some cases, discontinuing the pension payments to some veterans and to some widows and orphans of veterans.

The position of the American Legion in relation to the effort to deny veterans benefits because social security laws in existence or proposed may provide other benefits is contained in the report of the Legion's special committee which reported on its study of the Bradley Commission recommendations:

The veteran who, as any other citizen, has fulfilled his social security contract, is entitled, as a matter of law, to receive the benefits of that contract. It is a tragic error, however, to say that he is entitled to nothing more. The ingratitude and contempt which produced such an error are emphasized by the basic factual differences between the two programs * * * when the day comes that social security provides security to war veterans sufficient to replace veterans' pensions, that will be taken care of automatically. When social security benefits actually do that, such assistance which will carry all veterans over the income ceilings prescribed in the present pension laws will make itself known by the workings of the present law. On that day, the Veterans' Administration will report that it is paying no pensions, because of other programs have carried every living veteran's income over the ceilings defined in the present pension laws.

The same statement may be applied to proposed social security legislation to deal with those needy veterans who would be cared for under the provisions of H.R. 8009. Continuing now with the description of the act under consideration.

(2) Providing for limited care in a private nursing home for certain Veterans' Administration patients who have received maximum hospital benefits in the VA.

All indications and information available to the American Legion show that this provision of H.R. 8009 is vigorously opposed by the Veterans' Administration.

Should the Veterans' Administration statement to your subcommittee confirm the belief that the action sought here does bear the opposition of that agency, then it is submitted that there is an area of inconsistency in their thinking.

At present, the social work service of the department of medicine and surgery is supporting an intensive program designed to prepare the long-term patient for return to his community. Transfer to nursing homes and to foster homes is being explored exhaustively. At this time, the main difficulty is lack of income of the veteran patient.

The social work service is using pension and other income the patient may have to pay for care in foster homes and nursing care homes. When these sources are not sufficient to pay for nursing home care,

the social work service turns to the welfare agencies—puts the veteran on relief—to secure a bare minimum of funds necessary for the patient's transfer. When all of the veteran's and other resources are exhausted, the veteran, or the veteran and his dependents, is deprived of other funds necessary to live at a minimal standard.

The American Legion believes the Veterans' Administration, within its own experience, shows that this is a good provision. It closes a wide gap in providing for the return of the veteran to his community.

(3) Increasing aid to State homes by providing for a 5-year program of capital outlays, on a matching basis, and a larger per diem contribution for the care of nursing home patients.

On the basis of statements of Mr. Philip Hughes of the Budget Bureau, and of representatives of the Veterans' Administration, opposition by them to this part of H.R. 8009 is assumed.

The Federal Government, through the Hill-Burton plan, through its various housing programs, is and has been expending liberal amounts of funds to provide additional services to the people of the United States. These various programs, and they are extensive in nature and scope, are denied to the States for the purpose of modernizing the State veterans homes, or for creating new ones where they do not presently exist.

The State veterans home program is not a new program. In terms of other Federal expenditures, it is not a costly program. It provides already for State fund matching such as the Federal Government is advancing in other programs. It fills a need that is not met in other services, existing or proposed.

It is the opinion of the American Legion that the Congress would be providing a useful assistance to the State veterans home system, and would be providing incentive for initiation of such programs where they do not presently exist.

We repeat the statement that, in our opinion, this is not an additional cost to the Federal Government. It is an offset to the cost of other Federal programs, to the extent that these State veterans homes are given assistance through H.R. 8009.

(4) Encouraging veterans receiving aid and attendance pension to reenter hospitals for brief stays without loss of their pension, thus preventing longer stays and more serious illnesses.

It is believed this portion of H.R. 8009 would be approved by the Veterans' Administration. This is a humane method of encouraging the veteran who is so badly disabled that he is entitled to aid and attendance allowance to seek medical and hospital care. It removes the fear that he would be deprived of a portion of his benefits income in the event one of his many possible illnesses required hospitalization. Since the Congress has approved the aid and attendance allowance, it seems obvious that inclusion of this provision in the bill would meet with approval.

(5) Furnishing prosthetic appliances to certain aid and attendance pensioners on an outpatient basis of the type and variety required in their everyday lives and which would be furnished if they were in a hospital.

Providing these devices to badly disabled veterans is proposed on an extremely limited basis. Only those eligible for an invalid lift would be covered. Since only 270 of such lifts have been issued in the time

since the Congress approved Public Law 86-211, it will be seen that the cost is not large.

(6) Extending the CBOC, postbed, program to keep prospective nursing home care patients in their own homes and in their own environment as long as possible.

This provision of the bill is limited to six particular diseases. Care could be given by VA so long as medical judgment dictated such action.

CONCLUSION

In conclusion, Mr. Chairman and members of the subcommittee, may I invite attention to the problem we face? I do this by citing the Administrator of Veterans' Affairs, himself. When he appeared before the House Veterans' Affairs Committee, April 3, 1963, he said:

We are faced with an ever-growing problem concerning the increasing numbers of our aging war veterans who require a type of care not generally provided by the present system of hospital, domiciliary, and outpatient services. * * *

The crux of the problem is that despite our efforts to place these patients in suitable community facilities, it is often impracticable to do so, especially where the veteran's income is severely limited. * * *

What to do for this group poses a large question to which we have not found the answer.

Gentlemen, we of the American Legion submit that H.R. 8009 is the answer.

H.R. 8009 is a good act. It puts the stamp of congressional approval on many services the Veterans' Administration is doing in practice.

The Veterans' Administration has been studying the problem of aged war veterans for years. It wants to delay the acceptance of its responsibility in the field of the aging for still further study.

H.R. 8009 is not a proposal to add to costs for other programs already existing or proposed. To the extent that it provides care for an extremely limited number of needy veterans who are badly in need of assistance, it merely serves to narrow the gap existing in the broad program of care provided already in the department of medicine and surgery. It is an offset to the cost of any other program already in existence or proposed.

So far as opposition to H.R. 8009 has been expressed by the Budget Bureau and the Veterans' Administration, such opposition is either inconsistent with the action of the President in establishing a nursing care program, or it is a continuation of the thinking of the Hoover Commission and the President's Commission on Veterans' Pensions. The Congress has not accepted the recommendations of the Hoover Commission and the President's Commission on Pensions insofar as they apply to veterans benefits.

The Veterans' Administration is supported as the one-stop agency to handle veterans benefits. As such, the agency has the limitless opportunity to be the means of research in medical care for the aging and aged, and thus provide benefits for all mankind. We believe the final enactment of H.R. 8009 would permit the staff of the Veterans' Administration to get on with its work in this field; first, as a means to meet the problems of the needy aged veteran and, second, as a program to free many thousands of beds in the Veterans' Administration hospital system for the projected increase in demands for acute medical and hospital care.

Again, Mr. Chairman and members of the subcommittee, we thank you for extending to us the privilege of appearing before you on this most important subject. The aged and chronically ill, needy veteran faces grave problems. H.R. 8009 proposes a rather comprehensive program aimed at alleviating those problems. The American Legion solicits, and will be indebted to you for your careful and sympathetic consideration of this entire matter.

Mr. Chairman, may I summarize the type of problem that seems to be confronted by the VA, and for authority I go to the VA itself, the Administrator's statement on April 3. In that statement, in part, the Administrator said, with reference to the VA :

We are faced with an ever-growing problem concerning the increasing numbers of our aging war veterans who require a type of care not generally provide by the present system of hospital, domiciliary, and outpatient services.

The Administrator continued :

The crux of the problem is that despite our efforts to place these patients in suitable community facilities, it is often impracticable to do so, especially where the veteran's income is severely limited.

And, in conclusion, the Administrator said :

What to do for this group poses a large question, to which we have not found the answer.

We submit, Mr. Chairman, and members of the subcommittee, that H.R. 8009 is the answer to that problem.

Thank you, Mr. Chairman.

As Mr. Olson indicated earlier, we hope to have the opportunity, in addition to answering any questions that might be raised, of additional statements by Mr. Horton and Mr. McCurdy.

Senator YARBOROUGH. Thank you, Mr. Corcoran.

We will proceed with the additional statements, and then we will have questions by the subcommittee.

STATEMENT OF ROBERT M. McCURDY, CHAIRMAN, NATIONAL REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. McCURDY. I am Bob McCurdy, the national chairman of the rehabilitation commission.

When this bill was originally introduced, it was very heartening—that there had been great study and great time and effort given to the formulation of an approach to the solution of one of our very hardest problems.

Then it was very heartening when the President lent his support to the bill by administratively requesting and authorizing the Administrator of Veterans' Affairs to open 2,000 beds.

I say it was heartening because it fixed a responsibility and accepted the responsibility of Federal Government for this type of care which up until this time had been a considerable problem for all of us.

The need has been pointed out. Within the VA hospitals there are 9,000 chronic cases that need this type of care.

If you commit to the principle that it is Federal Government responsibility—and the administration has committed to that principle—then the other portions of the bill just make good sense, in this way.

This is an economical program from the viewpoint of total overall cost to the Government. You have these 9,000 patients in general medical surgical hospitals—and I am not talking about the NP patients at this time—where these patients are costing an average cost per diem of around \$28.

This bill says nursing home care at one-third the cost of hospital cost, in other words the Federal Government, by instituting the program in its entirety, as provided in the bill, would reduce these from \$28 a day to \$9 a day. And they have committed and said they are responsible for the care of the sick and broke veteran who has no place to turn.

Now, the next instance is the aid to the States. Again, let us look at this provision of the bill from the viewpoint of the Federal Government has now accepted the responsibility.

Well, now, as Federal Government we are not going to accept the responsibility and then tell the States, "Yes, we have this responsibility, but we are not going to let you help. If you want to pay half the money, we don't want you to do that. We will pay all the money."

Now, what I am talking to is raising the aid to State soldiers' homes, where the State is willing to construct the facilities and to share with you the cost—wouldn't it be a great conflict in policy to say, "Yes, we accept the responsibility but we don't want anybody else to help us."

That doesn't make sense to me.

Senator YARBOROUGH. It doesn't to me, either, Mr. McCurdy.

Mr. McCURDY. Then it seems to me that the opposition to this has always come on these type of things from the Bureau of the Budget. And the Bureau of the Budget has one approach. They project it to what it would cost in the year 2000, and frighten you to death with an astronomical figure that we cannot pronounce. And when they do this kind of thing—we now have some of those projections documented, where the cost has been absolutely and completely wrong. As an example, on 86-211, in their first 2 years, their projection was \$90 million a year—too high for each of the first 2 years. I cite that just as a small example of don't be frightened by the projection.

But I recall—I am recalling the statement of the President in a recent speech where he said these things are relative, and that when you are talking of the cost of government that you must take in the overall picture. Don't tell half of the economic truth—tell all of the economic truth, and base it on your total gross national product.

Now, the gross national product, which is now just under \$600 billion—veterans benefits in their entirety are now a little less than 1 percent of your total gross national product. That was true in 1898. It was 1 percent then, and it has been 1 percent all the way through, and is less than 1 percent today. And it is one of the agencies that has held the percentage of their costs to our public.

Senator YARBOROUGH. Now, Mr. McCurdy, about 1947 it got up to over 2 percent, did it not?

Mr. McCURDY. It got over 2 percent during the period of the Education Act, when we in the ultimate educated 12 million men—just a little over 12 million.

Senator YARBOROUGH. While you mention the budget, we find the same scare tactics being used on the cold war GI bill. No veteran could get over 36 months' training under it. That is the maximum

for any one veteran. You would think from the Bureau of the Budget scare figures they were going to be in school the rest of their lives.

Mr. McCURDY. And the money was plowed back into the economy, too.

Senator YARBOROUGH. Sure. That is the difference from the care of a man who is going to be totally disabled the rest of their lives. Those young fellows get a maximum of 36 months' training, and they go out and help produce the taxes to support these nursing homes that we need for the elderly.

Mr. McCURDY. Yes, sir.

Now, John Corcoran has mentioned the prebed care and the post-bed care for nonservice connected. Again, this is care outside of the VA facility for nonservice connected.

In other words, it sets a policy—it is the policy to do this. And within the last 10 days we have a case that I want to show you that it is the policy of the VA to put men in private nursing homes today, and that to oppose that section of the bill would be contrary to their own activities and actions at the present time.

I just want to take one case. This was the case of a man who is totally disabled, in the hospital for a period of years. He is 82 years old. He is service connected. And, in my opinion, this makes it even more important. He is service connected with a total compensation of \$273 a month.

And within the last 10 days the VA has written to the man and his wife and said that: "We are now going to take him out of the hospital and place him in a nursing home"—"We are going to place him in a nursing home."

Well, now, that is all right; \$270 just happens to be 30 times \$9 a day, or \$270, what the bill calls for—about \$9 a day. They say, "Yes." Well, he is 82, and his wife is 84. And to take his \$270 to pay his nursing home care leaves his wife without a nickel. She has nothing.

That is a problem. The Legion had to ask the manager to please hold it until we can make provision to take care of the wife, because the VA had no way, of course, under law, to do that.

Here is an example. And the reason I am giving the example is to demonstrate that the VA or the Bureau of the Budget or the administration or anybody else can tell this committee that it is not the policy of the VA to put them in, because we can cite case after case after case where they are doing everything they can to put these terribly disabled men in private nursing homes.

Well, I think that our written testimony presented our case in a very scholarly manner, as our good attorney director, John Corcoran, does for us. And I want to express my own appreciation to the chairman of the committee for the privilege of adding these few words.

I have been here a long time, and I have never seen a bill that helps those who need the help the most any more than this one.

I sincerely hope that it will have the favorable action in both the committee and the Senate. Thank you, sir.

Senator YARBOROUGH. Thank you, Mr. McCurdy. I agree with you on your estimate of your director's capabilities in this fine presentation. I agree with you that these elderly veterans need care. But I think the cold war GI bill is also urgent. These men are going to

have some long years in the twilight of their lives when they need help. But these young fellows are being denied their opportunity in life on the threshold.

I want to urge the American Legion, in addition to getting behind this bill, to get behind the cold war GI bill, and do that for your country, too.

I am as sympathetic as you are for these elderly veterans. I ran for years on the platform of aid to the elderly, because it was neglected in my State. One of the bottom 10 States of the Union in the care of the aged, in the average annual old-age pension—many other things. That has been a prime part of the tenets of my political faith.

But I do want to urge, for the strength of the country, the importance of this other measure, too. Thank you for your fine presentation, as usual.

Mr. Horton?

STATEMENT OF C. C. HORTON, CHAIRMAN, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. HORTON. Thank you, Mr. Chairman.

I am Clarence Horton, from Alabama, and am chairman of the national legislative commission, as you have been advised.

I appreciate the privilege of appearing before you and the gentlemen of the subcommittee in respect to this bill.

It only takes one glance at me to determine I have been around a long, long time, and have observed legislation over most of my years.

Perhaps one of the great feelings of pride which come to me in my affiliation with the American Legion lies in the fact that I have found the Legion always presenting reasonable and moderate legislation.

I think H.R. 8009 is a splendid example of just that type of legislation, the kind that is helpful to the economy of the country, helpful to its needy citizens, and capable of justification in any atmosphere.

I am a minor witness here, and can contribute far less to the testimony than those who have preceded me. Yet I feel that in 8009, which, incidentally, is difficult to express properly, because some of us say 8-0-0-9, and some say 8-double 0-9, and some use still other phrases with which to try to express the title of the bill, or the number of the bill.

I am particularly interested in the fact that we are dealing here with a need which continues to increase from day to day, and which will not, in our lifetime, diminish. Therefore if we can prevent even one avenue of a reasonable approach which will help solve a part of this problem, then we have done a constructive thing, we have done a helpful thing.

Being from Alabama, Mr. Chairman, and Senator Metcalf, you perhaps will forgive me if I refresh your recollection in reference to State veterans homes. They exist principally across the northern tier of States, because they had their first great impetus following the close of the War Between the States. And because of a provision in the law of 1888 which first set up the State veterans homes, it was not possible for the Federal Government to provide money for the construction of a facility which could be utilized by those who had participated in an insurrection against this Union. Therefore States like Alabama and so forth did not and could not build State veterans homes.

The needs in Alabama and Texas, however, are just as great as they are in other States. And with the incentive and the opportunity provided by H.R. 8009, it is quite probable that many of the States not now possessing State veterans homes would see the advantage of building them, thus contributing to the total overall solution of this problem and, as Mr. McCurdy has so ably pointed out, do it with a share-and-share-alike expense of the local community and its own government.

It seems to me that there is no question, there could be no question in the minds of the committee, or of the Congress, as to the need for this type of facility for the care of the aged, needy veteran, who, as Bob says, is sick and broke, and with no place to go.

And the failure of the Veterans' Administration to place more of their patients in that type of home is due primarily to the lack of income on the part of the veteran.

So if we can at one and the same time provide care in a private nursing home which can be accomplished at one-third the cost of that in the Veterans' Administration, then we can do two very great things. We can free the beds presently being occupied by the 9,000 or 22,000 veterans who could be placed in private nursing homes, or in the facilities authorized by H.R. 8009, and we could defer, at least for a time, the need for additional Veterans' Administration hospital beds.

So it seems to me to add up to what I said in the beginning—reasonable, desirable, moderate legislation that I certainly hope this committee will see fit to report favorably.

I will be glad to expose myself to any questions.

And, again, may I thank you for your courtesy in allowing me to present my viewpoint in this matter. Thank you, sir.

Senator YARBOROUGH. Thank you, Mr. Horton. Mr. Olson, does Dr. Brick have any testimony to add before we get to the questions?

Dr. BRICK. I would be delighted to answer any questions that might come up, but I have nothing primarily to offer.

Senator YARBOROUGH. Before we begin the general questions, I wanted to just direct one or two specific ones to Mr. Horton.

Mr. Horton, the trans-Mississippi part of the Confederacy, after these veterans' homes were built in the North, the States there generally built a State Confederate Veterans' Home, Arkansas and Texas in particular. Now, back east of the Mississippi, were there not veterans' homes built in those States?

Mr. HORTON. Yes, sir, there were. But you will recall—and perhaps this applies to Texas—I am not at all sure—when the number of Confederate veterans and their widows declined to the point where it was no longer feasible for the State to operate this facility, and when there was yet no great demand from the general public for this type of institution, the homes were closed and allowed to go to ruin, so to speak.

But most of the States—and this is what I am trying to get to—most of the States now own real estate or property upon which such a home could be constructed. Certainly that is true in Alabama.

Senator YARBOROUGH. I think that was true of my home State of Texas, too. I think the buildings are still there, but converted to some other use.

But they were purchased under a special provision of the State constitution that provided for its establishment, to purchase the land and

construction of the buildings. I think that under these provisions, that the land, even some of the buildings themselves might be re-modeled and again made available.

Mr. HORTON. That is certainly true, Senator.

Senator YARBOROUGH. It is largely because of the decline in the number of veterans. And only after World War II did we have as many veterans in proportion to the population as we had had after the Civil War. For the first time the number was in proportion. And in all of our wars still, the number of men whose lives were lost in the Civil War exceeds the number of lives lost in all other American wars combined from 1744 to the present.

So that we just now are beginning to have an experience like that after the Civil War, when such a high percentage of the population had participated in the armed services.

We will start with general questions.

Senator Metcalf, do you have any questions to any member of the panel?

Senator METCALF. I have no questions at this time, Mr. Chairman.

Senator YARBOROUGH. This resolution, 452, of the 1962 National Convention of the American Legion, recommended \$5 million be appropriated annually for 5 years for the construction of State veterans' nursing homes.

Now, how was that figure of \$5 million for 5 years arrived at? Do you know what the basis of that recommendation was?

Mr. CORCORAN. Sir, first of all, a general comment about how figures and statistics and resolutions are arrived at in national conventions and other bodies.

I think it sometimes is difficult to document scientifically why any particular figure was selected by the delegates. Very often you find that this is just an expression of what the group, based upon background, experience, and common knowledge, feel would be an adequate goal, and one which would be attainable.

It is my understanding that the State association—the National Association of State Homes themselves recommended this figure to those people in the American Legion who were interested in this subject. So I say now in direct answer that, (1), we took the advice of the national association itself on what it felt would be of great benefit to them in such a program; (2), we estimated the capability of the U.S. Government at this time; and (3), we included those figures in our request.

Senator YARBOROUGH. Well, now, this H.R. 8009, or eight thousand and nine, or 8-double 0-9—

Mr. CORCORAN. Senator, I suggest perhaps if we attach a public law number to it, it might solve the whole problem.

Senator YARBOROUGH. You know, we have an experience in Congress. We often have some mornings we wake up and come in the office with a deluge of telegrams saying, "Vote for"—we in the Senate get them—"H.R. so-and-so." Of course the bill is in the House committee, we have never seen or heard of it in the Senate. One Senator one time recognized a name on the telegram, Senator Magnuson, of Washington, a close friend, so he picked the phone up and phoned him and said, "What in the Sam Hill is this bill about that you recommend I support?" And the man said, "Dogged if I know. They just told me it was a good bill and a good number, and I wired you."

So we often in the Senate get numerous wires and letters requesting that we vote a certain way on proposed amendments of House rules. So the identification of bills by numbers is widespread over the country—I mean organizations in Washington tell the people the bills by numbers. And we do have to put researchers on Senate and House bills to know what our constituents are wiring us about, because very often those wires reach us before the bills even reach the floor of the House.

We have heard quite a bit about this bill by number, by various media of communication, written and oral, letter and telegram.

Now, this H.R. 8009 has provisions that forbid the administrator to use any of the money to help finance a State nursing home if it will result in the State having more than one-half a bed per thousand war veterans in that State, is that correct?

Mr. CORCORAN. Yes, sir.

Senator YARBOROUGH. Do you regard the figure as half a bed per thousand as a correct approximation for veterans, for nursing home care at the State level there?

Mr. CORCORAN. Mr. Chairman, I don't think I am really fully qualified to give a reliable answer to that.

Senator YARBOROUGH. I wondered if that was to keep one State from getting a disproportionate share of the money.

Is that the reason—to keep one State from getting more money out of the \$5 million than it might need, and then some other State fail to respond to its obligations there?

Mr. CORCORAN. This is true.

Now, there are several deficiencies which suggest themselves when you follow such a formula.

For one thing, you may wind up with a facility that has too small a number of such patients to be operated efficiently or effectively, that is that the State veteran population is so small.

Another defect that suggests itself is that perhaps this will nowhere begin to approach the problem in some areas.

But we certainly, I think—although we have no official position on this point—I think would be willing to accept this formula as a beginning place from which to start, to find out whether or not it is feasible, and whether or not some change may be made subsequently.

Senator YARBOROUGH. What is your estimate of the number of veterans who are not presently in domiciliaries or have a hospital bed who require nursing home care and would use the VA nursing home beds if they were available?

Mr. CORCORAN. Here, again, Senator, I don't think I can give you an answer that would be dependable. I would hope that other authorities would have greater access. We have heard it said that throughout the United States it is believed that 500,000 such beds are needed.

Senator YARBOROUGH. How many?

Mr. CORCORAN. 500,000—this is for the entire population. Studies, of course, have been done and are part of the record.

Senator YARBOROUGH. You mean the entire population, veteran and nonveteran, male and female?

Mr. CORCORAN. That is correct. I would think that the VA would be in a position to give some helpful answer on this, based upon, first

of all, the number of patients that they already have in their system, added to the number of patients that have tried to get into the system and have been rejected because they are not a "hospital" type of patient.

Excuse me, sir.

Dr. Brick, do you have anything to add?

Dr. BRICK. There was a survey by one of our departments, Mr. Chairman, in which tabulation of nongovernmental nursing homes was made with reference to the percentage of veterans among the male groups in these private nursing homes, and it came to something, as I recall now, between 40 and 50 percent were veterans, receiving no remuneration from the Government or governmental sources, but in nursing homes.

This brings up the question that the 2,000 bed or 4,000 beds proposed in H.R. 8009 is just a beginning. And I think the importance of this bill, from a medical point of view, is that for the first time an opportunity will be given for the medical services in the Veterans' Administration to get into this field and see which way they are going to proceed in the future, when the needs are going to be greater than they are today.

So, from that point of view, this bill is very important because, too, it ties in the nursing homes with a general medical surgical hospital.

As you know, in many of the States where the problems have particularly been highlighted in newspaper articles about the very poor care given in many privately owned nursing homes, we hope that some standards will come of this particular experience to enable the whole country to benefit, because this is going to be a very, very great and grave problem in the future as all of us are aware.

Mr. McCURDY. May I add one word?

I think that to obtain a reasonable figure of this kind you would have to approach it with extreme caution. A survey that is made of private nursing homes, and what their situation is at the present time, would not be an indication of the obligation of the VA, because many of these people in private nursing homes, or many of those veterans, do not have the need factor. And this doesn't change the need factor at all.

So in the projection of what your problem might be, we want to be sure that we are not including every person that is a veteran that might need nursing home care, because there are a great many thousand of them, as we have in nursing homes today, that are fully capable and able and do pay their own way, all the way.

I would suggest and recommend that there be a note of caution in accepting astronomical figures of what this might be. It is like the projection of 22 million men entitled to hospitalization. That is a bunch of hogwash. It never has been 22 million entitled to hospitalization under the law. You still have to have the needs clause just the same, it doesn't change that at all.

For us to project it is quite an impossibility. But the automatic data processing and all the pension records of those who have qualified as totally disabled, and broke to the place where they qualify for pension—I would think that taking the percentage of pensioners hospitalized, that a reasonably scientific figure could be arrived at.

But it would have to be done with a full knowledge of all the problems and not saying there is this many veterans, 10 percent are in nursing homes, so it is going to be this many—because that would not be valid at all. There are too many factors involved.

And unless all factors are considered, the projection will not be valid.

Senator YARBOROUGH. Well, from the testimony, how many veterans who have received maximum hospital benefits and could be transferred to nursing home beds if they were available—how many are there? There is a figure of 9,700 somewhere. It seems to me like I recall 22,000 somewhere. Is the number somewhere in between 9,700 and 22,000? What is the figure?

Mr. McCURDY. There are two categories. There are in excess of 9,000 that are general medical cases in general medical facilities.

Senator YARBOROUGH. Who have already received the maximum benefit?

Mr. McCURDY. Yes; who now, from the testimony previously given, would be eligible for this type of care.

The second group, which it is doubtful might ever be eligible for this type of care, are those that are in neuropsychiatric hospitals, which when that group is considered goes to something like 22,000.

Now, those of us who are wholly familiar with an NP hospital know there are hundreds of those men that are not going to be able to be cared for in a nursing home, because you have the whole scope of NP disability to contend with, where physical custody is a very vital and important part of the care of this veteran, and nursing homes for the most part don't give restricted custody as such as a service.

So it would be somewhere in excess of 9,000.

But, again, you would have to approach the NP cases with caution.

Senator YARBOROUGH. Well, now, in the light of those two figures, those two groups, that statistical information, do you regard, Mr. McCurdy, this 2,000-bed figure, of H.R. 8009, as adequate, for those who have already received the maximum hospital benefits?

Mr. McCURDY. Well, to me it seems obvious that it would only be the start. But if we had these 4,000 beds, it would certainly be a good start and give us an opportunity to take a look at the program and to see if it does accomplish our mission of lessening the costs materially.

And with the 2,000 beds already authorized by the President, 2,000 authorized by the Congress, we would have a big enough start to at least know where we are going and to build a table of experience, and to immediately relieve our acute situation in the hospitals.

Senator YARBOROUGH. Do you have any figures indicating any correlation between the number of veterans on the waiting list for VA hospital care and the number of maximum hospital benefit veterans now occupying beds?

Mr. McCURDY. Well, the last figure I think that we discussed—and by “we” I mean the staff—we discussed this the other day—I believe the last figure was June 30 and at that time there were some 19,000 on the waiting list who are certified as eligible for hospitalization but were awaiting a bed.

So if you took the whole 9,000 out of general medical, you would reduce your waiting list to 10,000 people.

Senator YARBOROUGH. You still would not cut that waiting list—you still would not do away with the long waiting list, if you furnished every one of these beds.

Mr. McCURDY. No; it would not do away with all of it, but it would materially help.

Again, you cannot just take the number of beds relieved. You have to project it with its turnover in the beds.

Senator YARBOROUGH. If you have straight medical cases, the turnover would help relieve the waiting list much faster.

Mr. McCURDY. If you had the immediate availability of 4,000 and then with the turnover you would make a great big hole in your waiting list. As Mr. Corcoran pointed out, or Mr. Horton pointed out, they complement each other.

Now, if we don't do this, expansion of the VA hospital system—and since 1957 there certainly has been extensive plans made on how this is going to be expanded to pick up the load that is coming, just as sure as we are sitting here. Here is one that economically is going to aid and assist in this program. I think this is the economic overall way to do it.

Mr. HORTON. Further comment, Mr. Chairman, on the same point—if I could make it.

That is, remember that under this law, we could immediately free these 4,000 beds. Now, hospital waiting lists are made up of various categories of people.

So it would be logical, I think, to assume that we could take the 4,000 on the waiting list who were more urgently in need of treatment, and hospitalize them immediately.

Waiting lists have a way of diminishing of their own, because of changed situations.

But for those who need acute, intensive, urgent treatment, 4,000, I would hazard a guess, would take care of the present waiting list—I am stating it awkwardly. But I am trying to state that in my judgment, of the present waiting list, 4,000 perhaps would be the total number who urgently need immediate hospitalization—some hospitalization could be deferred.

Senator YARBOROUGH. I think that is an important point in this bill—in addition to getting that care for the 4,000, release hospital beds for turnover, so they can get true medical care as distinguished from rest homes, custodial care.

Mr. McCURDY. Mr. Chairman, I just want to add one other point, while we are talking about the waiting list.

The figure used, 19,000, is the official waiting list. Now, we know from long experience that a man makes application for hospitalization, and they say, yes, they find him eligible, and they say he will go on the waiting list. And there are a thousand ahead of him in the hospital. And he says, "The heck with it," and he doesn't become an official part—from purely experience over 20 years in this field, I would suggest there are at least that many more that if beds were available would take advantage of the thing.

But they go without help, because they cannot possibly get in for so long that they are discouraged.

Senator YARBOROUGH. Yes. This is a very informative discussion here. I would like to remain until all the questions are finished.

But I have an urgent call to go to another meeting. I am going to ask Senator Metcalf to take over for the remainder of the session today.

Mr. OLSON. Before you go, Mr. Chairman, we want to again thank you for your courtesy and the opportunity to be here.

Senator YARBOROUGH. Thank you very much. We will be having further hearings from time to time. We want everybody to know these hearings are underway, so that their requests will come in, and we will start accumulating this evidence.

Mr. OLSON. We would also like you to know that we very sincerely appreciate the fine work of your able counsel and his staff, and are deeply appreciative of their cooperation and courtesy.

Senator YARBOROUGH. They have been very diligent.

Senator METCALF (presiding pro tempore). I thank the members of the panel. I appreciate the opportunity to continue this hearing.

The staff has prepared some other questions that they know much more about than I—because as was already brought out, this is my first meeting as a member of this subcommittee. And I want to compliment all the witnesses for bringing very informative and helpful testimony.

The chairman wants these matters in the record.

Do you have any information as to the nature of the afflictions of those maximum hospital benefit veterans who are presently occupying Veterans' Administration hospital beds?

Mr. CORCORAN. Do we have any information on what?

Senator METCALF. As to the nature of the afflictions that these people have.

Mr. CORCORAN. I don't have any personal knowledge, Mr. Chairman. We indicated earlier a citation from Dr. Haldeman which indicated the general characteristics of patients. Here, again, I am quite sure that the Veterans' Administration could elaborate on that point.

I think, Mr. Chairman, that the Veterans' Administration—

Senator METCALF. This is information we will have to elicit from the Veterans' Administration.

In section 6 of the proposed legislation, H.R. 8009, the CBOC program, it has a list of diseases. Do you have any idea as to whether or not that is an adequate list, or should that list of diseases be increased?

Mr. CORCORAN. Our present impression, Mr. Chairman, is that this is an adequate list.

We think these diseases constitute a fairly good representation of those cases in which the CBOC authority ought to be further extended. But let me ask our senior medical consultant if he concurs in that statement.

Dr. BRICK. The list of diseases mentioning cardiovascular disease, including hypertension, endocrinopathies, diabetes mellitus, cancer, and then as a separate category are neuropsychiatric disorders, covers, I would say, 95 percent or more of the type of patient that would be covered in the nursing home type of care. This is the general experience in nursing homes at the present time throughout the country, too.

Senator METCALF. At least for a start, this list of diseases would take care of most of the ones—most of the cases that had to be—

Dr. BRICK. Absolutely.

Senator METCALF. The staff has called my attention to page 15 of the House hearings, where Dr. Brick testified that if a veteran was moved from a general medical or surgical ward to a nursing home installation, the costs of laboratory tests and X-rays would be less.

Would you expand on that testimony?

Dr. BRICK. Well, in this proposed arrangement of facilities within a hospital sphere, the patient who is moved into the nursing home type of bed will already have had the essential laboratory and X-ray data that is necessary to continue his care.

Furthermore, as the patient remains in this nursing home type of bed, the necessity for X-rays and laboratory data diminish considerably, and therefore, the cost of the auxiliary services of X-ray and laboratory are substantially diminished, as compared to being in an acute institution, acute medical institution.

This is what I had reference to.

Mr. CORCORAN. Mr. Chairman, may I supplement that with a comment, not bearing precisely on the cost element, but on the desirability aspect of it?

In a letter dated June 26, 1963, Thomas E Chalmers, M.D., answered an inquiry from the Subcommittee on Intermediate Care for Veterans, and his statement is found at page 1639 of those hearings.

In the first part of his letter he pointed out that in his opinion three types of hospitals or medical care were necessary, the third of which was the institution where nursing or custodial care ought to be provided. And then, again, not discussing the cost element, but discussing it from the patient's standpoint, he said:

The reasons for this division are purely professional. In the acute general hospital, the doctors and nurses are oriented toward emergency treatment and quick results. They must be able to drop everything for the dramatic problems that enter every day. They are bound to lose interest in the patient whose improvement requires weeks or months instead of days. The long-term patient does much better in an institution where the staff is oriented toward less dramatic changes, and more interested in reconstructive and supportive types of therapy, rather than cure. However, in the intermediate hospital, the patient is seen just as often by the physician, and presents just as complicated and difficult a medical challenge. Staffing can be no less complete because patients with chronic illnesses are constantly developing acute complications which require full scale treatment. In the third type of hospital, however, professional staffing can be much less, because the patients need only be seen by a physician on a once a month or occasionally more frequent basis. It is most important in order to maintain the highest quality of medical care that the first two types of hospitals should be closely associated with medical schools and the third not too far away.

I mean here to point out the desirability of having specialized attention for this type of patient.

Senator METCALF. Yes.

I believe you touched on this earlier in your statement before I came in—that it would be desirable to have these nursing homes geographically located near regular hospital installations.

Captain, Columbia Falls, for instance, which is a State home, must be 300 miles from Fort Harrison, wouldn't you say?

Mr. OLSON. Yes, sir.

Senator METCALF. None of these advantages would accrue if the nursing home were as remote as 300 miles—laboratory facilities, convenience of medical attention, and so forth, would not accrue, unless they were in the same locale.

Mr. CORCORAN. That is correct, Mr. Chairman.

And, as a matter of fact, I am convinced that the Veterans' Administration, when it implements the Presidential memorandum, and the proponents of H.R. 8009, all envision that the nursing care facilities would be provided either in the VA hospitals or close to a GMS hospital.

Senator METCALF. A result of this bill would mean that nursing home custodial facilities will almost inevitably grow up in and around presently located veterans' hospitals.

Mr. CORCORAN. We believe so, sir—with the possible exception, of course, of the two other major provisions of the bill, the private nursing homes and the State soldiers' homes.

As you know, many State soldiers' homes have adequate hospital facilities, and adequate general medical hospital service.

Senator METCALF. Even private nursing homes would be more desirable located in or near the community where the regular medical facilities are located.

Mr. CORCORAN. That is very true, sir.

Senator METCALF. I have no more questions.

Again, this has been very informative and a helpful hearing for me in a field that I am just beginning to embark upon. And I thank you all for coming and participating.

I look forward to further hearings and further help from all of you.

Unless there is something else before the subcommittee, we will be recessed subject to the call of the Chair.

Mr. CORCORAN. Thank you very much.

(Whereupon, at 11:50 a.m., the subcommittee recessed, subject to the call of the Chair.)

NURSING HOME CARE AND FACILITIES FOR VETERANS

TUESDAY, DECEMBER 10, 1963

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

The subcommittee met, pursuant notice, at 10:17 a.m., in room 4200, New Senate Office Building, Senator Ralph Yarborough (chairman of the subcommittee) presiding.

Present: Senators Yarborough (presiding) and Kennedy.

Committee staff members present: Stewart E. McClure, chief clerk; Charles Johnston, counsel; John Strasburger, associate counsel; and Raymond D. Hurley, associate minority counsel.

Senator YARBOROUGH. Gentlemen, the Subcommittee on Veterans' Affairs will come to order, and we have with us this morning, as we resume hearings on H.R. 8009, Mr. John P. Harrington, superintendent of the State Soldiers Home in Massachusetts. Is that the correct title of the home?

Mr. HARRINGTON. Soldiers Home in Holyoke, Mass.

Senator YARBOROUGH. You have been superintendent of the home since 1956?

Mr. HARRINGTON. Yes, sir.

Senator YARBOROUGH. Mr. Harrington is a member of the American College of Hospital Administrators, Massachusetts Hospital Association, and is now president of the National Association of State Veterans' Homes.

Gentlemen, this morning I have four committee meetings and two other meetings now in executive session. That means we are voting bills out and they have a priority over our hearings. This late in the year, of course it is very difficult to have hearings because of these executive sessions and a little before 10:30 I will have to recess the hearings to go to that. At 11 o'clock we meet in conference between the House and Senate. Of course that has priority even over executive sessions.

We have contacted all members of the Veterans' Subcommittee. Each member of this subcommittee is in the same position that I am in and no other single member is free from his committee commitments to hold the hearings. If they were, one of us could hold the hearings while the other was gone, but in these final days before the end of the month we are endeavoring to terminate as much legislation as possible, voting it up, voting it down, to pass on it and get it completed.

So I hope you gentlemen will bear with us if we have to recess to go to these executive sessions.

Mr. Harrington, I understand you have several officers from your national association with you, and you will please introduce all you have at the witness table with you who will participate in the presentation.

I want to say I think this is a very important bill or I would not schedule hearings here in the midst of all these executive sessions. If it were just a routine bill, we would not schedule hearings this late in the year. We think it very important and we believe that each day's progress made on the hearings is progress on the measure.

Will you proceed, President Harrington, in your own way, and introduce those with you who might be participating?

STATEMENTS OF JOHN P. HARRINGTON, PRESIDENT, NATIONAL ASSOCIATION OF STATE VETERANS' HOMES; AND JOHN L. QUIGLEY, ERNEST W. WIXOM, LAWRENCE E. EATON, AND EUGENE COPENHAVER, MEMBERS OF THE NATIONAL ASSOCIATION OF STATE VETERANS' HOMES

Mr. HARRINGTON. Thank you, Mr. Chairman.

Mr. Chairman, I want to thank you for your invitation to come here today to appear before you and your subcommittee in the interests of this legislation, and with your permission I would like to present and introduce to you Mr. John L. Quigley, who has been the commandant of the Soldiers Home in Chelsea, Mass., since 1948. He is a past president of the National Association of State Veterans' Homes; he is a past president of the Massachusetts Hospital Association; he is currently secretary of the New England Hospital Assembly; he is a delegate to the American Hospital Association from the Massachusetts Hospital Association. He is chairman of the Legislative Committee of the National Association of State Veterans' Homes, and he is a member of the Council on Long-Term Care of the American Hospital Association. Mr. Quigley will present to you and your subcommittee, sir, the position of the National Association of State Veterans' Homes and the care that is now being provided by the State veterans' homes and the recommendation of the national association.

With us, also, today is Mr. Ernest W. Wixom. Mr. Wixom is the commandant of the Michigan veterans' facility in Grand Rapids, Mich., and has been commandant since 1955. He is a past president of the National Association of State Veterans' Homes. He is a past executive secretary of the Crippled Children's Commission in the State of Michigan.

And we have with us, also, sir, Mr. Lawrence E. Eaton. Mr. Eaton is the commandant of the Soldiers and Sailor's Home at Grand Island, Nebr., and the Norfolk Soldiers and Sailor's Home at Norfolk, Nebr., since 1956. He is a past president of the National Association of State Veterans' Homes.

We have with us Mr. Eugene Copenhaver. Mr. Copenhaver is the superintendent of the Oklahoma State War Veterans' Home facilities at Sulphur, Okla., and has been since 1957. He is the vice president of the National Association of State Veterans' Homes. He has been the chief property accounting and supply officer in the Veterans' Administration regional office at Muskogee, Okla., from 1946 to 1952.

He has been an administrative assistant to the Oklahoma War Veterans' Commission from 1952 to 1957.

Each of these men have been actively engaged in the care of veterans and with the problem which the subcommittee is hearing today.

I am very pleased to present to you, sir, Mr. John L. Quigley, who will present the association's position on this bill.

Senator YARBOROUGH. Mr. Harrington, we are very fortunate to have Senator Kennedy of your own State here at this time. He has finished a very important hearing that he was chairing this morning, and now has come here to help us. So there will be no break in this hearing. I must go to executive committee meetings, of which I have two at 10:30, one Post Office and the other Commerce.

I will come back and assist Senator Kennedy, and then I have a conference committee on the vocational education bill at 11. Each time I get away from those committees I will come back up here.

Senator Kennedy, Mr. Harrington introduced the other gentlemen. If you will take over, Senator Kennedy, we all appreciate your spirited cooperation here.

Senator KENNEDY (presiding pro tempore). I want to extend my very good welcome as has been extended by Chairman Yarborough, to Mr. Harrington and Mr. Quigley, whose work I know of intimately in the State of Massachusetts.

I think you are aware of the work they have done and their great interest, and I know this subcommittee is extremely fortunate to have them as well as the other witnesses who come down here to testify before this subcommittee this morning.

So, Mr. Quigley, if you will continue in your own way on this, we will appreciate it.

Mr. QUIGLEY. Thank you very much, Senator Kennedy, and members of the staff.

We would like to first attempt to stress what to our mind is the most important problem in the public health field today, not only that in the care of veterans but the care of the aged or long-term care type of case.

Much attention has been given by public officials, by the Senate, and the Congress to the effect that this legislation will have and the needs of this type of legislation.

We would first like to relate just where this problem of medical care is in relation to our entire dollar.

First, we will note that of the consumer dollar that we estimate some 6 cents alone is spent for medical care.

We are told constantly of the high cost of medical care and attention, hospitalization and so on, but we note it actually costs no more than what we spend for recreation and slightly more than what we spend for tobacco and liquor.

We also note the changes that have taken place from 1940 to 1950 to 1960. We notice that there are changes where at one time physicians were receiving some 30 cents of the medical care dollar which decreased to 28 cents and now to 25 cents.

Correspondingly, hospitals and inpatient care institutions generally have increased from 18 cents to 23 cents to 26 cents. We estimate that nursing home costs, too, will increase considerably in the future.

With this very brief and sketchy relationship we would like to next outline to you what we have in mind in our presentation this morning.

Outline of Presentation ~

- a. HISTORY-PURPOSE-LOCATION OF STATE AND FEDERAL HOMES
- b. CONCERN OF STATES OF NURSING HOME CARE
- c. VA MEDICAL AND HOSPITAL PROGRAM GEARED TO 1946 CONCEPT OF CARE
- D. RECOMMENDATIONS OF NASVH

First, we thought we might discuss briefly a history including the purpose and location of some of the both Federal and State homes around the country.

Secondly, we thought we would like to point out the concern that rests with the State government at the present time regarding nursing home care, particularly of aging veterans.

Thirdly, we would like to make certain recommendations. We would like to point out to you that in our opinion the VA medical and hospital program is actually geared to a 1946 concept of care.

And, lastly, we would like to make some recommendations to you.

Basically, we would like to think of this morning's session as offering an open forum in which you or members of the staff would be able to question us after we have made certain presentations to you.

Now, the State homes as we know them today—first, there are some 10,000 veterans cared for in our State soldiers' homes throughout the country;

Secondly, there are about 16,000 veterans cared for in the Veterans' Administration homes or dormitories as they are more properly called.

So we see there are roughly 26,000 veterans of the 22 million veterans cared for in some form of a sheltered or home type of existence.

We find that the homes generally started shortly after the War Between the States when the returning veterans had no veterans administration nor pension bureau to care for their needs. It was the State's responsibility.

In your own State, Senator Kennedy, the same group of individuals who founded Massachusetts General Hospital and other hospitals of this type banded together to form a charitable corporation so that the veterans would not be cared for in the alms hospital or the poor farm of the period.

Actually, the State homes in many instances predated the existence of similar institutions on the part of the Federal Government.

We find that the act of 1888 which was the first recognition by the Federal Government that there was some Federal responsibility established that any State or Territory that would establish a State soldiers home would be reimbursed at the rate of \$120 a year. That has since been increased to \$912 per year or \$2.50 per day; through recent Congresses that has gone up considerably, and this \$2.50 a day does help a good deal to States who are caring for veterans, but basically, the State stepped in because there was no Federal program in this area.

Later substantial Federal programs did develop, and the States continued their operation, for the most part, to supplement the work of the Veterans' Administration, not to compete, not to duplicate, not to emulate, not to repeat, but rather to take over where the VA left off.

Now, we will show in this next chart that there are located around the country as marked out in these States colored in blue several State homes. Note that there is a broad band of them running from the New England States to the Northwest, with the exception of Georgia and Oklahoma, and California in the Far West.

For the most part these homes are operated by States, and they vary in size and program from pure dormitory where they offer sheltered care for disabled veterans unable to earn a living on the outside, to acute hospital, chronic hospital, long-term nursing home, even out-patient care in some types of institutions.

But basically the States want us to supplement the work of the VA, not to compete with the VA for cases, not to take over their work from the VA but rather to take over where they leave off.

Just as the States operate these homes, we find on the next chart in these States which are colored in red that the Federal Government operates some 16 or 17 dormitories throughout the country, where they care for about 16,000 to 17,000 veterans.

Just as we notice the broad band of States across the upper region of the country on the previous chart, with State homes, so, too, here we notice that there are many blank areas in the North Central and West. Here we notice a blank area and the entire New England area is blank, the Midcentral States—these are States where there are no Federal dormitories, those are States that are covered in red that have at least one Federal dormitory.

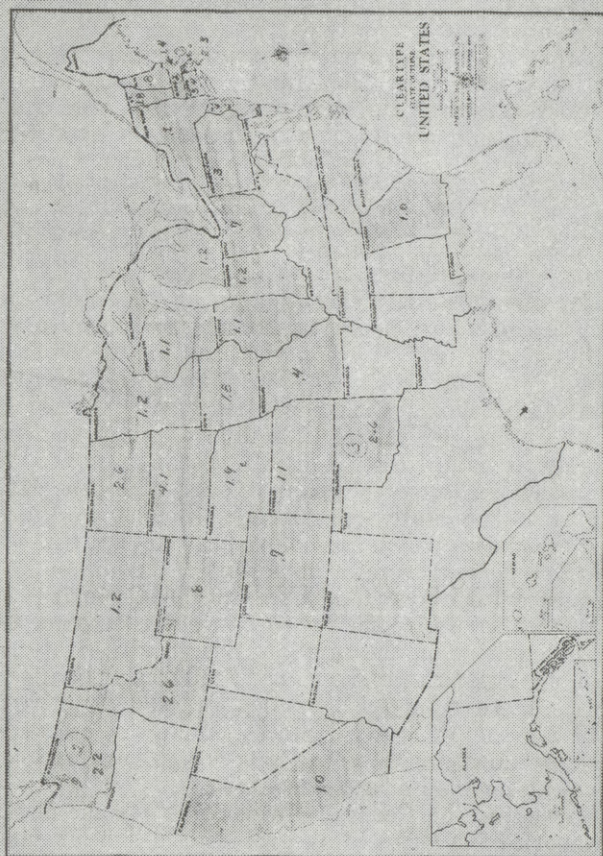
So we find the Federal Government in some instances is taking over the work of the States by providing a similar facility to that which the State provides.

The States are unable to do much of the work of the Federal Government. The VA does much rehabilitation and restoration work.

There are some of us who have been led to believe that the Veterans' Administration is contemplating the phasing out of the dormitory program. They are anxious to get out of the business, we are told, although this has not been officially stated; instead, they are setting up these rehabilitation and restoration centers at Hines, Ill., and East Orange, N.J.

Now the States are very much concerned regarding the shift of nursing home care or responsibility from the Federal to the State government, if only because of the pure size of the potential load. If I were in Federal administration, this would indeed be a wise decision to concentrate such care in the hands of the State governments.

Location of State Homes



Location of V.A. Dormitories



In our aging population we will note that by 1970 we are told that there will be some 20 million people over 65 and by 1980 it is going to be 25 million, 24½ million people, roughly.

AGING POPULATION

1900-62

YEAR (JULY 1)	TOTAL (IN MILLIONS)	PERSONS 65+OVER (IN MILLIONS)	PERCENT OF TOTAL POP. BY AGE			
			UNDER 19	20-44	45-64	65 & OVER
1900	76.1	3.1	44.2	37.9	13.8	4.1
1910	92.4	4.0	41.8	39.1	14.7	4.3
1920	106.5	4.9	40.7	38.5	16.1	4.6
1930	123.1	6.7	38.6	38.4	17.5	5.4
1940	132.1	9.0	34.3	39.0	19.9	6.8
1950	151.7	12.3	34.0	37.7	20.3	8.1
1960 (APR.)	180.0	16.6	38.4	32.4	20.0	9.2
1962	186.6	17.3	39.1	31.6	20.0	9.3
PROJECTION						
1970						
II	214.2	20.0	40.4	30.5	19.7	9.4
III	208.9	20.0	38.9	31.2	20.2	9.6
1980						
II	259.6	24.5	41.9	31.6	17.0	9.4
III	245.7	24.5	38.7	33.4	18.0	10.0

There is a heavy terminal chronic long-term patient load inherent in these gross statistics.

On the next chart we will try to point out that these different breakdowns of figures will show a change in the VA domiciliary staffing. The VA has 17 dormitories throughout the country. We pointed out earlier that they were located in different States. So that we cannot say that any one State is getting more than the other, we took the VA areas; these are the areas of the New England and New York area, the mid-Atlantic with headquarters in Trenton, the Southeast with headquarters at Atlanta, and so on. We took how many VA beds, dormitory beds there are in these areas.

Look at the differences. In the New England-New York area, area 1, I believe the VA calls it, there is 0.3 of a dormitory bed for every 1,000 veterans in that area. And yet we can go to other parts of the country, and in the eastern area here we will find 0.46 of a bed, a little bit more than 0.4 of a bed per 1,000 veterans; 0.5 of a bed in the Midwest area, 2.57 in the Southwest.

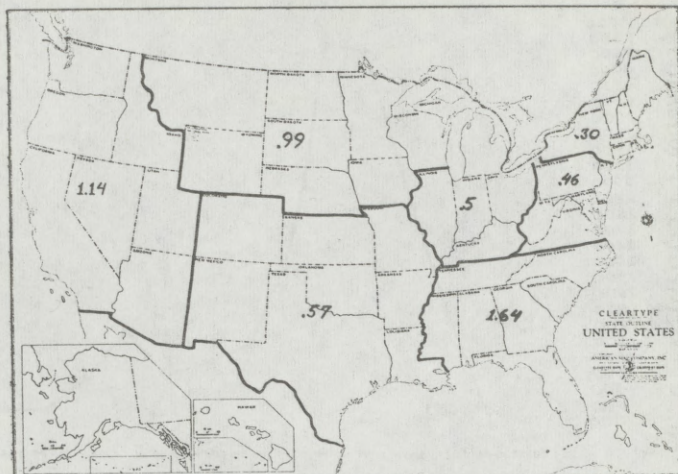
But look at some of the other areas of the country where they will have almost 1 bed per 1,000 veterans in the Upper Northwest, 1 in 1,400 beds per 1,000 veterans in the Far West and 1 in 640 in the Southeast.

This shows that the Federal Government is doing the work primarily of the State governments. That means that the States in those areas are being saved a considerable amount of money.

So there is a disparity between the location of beds into the various areas.

VA Domiciliary Beds

PER 1000 VETERANS



The States realize only too well that the VA is getting a wonderful bargain when they pay \$2.50 per day for care that in a VA facility at the dormitory level runs to a minimum of \$5, \$6 and for the nursing home care runs to \$9 to \$10, and yet the VA only pays to the States some \$2.50.

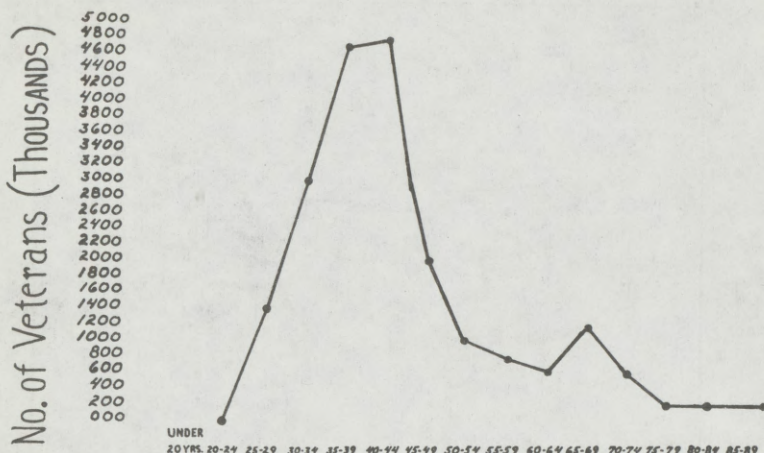
The State appropriations we point out are just as limited as they are in the Federal Government and perhaps even a little bit more so because of the limited tax base upon which they can operate.

We have tried to cite in these four or five reasons why States are concerned with the present change of nursing home care from the Federal Government to the State government. Later we will try to point out that we have recommended \$5 million capital outlay appropriation. Hopefully this capital outlay appropriation will help some of the States to modernize some of their facilities and at the same time it will help some of the States to provide new facilities wherever possible.

The VA does have a very sound program, and they often release to the States people that the State at the present time, are not properly qualified to care for. Now, the States are finding a need in the change from dormitory to nursing home care.

This next chart will give an estimated age of veterans in civil life. If we were to take the group of people over at the far right of that chart over 75 we would find that they are limited numbers, roughly 600,000. The point we would like to make on this and the next chart is that if we cannot begin to take care of, say, the 600,000 over 75 or 2.5 million veterans who are over 65, how can we possibly take care of them when we reach these high points where eventually we are going to have up to 2.5 million veterans to take care of.

Estimated Age Of Veterans In Civil Life



On this next chart we have tried to break down by individual groupings of 10 to 15 years the only purpose that this chart will show is that from 75 to 90 we have roughly 600,000 veterans. We have from 60 to 74 years of age, 2.5 million roughly; and from 45 to 60, roughly 3.8 million. But we have 12 million from 30 to 44. We have broken these down into 15-year groups, 25-year groups, and 10-year groups.

The point of each of these charts is that if we cannot take care of the small number that we are facing now what possible chance will there be when we get into groups that are 2, 3, 4, 5, and even 20 times as large as the group that we are facing up to at the present time.

We find in State soldiers' homes, in State homes throughout the country that there is a definite change in the composition of the dormitory member. The majority of us here have had experience in our homes. We no longer find the individual to be an outcast of society. He has all of the attributes of other people over 65. It is surprising that probably at no other time in their life do people have as much in common as they do when they are over 65. We could take a group of individuals from the industrialized areas of Chelsea, Charlestown, Revere, and East Boston in our own State and match them up against people of Wellesley, Weston, and Dover areas and probably they would be motivated by many of the same desires. They would have more in common at that time of their life over 65 than at any other time.

So, too, with these veterans today we are finding increased social security payments, they have part III pensions and other incomes. They are lacking in home facilities at the present time. They are in need of long-term care of varying types.

LONG-TERM CARE BEDS

JANUARY 1, 1962

	NUMBER	PER 1,000 POPULATION	PER 1,000 AGED 65 AND OVER
EST. TOTAL NEEDED	802,734	4.46	48.48
EXISTING ACCEPTABLE	255,897	1.42	15.45
EST. ADDITIONAL NEEDED	546,837	3.04	33.02

GENERAL SHORT-STAY HOSPITALS

AGE GROUP	DISCHARGES PER 100 PERSONS	HOSPITAL DAYS PER 100 PERSONS	AVERAGE LENGTH OF STAY (DAYS)
UNDER 65, TOTAL.	11.2	85.0	7.6
65 AND OVER -----	14.6	217.6	14.9
UNDER 45 -----	9.0	70.1	6.3
45-54 -----	11.1	128.0	11.5
55-64 -----	12.2	148.7	11.2
65-74 -----	14.1	204.1	14.4
75 AND OVER -----	15.4	243.5	15.8

UTILIZATION OF GENERAL HOSPITALS AND SKILLED NURSING HOMES 1960

REGION	TOTAL	DAYS OF CARE PER 1000 POP.		% DIST. OF DAYS OF CARE			
		GEN'L HOSPS.		SKILLED		GEN'L HOSPS.	
		SHORT	LONG	NURSING	HOME	SHORT	LONG
		TERM	TERM		TOTAL	TERM	TERM
TOTAL	1,651	972	119	560	100.0	58.9	7.2
NEW ENG.	2,330	1,068	230	1,032	100.0	45.8	9.9
MID. ATL.	1,973	1,143	207	623	100.0	57.9	10.5
EAST NO. CENT.	1,744	1,029	141	574	100.0	59.0	8.1
WEST NO. CENT.	1,991	1,127	73	791	100.0	56.6	3.7
SOUTH ATL.	1,246	893	52	301	100.0	71.7	4.2
EAST SO. CENT.	1,025	798	37	190	100.0	77.9	3.6
WEST SO. CENT.	1,350	837	25	489	100.0	62.0	1.8
MOUNTAIN	1,462	898	41	523	100.0	61.4	2.8
PACIFIC	1,646	807	157	682	100.0	49.0	9.6
POSSESSIONS	620	547	21	52	100.0	88.2	3.4

In spite of all the rehabilitation efforts that we may attempt to make we do find that these men need a special type of shelter care, whether it is rest home, convalescent home, or eventually nursing home.

We do make rehabilitation efforts and try to return these people to our community. But many of them cannot be returned to their community. We do find that by providing nursing home type care we are not trying to keep them with us for years, but we want to return them, but oftentimes this nursing home type care is the interim or the interval between acute hospitalization on the one hand and eventually getting to their home. So some midway station is necessary, and it is this that we are striving for basically in this legislation.

We find in this bill, H.R. 8009, that is before you, that this would call for one-half bed for every 1,000 veterans. We feel that that figure is desirable because it represents a starting point. It represents some place that will provide a State with a minimum number, admittedly, but at least it would provide some nursing home beds.

Now, the principle is well established by the Senate chairman of this overall committee, I believe, Senator Hill, in the Hill-Burton Act. And this principle established that there should be approximately 4 general medical and surgical beds per 1,000 general population in a community. Well, this is the principle upon which we are trying to operate in establishing nursing home beds; namely, that some minimum number are needed, to provide the nursing home care for veterans or other members of the community.

Now in our earlier presentation we indicated to you that we were going to talk about the States' concern on the shift of the load from the Federal Government to the State. We have tried to do so and give you reasons for it.

Secondly, we have tried to point out that the States are finding a change in the appearance of the veteran who is coming in for long-term care.

The third point, that we earlier alluded to in our outline, we said we would like to show that the VA medical and hospital program in our opinion is geared to a 1946 concept of care. By this we mean that we must first recognize that the dean's committees was established, by and large, immediately after World War II, for until then the VA medical program was not worthy of comparison with today's medical program; not that it was not good, but it did not really compare to what we have available today—the dean's committees were selected and established in 1946. They have upgraded the quality of care and the personnel in veterans hospitals. There can be no question of this whatsoever. Today with all due respect to some of the great teaching centers of yesterday year, not the Vienna's and Strasbourg's and the London's and Paris', but within our own country—the great teaching hospitals today, for the most part, are the equal of the teaching VA hospital so that a man gets a better residency by and large. He perhaps does not have the name that the Massachusetts General, or Mayo Clinic, or some of the others have, but within the VA he normally receives a better residency, so there is better medicine being practiced in VA, probably, than in any other hospital system in this country, and better than even in most other hospitals. They have excellent residency programs. They have stressed the importance of acute cases in their teaching program.

The dean's committee has promoted quite a bit of research. But I think we must also recognize that the dean's committee has created what I refer to as an "artificial need" on the part of the VA. They have so geared their concept of hospital orientation and residency program to a teaching concept of care that they have ever stressed the acute short-term case to the exclusion at times of the long-term case.

Now, in meeting this "artificial need" they have given insufficient attention to the ambulatory care programs or to the long-term care programs, or to the continuity of care programs that are developed in some of our hospital programs.

Now, at congressional insistence, the VA has devoted some attention under the CBOC program and other areas. They have developed their ambulatory programs to an extent, but by and large this has come about because of the congressional insistence, and the VA program from 1946 to the present time, 1963, I would say, unequivocally, is geared to a teaching concept of medicine.

I think that we should show better imagination in the different programs that the VA is carrying at the present time. I think that here are many new programs that can be developed to achieve the same eminence in today's concept of hospital care that the VA has thus far achieved in its teaching programs.

Now, the American Hospital Association, which does have a good deal of experience, has voted in two votes through their board of trustees. The first was a recommendation that they be recorded in favor of an increase in the aid and attendance allowance that Congress has voted, and the second was the approval of the adaptation of the VA hospital system to long-term or chronic care so long as we do not increase the 125,000 maximum bed capacity in the Veterans' Administration. This I think is important, for most certainly, while not speaking for them and simply commenting that they have made these votes or taken these votes, this would appear to be a recognition by the community hospital that the attention today must be directed to the long-term care patient.

Now, the new Chief Medical Director of the VA, Dr. Joseph McNinch, I think, may well change this orientation. The previous incumbent, Dr. Middleton, is a wonderful man. He was oriented to medical school teaching and concept of care, and therefore he gave great attention, as did his predecessors, to the teaching obligations of the VA. But Dr. McNinch hopefully is research oriented and, second, clinically oriented, having been a major general in the Army in charge of research programs for many years. We hope that he will change this attention from the teaching program to that of the actual care of the patient, the meeting of the real need, the meeting of the long-term care need that presently exists.

If we are going to face up to this care of some 2.5 million veterans over 65, then we must recognize that the VA program must meet the need of caring for these people.

Now, in any one day only 50 percent of the people who are veterans are hospitalized in the VA system. There is a day in June when all hospitals throughout the country receive a questionnaire from the American Hospital Association and I think this questionnaire has shown repeatedly that just about as many people are hospitalized who

are veterans or hospitalized in community hospitals or teaching hospitals or proprietary hospitals on that one day as are hospitalized in the VA system; and the community hospitals are concerned with this, because they do have the same problem of disposing of the long-term case, of the disposing—which is a selective word—because this is the position that the hospital often finds itself: What will we do with Mr. X who has received maximum hospital benefit and now needs some intermittent type of care?

The medical-care type of legislation in the future, we think, could have some affect on this type of legislation, and for this reason we suggest that we watch it carefully. We are not certain what affect it will have, but we commend this to your staff for their consideration.

The question comes as to whether we can extend the VA services on an outpatient basis by caring for the inpatient as we have heretofore done. We feel that the allocation of 2,000 beds to those areas needing beds is most important.

Just as this chart shows there is a disparity, a difference between the allocation of VA dormitory beds in different parts of the country so, too, if we were to make an analysis of the general medical and surgical beds we would find that some States have as few as one-half a bed per 1,000 veterans—New Jersey. Your own State, I believe has about 1.6 beds per 1,000 general medical and surgical beds per 1,000 veterans. The national average is 2 beds per 1,000 veterans, and yet there are some States that have 4 and 5 beds, general medical surgical beds per 1,000 veterans.

Now it seems to us that if we are going to allocate the 2,000 beds that are to be provided within the VA for long-term or chronic care to those States that already have an excess of beds, then this will not be a very wise allocation, for it will simply compound a problem that we presently have, whereby States with the fewest number of general medical and surgical beds will have their condition aggravated as other States receive additional beds. So that one of the early provisions of this bill is to call for 2,000 beds that have already been accomplished by Presidential directive. These 2,000 beds we would hope would be allocated wisely to the various States.

We do have available material that shows that at the present time these allocations have been contemplated and made. And here, again, we see some States receiving beds that we know have 3, 4, and 5 general medical and surgical beds per 1,000 veterans, and yet they are going to receive additional nursing home beds on top of that; while we see other States that we know have 1 or 1.5 beds and they are not going to receive any beds. So, hopefully, this allocation could be made rather wisely.

Now, what are the various methods of trying to resolve this problem?

First, we would look to areas. We can look to institutions. We can look to proprietary nursing homes. We can look to voluntary nursing homes. We could look to private homes to try and care for the long-term veteran patients. Many of these fields are presently being exhausted at the present time.

OWNERSHIP & SIZE

OWNERSHIP OF FACILITY	NUMBER		PERCENT		AVERAGE SIZE (MEDIAN)
	HOMES	BEDS	HOMES	BEDS	
TOTAL	9,582	330,981	100.0	100.0	25
PROPRIETARY	8,297	236,845	86.6	71.6	24
VOLUNTARY NONPROFIT	853	53,295	8.9	16.1	44
CHURCH-RELATED	438	28,740	4.6	8.7	50
OTHER NONPROFIT	415	24,555	4.3	7.4	39
PUBLIC	432	40,841	4.5	12.3	61
<u>SIZE OF FACILITY</u>					
LESS THAN 10 BEDS	988	6,207	10.3	1.9	—
10-24	3,803	65,401	39.7	19.8	—
25-49	3,214	109,599	33.6	33.1	—
50-99	1,165	77,240	12.1	23.3	—
100 AND OVER	412	72,534	4.3	21.9	—

The VA social services is doing wonderful work in attempting to allocate these cases and to place them as successfully as possible. I am sure I might be criticized for this simile, but the system is not unlike the parole system of institutional care, for there these people must be placed and they must be followed up and they must receive care and attention, and this can only be done by expanding the social service force of the Veterans' Administration.

We feel that there are different methods of providing this care in answer to the problem: first, we can try to provide for institutional care if at all possible.

Secondly, we could allow for funds for the purchase of home care; and

Thirdly, we could try to develop our present hospital programs.

The recommendation that we would make from the national association of State veteran homes is listed here. We feel that a minimum percent of VA beds for long-term care should be established.

We feel that Veterans' Administration in order to meet what I have referred to as the real need, the need of the community, should have a definite percentage of its beds in long-term care constantly.

Now it is not sufficient to say that, as the VA will do, that on any given day x percent of our people are over 65—gentlemen, people over 65 have acute conditions just as people under 65. We all in the hospital field know that at any time we could get an 82-year-old strangulated hernia over to the VA with no trouble whatsoever, but on that same day we could not get a long-term or terminal cancer case admitted even though that man may be 42 years of age.

So we must concentrate in the field of long-term care rather than purely on age.

N.A.S.V.H. Recommendation

1. *MINIMUM PER CENT OF V.A. BEDS FOR LONG-TERM CARE.*

2. *DEVELOP STATE-HOME PROGRAM.*

a. *FUNDS FOR CAPITAL OUTLAY*

b. *INCREASE ALLOWANCE TO \$5 PER DAY FOR NH CARE*

c. *ELIMINATE "SPLITTING PROVISION"*

d. *ELIMINATE 51% REQUIREMENT*

3. *INCREASE PL-149-AID AND ATTENDANCE LAW*

HOSPITALS MAINTAINING NURSING HOME UNITS

<u>TYPE OF HOSPITAL</u>	<u>NUMBER OF NURSING HOME UNITS</u>	<u>NUMBER OF BEDS IN NURSING HOME UNITS</u>
TOTAL -----	488	46,850
NON- V. A.	469	30,892
V. A.	19	15,958

LIVING ARRANGEMENTS OF AGED

<u>PERCENT DISTRIBUTION OF PERSONS AGED 65 & OVER</u>			
<u>STATUS</u>	<u>TOTAL</u>	<u>MALE</u>	<u>FEMALE</u>
TOTAL, 65 AND OVER -----	100.0	44.8	55.2
MARRIED, SPOUSE PRESENT -----	50.9	31.2	19.7
OTHER BY LIVING ARRANGEMENTS -----	49.1	13.6	35.5
IN FAMILIES -----	23.1	6.0	17.2
LIVING ALONE OR LODGING -----	22.3	6.1	16.2
IN INSTITUTIONS -----	3.7	1.5	2.2

The second recommendation we would make is that to develop a stronger State home program. We would feel that it is necessary in order to strengthen a program—and you may remember that early chart of the country with the States marked in blue that have present State homes—to have funds for a capital outlay program. We have recommended \$5 million that would be matched by the States so that for 5 years there would be \$10 million per year or a total of \$50 million, half by the Federal Government, half by the State government, to modernize and repair some of the existing facilities and in the same time to encourage other States who do not have facilities at the present time to provide additional facilities.

Secondly, we would recommend an increase in the allowance to State homes of \$5 per day for nursing home care. We feel that the present \$2.50 is completely unrealistic. We feel any increase even to \$3.50 does not begin to resolve the problem. It is a step in the right direction and, frankly, would be acceptable although it would be unwise for the State homes to accept it, but they would be willing to accept it.

Thirdly, we would recommend the elimination of the splitting provision. This is a technicality, but at the present time if the State homes make a charge to Quigley for services and if the State home collects \$100 per month, then under most conditions they must give \$50 of that \$100 to the Veterans' Administration. For the reason many of the States decline to go into the charge programs or the States that do make charges make them realizing they are going to have to turn over 50 percent of whatever they collect to the Veterans' Administration.

There are varying subterfuges of ways to try to get around this, frankly, but all of these lead to increased hardship, both on the part of the VA and on our part.

The 51-percent requirement we have learned can be cared for administratively. This is another technicality that we need not bother with this morning.

The last recommendation we would make is that of increasing Public Law 149, the aid an attendance law, to allow patients who are in need of constant aid and attendance to be in a better position to purchase nursing home care. Once they can make that purchase of nursing home care we feel than many of the men will try to leave the Veterans' Administration facility so that they can go to a nursing home near their community.

Now, we have tried on this next chart to list the different payments of Federal aid to State homes for 1961, 1962, and 1963. The chart itself is for 1962. This will show that in that year there were 9,962 veterans in State homes, costing an average of \$2,476 per veteran; never mind going into total costs, but how much was cleared by the VA. Note the last two columns. Roughly 33 percent of the cost was borne by the Veterans' Administration, 32.98 and 67.02 was borne by the State.

Now the figures in green are for 1961. Note that the State's share has increased from 65 to 67 percent and in 1963 the latest VA figure shows the States are now paying some 68 percent of the cost of operating the State home program where some 9,161 veterans were cared for last year. This means that the States are paying for some 68

PAYMENT OF FEDERAL AID STATE VETERANS HOME 1962

STATE	AVERAGE PRESENT	COST PER CAPITA	TOTAL COST (1,000)	AMOUNT DEDUCTED BY STATE	% COST VA	% COST STATE
CALIF.	1822.	2493.	4,544.	0.	36.59	63.41
COLO.	70.	2274.	160.	0.	40.11	59.89
CONN.	719.	2587.	1,861.	0.	35.27	64.73
GA.	168.	1274.	214.	0.	50.00	50.00
IDAHO	107.	873.	93.	0.	50.00	50.00
ILL.	615.	2202.	1,356.	40,456.	39.94	60.06
IND.	231.	2219.	514.	102,987.	31.09	68.91
IOWA	294.	2438.	719.	136,746.	27.90	72.10
KAN.	91.	1240.	114.	29,640.	37.05	62.95
MASS. (Chelsea)	633.	5079.	3,216.	63,557.	16.98	83.02
MASS. (Holyoke)	173.	6707.	1,166.	13,004.	13.05	86.95
MICH.	745.	1964.	1,464.	185,317.	40.12	59.88
MINN.	384.	1437.	553.	92,081.	41.67	58.33
MISSOURI	67.	1780.	120.	13,749.	44.25	55.75
MONT.	50.	1883.	96.	0.	48.44	51.56
NEB.	141.	2285.	324.	45,182.	32.96	67.04
H.H.	37.	3127.	116.	6,001.	26.60	73.40
N.J. (Merile Pk)	75.	2597.	195.	0.	35.13	64.87
N.J. (Vineland)	108.	3495.	379.	0.	26.11	73.89
N.Y.	3.	3599.	13.	637.	22.97	77.03
N.D.	78.	2078.	163.	0.	43.90	56.10
OHIO	665.	1311.	873.	0.	50.00	50.00
OKLA. (Ardmore)	151.	1892.	286.	13,802.	45.80	54.20
OKLA. (Norman)	195.	1506.	294.	30,438.	44.83	55.17
OKLA. (Sulphur)	172.	3152.	543.	11,979.	27.84	72.16
PENN.	179.	2051.	368.	0.	44.48	55.52
R.I.	243.	2810.	683.	0.	32.46	67.54
S.D.	131.	1848.	244.	211.	49.31	50.69
VT.	40.	3300.	133.	4,705.	25.88	74.12
WASH. (Orting)	152.	2864.	438.	0.	31.85	68.15
WASH. (Refsil)	216.	2068.	447.	6,455.	43.39	56.61
WIS.	277.	2548.	707.	130,536.	26.57	73.43
WYO.	16.	2784.	45.	5,378.	26.84	73.16
TOTALS	9062.	2476.	22,442.	932,870.	32.98	67.02

percent under a law that initially intended 50 percent, so that the VA would pay up to 50 percent and the State would pay up to 50 percent. Today, however, owing to the increase in cost we find the States paying some 68 percent and in the 3 years cited it has gone from 65 to 68 percent.

On the next chart we made query of some of the State homes to find out how many additional beds they would provide. If this H.R. 8009 were enacted into law immediately there would be just on a sampling of some of the States who did reply some 1,400 nursing home beds that would be provided. By projecting those States who definitely replied, we came up with the figure of slightly over 2,500 beds, additional nursing home beds, that would be provided by State homes, if the VA were to provide additional income. This would mean when coupled with the 2,000 beds that the VA would have 4,500 beds.

STATE HOME INFORMATION

STATE	ADM. WIVES & WIDOWS	HOSPITAL BEDS	DORM. BEDS	N. H. BEDS	COSTS	INT. IN MATCHING FUNDS
CALIF.	NO	476	1531	406	6.83	YES
COLO.	YES		120	30	6.23	PROBABLY
CONN.	NO	496	729		7.09	PROBABLY
GA.	NO	394			3.49	UNKNOWN
IDAHO	NO		120		2.39	UNKNOWN
ILL.	YES		1294	115	6.03	NO
IND.	YES		545	130	6.08	YES
IOWA	YES		415	185	6.68	YES
KAN.	YES	34	244		3.40	YES
MASS. (Chelsea)	YES	300	425		13.92	YES
MASS. (Holyoke)	YES	82	160		18.38	YES
MICH.	YES	266	834		5.38	YES
MINN.	YES	84	416		3.94	UNKNOWN
MISSOURI	YES	91	146		4.88	YES
MONT.	YES		100		5.16	UNKNOWN
NEB.	YES	117	183		6.26	YES
N.H.	NO		42	24	8.57	YES
N.J. (Menlo Pk)	NO		69	11	7.12	UNKNOWN
N.J. (Vineland)	YES	66	234		9.58	YES
N.Y.	YES	85	152		9.86	YES
N.D.	YES		147	3	5.69	YES
OHIO	NO		620	280	3.59	YES
OKLA (Ardmore)	NO		219	17	5.19	UNKNOWN
OKLA (Norman)	NO		210	40	4.13	YES
OKLA (Sulphur)	NO	105	112		8.64	UNKNOWN
PENN.	NO		364	34	5.62	UNKNOWN
R.I.	NO	100	140		7.70	YES
S.D.	YES		279	21	5.07	YES
VT.	YES		56	24	9.04	UNKNOWN
WASH. (Cortina)	NO		153	47	7.85	UNKNOWN
WASH. (Retsil)	YES	130	440	40	5.67	UNKNOWN
WIS.	YES	95	401		6.98	YES
WYO.	YES		36	1	7.63	UNKNOWN
TOTAL		2445	10,936	1408	6.79	

This will not seem like much to anyone looking at the 125,000, but we must remember that of the 125,000 VA beds, only 50,000 approximately are general medical and surgical beds, so this, in effect, would give the VA an additional 9 percent of the beds, and at the same time would begin to provide long-term care and meet the real community need.

Now, on this next chart we have tried to make an analysis of H.R. 8009. There are two State homes, eight separate provisions. There would be 2,000 additional chronic beds.

We feel, first, that the benefit that would come to the State homes is that this would relieve part of the demand upon State homes. We are literally wallowing in a mass of requests for admission to our homes of long-term patients. We are one of the early sources that the VA turns to, to effect the discharge of a chronic or long-term patient. Your office, Senator, and I am sure your office is no excep-

Facilities Available

<u>KIND OF FACILITY</u>	<u>FACILITIES</u>		<u>BEDS</u>		<u>AGED 65 & OVER</u>
	<u>NUMBER</u>	<u>PERCENT</u>	<u>NUMBER</u>	<u>PERCENT</u>	
TOTAL	23,000	100.0	592,800	100.0	35.5
NURSING OR CONVALESCENT HOMES	11,600	50.4	369,300	62.3	22.1
OTHER FACILITIES FOR THE AGED	11,400	49.6	223,500	37.7	13.4

LEVEL OF CARE NEEDED BY NURSING HOME PATIENTS

13-STATE STUDY, 1953-54

NOT ORD. GIVEN IN PT. HOME -----

MIGHT BE GIVEN IN PT. HOME -----

MAINLY BOARDING CARE -----

MICHIGAN STUDY* 1957 -----

NURSING -----

NURSING AND SHELTER -----

CUSTODIAL AND PERSONAL -----

CUSTODIAL, PERSONAL AND SHELTER -----

SHELTER -----

UNKNOWN -----

PERCENT OF PATIENTS

48

41

11

55

10

14

5

15

1

tion, and many of the other offices constantly have this type of request: "Can we be of assistance to X, Y, or Z or A, B, and C in effecting his admission to the State home because he is to be discharged from the VA?"

Now, the providing of 2,000 beds by the VA and additional 2,500 by the States would mean that there would be 4,500 nursing home beds which, as we have already indicated, would be 9 percent of the present VA general medical and surgical load.

Elimination of the splitting provision would help homes by allowing those who are not making charges to institute the charges and thereby recapture some of the income and those who are making charges it will allow them to retain some of the income for the services that they are rendering.

The capital outlay provision of \$5 million to be matched by \$5 million of State funds would allow for new facilities or repair of existing facilities.

The \$3.50 nursing home rate, which as we have already pointed out is low, would increase nursing home beds because homes are basically giving nursing home care now, State homes are, and we feel that they would go into this business on a further and a greater extent if at all possible.

The purchase of 6 months of nursing home care again would relieve the demand and would provide that sheltered area or atmosphere that the patient needs for his discharge from the hospital, from the VA hospital.

LENGTH OF STAY OF NURSING-HOME-PATIENTS

13-STATE STUDY, 1953-54

	PERCENT OF PATIENTS
LESS THAN 6 MONTHS -----	32
6 MONTHS - 1 YEAR -----	18
1-2 YEARS -----	19
2-5 YEARS -----	23
5 YEARS AND OVER -----	7
AVERAGE (MEDIAN) -----	1-YEAR

MICHIGAN STUDY, 1957

LESS THAN 6 MONTHS -----	30
6 MONTHS - 1 YEAR -----	19
1-2 YEARS -----	21
2-5 YEARS -----	25
5 YEARS AND OVER -----	6
AVERAGE (MEDIAN) -----	1-YEAR

The increase in Public Law 149, the aid and attendance law, would relieve demand on State homes because at the present time if the man goes into the State home he gets the aid and attendance money, if he goes into the VA he does not.

When the veterans learn they get aid and attendance when they go to the State home they will not get it when they remain in the VA, this would help them. CBOC would help the patient be retained under the VA and cared for on the outpatient basis, and providing of prosthesis would be of considerable help to the individual in the State home since we do have the facility of funds to provide these at the same time.

We feel that this program, H.R. 8009, if enacted, will provide a high quality of care for chronic cases within the VA. We feel that it will avoid many of the medical and social adjustments of patients that must be made at the present time. We think also that it would utilize the existing facilities for teaching for indigent cases rather than for solely teaching material.

We feel that the passage of the bill will encourage many of the State homes to modernize their existing facilities. We feel also that it will encourage new facilities in other States.

We feel that it will provide funds for the purchase of high-quality nursing home type of care and will encourage nursing homes to upgrade their standards.

We have tried to condense our presentation Mr. Chairman, although I am sure we have gone longer than we had anticipated, but we tried to condense this because we know the position you are in, and you are more than kind to be here this morning.

Senator KENNEDY. I would like to thank you for your comprehensive analysis of this problem. I know that you have spent a great deal of time and effort studying this situation over many years. Your testimony has been extremely helpful to this subcommittee.

I would like to ask that the charts you have used be inserted as an appendix to the record. Would that be appropriate?

Mr. QUIGLEY. Be pleased to do so.

Senator KENNEDY. With your permission there are some questions that I would like to ask.

What would be your estimate of the number of veterans who failed to gain entrance into a State facility because there was none available to them?

Mr. QUIGLEY. Well, we would have to first say that there are 22 States in which there are no facilities, so that presumably all of the veterans in those States.

Secondly, there are some of the States who offer different types of care. It runs all the way from the pure and simple domiciliary to the more complicated chronic or long term, to the hospital, to the mental hospital, to the outpatient.

So it would pretty much depend on the State which the man came from. If he were from New Hampshire or Vermont with a pure dormitory-type care, if he needed nursing home long-term or terminal care, he would not be able to receive it.

So there would be substantial numbers in many of the States that have homes, but do not have the particular type of care that we may need.

Type Of Care

1- *SKILLED NURSING CARE*

2- *PERSONAL CARE*

3- *RESIDENTIAL CARE*

Type Of Home

1- *SKILLED NURSING HOME*

2- *PERSONAL CARE HOME* *WITH SKILLED NURSING*

3- *PERSONAL CARE HOME* *WITHOUT SKILLED NURSING*

4- *RESIDENTIAL CARE HOME* *WITH SKILLED NURSING*

5- *RESIDENTIAL CARE HOME* *WITHOUT SKILLED NURSING*

In our own State there are roughly 700,000 veterans. We have a list of some 80,000 active cases and approximately 22,000 who are inactive, or 100,000.

How many do you have, John?

Mr. HARRINGTON. In the 11 years we have been open we have 22,000.

Mr. QUIGLEY. Well, it would mean 124,000 veterans of 700,000 have received treatment at one time or another from either of our facilities.

Senator KENNEDY. Is there any procedure which must be followed by these veterans insofar as having a statement from a VA hospital prior to their admission to a State facility?

Mr. QUIGLEY. No, sir. The majority of our admitting policies are quite independent of them, although the majority of us, too, I think, follow exactly the same admitting procedures that the VA does, including the standards of indigency, the availability of funds for admission, the certification on the forms P-10 and P-10A, and so on. But normally we will take a case from the VA on reference just as we would from a private hospital, a private physician, or man who came to us seeking admission.

I do not think we content there is any failure of admission for VA cases. I think there is a better working arrangement and because we do business with one another in volume it is easier to get a man in to us through the VA, and most of our State homes, but I do not think there is, I know there is no legal preference. Perhaps, one of the other commandants, either Mr. Eaton or Mr. Wixom, or Mr. Copenhaver would have something to add on that.

Mr. COPENHAVER. No.

Mr. EATON. No.

Senator KENNEDY. Have you made a cost comparison between the State homes and the VA facilities?

Mr. QUIGLEY. We have had interesting programs going on at our own and some other State homes are becoming interested in it, whereby we have an outside firm for management purposes as well as reimbursement purposes develop a cost analysis program so we can tell what it costs for an outpatient day, for a dormitory day, for an acute surgical and an acute medical, or a long-term day. Our costs do compare reasonably favorably with VA.

We think, for example, that Michigan operates one of the better dormitories in the State home system. Our dormitory cost is quite comparable with Michigan. It is lower than VA. Our acute surgical is quite comparative with VA, a cost that runs us about \$43 a day. Our medical or acute medical floor runs us something close to VA. It is about \$31 per day. Our long-term care unit which is the chronic hospital, not nursing home, runs us to about \$18 per day. I do not know how that rates on a VA comparison, but we do have such figures available from some of our places, Senator, that we have made available to the Comptroller and the House committee.

Senator KENNEDY. What does nursing home care alone cost the State home?

Mr. QUIGLEY. This is a new area to us. We are running what we call a supervised section in our dormitory which has most of the aspects of nursing home care. Our pure dormitory cost would run into about \$4.61 per day. We know that included in that is something for the supervised section. We would estimate that our supervised

section, which is nursing home care, is running us to approximately \$7.50 to \$8 per day. That is an estimate. We are going to try and refine our cost on the next allocation period for the June 30 to designate nursing home. We are not sure that we can.

Senator KENNEDY. Mr. Quigley, have any of the 22 States, which do not have State homes, indicated to members of the panel that they would be interested in building State facilities if H.R. 8009 were enacted into law?

Mr. QUIGLEY. We have not made inquiries of these 22, Senator, but over a period of 8 to 10 years we can refer to the State of Nevada, the State of Florida, and the State of Maine, and the State of Maryland where we have had more than unofficial inquiry. In a recent case the majority leader of a legislative commission in Maryland made an inquiry of many of our homes as to cost of operating and other facilities of that nature. Other States—New York has made inquiry, too, Mr. Harrington reminds me—have made official inquiries as to what it cost us to operate by legislative groups within the States referred to.

I am also told in addition New Mexico is giving some consideration to this.

Senator KENNEDY. I would like to ask at this time whether any of the other members of the panel have any comments they would like to make before we conclude.

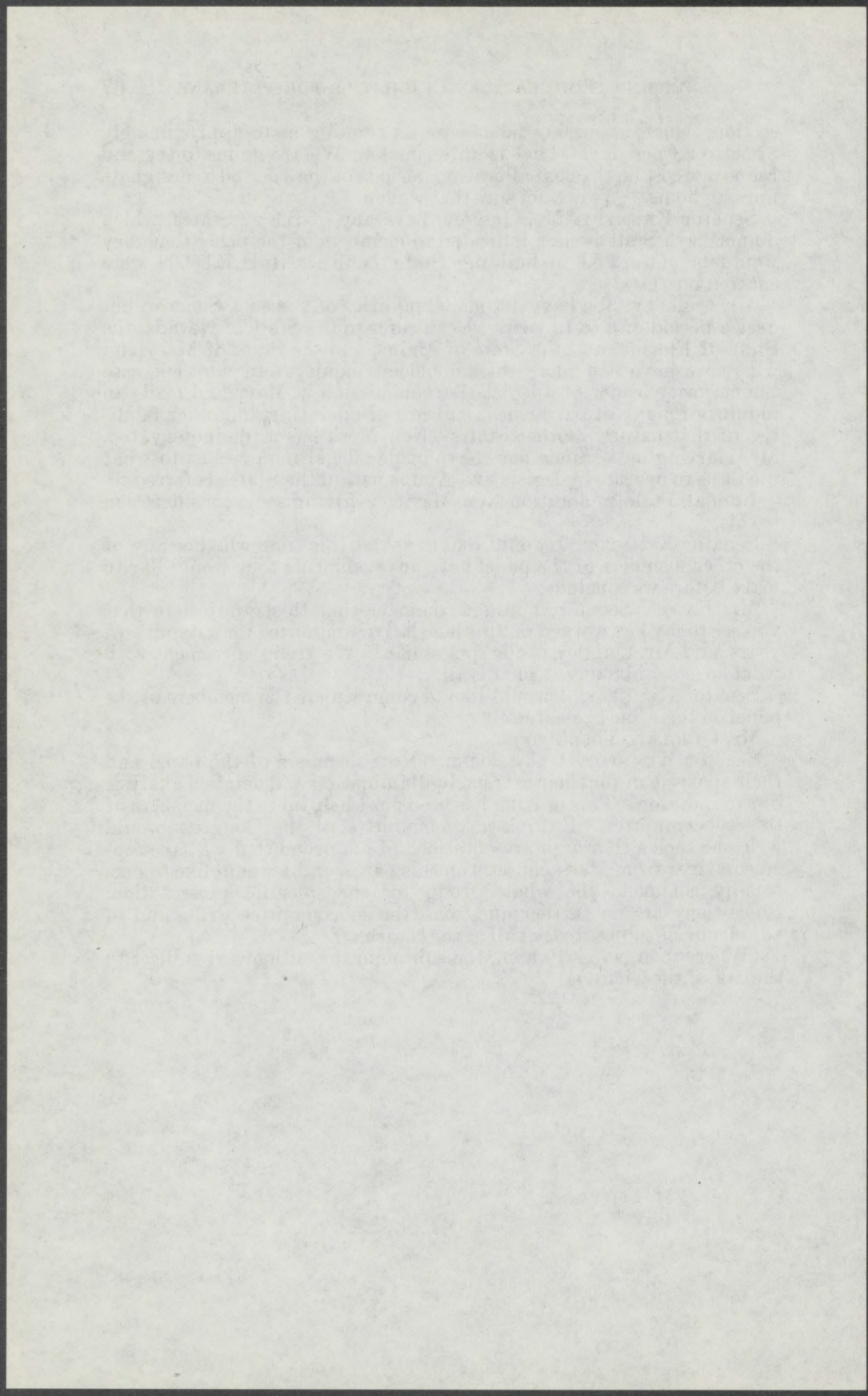
Mr. EATON. Senator, I might comment that this group here that you see today has worked on this legislative committee for a number of years, and Mr. Quigley is our spokesman. We are in agreement with what he has said today. That is all.

Senator KENNEDY. I would like to congratulate the members of the panel on their fine presentation.

Mr. QUIGLEY. Thank you.

Senator KENNEDY. I also commend the members of the panel and their spokesman for their extremely illuminating and detailed analysis of this question. This hearing has been most helpful to the members of this subcommittee. I think any committee of the Congress would welcome such a thorough presentation. I am proud that we have representatives from Massachusetts on this panel, and I would like to personally commend the whole group for the splendid presentation. Since there are no further questions, the subcommittee will stand in adjournment subject to the call of the chairman.

(Whereupon, at 11:10 a.m., the subcommittee adjourned subject to the call of the Chair.)



NURSING HOME CARE AND FACILITIES FOR VETERANS

WEDNESDAY, JANUARY 29, 1964

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

The subcommittee met, pursuant to call, at 10:30 a.m., in room 4232, Senate Office Building, Senator Lee Metcalf presiding.

Present: Senator Metcalf (presiding).

Committee staff members present: Stewart E. McClure, chief clerk; Charles M. Johnston, counsel; John Strasburger, associate counsel; and John Stringer, associate minority counsel.

Senator METCALF. The subcommittee will be in order.

This is a continuation of a hearing on H.R. 8009. Our first witness this morning is Mr. William E. Beaumont, who is representing the American Nursing Home Association.

Mr. Beaumont, will you come forward and present your statement?

STATEMENTS OF WILLIAM E. BEAUMONT, JR., PRESIDENT; AND ALFRED S. ERCOLANO, EXECUTIVE DIRECTOR, THE AMERICAN NURSING HOME ASSOCIATION

Mr. BEAUMONT. I am William E. Beaumont, Jr., and with me is Mr. Alfred S. Ercolano, our executive director.

Senator METCALF. You may proceed.

Mr. BEAUMONT. Mr. Chairman and members, I am William E. Beaumont, Jr., president of the American Nursing Home Association, whose national offices are located at 1346 Connecticut Avenue NW., Washington, D.C. I am also past president of the Arkansas Nursing Home Association and am the owner-administrator of a 47-bed nursing home at Little Rock, Ark.

I have with me today Mr. Alfred S. Ercolano, executive director of the American Nursing Home Association.

The American Nursing Home Association has a membership in excess of 4,350 nursing homes in 48 of the 50 States, and affiliated State associations in 47 States. Our membership represents some 156,000 beds. Among its member homes are both private, proprietary, and voluntary nonprofit homes.

We who must deal with the problems of caring for our aged and chronically ill on a day-to-day basis appreciate the opportunity afforded by this subcommittee to present to you our views on H.R. 8009.

Since its inception in 1949, the American Nursing Home Association and its predecessor organizations have provided leadership in improving nursing home facilities and standards of care in nursing

homes throughout the country. We have worked diligently with other organizations in medical and paramedical fields in meeting the health problems of the aged.

Our association is a member of the National Fire Protection Association, the National Health Council, the National Safety Council, the National Council for the Accreditation of Nursing Homes, and the Joint Council To Improve the Health Care of the Aged. We also have cooperated with governmental agencies at National, State, and local levels to raise the standards of care in nursing homes and to bring about realistic laws regulating and licensing nursing homes.

While only five States had licensing laws in 1950, today all States require licenses for nursing homes. The American Nursing Home Association membership includes only licensed nursing homes. We for many years have worked to establish an accreditation program which goes beyond licensing standards and encourages greater professionalism in personnel and methods of care in rehabilitation.

Our earliest efforts were in individual States where such accreditation programs effected resulted in improvements and standards of care that were phenomenal. In 1962 we were instrumental in establishing a national accreditation program. As of April of last year, our association joined with the American Medical Association in the joint sponsorship of the National Council for Accreditation of Nursing Homes.

The national council officially opened its new offices in Chicago in September under the direction of Dr. Henry H. Holly, former public health officer from the State of Texas.

There were some 23,000 nursing homes and related facilities with a bed capacity of nearly 600,000 in 1961. Of this number, 9,700 were skilled nursing homes, under the Public Health Service definition, with a bed capacity of 338,700. Nine out of ten of these homes have registered, professional or licensed practical nurses or both on their staffs. The number of skilled nursing home beds has nearly doubled since 1954.

I might point out to you that at this time 72 percent of skilled nursing home beds are in private or proprietary homes and 16 percent in nonprofit homes. Publicly operated homes accounted for only 4.5 percent of the homes and 12 percent of the beds.

The average age of our patients is 80. Most spend at least a year with us and one-third are with us 2 or more years. Many return to their own homes. About 70 percent of those 65 and over, and 83 percent of those 75 and over, have one or more chronic illnesses; 2 out of 3 suffer from a cardiovascular disease and 1 in 4 have some degree of senility, although more than half have periods of disorientation.

We have supported legislation which we believe truly benefits the patient and tends to upgrade nursing home facilities and standards of care. As examples, we have supported Government programs such as the mortgage loan insurance program of the Federal Housing Administration, the nursing home program under the Small Business Administration, and the Hill-Burton nonprofit nursing home grant program. Without a doubt, they have provided the impetus for the rapid construction of nursing homes and resulted in improvement in facilities.

Under the FHA program, 150 loans involving 13,250 beds and a total mortgage amount of \$80.8 million have been insured as of June 30. As of the same date, there were an additional 270 projects involving 19,972 beds, covering either by applications in process or outstanding commitments.

As of December 31, 1962, Hill-Burton grants of \$143 million had been made to 234 chronic disease hospitals and 439 nursing home projects involving a total of 42,639 long-term-care beds.

Under the SBA loan program, 337 loans amounting to \$23.4 million had been approved for nursing homes.

Our association wishes to commend the chairman of this subcommittee and its members for their deep interest in this important legislation. Basically, our association favors this particular legislation and feels there are many good points covered within the bill.

There is, however, one section of the bill to which we must voice opposition. The section which we oppose is the section that provides for the granting of funds by the Federal Government to the State governments for the construction of State veteran home facilities for furnishing of nursing home care to veterans. The association feels that at the present time there are already in existence more than enough beds and licensed facilities to meet the needs of the veteran population. The association feels that existing facilities within the veteran's home community should first be utilized for the providing of this care. If these facilities prove inadequate or if they cannot meet the needs of the veteran, then steps should be taken by the Federal and local governments to meet this need.

I do not mean to infer that licensure alone should be used as a criteria for payment. The ANHA realizes that in some States the level of licensure is less than satisfactory.

One of the essential parts to the long-term care of patients is the maintenance of a homelike atmosphere for the individual. If a homelike atmosphere cannot be provided as such, then a setting for the patient should be as noninstitutional as possible.

I feel that we would be doing a disservice to the veteran and his family if we were to attempt to locate him in a facility that in all probability would be placed for the convenience of others as close to Veterans' Administration facilities as possible. I doubt if any one group of persons knows the total need that exists for this new approach to veterans' health care.

It is my understanding that the Veterans' Administration is in the process of conducting a study dealing with the needs of the long-term patient and the availability of resources to meet these needs. Possibly we should wait and see what this study group reports before further action is taken on this legislation.

There are other items in this legislation that we feel this subcommittee should study further. We are not opposed to these items, but we do feel that further consideration should be given to them before they are included in the final legislation.

First, as reference to the length of stay, the maximum length of stay should be extended beyond the present 6-month period. As I mentioned earlier in my testimony, the average length of stay for nursing home patients is 1 year, with approximately one-third of the patients staying 2 years. Although the bill in its present form does

provide for the review by the Administrator for possible extension of time, I feel much administrative work could be eliminated or reduced considerably if a more realistic length of stay was incorporated into the bill.

Methods of reimbursement to private facilities: The present allowance for payment to private facilities is adequate. However, the committee might want to consider the possibility of providing reimbursement on the basis of patient need and services offered by the facility. I feel it is reasonable to suggest that reimbursement should be associated with these two items of need and service. The cost of providing care to a total bed patient in need of nursing service and medical treatment is much greater than the cost of providing domiciliary care.

Another item of concern is the provision that up to 10 percent of the bed occupancy in the State home facilities could be used to house non-veteran patients. If these facilities are to be built with Federal and State funds for the benefit of veterans, why should they offer to provide care for nonveteran patients?

I again want to commend the subcommittee for its interest in this vital legislative matter and to thank the chairman for the opportunity to testify.

If there are any questions, I shall be happy to attempt to give the committee the information requested.

Senator METCALF. Thank you very much, Mr. Beaumont, for a very helpful statement.

Mr. BEAUMONT. Mr. Chairman, I have a letter from one of our members written to Senator Ralph Yarborough. The letter is over the signature of Mr. Eldred Thomas, of Dallas, Tex. He asked that it be submitted for the record.

Senator METCALF. Without objection, it will be incorporated into the record at this point.

(The letter referred to follows:)

AMERICAN NURSING HOME ASSOCIATION,
Washington, D.C., October 15, 1963.

Senator RALPH W. YARBOROUGH,
U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: I am writing you with respect to H.R. 8009, which I understand was passed by the House on September 16, 1963. I am informed that you as chairman of the Subcommittee on Veterans' Affairs will have this bill up for consideration in the Senate. I am writing you as legislative chairman of the American Nursing Home Association, however, you may remember me in connection with my work in the Texas Nursing Home Association since I served several terms as president of that organization. We still remember happily our banquet at which you gave the main address.

While the nursing home operators, as every citizen who feels grateful for the sacrifices made by members of our Armed Forces in time of war, would wholeheartedly join in the proposition that our veterans should have their needs met, particularly where these needs grew out of sacrifices they made in time of war, nevertheless, the nursing home administrators of this country are particularly alarmed over some of the provisions of the above-mentioned bill.

I am sure that you agree generally with us that health care should remain in the hands of private physicians and private institutions, allowing a complete freedom of choice on the part of the patient, except in instances where there is complete breakdown or failure to render the required health care or service. Present health care has some shortcomings, perhaps the greatest of which is an excessive cost, however, the nursing home field and the nursing care rendered in the private nursing home is a notable exception to this failing due to the fact that nursing homes are now giving a high type of care to the aged for an economical cost.

We are greatly disturbed by the provisions of the bill mentioned for the following reasons:

1. By authorizing the creation of 2,000 additional beds for furnishing nursing home care to eligible veterans, the Government is going into the nursing home business, and we do not believe this is justified, either economically or from the standpoint of the needs of the veterans. This inroad would merely be the beginning of a Government program that like so many, would grow like "Topsy" at a completely unwarranted expense to the taxpayer. If adequate Government payments can be authorized on behalf of veterans needing nursing home care, we are confident that the nursing home administrators can demonstrate that there are first-class facilities available to take care of these veterans under Government standards laid down by the Veterans' Administration and at a small part of the cost that the Government would incur in creating these facilities.

2. We are also greatly concerned with the provisions of the proposed act that would encourage the States to go into the nursing home business. Here again, the creation of a new matching program in the health field would be an entering wedge by which both State and Federal Government would make an unwarranted entry into the health field. Here again we are certain that an investigation of existing facilities and those which are on the drawing board would demonstrate that veterans need in the nursing care field could be most admirably met by private enterprise at a substantially lower cost than would be the case in State institutions built with Federal matching funds.

While there may be other objections to the act, those stated above are very fundamental and the American Nursing Home Association and its affiliated State associations would urge you and your committee to give this bill its most careful consideration and that it not be passed out in its present form.

As an alternative suggestion, we believe the Veterans' Administration should be given broad powers to contract for the care of veterans who are eligible and should properly be in a nursing home prescribing standards for the contracting homes that would insure the best care for the veteran patient. We are confident that this would still meet the need and that the veterans involved would be happier, nearer to their homes and friends than would be possible were they assigned to Federal or State institutions of great size concentrated in populous places.

I am sure you are aware of the fact that the American Nursing Home Association, in conjunction with its State affiliates, is now in the process of inaugurating an accreditation program which will categorize nursing homes according to meaningful standards. The American Medical Association is a partner with our association in this undertaking and it realizes the tremendous benefits that would come to this field through such a program.

We would be glad to have your views on these problems and to volunteer our assistance in any way possible to get you or your committee authentic information concerning the availability of private nursing home beds of a quality that would take care of the veterans problems.

Very truly yours,

ELDRED THOMAS,
Chairman, Legislative Committee.

Senator METCALF. I see that you say that some 23,000 nursing homes had facilities with a bed capacity of nearly 600,000 in 1961. Those are the latest figures that you have?

Mr. BEAUMONT. That is correct, sir.

Senator METCALF. How much capacity do you anticipate will be needed 5 years from now?

Mr. BEAUMONT. It depends greatly on the public assistance programs and what the commercial insurance companies do to expand the utilization of nursing homes.

Senator METCALF. If we had the welfare expenses, the insurance and health insurance and all that to take care of all these people, how many nursing homes would be required?

Mr. BEAUMONT. In 5 years? I don't know exactly, sir.

Senator METCALF. You cannot project that far? You don't have any information to project that far?

Mr. BEAUMONT. No, sir. We have not projected that far.

Senator METCALF. I notice you distinguish skilled nursing homes and the other variety. Would you elaborate on that a little bit and tell us what the difference is and what kind of care is given in skilled nursing homes?

Mr. BEAUMONT. Basically, nursing homes and related types of facilities fall in three categories—the skilled nursing home; and at the other extreme is a personal care and domiciliary home. Then within these two extremes is the practical-type nursing home that gives very minimal nursing care services.

The personal care home would care for patients that are primarily senile and need some supervision, possibly some assistance with bathing, dressing, and dietary items. In the other category, a practical-care home would require some degree of medical supervision. Possibly a practical nurse would be in charge of the nursing program.

In a skilled-nursing home, registered professional nurses would be in charge of it. These would be of more severe medical needs. Many of them would be bedfast, with severe limitations.

Senator METCALF. I was very much surprised when I heard you state that you felt you would be doing a disservice to the veteran if we attempted to locate the facility close to the Veterans' Administration facility. It would seem to me that especially those veterans who have been in need of medical attention in regular Veterans' Administration facilities or are in the convalescing and recovery stage in what you would call the skilled-nursing homes would be better cared for in some area adjacent to a Veterans' Administration facility than some remote area.

Mr. BEAUMONT. Senator, the point I was attempting to make there is that, if at all possible, the veteran should be cared for in his own community where his family and friends live, so that they can visit frequently, and there can be some degree of hope to return to the community situation.

The veterans hospitals are not strategically located throughout all communities in the United States. If we move the patient from his community 100 miles or more away, this breaks off family ties. My point was that it should be done as close as possible to the community.

The home adjacent to the VA hospital in a particular community would be excellent, but it doesn't provide the same type of service for the others.

Senator METCALF. However, it would seem to me that we need both. Doesn't it seem to you that perhaps for just the kind of care that the older patient needs, something near his home would be better, but, say, for a patient who is convalescing from surgery or some serious disease, it would be better to have him where he has an opportunity to get medical attention if he needs it?

Mr. BEAUMONT. Yes, sir. This is true. But it can be available in the local community.

Senator METCALF. In your statement you say that we already have enough beds in licensed facilities to meet the needs of the veteran population. That is a statistical statement. It is easy to add up beds and say, "We have enough," but don't you feel that there is a need for more beds and more nursing homes in many locations where there are none at all? It is just like adding up the number of classrooms

and saying, "We have enough classrooms for all the students," but in some areas we have very overcrowded classrooms and in other areas we have abandoned schools.

It would seem it would take more than just a statement that "we have needs for so many people and we have so many beds." For I know that in my own State there are many communities that have no facilities at all.

Mr. BEAUMONT. This is true. The background of that statement was predicated upon the fact that in most areas of the United States now there do exist vacancies in skilled nursing homes. In Miami, in Dade County, there are 600 vacancies today. In my own State, it chronically runs 7 percent, which we consider a healthy figure. In some areas in Iowa, it is very high, where there has been an overbuilding.

There are some few areas, and your area is one of them, where there needs to be many more nursing homes in the community.

Senator METCALF. I will certainly accept your statement that there are enough beds, but sometimes they are not always in the right locations.

Mr. BEAUMONT. Not properly distributed. There is a study which I referred to which is going on by the Veterans' Administration which would indicate the number of beds needed for their services and the number of beds available, and the quality of those beds.

Senator METCALF. You say that the American Nursing Home Association realizes that in some States the level of licensure is something less than adequate. I take it that you don't regard all State licensing as sufficient. You say in your statement, however, that all States require licensing.

Mr. BEAUMONT. Yes, sir.

Senator METCALF. Would you object to legislation on the Federal level imposing minimum standards?

Mr. BEAUMONT. Frankly, I believe that there has been such an increase in standards throughout the States that Federal legislation of this type would not be needed. Those States that are lagging are very small in number, only three or four. I don't think the Federal legislation on standards would be needed.

I think we need some Federal leadership in this area. We work very closely with the Public Health Service. They are marvelous in their leadership. This needs to be continued and possibly even expanded. Unfortunately, there is a breakdown of lateral communications many times between the health and welfare agencies which needs to be corrected so that the patient can be cared for better and adequate standards can be adopted and be meaningful.

Mr. ERCOLANO. Senator, if I could add something to that, sir, sometimes the problem exists not with the licensing law. Many of the States have licensure programs that are more than adequate. But within the licensing law they have no enforcement mechanism so that the State agency that is doing the licensing has no provision within the law to enforce these standards. They can't take someone to court or they can't take their license away from them.

So it is not only the question of licensure, but the enforcement power that lies within the law that makes it an effective law.

Senator METCALF. Do you have something to add?

Mr. BEAUMONT. No, Mr. Chairman.

Senator METCALF. You have anticipated what was going to be my next question; that is, your feeling about adequate State enforcement of standards. So it is your feeling that in many States there is inadequate enforcement of even minimum standards imposed?

Mr. ERCOLANO. In some States; yes, sir. We have had an example of this in the State of Ohio, where the health department and our affiliate, the Ohio Nursing Home Association, both worked together to develop a new set of standards which were much higher than the standards that were in effect. However, these new standards, even though they were passed by the health department, could not be enforced because another group within the State took the State health department to court, and has had the new standards tied up in court for almost a year now.

It ties in with public reaction to new licensing programs, and public support of these licensing programs.

Senator METCALF. Don't you feel that in justice to the veterans, in justice to the nursing homes, most of whom are members of your association, who are maintaining standards, that we should write some minimum standards into this legislation if we are going to pay for this kind of care?

Mr. ERCOLANO. Yes, sir. This is why in Mr. Beaumont's testimony he said that we did not infer that State licensure alone should be the criteria. I think the original House bill 244, introduced by Mr. Teague, had a standard in there that they would have to meet the Federal Housing Administration building standards.

I do think there needs to be something beyond licensure for the Veterans' Administration and for the veteran to be assured of receiving the proper type of care.

Senator METCALF. I would think so, too.

What is the average cost per day for care in homes that are members of your association?

Mr. BEAUMONT. It runs slightly above \$6 a day.

Senator METCALF. Is there some variance between care in what you call the skilled nursing home and the other variety?

Mr. BEAUMONT. Yes, sir. It would be directly associated with the need of the patient. A person that is primarily in need of domiciliary care, supervisory care, would not need the degree of professional nursing that a person that, say, had cardiovascular disease, ulcers, or paraplegic or something of of this nature.

We take the position that in a home where nursing care is controlled by a practical nurse, if this is all the care that the patient needs in that home, this can be a good home. By the same token, it can be a good home as long as the nursing and the patient's needs are kept together. You can have a skilled nursing home that gets over its head in hospital-type services and this can be a bad home, even though they have many registered nurses.

Senator METCALF. You say the average is about \$6 a day. What would be the highest cost and the lowest cost? Give me the extremes, if you can.

Mr. BEAUMONT. Excluding some extremes, the average high cost would be in the area of \$10 to \$10.50, and the lowest cost would be in the area of \$4.

Senator METCALF. It has been called to my attention that we don't have a specific answer to the question of your position as to the provisions for nursing home care by the Veterans' Administration in Veterans' Administration facilities. You stated in your statement that you oppose that section of the bill providing for loans. I wonder if you would elaborate on that a little bit. That is the only section to which you are outright in opposition.

Mr. BEAUMONT. You have reference, Mr. Chairman, to the section where we feel that we are in opposition to a grant to the States to construct.

Senator METCALF. Yes. We have a State-operated soldiers' home, for example, in Montana. I assume under the terms of this legislation that would be eligible for a grant for expansion or assistance.

Mr. BEAUMONT. Our position in this is that, as long as the needs can be met by private voluntary groups within the area, they should be done in that way. But if they are so inadequate as not to accomplish the job, or if private and voluntary groups cannot do it, then it would be the prerogative of the Federal Government, through the VA programs, to do this. However, we believe that in almost every section in the country there are adequate facilities now available.

If the Veterans' Administration hospitals would utilize the facilities—the demand for service precedes the service itself—there would be additional nursing homes constructed by private firms and also by voluntary groups, such as your religious groups in communities.

Mr. ERCOLANO. I would like to add to that, Senator, if I might.

Senator METCALF. Certainly.

Mr. ERCOLANO. Another thing you have to consider is that we already have in existence five Federal programs giving assistance for the construction of nursing homes and related facilities. We have the Hill-Burton program under the Public Health Service. We have the Small Business Administration involved in the guaranteeing of loans. We have the Federal Housing Administration involved in the guaranteeing of loans. Under the Commerce Department, in the Area Redevelopment Administration, we have two programs there.

The feeling could be that if we already have these Government programs in existence to construct nursing homes and related facilities, why create another mechanism? If it is necessary, why can we not utilize those programs that are already in existence?

Senator METCALF. What about construction of additional homes at the Veterans' Administration facilities themselves?

Mr. ERCOLANO. I am sure that under the Hill-Burton program, which is for nonprofit ventures, the State health departments, the State agencies, are involved in certifying that a need exists for these beds. I do not know whether the State veteran homes would come under the jurisdiction of the Hill-Burton program or whether they could apply for a grant-in-aid. This would have to have research to find out.

But there are programs where there are grants-in-aid of Federal moneys to build nonprofit facilities.

Mr. BEAUMONT. I don't believe this bill would affect that anyway, the construction of nursing home facilities on Veterans' Administration properties.

Senator METCALF. Gentlemen, I think you have made a splendid statement of your position. The committee is grateful for your appearance today. It will be helpful in our consideration of the bill.

Mr. BEAUMONT. Thank you.

Mr. ERCOLANO. Thank you.

Senator METCALF. The next witness was scheduled to be Oliver C. Bacon, executive director of the Blinded Veterans Association. He is ill and cannot be here today. His statement will be incorporated into the record at this point.

(The prepared statement of Mr. Bacon follows:)

PREPARED STATEMENT OF OLIVER C. BACON, EXECUTIVE DIRECTOR, BLINDED
VETERANS ASSOCIATION

Mr. Chairman, I am Oliver C. Bacon, executive director of the Blinded Veterans Association. We represent most of the blinded veterans in the United States, both service connected and nonservice connected.

The Blinded Veterans Association wholeheartedly endorses in its entirety, H.R. 8009, a bill designed to provide certain veterans with urgently needed nursing home care and nursing care facilities.

In testifying in favor of this bill, the Blinded Veterans Association is primarily concerned with the non-service-connected blinded veteran. We believe the benefits provided by this bill would be indispensable to those men who badly need this care. The Blinded Veterans Association, in its 18 years of existence, has found that the problems of blindness are many times increased with advancing age, and just as disabling regardless of the cause of blindness. When a blinded veteran reaches the age where other physical problems require nursing care, we would like to feel that there are facilities available for the men who would be entitled to this coverage.

Today, these veterans who are not acutely ill but yet require skilled nursing care and related medical services, combined with their blindness, have the most difficulty in obtaining the necessary care. They are not now covered in title 38 of the United States Code. In most cases, these men are homebound due to their blindness, and their additional physical health breakdown enlarges the need for the care which this bill would provide.

These circumstances are further complicated by lack of financial ability to provide such medical services independently.

It is respectfully requested that favorable consideration be given to H.R. 8009.

The Blinded Veterans Association wishes to express its appreciation for the privilege of being heard on this matter.

Senator METCALF. The next witness will be Mr. Frank E. G. Weil, chairman of the Veterans Armed Forces Commission, American Veterans Committee.

STATEMENT OF FRANK E. G. WEIL, CHAIRMAN, VETERANS ARMED
FORCES COMMISSION, AMERICAN VETERANS COMMITTEE

Mr. WEIL. Thank you very much, Senator.

Senator METCALF. We are pleased to have you with us this morning. You may proceed.

Mr. WEIL. Thank you, sir.

Mr. Chairman, my name is Frank E. G. Weil. I am a member of the bar of the District of Columbia and of the State of New York. I appear here today as chairman of the Veterans and Armed Forces Commission of the American Veterans Committee.

The American Veterans Committee is an organization composed primarily of veterans of World War II, although our constitution admits veterans both of World War I and of Korea.

In the approximately 21 years of our existence, we have followed our motto, which is "Citizens First, Veterans Second." We are, I think, unique among veterans organizations in that we do not generally seek a special, preferred position for the veteran. We feel generally that the veteran who comes out of the armed services with a disability requires the best that the country has to give; that the veteran who is killed in service, his survivors require the best the country has to give; but that the veteran who comes out of the armed services enriched by his experience has fulfilled the duty of citizenship to the country and need not reap many years later additional rewards because he has some years previously spent some time in uniform.

I would like to thank Chairman Yarborough and yourself for the opportunity to testify at this time on H.R. 8009, the act to amend title 38 of the U.S. Code to provide certain veterans with urgently needed nursing home care and nursing facilities, while reducing the cost to the United States for caring for such veterans.

As it applies to veterans with service-connected disabilities who require the care proposed by this act, for the care and treatment of the disability involved, the American Veterans Committee approves and endorses the proposed legislation. Any program which increases the facilities available to the veteran with a service-connected disability at less cost to the taxpayer fits within the AVC platform and AVC philosophy and deserves AVC's support and endorsement.

This has been our position for the past 21 years. As it applies to veterans without service-connected disabilities, and veterans who may have a service-connected disability but whose need for care or treatment is not related in any manner to the disability involved, a man, let's say, who has a leg amputated and needs treatment for pneumonia, unrelated, the American Veterans Committee favors the application of the same standards which it has recommended for admission to veterans' hospitals themselves.

The following is quoted from the veterans and armed forces affairs platform of AVC as adopted at its 20th anniversary convention held in Washington, D.C., from May 30 to June 2, 1963:

Treatment of non-service-connected disabilities in Veterans' Administration hospitals be continued on a space-available basis, but that such treatment be charged at the full cost if a patient has the means to pay for such services. Certificates that a veteran is unable to pay should be investigated thoroughly to determine the true ability to meet the cost of hospitalization; that the terms of coverage of all prepaid medical associations, plans, and companies be amended by action of the legislatures, supervisory bodies, or membership so as to provide payment to VA hospitals for non-service-connected treatment on the same basis as payment to private, voluntary, and public hospitals.

In addition, AVC feels very strongly that one of the conditions under which the Veterans Administrator will deal with State and other agencies involved should be strict adherence to policies of nondiscrimination, including nonsegregation. No funds should be made available under this act to agencies which discriminate or segregate on the basis of race, religion, or national origin.

The following is quoted from our platform adopted as above:

Veterans' benefits should be administered without regard to race, creed, color, sex, or national origin. Since benefits are a Federal responsibility, uniform standards of administration and compensation should be applied throughout the Nation.

Thank you very much for the opportunity to present the views of the American Veterans Committee.

I would be delighted to answer any question you might have.

Senator METCALF. I appreciate the statement that you have presented, Mr. Weil. I haven't very many questions.

Let me ask you about segregation and discrimination for a moment. Do you feel it is necessary to write into this legislation a prohibition against segregation or discrimination?

Mr. WEIL. I would say, Senator, that my answer would depend somewhat on the fate of the present civil rights bill. If the present civil rights bill contains a flat and general prohibition against the use of Federal funds for any discriminatory activity, there would be no need to put additional language into this particular bill.

If the civil rights bill does not contain such prohibition, the American Veterans Committee would recommend the insertion of such language into this legislation.

Senator METCALF. It has always been my feeling that, since the decision of the Supreme Court was based upon a constitutional provision, these matters could be taken care of by Executive order. We have learned that such things as housing can be taken care of by Executive order. These amendments for antidiscrimination or antisegregation cause a great deal of difficulty and sometimes prevent the passage of otherwise worthwhile legislation.

It would seem to me that you have pointed out the way in which it should be done, that is, the passage of a civil rights bill or general legislation. We don't put in that burglary and murder shall not be committed in Veterans' Administration facilities, and yet if such a thing occurred we have plenty of laws to cover it.

Mr. WEIL. Yes, sir. Let me put it this way, Senator: I think the result should be admission to these nursing homes for the veterans with service-connected disabilities or for veterans with non-service-connected disabilities who are prepared to pay, or whose insurance is prepared to pay, the necessary costs of those who are genuinely destitute, on a nonsegregated basis.

We have no real preference as to whether the nonsegregation comes from the civil rights bill, from this legislation, from Executive order, or possibly from actions of the States in which this is to take place. We want to be sure it takes place.

Senator METCALF. You are afraid we can't rely on action by the States?

Mr. WEIL. Some States we could.

Senator METCALF. You, in behalf of your organization, have taken a little bit different position as to non-service-connected disabilities than some of the other veterans' organizations.

Mr. WEIL. That is correct, Senator.

Senator METCALF. As far as this bill is concerned, you recognize the need for this useful tool in taking care of service-connected disabilities.

Mr. WEIL. Yes, Senator; we do.

Senator METCALF. And you do support the legislation for that, even though you question the present policy as to the admission of non-service-connected disability people in Veterans' Administration facilities.

Mr. WEIL. That is correct, Senator. We regard the nursing homes provided by this bill as an extension of the Veterans' Administration hospitals, at lesser cost to the taxpayer, and we feel the same criteria should apply as to service-connected disabilities as to non-service-connected disabilities, and, to recapitulate, as to discrimination.

Anything that applies to the veterans' hospital itself should apply to the veteran patients in State and private nursing home facilities who are placed there by reason of this legislation.

Senator METCALF. So this would be a desirable extension of the facilities we need to take care of the service-connected disabilities.

Mr. WEIL. Certainly, Senator.

Senator METCALF. Thank you very much, Mr. Weil, for your appearance. You have been very helpful to the committee.

Mr. WEIL. Thank you, Senator.

Senator METCALF. Mr. Weil was the last witness this morning.

The subcommittee will stand adjourned, subject to the call of the chairman.

(Whereupon, at 11:15 a.m. the subcommittee adjourned, to reconvene at the call of the Chair.)

NURSING HOME CARE AND FACILITIES FOR VETERANS

TUESDAY, FEBRUARY 25, 1964

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

The subcommittee met, pursuant to call, at 10:05 a.m., in room 4232, Senate Office Building, Senator Yarborough (chairman of the subcommittee) presiding.

Present: Senators Yarborough (presiding), Metcalf, and Jordan of Idaho.

Committee staff members present: Stewart E. McClure, chief clerk; Charles M. Johnston, counsel to the subcommittee, and John Stringer, minority associate counsel.

Senator YARBOROUGH. The Subcommittee on Veterans' Affairs will come to order and hearings will be resumed on H.R. 8009.

The first witness this morning will be Senator Prouty, of Vermont. Unfortunately I must go to another committee—unfortunately for me—where we have an executive session and need every member there for a quorum, but fortunately for the committee, Senator Metcalf of Montana is going to preside during the rest of the morning. If we finish the executive committee meeting early enough, I am coming back to sit in with him and hear the rest of the testimony.

I particularly regret that I won't be here because we not only have a fellow Senator, but we have some witnesses here this morning who have given this matter great study and their testimony will be most beneficial to the subcommittee and to all of the Senators. I appreciate Senator Prouty coming here this morning. He can lead off. Senator Prouty.

STATEMENT OF HON. WINSTON L. PROUTY, A U.S. SENATOR FROM THE STATE OF VERMONT

Senator PROUTY. Mr. Chairman, and members of the subcommittee, I deeply appreciate this opportunity to testify on the bill, H.R. 8009.

I consider this legislation to be among those bills which can genuinely be regarded as both necessary and desirable.

It is necessary because the number of aged veterans in the United States is ever increasing, and they are the ones for whom the benefits of this legislation will be most obvious.

It is desirable, because of all the means suggested and proposed for recognition of the inestimable service which veterans have rendered to this Nation, provision for their care when they are ill seems to be most justified, most sensible, and most appropriate in times of needs.

Mr. Chairman, Col. Edward H. Giles, commandant of the soldiers' home in Vermont has written to me endorsing this legislation. I am well aware of the wonderful service which this home provides for the veterans of Vermont, and Colonel Giles' letters to me have convinced me absolutely of the value of H.R. 8009, and particularly subchapter III of the bill which relates to the State home facilities for furnishing nursing home care.

In addition to the support which it receives from Colonel Giles, the American Legion, Department of Vermont, also supports this bill. At its midwinter conference, the Legion at its headquarters at Montpelier, our capital city, adopted a resolution urging passage of H.R. 8009. In addition, the Legion has also urged enabling legislation by the Vermont Legislature to permit the State to be prepared to participate in the program set up under the bill.

I am particularly pleased that this bill authorizes appropriations for the next 5 fiscal years, including the current one. That should be ample time for the legislatures of all the States to make whatever adjustments their local laws require to participate in this program. Since, also, many of the States have a "short legislature" this session, and Vermont is included in that number, I am particularly happy that the bill provides that the sums to be appropriated will remain available for 2 additional years.

I hope that these two provisions will be retained in the bill for the reasons which I have stated.

Mr. Chairman, I endorse this bill and what it will mean to the veterans of my State, and indeed, to veterans throughout our country. Although I am not a member of your subcommittee, I do sit with you on the full committee, and I wish you to know that you will most certainly have my support for this bill both in the full committee and when it reaches the floor.

Thank you very much.

Senator YARBOROUGH. Thank you, Senator Prouty, for your statement. You mentioned the fact that you are not on the Veterans' Subcommittee, but you did serve on this subcommittee for years and are very familiar with the problems of veterans. We had the privilege of participating with you at the time we were both members of the Veterans' Subcommittee. Now we are both on the full Labor and Public Welfare Committee. I hope we have further opportunity to consider it before that committee. Any questions, Senator Metcalf?

Senator METCALF. No questions. Senator Prouty, I think it is useful and significant that you have conveyed to us the endorsement of this bill by veterans committees in your State. After all, it is the people who are actually running the programs in the various States who know most about the veteran's needs and it is most helpful to the subcommittee to have the views of Vermont's veterans' organizations before us.

I am grateful to you for appearing before the subcommittee, and I assure you of my support both on the subcommittee and the full committee.

Senator PROUTY. Thank you, Senator Metcalf, and I can assure you that the veterans in Vermont, and I am sure throughout the country, are very much in support of this bill. It is very appropriate legislation, and one which we can certainly justify, not only to veterans but to our constituents in general.

Thank you.

Senator YARBOROUGH. Thank you for this contribution to this hearing, Senator Prouty.

Senator METCALF, if you will take over, I will rejoin you when we finish this executive committee I have to go to.

Senator METCALF (presiding pro tempore). We are pleased to have as our next witness Mr. James H. McElroy, adjutant general, United Spanish War Veterans, Washington, D.C. Mr. McElroy, you have some people with you, and if you will come forward and identify them for the record, we will be delighted to hear your testimony.

STATEMENT OF JAMES H. McELROY, ADJUTANT GENERAL, UNITED SPANISH WAR VETERANS; ACCOMPANIED BY ARCHIE J. HOUSE, COMMANDER IN CHIEF; SAM HUTCHINSON, PAST COMMANDER IN CHIEF; AND THOMAS H. HAMMOND, PAST COMMANDER IN CHIEF—ALL OF THE UNITED SPANISH WAR VETERANS

Mr. McELROY. Yes. Senator Metcalf, I have some of our national legislative officers with me to kind of bolster up my courage, and I would like to introduce them.

Senator METCALF. You don't need anyone to bolster up your courage here. You are in friendly territory.

Mr. McELROY. I see. Well, thank you ever so much.

On my right is Archie House, commander in chief. Sam Hutchinson, past commander in chief, and Tom Hammond, past commander in chief.

Senator METCALF. You have a prepared statement. Mr. McElroy, you may proceed.

Mr. McELROY. No doubt the Senate has been pretty well canvassed the last few years on this nursing home bill, and it finally took shape and was passed by the House on a voice vote unanimously, and we have been waiting for the Senate to reach it. This is the day we have been looking forward to. And the testimony, to kind of get prepared briefly—these remarks come from correspondence I have had with Senator Yarborough in the past, the chairman of the committee.

The United Spanish War Veterans has been very anxious for this hearing on H.R. 8009, as this is vitally important to our organization and its members who have been endeavoring to have a nursing home bill enacted into law for the past 31½ years. Through the efforts of the House Veterans' Affairs Committee, headed by the Honorable Olin Teague, our own comrade, Congressman Barratt O'Hara, and Speaker John W. McCormack, H.R. 8009 was finally speeded through the House.

This bill is the end result of a long study by a special House Veterans' Affairs Subcommittee, headed by the Honorable Robert Everett, of Tennessee. One overlooked aspect of this bill is the fact that it will do more for our aged veterans than any other single group.

I wish to say here our average age is just around 86, within a month or two of 86 years at the present time.

A hearing was held on Wednesday, June 5, 1963, by the above-mentioned subcommittee and up to that time the bill was known as H.R. 244 but, after this hearing, it was changed to H.R. 8009, by which

it is now known. On September 16, 1963, it was passed by the House on a voice vote and then sent to the Senate.

The benefits, contained in the bill as passed by the House and which we wish to stress, are twofold: First, provision was made for the use of private nursing homes and, secondly, the act to become effective January 1, 1964. This is one item that has disturbed us considerably because we have had indications and reports that it wouldn't go into effect until probably next July, and taking into consideration the rapid rate that our comrades are passing on, and working so long on the bill, we would like to have them benefit as soon as possible in any benefits pertaining to the nursing home.

And the testimony I have got here is this is a critical matter when considering the death rate of our veterans and recalling a recent statement, attributed to the Veterans' Administration, that it may be June 1964 before the act could be put into operation, which is most discouraging. Keeping in mind the letter from President Kennedy of August 3, 1963, containing the statement made on May 15, 1963, by Mr. Phillip S. Hughes, Assistant Director for Legislation Reference for Bureau of the Budget, copy of which letter accompanies this testimony, and furthermore bearing in mind a memorandum of August 12, 1963, from the White House, also signed by President Kennedy, to the Veterans' Administration to expedite this nursing home situation at a minimum of expense. The President authorized the Veterans' Administration to activate and operate 2,000 beds for nursing home type patients. Now, on both these letters from the White House, I would like to have them entered in the record.

Senator METCALF. Without objection they will be entered in the record.

(The memorandum dated August 12, 1963, follows:)

MEMORANDUM FOR THE ADMINISTRATOR OF VETERANS' AFFAIRS

The changing characteristics of our veteran population, particularly those who served during the First World War, are resulting in an adverse effect on the acute medical programs administered by the Veterans' Administration. Nearly 1 million war veterans are aged 70 and over. The number will increase 50 percent by 1966.

Older veterans account for one-third of your hospital admissions and they comprise the bulk of the long-term care patient load. Many have attained maximum benefits of hospitalization but attempts at community placement have been unsuccessful because of the lack of facilities, inadequate financial resources, absence of family ties, and other reasons. Retention of these patients in facilities designed for acute care is costly and places an undue strain on the 125,000 hospital bed limit under which you are now operating.

In order to relieve this situation, I authorize you to activate and operate facilities and beds for 2,000 nursing home type patients in addition to the 125,000 hospital beds presently authorized. This will provide arrangements more consistent with patient requirements and improve utilization of acute care facilities. The higher patient turnover will also defer the need for increasing present bed levels. Existing buildings best suited for this purpose and appropriately located throughout the country according to your judgment, should be utilized. No construction, other than for necessary conversion of existing facilities, is authorized.

This authorization is to enable the Veterans' Administration to gain first-hand knowledge and experience in the operation of beds specifically designated for patients requiring attendant-type services. It will be possible to evaluate a full range of care from domiciliaries through acute medical care, restoration centers, and nursing home care where outplacement is not possible.

I am sure that as a part of your administrative studies, cost control systems will be established so that direct cost comparison will be definitive; also that you will continue to work toward the development and utilization of community and private resources in the best interest of the veteran and the Nation.

JOHN F. KENNEDY.

Mr. McELROY. I will submit them. I will just finish another paragraph here, Senator.

Senator METCALF. Fine.

Mr. McELROY. The successful passage of H.R. 8009 by the House was generally received by the major veteran organizations as the most successful bill for veterans passed in years. An article from the American Legion magazine of January 1964, page 25, also VFW newsletter October 1963, page 2, paragraph 3, quote remarks of Congressman Everett confirming this statement.

We greatly appreciate the opportunity to appear at this hearing, and thank the members for taking an interest in us, and we are looking forward to favorable action in the Senate if you can see your way clear to help this get by because it is an important bill. We thank you for your consideration. And keep it in mind, the rapid rate that we are passing on. We would ask that you give this bill favorable consideration. And, Senator, I thank you for the time taken.

(The letter previously referred to, dated August 3, 1963, follows:)

MEMORANDUM

NATIONAL HEADQUARTERS,
UNITED SPANISH WAR VETERANS,
Washington, D.C.

The purpose of including insert No. 3, letter from the Imperial Order of the Dragon, an organization originally consisting of those who served in the China Relief Expedition in 1900, is intended for use as supporting evidence.

Attention is called to the second paragraph which describes the naval and military order, whose membership is that of officers who held commissions in the armed services.

Paragraph three points out the rapid shrinkage in our membership which we call to the attention of the committee, and which, in turn, brings out the necessity of having H.R. 8009 activated immediately so that the remaining veterans will benefit thereby.

The original bill, as passed, specified that the VA was authorized to use private nursing homes and it was intended that it be effective January 1, 1964.

[Insert No. 3]

GREAT YAMEN, IMPERIAL ORDER OF THE DRAGON,
San Francisco, Calif., February 25, 1964.

DEAR CAPTAIN McELROY: This typewriter is the property of one of my sons, so please excuse the typing. Conditions in California are in a sad shape. We held our last Great Yemen meeting last May, then the IOD went inactive, except for the Mandate, which will continue as a quarterly as long as I am able to do the printing.

I did not print a naval and military order bulletin last month for the reason our two chapters, San Francisco and Los Angeles, have reached the "end of the trail." Colonel Murphy, Bliss, and myself are the only members in San Francisco area who are able to attend a luncheon, and Bliss is badly handicapped now—wife helpless in the hospital, and it is doubtful if she will get out. Los Angeles, only four to five able to turn out, and I understand they were to vote last Thursday whether to try to continue or go inactive.

About all that is left of our activities is to try to hold a commandery dinner while we last, an annual California department encampments.

Nelson A. Miles Camp No. 10, 100 members, had a mere quorum—5—at meeting yesterday, and at a funeral of one of our members 2 weeks ago the chaplain and I conducted the entire USWV service, and he in 98th year of age.

Miles membership is spread all over the United States; only about 45 actually in San Francisco, and mostly shut-ins or in hospital.

I attended funeral of Department Commander Gump at Santa Monica last Thursday, and now I am in the "saddle," which means added work for me.

We hope your health is holding up.

Yours in F.P. & E.,

ENOCH R. L. JONES, Sr.,

THE WHITE HOUSE,
Washington, August 3, 1963.

Mr. JAMES H. McELROY,
Adjutant General, United Spanish War Veterans, National Headquarters, Washington, D.C.

DEAR Mr. McELROY: The President has requested that I reply to your letter of July 23, expressing interest in the proposed bill, H.R. 244, establishing nursing homes for aged veterans.

In this connection, you may be interested in the enclosed statement made on May 15, 1963, by Mr. Phillip S. Hughes, Assistant Director for Legislative Reference of the Bureau of the Budget, in regard to H.R. 244 and similar legislation, before the Subcommittee on Intermediate Care of the House Committee on Veterans' Affairs.

As you know, Spanish-American War veterans are not without resources in the event they suffer disabilities, whether service connected or nonservice connected, which require prolonged care. Such veterans are currently eligible for full care, both inpatient and outpatient, in the facilities of the Veterans' Administration. Such free care includes all necessary medical and domiciliary services as are appropriate for veterans at the advanced ages of the Spanish-American War veterans.

Your interest is appreciated.

Sincerely,

RALPH A. DUNGAN,
Special Assistant to the President.

Senator METCALF. Mr. McElroy, I am grateful to you and your staff, former commanders and the commander of the group, for your appearance here. I am especially grateful to you for your reference to Congressman Barratt O'Hara, that delightful gentleman with whom I had the privilege of serving for 8 years in the House of Representatives and who has been such an eloquent and able spokesman for the Spanish War veterans.

Mr. McElroy, how many members are there in the organization?

Mr. McELROY. We are down to—the VA, on their list, has got something around 18,000 members, but on our organization list we are down around 8,600 or 8,700, but at the rate we are passing on—I have just got a memorandum here. You see, it is hard to get the reports from the old fellows that are not good on bookkeeping any more. You have to kind of get after them.

From November 20 to December 20 last year we lost 180 members in that month. That is out of the organization of about 8,700, or at a yearly rate of 2,160. And that rate is due to climb as time goes on, as we become a little more aged.

Does that answer your question, Senator?

Outside of handing in these letters that we would like to have inserted in the record, I think that is about all I have got to say unless there are more questions to be asked.

Senator METCALF. Mr. McElroy, all material that you want inserted in the record, you will supply to the members of the subcommittee

staff. Without objection, they will be incorporated into the record following your testimony.

You say you have 8,700 members in your organization, and about 18,000 veterans of the Spanish War?

Mr. McELROY. That is the total veterans.

Senator METCALF. I understand.

Mr. McELROY. That is unpensioned. You know, there were always some free riders that never joined the organization. The difference between our present membership and the membership as shown by the VA is that difference.

Senator METCALF. I understand.

Mr. McELROY. So for a quick way to determine that, any time the VA sends out or issues a statement, it is just take—just take about half of it as being members of the organization or a little less.

Senator METCALF. All I want to comment was that this is the last volunteer, completely volunteer army for the United States.

Mr. McELROY. Every man was a volunteer. The last volunteer organization.

Senator METCALF. I hope that by reporting this bill to the current session this committee will be able finally to do something for the rest of you who performed so valiantly.

Mr. McELROY. Well, Senator, we will all pass on happy if you do.

Mr. METCALF. What happens to the infirm veterans? Do they go to a veteran's hospital and occupy a bed?

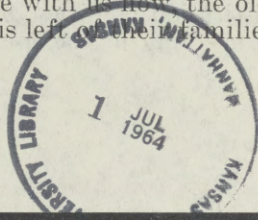
Mr. McELROY. Well, in some cases, but in other cases it is largely family donations, families putting them in a private nursing home. In fact, we have got some comrades that the families are carrying them at around \$400 a month in nursing homes, all the way from \$175 up. We suggested to the VA to use private nursing homes. We would like to see them do it. It would be much cheaper than the rate they carry on. They claim it is around \$27, \$28 a day to keep a patient in the VA hospital. One of our arguments early in this campaign was to have the veterans raised to double aid and attendance allowance. The aid and attendance allowance is \$135.45. Doubling that up would bring around \$271, and that would be still at the rate of about \$9 a day. You see, that would be cheaper than putting them in VA hospitals—that would be one-third, and there was a bill written up in the past, and I don't know what has become of it. It doesn't come to mind right now. But that would make us happy. But right now our pressing need is to get the veterans in the outside nursing homes. The VA is not prepared to take them right now. This bill was drawn up, the original 8009, to put the thing in effect the first of this year, but it is a long way off and possibly a further delay.

Senator METCALF. The bill will provide that the authorization will go into operation immediately upon its passage and approval.

Mr. McELROY. Well, I hope so. We all hope so. And Senator—

Senator METCALF. With other problems that are confronting the Senate, it may be delayed, but we hope that that day that you mentioned you were all looking forward to will arrive during this session of Congress.

Mr. McELROY. Well, we are sure that some of our old comrades in your home State would be—if they were with us now, the old judge, Jim Nugent, and that crowd, and what is left of their families is still watching this bill.



Senator METCALF. I am pleased, Mr. McElroy, that you and your colleagues came up here today to testify on this bill. Your testimony will be very helpful. Thank you very much.

Mr. McELROY. We thank you, Senator.

Mr. HOUSE. Senator, if I may say a word.

Senator METCALF. Surely. I am sorry I didn't ask you.

Mr. HOUSE. You spoke of Barratt O'Hara. Barratt and I served in the same company. He was 15 years old. I was 16. I am way older than Barratt, from January to April, and Barratt and I have been friends for 66 years right now. And I want to extend my thanks to this subcommittee myself as commander in chief of the United Spanish War Veterans.

Senator METCALF. Thank you very much for those remarks.

Mr. HOUSE. Thank you, Senator.

Senator METCALF. Our next witness is Mr. John J. Farkas, Pittsburgh, Pa., president and legislative director of the Paralyzed Veterans of America.

Mr. Farkas, I am pleased to have you before the subcommittee this morning, and will you introduce the people that are accompanying you.

Mr. FARKAS. Certainly. Thank you, Senator Metcalf. Accompanying me at this hearing is the most distinguished gentleman from our organization, Mr. William P. Green, national service director of the Paralyzed Veterans of America, who is a gentleman of much knowledge on legislation and hospital needs and care of all veterans and veterans organizations in the country.

STATEMENT OF JOHN J. FARKAS, PRESIDENT OF THE PARALYZED VETERANS OF AMERICA; ACCOMPANIED BY WILLIAM P. GREEN, NATIONAL SERVICE DIRECTOR OF THE PARALYZED VETERANS OF AMERICA

Mr. FARKAS. Thank you, gentlemen of the subcommittee and Mr. Chairman, for the signal privilege of appearing before you today and discussing one of the most important pieces of legislation to come before this or any Congress since the end of the Second World War—H.R. 8009.

I am the national president of the Paralyzed Veterans of America which has more than 3,400 members in 15 regional area chapters throughout the United States and its territories. The PVA, founded in 1947, has as its members those veterans of World War I, II, and Korea who are disabled by reason of injury to the spinal cord. These are our most seriously disabled former service men and women who by the foresight and good grace of an enlightened and generous nation, are the beneficiaries of patient care and rehabilitation services. For that provision, we are grateful and aware of the sober responsibility to respond with a meaningful participation in public affairs. Our appearance here today is part of that interest in programs designed to provide leadership in veteran affairs.

The PVA is unique among veterans groups in that it actively cooperates with the Veterans' Administration in making a more efficient use of institution facilities; makes more "in patients" "out patients"; provides meaningful and useful placement for disabled veterans and

the fostering of nationwide research programs. We want to serve and not be served. We want to earn our way. We want to help in the finding of the best spending of the VA dollar. H.R. 8009 is an important progressive step in the path of better care with the same high standards always associated with the VA.

H.R. 8009 is a wide-open opportunity for an experiment of community help by the VA. It will in essence relieve the present installations and will offer more care for more qualified veterans. It will also offer, for the first time, needed assistance for the presently neglected non-service-connected veteran. PVA is in favor of this legislation. But we would not be doing our job if we did not detail certain areas of concern and suggest guidelines for the administration of the bill.

The nursing home, originally in America, was a final way station for the aged before expiring. They were small, very expensive, and uneven in the matter of care standards. Within the last 10 years, a succession of local and regional investigations have been launched into nursing homes. All States now have licensing of nursing homes but this by no means is evidence that the standards of quality are the same everywhere. We want to be sure that the VA institutes protective safeguards to insure the following:

(a) Examination and treatment facilities by a top hospital standard.

(b) Adequate beds to be continually maintained.

(c) Rehabilitation program be in force and directed by qualified therapists.

(d) Qualified medical supervision be maintained.

A special VA study committee should determine that existing nursing homes have facilities and staff that will be needed to meet the provisions of the bill. The Veterans' Administration must be free to decide if it is necessary to build its own, original facilities to provide the basic care program required by this legislation.

There are 22,000 receiving nursing home care under the Veterans' Administration in medical, surgical, and mental hospital facilities. These same veterans have no homes of their own to go to and need the shelter of VA care. H.R. 8009 will help to relieve that patient load. A high-level recognition of the importance of nursing care was shown by the August 12, 1963, memorandum from the President to the Administrator of Veterans' Affairs. It provides for 2,000 more beds for nursing care and in the act, agrees with the spirit of H.R. 8009.

The VA has in effect been operating a system of nursing homes for many years through the supported "soldier homes" and the State veterans' homes. The VA has lent the important ingredient of teaching high-level inpatient and outpatient care and a built-in rehabilitation program. This has made the Federal, VA-supported "nursing home" care meaningful. The nursing home provisions of H.R. 8009 would add that proven element to the present day community nursing facilities. As a matter of fact, the very passage of this legislation will obviously result in the construction of a number of new nursing homes and the modernization of present facilities. The affiliation of the Veterans' Administration with the private nursing homes will bring the VA's know-how into the community and form a significant bond of interest in citizen patient need.

It is in the best interests of the VA to support an enlarged nursing care program in this country. It will permit a greater use of VA institutions for those now on waiting lists for VA care. This program will also assist in the return of the disabled to his home.

Aging veterans are in need of care that can be easily provided through nursing homes. But there are limited numbers of these veterans and only because of this legislation can they receive proper care without using the still prime-need VA institutional facilities. This bill forms a happy union between the private nursing center, VA authorized, and the medical knowledge of the Veteran's Administration.

In 1961, there were more than 23,000 nursing homes and like facilities with a bed capacity of about 600,000 in all parts of the Nation. Many of these will measure up to VA standards, others will need refurnishment—but they certainly form a nucleus for commencing the program as proposed in H.R. 8009. In most States, there is a licensing procedure for nursing homes and these would have to be studied, reviewed and placed against VA standards so they will fulfill the requirements of 8009.

The American Nursing Home Association, representing 4,350 nursing homes in 48 States with some 156,000 beds, contends that there are now sufficient nursing homes to take care of the needs as outlined in this proposed legislation. But we earnestly hope that the Veterans' Administration will strictly enforce the care standards of this bill and maintain them. If the presently existing nursing homes do not fulfill the needs on requirements of this legislative program, then new ones will have to be built.

The provision of issuance of prosthetic devices to those in need, by request and by medical prescription, is especially important in our view. The progress made in the modern day rehabilitation care of the seriously disabled has been possible because of research and engineering development. The productive partnership between the prosthetics industry and research has opened a whole new world of ability for the disabled. The case history of the use of prosthetic devices illustrates the progress made in this field. Couples have found the key to marriage and meaningful occupations through the use of new-type patient lifts, disabled doctors and lawyers have been able to resume their practice because of new devices allowing for greater mobility; travel and new business opportunities have been opened due to the same devices. Rehabilitation is no longer happenstance or only a way station between injury and demise. It is now the open door to a new life and even a step in the research efforts for a cure of these disabilities. These devices are as important as the medication, exercises, and occupational therapy we now consider essential.

The prosthetic device provision may allow for the development and eventual issuance of even newer and more advanced equipment. Our organization continually supports spinal cord research which includes investigation of new prosthetic equipment. Some of the research programs we support are in cooperation with the VA and would assist in the effective enforcement of this bill's provisions.

We support this bill and its implementation. We suggest that it is in the best interests of both the Federal Government (the VA) and the veterans, and certainly the community, to have H.R. 8009 as the

law of the land. Our members support its passage and we commend it to this committee for a favorable report to the Senate of the United States.

We also wish—I have an addendum to this, Senator. Our main concern of the paralyzed veterans is that the paraplegic not be included in nursing home care.

Senator METCALF. Thank you very much, Mr. Farkas, for the helpful statement. Do you have any questions, Senator Jordan?

Senator JORDAN. Just one, Mr. Farkas.

Of the 22,000 veterans who are now in medical, surgical, and mental hospital facilities, how many do you expect will be taken care of in proper nursing homes under the provisions of the bill?

Mr. FARKAS. With your permission, Senator, Mr. Green may have the answer to that as he is well acquainted with the procedures and the statistics of the hospitals, the Veterans' Administration, and its care.

Mr. GREEN. Well, actually, Senator, I would say about 25 percent would be capable of being serviced under this bill because in this bill you have got a 6-month limit on your nursing home care, and the majority of the cases which are covered by these 22,000 that are estimated are patients whose care is going to be more than a 6-month period.

Senator JORDAN. Yes.

Mr. GREEN. So you would only be covering approximately 6,000.

Senator JORDAN. Thank you. It is a good statement, Mr. Chairman.

Senator METCALF. Actually you pointed out that at one time nursing homes were the last home for people who, as you say, were expiring. What we are trying to do is to get nursing homes for convalescent patients and presurgical patients, and so forth, induced into hospitals. Isn't that correct?

Mr. GREEN. Well, Senator, you have at the present time a prebed care program under the Veterans' Administration which takes care of those who are ready to be admitted to a hospital, and you have your acute care program. You have got rehabilitation programs. But the big point is that after you get through, you send some of these people out to a nursing home. Now, one of the things which we are recommending in this bill is, our recommendations to this subcommittee are—we hope that they are accepted—that this is not simply a way station, that this is a distinctive program of treatment. There is no program that is worth anything unless it has got a goal, and in this whole thing, the reason that we are recommending the rehabilitation services and everything else be included, is so that this does have a goal of return to community lives, because this should be the goal of any of our programs.

Senator METCALF. Then what you are saying is that there should be several different types of nursing homes.

Mr. GREEN. There should be several programs set up in the nursing homes to take care of those who can be rehabilitated and those who cannot be rehabilitated. There has to be both kinds of a program. There has got to be different types of programs set up to take care of the various needs.

Senator METCALF. I think we are saying the same thing in different ways.

Mr. GREEN. Yes.

Senator METCALF. Then how many types of programs do you think there should be? There should be the rehabilitation that you mentioned. There should be the prebed care program, the convalescent program, and the VA should move into all of these, shouldn't they?

Mr. GREEN. Yes; and also the domiciliary for those who have no place.

Senator METCALF. You have a statement, I think, Mr. Farkas? Do you want to say something?

Mr. FARKAS. I am agreeing with Mr. Green. He has the right answers, Senator Metcalf, that we have visited many of these institutions and with all respect to the gentlemen, and believe me with all sincerity as you know from my being here, we wish to establish nursing homes for the Spanish-American War veterans and we hope that the Senate sees——

Senator METCALF. We are delighted you addressed your remarks to the Spanish War veterans, but the reporter is having difficulty hearing you. Let us put it on the record.

Mr. FARKAS. We will do everything in our effort to support your bill and support whatever you wish and desire, because it is through people and veterans like you that have made it possible for us to appear here regardless of our condition because it is through the freedom that we have today that we can testify in a subcommittee of the Senate.

Senator METCALF. I think it should be mentioned here that under the terms of the bill the administration can extend the 6-month period.

Mr. FARKAS. Yes.

Senator METCALF. And I take it that you agree with that provision.

Mr. FARKAS. Yes, sir; very much so.

Mr. GREEN. Yes.

Senator METCALF. Mr. Farkas, unless there is another question, I want to tell you how grateful the subcommittee is for your appearance. You are certainly expert in what the needs are and you have given us the benefit of a knowledge acquired as a result of great sacrifice. You have been most helpful. Thank you very much.

Mr. FARKAS. Thank you ever so much, Senator, for letting us appear at this subcommittee.

Senator METCALF. This will conclude the hearing for today and this hearing of the Subcommittee on Veterans' Affairs on H.R. 8009 will be recessed subject to the call of the Chair.

(Whereupon, the subcommittee recessed at 10:42 a.m., to reconvene subject to the call of the Chair.)

NURSING HOME CARE AND FACILITIES FOR VETERANS

MONDAY, MARCH 16, 1964

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

The subcommittee met, pursuant to notice, at 9:15 o'clock a.m., in room 4232, New Senate Office Building, Senator Ralph Yarborough, chairman of the subcommittee, presiding.

Present: Senators Yarborough, Metcalf, and Jordan of Idaho.

Committee staff members present: Stewart E. McClure, chief clerk; Charles M. Johnston, counsel to the subcommittee, and John Stringer, associate minority counsel.

SENATOR YARBOROUGH. The Subcommittee on Veterans' Affairs will come to order. The hearings are being resumed at this time on H.R. 8009. This morning, we have with us representatives from the Veterans' Administration.

Come around, please.

Before I ask them to begin, I shall order the report Bureau of the Budget, dated February 20, 1964, and addressed to Hon. Lister Hill, chairman, Committee on Labor and Public Welfare, and signed by Phillip S. Hughes, Assistant Director for Legislative Reference, and also the report from the Veterans' Administration, dated March 9, 1964, and signed by Mr. Gleason, as Administrator, both pertaining to H.R. 8009, to be entered in the record.

(The departmental reports referred to follow:)

MARCH 9, 1964.

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

DEAR MR. CHAIRMAN: This will respond to your request for our report on H.R. 8009, 88th Congress, as passed by the House of Representatives on September 17, 1963.

The general purpose of this legislation is to authorize various forms of assistance by the Veterans' Administration to provide nursing home care and related benefits to seriously ill and disabled veterans. Since the bill is composed of seven sections, we shall discuss them separately under appropriate topical headings.

Section 1. Nursing home beds within the Veterans' Administration establishment

This section would amend section 5001 of title 38, United States Code, specifically to authorize the Administrator, subject to the approval of the President, "to establish and operate not more than two thousand additional beds for the furnishing of nursing home care to eligible veterans in facilities over which the Administrator has direct and exclusive jurisdiction."

We already have the authority under those provisions authorizing domiciliary care for veterans to provide necessary nursing home care as a form of domiciliary care in facilities directly operated by the Veterans' Administration. The statute (38 U.S.C. 5001) places no limit on the number of beds which may be established for this purpose. Pursuant to existing law and to implement this authority, Pres-

ident Kennedy issued a memorandum to me on August 12, 1963, authorizing the activation of beds within the Veterans' Administration system to provide nursing-home-type care for 2,000 veteran patients.

We are now engaged in planning to convert facilities at various locations throughout the country so that these nursing home beds can be set up and placed in operation as soon as feasible. It is my purpose to use this limited number of beds for the transfer of patients from our hospitals who have received maximum hospital benefits, who require further attendant-type care, and who cannot be reasonably provided for by placement at the community level. As requested by the Presidential memorandum, we shall of course continue our program of seeking to place veteran patients who require nursing home care in community facilities whenever this is feasible.

Under the circumstances, the first section of the bill is unnecessary. We feel that the action which will be taken under the Presidential authorization will adequately accomplish the purposes of that section. Since we already have authority under existing law to establish nursing home facilities, and the law specifies no limitation on the number of nursing home beds which may be established, we cannot favor the first section of the bill which is not only an unnecessary authorization but also an undesirable limitation on VA facilities.

Section 2. Nursing home care for VA patients in non-VA facilities

This section will authorize the Administrator to transfer from a Veterans' Administration hospital to a public or a private nursing home any veteran who has received maximum hospitalization benefits and requires a protracted period of nursing home care. This would be done at the cost of the Government, subject to a limit of 6 months' nursing home care on any one transfer, except where the Administrator determines that a longer period is warranted. The cost of such care could not exceed one-third of the cost of care furnished by the Veterans' Administration in a general hospital under its jurisdiction.

We fully appreciate the purpose of this section of the bill. However, the authority contained in section 2 raises some serious questions of discrimination. First, it would be limited to those who have been admitted initially to Veterans' Administration hospitals, and secondly, it would give the veteran no choice concerning where his future care may best be provided.

Here we are considering primarily those with non-service-connected chronic disorders as to whom we have no authority for providing contract institutional care at Government expense. Generally, where their income is low, and their disability severe, they would be entitled to pensions at the increased rate available for those in need of regular aid and attendance. In a maximum World War I, World War II, or Korean conflict case, where there is a wife or child, this would amount to as much as \$170 per month under the new pension program. In the case of a veteran without dependents, this maximum amount would be \$155. The average pension for war veterans under this program who are receiving pension based on need for aid and attendance runs at a level of about \$150 per month.

The increased pension provided for veterans requiring regular aid and attendance is designed to help those needing attendant-type care in meeting this need, whether such care is provided in an institution or at home. This is the sound and most equitable method of according a measure of relief to these individuals.

In view of the fact that there already exists a time-tested program of benefit payments to alleviate the need for attendant-type care of veterans with severe non-service-connected conditions, I do not believe that the authority proposed by section 2 of the bill for providing contract nursing home care would be justified.

Section 3. Payments for nursing home care to State homes

This section would amend section 641 of title 38, United States Code, to authorize the Veterans' Administration to pay, at the maximum rate of \$3.50 per day, for one-half of the cost of a war veteran's maintenance for nursing home care in a recognized State home. This would be restricted to veterans who are furnished such care by the State home for the first time after the effective date of the section, January 1, 1964. At present this law merely authorizes the payment of one-half the cost, not to exceed \$2.50 per day, of each war veteran receiving hospital or domiciliary care in a State home who would be eligible for hospital or domiciliary care in a Veterans' Administration facility. Existing law also provides for offsetting against the Federal payment of one-

half the amount of pension or compensation collected by the State home and the total of other types of collections, if in the latter case wives and widows are not admitted to the home. It also precludes payments if a bar or canteen is maintained at the home for the sale of intoxicating liquors. Section 3 of the bill would eliminate the offset requirements and the ban against operation of such a bar or canteen.

Section 3 offers another, and very appealing, approach to the increasing problem of providing nursing home care for our aging veterans. It recognizes a basic responsibility on the part of the States to assist in meeting this problem by placing the Federal aid on a sharing basis. We favor the purpose of this section and believe it would considerably help the Veterans' Administration in operating its own medical plant to maximum advantage for veterans needing various forms of care. However, we do not believe there is justification for paying the increased rate of \$3.50 per day to State home members receiving nursing home care while continuing at the lower rate of \$2.50 for those receiving hospitalization or domiciliary care. Particularly with respect to hospital care, this would be highly discriminatory.

It is our position that the per diem of \$2.50 represents an adequate measure of Federal responsibility for State home care, whether in the nature of hospital, domiciliary, or nursing home care. Moreover, we would not favor repeal of the offset requirements because this would amount to an indirect increase in payments to some State homes which require payments to the home by veteran members of their pension or compensation but would not benefit those which, as a matter of policy, do not collect these benefits from veteran members. It is our view that the provisions for certain offsets against the Federal payment are sound and should not be changed.

Accordingly, we recommend that section 3 be amended to change the per diem rate of \$3.50 for nursing home patients to \$2.50. If this is done, the proposed section 641(b) on page 4 of the bill, which limits nursing home patients to veterans admitted for such care after the effective date of the amendment should, in our opinion, be omitted. A uniform rate of \$2.50 per day for all types of patients would properly be payable for those who receive care in State homes without distinction between hospital, domiciliary, and nursing home care. We also recommend that there be substituted for the proposed new subsection 641(b) the existing provisions of 38 U.S.C. 641(b) dealing with offsets against the Federal payment. If the offset provisions are thus restored, the exception clause in the proposed subsection 641(c) in lines 12 through 16 on page 4 of the bill should be deleted.

If the suggested amendments are adopted, we would favor the enactment of section 3 of the bill.

Section 4. Grants to States for veterans' nursing home facilities

By this section a program of matching grants would be established to enable the States to construct State home facilities for furnishing nursing home care to war veterans. An aggregate appropriation of \$25 million over a period of 5 years, at the rate of \$5 million per year beginning with fiscal year 1964, would be authorized. Any State would be subject to the limitation that not more than 10 percent of the appropriation for a fiscal year shall be used for such State and the number of nursing home beds for war veterans could not exceed one-half bed per thousand veteran population in the State. General standards of construction, repairs, modernization, alteration, and equipment would be prescribed by the Administrator. The amount of the Federal grant could not exceed 50 percent of the estimated cost of construction of a project.

This grant-in-aid program would correlate with the proposed per diem payments under section 3 for maintenance of veteran nursing home patients in State homes. It would undoubtedly assist those States having resources to share the financial requirements in expanding their State home programs to include nursing home forms of care.

We note, as bearing on the policy aspects of this matter, the recommendations of the President for increasing the basic authorizations for funds to advance the general program under the Hill-Burton Act for aid to the States in constructing nursing home facilities for the general population, including veterans.

We are engaged in special studies concerning the precise extent of our veteran needs for nursing home care and the availability of existing community facilities to meet present and foreseeable needs. When these studies are completed, we will be in a much better position than at present to appraise the situation from

the standpoint of whether additional Federal assistance is indicated to help the States share their responsibility for meeting the needs of our veterans in the nursing home area. These studies will be even more informative as we gain experience in the operation of beds for nursing home patients within the Veterans' Administration system pursuant to the President's recent authorization.

Under the circumstances, we cannot recommend enactment at this time of the special program of matching grants for nursing home facilities for war veterans which is proposed by section 4 of this bill.

Section 5. Discontinuance of aid and attendance allowances during hospitalization

This section would amend 38 U.S.C. 3203(f) to provide that where a veteran is hospitalized by the Veterans' Administration the amount of his pension payments based on need of regular aid and attendance or the additional compensation based on such need under certain provisions of the law shall not be discontinued earlier than the first day of the second calendar month beginning after the date of the veteran's admission to the hospital.

At the present time, these allowances are generally discontinued immediately upon the veteran's entrance into the hospital on the theory that to continue their payment during Veterans' Administration hospitalization would be a duplication because aid and attendance services are being provided directly by the Government.

A partial exception has already been made by law to this general practice in the cases of veterans who are receiving the special additional compensation allowance of \$200 per month under section 314(r) of title 38. This amount is added to the veteran's basic compensation where he is in need of aid and attendance and is receiving the maximum basic rate. A recent amendment specifically provided that this \$200 aid and attendance increment shall not be discontinued during Government hospitalization until the first of the second calendar month beginning after the date of the veteran's admission. However, there are other aid and attendance compensation allowances, in cases where less than the maximum rate is payable, which are still subject to immediate discontinuance when the veteran enters a Veterans' Administration hospital.

We favor section 5 of the bill. It recognizes that many seriously disabled veterans, receiving aid and attendance allowances in addition to their basic compensation and pension payments, may actually refrain from entering a Veterans' Administration hospital for needed short periods of hospitalization because of their knowledge that the aid and attendance allowance will be immediately discontinued, thus creating problems in meeting current financial obligations. It also recognizes that even where the veteran must enter the hospital for a long period of care he may have outstanding obligations which must be met and that some reasonable period should be allowed for financial adjustments. We consider it appropriate to permit the continued payment of these allowances in all cases for the relatively short span of time specified in section 5.

Section 6. Therapeutic and rehabilitative devices for certain veteran pensioners

Section 617 of title 38 now authorizes the Veterans' Administration to furnish an invalid lift, if medically indicated, to any veteran in receipt of pension based on the need of regular aid and attendance. Section 6 of the bill would expand this authority to include the furnishing of any type of therapeutic or rehabilitative device, as well as other medical equipment and supplies (excluding medicines), if medically indicated, to any veteran pensioner who is eligible under section 617 to receive the invalid lift or who would be eligible but for the fact that he has such a lift.

This proposal has been carefully considered, not only with respect to the limited group of veterans involved but also with respect to its effects as a precedent. Our outpatient program, including the furnishing of prosthetic appliances, is generally restricted by law to veterans needing such care for service-connected disabilities.

We regard the policy of restricting outpatient care to service-connected conditions as basically sound and we do not believe that section 6 of the bill would be justified as an exception to that policy. It is true that Congress has seen fit to provide for the furnishing of invalid lifts, where medically indicated, to veterans receiving pension based on the need of regular aid and attendance. Presumably, this was because of the unusual severity of the veteran's condition which makes it highly desirable that he have an invalid lift to assist him as a bedridden patient. But the case for rehabilitative and therapeutic devices, as

well as other medical equipment and supplies is not one restricted to those who qualify for the invalid lift.

Many other veterans who are receiving benefits for aid and attendance might show an equal need for various types of appliances, devices, medical equipment and supplies. This bill could therefore lay the foundation for a broadening of this authority on a general basis to include all those who can demonstrate a need for this form of assistance for non-service-connected disabilities and who are receiving pension based on the need for regular aid and attendance. This, in turn, could progressively lead to even broader extensions of the outpatient program to the point that the policy of confining it to the treatment of service-connected disabilities would, in effect, have been repudiated.

Here again it should be emphasized that the pension program, by providing substantial increases for veterans requiring regular aid and attendance, is intended to accord a substantial measure of relief to those whose severe disabilities produce special problems. In view of the considerations pointed out above and the availability of increased pension payments for those in this category, I am unable to favor enactment of section 6 of the bill.

Section 7. Posthospital outpatient treatment for certain veterans receiving aid and attendance benefits

As background to section 7 it should be noted that, in general, outpatient services for veterans are provided only for service-connected disorders. An exception is authorized by section 612(f) of title 38 which permits medical services for a non-service-connected disability where "a veteran has been granted hospital care, and outpatient care is reasonably necessary to complete treatment incident to such hospital care." This is geared to the situation where the Veterans' Administration has furnished hospitalization to the patient and it would be feasible to discharge him from the hospital and make the bed available for another patient if followup care on an outpatient basis to round out the course of hospitalization were immediately available.

Since this authorization, as added originally by Public Law 86-639, was not intended to afford outpatient treatment on a permanent basis in these cases, the Veterans' Administration has applied administrative measures to contain this program within reasonable limits. Currently, there is an administrative limitation of 1 year on the period of outpatient treatment following an episode of hospitalization.

Section 7 of H.R. 8009 would amend the law to permit the Administrator to furnish certain veterans, with specified non-service-connected chronic conditions who have received posthospital care for not less than 1 year, further care as reasonably necessary for the disease or disorder. The group of veterans comprise those who are so seriously disabled that they receive the higher rates of pension or compensation based on the need of regular aid and attendance. The disease entities are "(a) cardiovascular-renal disease, including hypertension, (b) endocrinopathies, (c) diabetes mellitus, (d) cancer, (e) a neuropsychiatric disorder, or (f) tuberculosis."

Careful analysis of section 7 has led us to the conclusion that it would, for the group involved, go well beyond the purposes of the limited posthospital program of outpatient treatment, which was established as an exception to the sound general policy that outpatient services will be limited to service-connected disorders. The bill selects a specific group of chronic disease entities as a basis for further exception and would permit treatment for a much longer period than that reasonably designed to round out the antecedent hospitalization. There are, no doubt, many other veterans receiving aid and attendance benefits whose disabilities are severe but not within one of the specified categories. To avoid discrimination, it would doubtless be urged that this extensive outpatient authority should be broadened to include all of those receiving aid and attendance payments who need further treatment for non-service-connected conditions. Such a substantial change of the legislative policy restricting outpatient care to service-connected disabilities might in turn set the stage for a large-scale outpatient program for veterans whose ailments are not of service origin and without regard to whether they had been furnished hospitalization by the Veterans' Administration.

We therefore recommend against favorable consideration of section 7. This recommendation is based not only on the factors which have already been discussed, but it also influenced by the fact that the pension program provides a substantial measure of assistance, including increased allowances for those re-

quiring regular aid and attendance, to needy war veterans with severe and continuing disabilities.

Estimated cost of H.R. 8009

We are unable to make a precise composite estimate of the cost of the bill if enacted. There is attached, however, a cost analysis of the several sections which we hope will be informative to the committee.

CONCLUSIONS

Summarizing, and for the reasons fully developed in the foregoing analysis, I recommend against enactment of the first and second sections of H.R. 8009; I favor section 3 if amended as suggested; I am unable to recommend present enactment of that part of section 4 dealing with matching grants for construction of State nursing home facilities; I recommend favorable action on section 5; and I am unable to recommend favorable action on sections 6 and 7 of the bill.

We are advised by the Bureau of the Budget that there is no objection to the submission of this report from the standpoint of the administration's program. The Bureau advised further that enactment of H.R. 8009 would not be in accord with the program of the President except for section 5 relating to discontinuance of aid and attendance allowances during periods of hospitalization and section 3 relating to payments for nursing home care in State homes, if amended as we suggest.

Sincerely,

J. S. GLEASON, Jr., *Administrator.*

COST ANALYSIS OF H.R. 8009

1. Section 1, authorizing "not more than two thousand additional beds for the furnishing of nursing home care" will be adequately implemented by action under the Presidential authorization of August 12, 1963, pursuant to existing law. Accordingly, the enactment of this section would not entail additional cost to the Government over that which will result from existing planning. In the debate on the floor of the House when H.R. 8009 was being considered, it was asserted that the enactment of section 1 would result in an authorization of 2,000 beds in addition to those authorized by the President. As presently drafted and as passed by the House, we do not agree with this conclusion. However, the cost of an additional 2,000 beds, if section 1 were amended to provide for them, would be \$12 million.

2. It is difficult to estimate the number of patients who might be transferred each year from Veterans' Administration hospitals to non-VA nursing homes for care at Government expense if section 2 were enacted. This might be influenced by other provisions of the bill. The average cost of such contract care on a nationwide basis is rather uncertain, but if a unit cost of \$8 per day were used this program could entail an additional cost for the first year of about \$8 million. During the following years the cost would probably increase, to an approximate \$12 million annually by the fourth and fifth years.

3. The cost of section 3, providing for an increase by \$1 of the per diem rate for new nursing home patients in State homes, is quite uncertain since we cannot determine how many new admissions in the State homes would be for nursing home care. If about 20 percent of the average member-load of 9,100 veterans in 33 State homes consisted, after enactment, of new admissions for nursing home cases, the annual additional cost of the \$1 increase for these cases would be about \$664,000. About \$500,000 annually must also be added to the cost because of the proposed repeal of the provisions for offsetting certain amounts collected by the home from members. Thus, the aggregate cost of section 3 could run at about \$1.1 or \$1.2 million annually. Over a period of time it may be assumed that this might materially increase as the volume of admissions of new nursing home patients grows. If our recommendations are adopted for keeping the nursing home rate at the existing level for hospital and domiciliary patients of \$2.50 per day and continuing the existing offset requirements, it is not anticipated that section 3 of the bill would result in any significant increase in Federal expenditures during the first 5 years following its effective date. This is based upon the assumption that there would not be any substantial increase in the average member load during that period due to the specific provision for payments covering veterans admitted for nursing home care.

4. Section 4 contains its own cost factors by authorizing appropriations of \$5 million per year for a 5-year period to defray the program of matching grants for construction of State home nursing care facilities for veterans.

5. Section 5 is difficult to estimate since certain assumptions must be made regarding the frequency of hospitalization of the type patients involved. However, it is anticipated that the first-year cost will approximate \$1.135 million.

6. Section 6, providing for certain appliances and equipment to veteran pensioners eligible for an invalid lift, is not susceptible for precise estimate since we have no way of knowing how many veterans might meet the requirements and what types of devices they might desire. We think the average cost per eligible veteran might be around \$200 the first year and somewhat higher thereafter; and that as many as 2,200 might qualify the first year, with some increase in the number in following years. Accordingly, it is estimated that the cost of section 6 could range from \$440,000 in fiscal year 1965 to \$624,000 in fiscal year 1969.

7. We have not attempted to estimate the cost of section 7 of the bill since we have no way of knowing how many veterans in the group receiving pension or compensation based on need for regular aid and attendance would require continuing outpatient services, following hospitalization, for the specified diseases. This will be particularly uncertain as to the frequency of such need for outpatient attention.

EXECUTIVE OFFICE OF THE PRESIDENT,

BUREAU OF THE BUDGET,

Washington, D.C., February 20, 1964.

HON. LISTER HILL,
*Chairman, Committee on Labor and Public Welfare, U.S. Senate,
New Senate Office Building,
Washington, D.C.*

DEAR MR. CHAIRMAN: This will acknowledge your letter of September 19, 1963, requesting the views of the Bureau of the Budget regarding H.R. 8009, to amend title 38, United States Code, to provide certain veterans with urgently needed nursing home care and nursing care facilities while reducing the cost to the United States of caring for such veterans, and for other purposes.

Sections 1 through 4 of H.R. 8009 authorize the Veterans' Administration to provide or finance nursing home care for veterans by (a) operation of 2,000 such beds in its own facilities, (b) transfer of patients from Veterans' Administration hospitals to public or private nursing homes at Government expense, and (c) assisting the States in the construction and operation of nursing home sections in State soldiers' homes. The purpose of this new authority is to permit the removal from Veterans' Administration hospital beds of those long-term patients who have derived maximum benefits from their hospitalization but whose discharge from the hospital is prevented because of lack of community facilities for their continuing care, inadequate personal financial resources, no family ties, or similar factors.

The Bureau of the Budget cannot recommend enactment of sections 1 through 4 of H.R. 8009 (although there would be no objection to section 3 if amended as suggested below) for a number of reasons. These are set forth in the following paragraphs of this letter.

1. Section 1 is unnecessary because the President has already authorized the Administrator of Veterans' Affairs to activate and operate 2,000 beds for nursing-home-type patients by conversion of existing facilities in Veterans' Administration hospitals. In addition, the 1964 appropriation and the 1965 budget each provide \$150,000 for the Veterans' Administration to explore ways to discharge more effectively patients who have derived maximum benefits from their hospitalization through outplacement in community facilities such as foster homes, nursing homes, and home care programs.

These two actions are consistent with the sound policy which has always governed the provisions by the Federal Government of care for veterans' non-service-connected disabilities—namely, the limiting of such care to that which can be provided within available Veterans' Administration facilities after caring for all service-connected disabilities. In considering the type of care needed by patients in Veterans' Administration hospitals and the possibilities of reducing the cost of such care—the stated objectives of the bill—it is important to bear two facts in mind. First, most of the patients in VA hospitals who do not need

hospital care do not need nursing home care either. Second, those patients who remain in VA hospitals without needing the full range of hospital services are receiving such care as they need so that most of the savings possible through nursing home type operations are, in fact, already reflected in VA hospital costs. Accordingly, neither the number of patients now concerned nor the differential between the cost of hospital and nursing home care justify H.R. 8009.

2. Section 2 of H.R. 8009, which would authorize the financing of nursing home care for non-service-connected disabilities in other than Federal facilities, would needlessly establish an undesirable precedent. Application of such a precedent to the hospital program—which can be supported by similar logic—would lead to payment by the Veterans' Administration for hospital care for non-service-connected disabilities in community hospitals, a step which would also be inconsistent with desirable public policy of looking to broader public programs to meet such need.

3. The nursing home proposals in sections 1 through 4 of the bill could result in an ultimate multibillion-dollar cost over the next 45 years if extended to all eligible veterans. At the present time only about 10 percent of the 22 million veterans are over 65, the age group for which the incidence of nursing home care is highest. However, because of the large number of World War II and Korean veterans, the number of living veterans over 65 will eventually climb over 8 million. By 1995, 6 out of every 10 males over 65 in the United States will be war veterans. It is conservatively estimated that by the year 2005, when the number of veterans reaching advanced ages begins to decline, from 80,000 to 120,000 nursing home beds would be required for veterans even at present utilization rates. The cost of this care would then be from \$300 million to \$500 million a year at today's prices and over the next 45 years would entail cumulative expenditures for nursing home care of from \$6 to \$10 billion. Even these estimates could be greatly exceeded, because with Government assumption of responsibility for financing veterans nursing home care, utilization rates and resulting costs would surely rise.

It is recognized that the legislation contains two limitations designed to hold down the cost to the Government of nursing care in non-Federal homes, but we do not believe either would be effective over the years. One is the limit of 6 months of Federal financial responsibility for any one episode of nursing home care and the other is the restriction of care to patients transferred from Veterans' Administration hospitals. The bill includes an exception to the first limitation, whereby the Administrator of Veterans' Affairs could extend the 6-month period of care where in his judgment a longer period is warranted, an exception which would lead, we believe, to large scale-demands for such extensions which would be difficult to refuse. The restriction of care to those transferring from a Veterans' Administration hospital could well result in the hospitals becoming the doorway through which any non-service-connected veteran in need of nursing home care would become a Federal responsibility.

4. Enactment of section 2 of H.R. 8009 would be tantamount to a substantial liberalization of a segment of the non-service-connected pension program. This would be the result of permitting cash payments for nursing home care in non-VA facilities—at rates far in excess of present pension rates—including amounts for aid and attendance. Furthermore, since enactment of this legislation would make the VA hospital a doorway to free nursing home care for some non-service-connected veterans, it would result in pressure for easier admission to VA hospitals for others or for their direct admission to nursing homes. Thus the bill would create immediately an inequity in the treatment accorded different groups of veterans which it would be tempting to try to remedy in the future by creating further and greater inequities between our treatment of all veterans receiving non-service-connected benefits and other citizens with equal or greater needs. The cost of such preferential treatment could total billions of dollars. In contrast, the President's proposal for self-financing hospital and nursing home insurance would cover all elderly people on an equal basis.

5. We have the same basic objection to the proposed financial assistance to the States for construction of State nursing homes for veterans (sec. 4 of the bill), namely, that it would involve the Federal Government in yet another program of benefits to non-service-connected veterans. We question the need for setting up new programs for special groups in the population especially when the Federal Government is already paying part of the cost of construction of nursing homes through the Hill-Burton program for which the President has

recommended increased authorization under new legislation and is also assisting in financing the cost of such care for older citizens in need of assistance through the general old-age assistance and Kerr-Mills programs.

6. In addition, it is doubtful that Federal aid for construction of State veteran nursing homes would be very effective in many States since under the bill the Federal construction assistance would be limited to a maximum of 1 bed per 2,000 of a State's war veteran population. This limitation would operate to provide some States with very few beds. For example, Vermont which has a veteran population of approximately 40,000 would be entitled to only 20 beds. In these instances unless the State chose to add a small unit to an existing facility, operation of so few nursing home beds would hardly be feasible. This factor assumes added significance in view of the fact that there are 22 States which are not now engaged in the operation of State soldiers' homes and which would not have facilities readily available to which nursing home beds could be added.

7. The solution of veterans' non-service-connected health problems can be through general programs which benefit veterans and nonveterans alike rather than through special programs which add to administrative budget expenditures and favor the veteran at the expense of the remainder of the general public. Federal expenditures from budget and trust funds for benefits and services for our aged will total an estimated \$19 billion in 1965. Additional improvements to take effect in future years have also been proposed, notably through hospital, nursing, and home care insurance.

In our judgment the administration's proposed program of hospital insurance for the aged provides a much more desirable approach than H.R. 8009 to the problem of nursing home care for veterans with non-service-connected disabilities. Under this proposal any insured individual would be entitled to 180 days of nursing home care following a period of hospitalization. It is estimated that 90 to 95 percent of all veterans will ultimately be covered by social security and thus be eligible for care under the administration's proposed program. In addition, as has already been noted, veterans in need are now eligible in an increasing number of States for assistance in obtaining nursing home care under the old-age assistance and Kerr-Mills programs and the new proposal would cover all presently aged persons who are not insured under OASDI.

We agree with the Veterans' Administration point in its report to you on H.R. 8009 that the present Federal payment of \$2.50 per diem for hospital and domiciliary care in State homes represents an adequate measure of Federal responsibility for this care. We would, however, have no objection to paying State homes this same per diem for nursing home care, as suggested by the Veterans' Administration. We also join the Veterans' Administration in recommending against repeal of the present requirement that one-half the amount of pension or compensation collected by the State homes be credited as an offset against the Federal payment.

The remaining sections of H.R. 8009 deal with matters other than providing or paying for nursing home care for veterans. Under section 5 any veteran who is receiving an aid and attendance allowance would not have his allowance reduced before the first day of the second calendar month which begins after admission for hospitalization. The effect of this provision would be to place aid and attendance pension allowances on the same footing as additional compensation for aid and attendance insofar as withholding during a period of hospitalization is concerned. The Bureau of the Budget would have no objection to this provision of the bill.

Section 6 authorizes the Administrator of Veterans' Affairs to furnish any type of therapeutic or rehabilitative device, medical equipment and supplies (excluding medicines), if medically indicated, to any veteran now eligible to receive an invalid lift because he receives a pension based on the need for aid and attendance. The Bureau of the Budget opposes enactment of this provision because of the precedent it would set. It would extend certain outpatient medical benefits to pensioners whose disabilities bear no relationship to their war service. It would, therefore, lay the foundation for demands for an undesirable and costly extension of the outpatient program to treatment of non-service-connected disabilities in general.

Section 7 would also set a precedent for extension of outpatient medical care to include non-service-connected disabilities by authorizing such care for six specific conditions, and the Bureau of the Budget strongly recommends against its enactment. Existing law is soundly based on the policy that outpatient services should be provided only for service-connected disabilities. An excep-

tion enacted a few years ago permits outpatient followup for completion of hospital treatment for non-service-connected disabilities as a means of expediting the discharge of such patients from Veterans' Administration hospitals. Administrative controls limit this followup care to a 1-year period. The proposal in section 7 would authorize unlimited outpatient care for six specific disease categories for those non-service-connected patients who are receiving, or eligible for, pensions based on need for aid and attendance.

If enacted, sections 6 and 7, taken together, would constitute a most serious breach of the very desirable policy of restricting Federal responsibility for outpatient care to disabilities incurred in war service. This is most clearly illustrated by the inclusion of cardiovascular and neuropsychiatric disorders among the conditions for which the 1-year limitation on outpatient treatment would be lifted. Most veterans beyond middle age and a great number of younger veterans will sooner or later incur one of these disabilities. There would, without question, be unrelenting pressure to remove the proposed restriction that the veteran must be eligible for a pension based on the need for aid and attendance. Once this were done, the cost of outpatient care for the six diseases covered by section 7 could, as the veteran population ages, amount to several hundred million dollars a year.

In summary, the Bureau of the Budget believes that H.R. 8009 would establish a number of undesirable precedents relating to provision of nursing home care, nursing home facilities, and special benefits for veterans with non-service-connected ailments. The Bureau does not believe enactment of the bill will reduce the cost of care now provided by the Federal Government, since the savings possible through using less intensive care facilities for veterans with longstanding chronic conditions are already largely being achieved. On the contrary, the bill would not only make the Federal Government responsible for providing nursing home care for non-service-connected veterans through VA facilities, community facilities or State homes, but would also constitute a major step toward making outpatient care available for disabilities totally unrelated to wartime service. Furthermore, if the 2,000 nursing home beds to be operated by VA are intended to be in addition to those authorized by the President, the bill's initial cost would be at least \$30 million a year, of which \$12 million would be for the 2,000 beds, and it would add more than 1,600 employees to the Federal payroll. Finally, policies and precedents would be created by this bill which, within a few years, could easily cost the Federal Government at least half a billion dollars annually and over the next 45 years could result in Federal expenditures conservatively estimated at more than \$10 billion, of which at least \$6 billion would be for nursing home care.

The Bureau of the Budget believes that the problems at which the bill is aimed can be solved in a far better way by enactment of the President's proposals for hospital insurance for the aged and increased support for construction of nursing homes under Hill-Burton programs. These actions, coupled with (a) the action taken by the President to authorize VA to operate 2,000 nursing home beds and (b) the study funded in the 1964 and 1965 budgets aimed at accelerating outplacement of VA hospital patients to community facilities under existing legal authority, constitute a constructive approach to these problems which avoids the many disadvantages of H.R. 8009.

The Bureau of the Budget, therefore, strongly recommends against enactment of H.R. 8009, enactment of which would not be in accord with the program of the President.

Sincerely,

PHILLIP S. HUGHES,

Assistant Director for Legislative Reference.

Senator YARBOROUGH. This morning, I believe we have Mr. Fable, General Counsel of the Veterans' Administration; Mr. Bland, Assistant General Counsel, and would you gentlemen introduce the other witnesses accompanying you?

STATEMENTS OF ROBERT C. FABLE, JR., GENERAL COUNSEL, AND RAY P. BLAND, ASSISTANT GENERAL COUNSEL, VETERANS' ADMINISTRATION; ACCOMPANIED BY DR. LINUS A. ZINK, ASSISTANT CHIEF MEDICAL DIRECTOR FOR PLANS AND COORDINATION; DR. A. J. KLIPPEN, DEPUTY FOR PLANS AND COORDINATION; DANIEL I. ROSEN, DIRECTOR, REPORTS AND STATISTICS; AND J. C. PECKARSKY, DEPUTY DIRECTOR FOR POLICY, COMPENSATION, PENSION, AND EDUCATION SERVICE

Mr. FABLE. Mr. Chairman, I am accompanied with Mr. Bland, by Dr. Linus A. Zink, Assistant Chief Medical Director for Plans and Coordination; by Dr. A. J. Klippen, Deputy for Plans and Coordination; Mr. Daniel I. Rosen, Director, Reports and Statistics. In addition, we have Mr. J. C. Peckarsky, Deputy Director for Policy, Compensation, Pension, and Education Service.

Mr. Peckarsky is in the rear of the room.

Mr. Chairman and members of the subcommittee, I am indeed appreciative of this opportunity to present the views of the Veterans' Administration concerning the comprehensive and far-reaching legislative proposal which is now before the subcommittee for consideration. You have the formal report of the Administrator on this measure and I shall refer to it from time to time in these remarks.

At the outset, I want the subcommittee to know that the Administrator's report and our comments here today are based on an intensive and continuing study of the basic problem with which the bill deals and that we are fully aware of the importance and magnitude of the problem.

We share with your subcommittee a very special concern in the health and welfare of war veterans. This mutual concern necessarily includes the increasingly serious problem represented by the growing numbers of our aging veterans who will require a special kind of care which is not generally available under our present program of hospital, domiciliary, and outpatient care.

However, our studies to date have served to strengthen our conviction that we are dealing here with a problem which peculiarly affects all of our aging and chronically ill citizens. As an overall national problem it, of course, will not be solved completely by the provision of relief for a special segment, however deserving that segment may be, of the general population. It is a problem which affects not only the veteran but also his wife and his widow.

In the President's message to the Congress of the United States relative to the health of the Nation, he recommended on February 10, 1964, a hospital insurance program for the aged to protect against the heaviest costs of a serious illness—the costs of hospital and skilled nursing home care, home health services, and outpatient hospital diagnostic services.

He proposed that these benefits should be available to everyone who reaches the age of 65 and for those who are not now covered by social security, the cost of the protection would be provided from the administrative budget. We are confident that the Congress in its wisdom will act to implement these constructive recommendations.

We in the Veterans' Administration have a special responsibility for our war veterans and we have long been aware of the deep and abiding interest which this subcommittee has in making sure at all times that our Nation's sense of obligation and gratitude to the veterans of our wars shall be fully and tangibly expressed. This has been shown in many ways, not merely by public expressions but more especially by the kind of legislation frequently reported by the subcommittee.

I just want you to know, Mr. Chairman, that for these reasons I am most grateful for the privilege of appearing and discussing this important legislation with you.

In that spirit, then, and for the convenience of your consideration of the several proposals embodied in the bill, let me proceed to a discussion of the measure on a section-by-section basis.

Section 1. Nursing home beds within the VA establishment: Section 1 would specifically authorize the Administrator, subject to the approval of the President—

to establish and operate not more than two thousand additional beds for the furnishing of nursing home care to eligible veterans in facilities over which the Administrator has direct and exclusive jurisdiction.

The Administrator points out in his report that we believe this section to be unnecessary. This is so because the section is an authorization and section 5001 of title 38 already gives an authorization which has no numerical limitation. Section 5001 provides—

The Administrator, subject to the approval of the President, shall provide hospitals, domiciliaries, and outpatient dispensary facilities for veterans entitled under this title to hospital or domiciliary care or medical services.

It is clear that nursing home care beds may be regarded as domiciliary care and that the existing statutory authorization for domiciliaries is fully and completely adequate to provide for an unlimited number of nursing home care beds.

Mr. Chairman, at this juncture I would invite your attention to the fact that when the bill now under consideration was being considered on the floor of the House, assertions were made that the enactment of section 1 would result in an authorization of 2,000 beds in addition to those authorized by the President. In that connection you will recall that the Administrator received authorization from President Kennedy on August 12, 1963—

to activate and operate facilities and beds for 2,000 nursing-home-type patients. Existing buildings best suited for this purpose and appropriately located throughout the country were to be utilized and it was specifically stated that this authorization would permit an evaluation of the—

full range of care from domiciliaries through acute medical care, restoration centers, and nursing home care where outplacement is not possible.

This authorization was received by the Administrator subsequent to the action of the Special Subcommittee on Intermediate Care reporting H.R. 8009 on August 8, 1963, to the full Committee on Veterans' Affairs. When the full Committee on Veterans' Affairs reported

H.R. 8009, it did so with an amendment which reduced the number of nursing home care beds from 4,000 to the 2,000 presently in the bill.

Manifestly, the 2,000 nursing home care beds authorized by the President have not yet been either established or placed in operation. It is anticipated that the President will submit a request to the Congress for a supplemental appropriation designed to secure funds to permit the conversions within existing facilities so as to permit at a point of time in the future the commencing of operation of nursing home care beds.

With this background it is our conclusion that the bill as presently drafted and as passed by the House would not authorize 4,000 nursing home care beds but instead would limit the present broad statutory authority in such a way as to restrict the authority of the executive branch to the operation of not more than 2,000 beds for the furnishing of nursing home care.

Senator YARBOROUGH. In other words, the interpretation of the Veterans' Administration is that if this legislation passed, it would limit the authority of the President and the Veterans' Administration to provide nursing home care beds to 2,000; that there is presently existing authority for the President to authorize an unlimited number of such beds in the VA system?

Mr. FABLE. That is correct.

Senator YARBOROUGH. Your point is this would be a restriction on the present unlimited authority?

Mr. FABLE. That is right, sir.

In the light of the matters I have discussed, the Administrator feels that the action which will be taken under the Presidential authorization will adequately accomplish the purposes of section 1 and believes that this section is not only unnecessary but would be an undesirable limitation.

Section 2 Nursing home care or VA patients in non-VA facilities: Section 2 would authorize the Administrator to transfer from a VA hospital to a public or private nursing home any veteran who has received maximum hospitalization benefits from VA and requires a protracted period of nursing home care.

The additional nursing home care would be paid for by VA but could not exceed one-third of the cost of care furnished by VA in a general hospital. This contract nursing home care would be limited to 6 months in connection with any one transfer, except where the Administrator determines that a longer period is warranted.

In the main, section 2 would deal with those veterans whose chronic disorders are non-service-connected and who cannot now be provided contract institutional care at Government expense. Such veterans, who have severe disabilities and whose income is low, are generally entitled to pensions at the increased rate available for those in need of regular aid and attendance. Under the new pension program, this can amount to as much as \$170 per month for the World War I, World War II, or Korean conflict veteran who has dependents.

The maximum for such a veteran without dependents is \$155 per month. The average pension under this program where there is need for aid and attendance, has been about \$150 per month.

Apart from the discriminatory feature of limiting this nursing care

benefit to veterans who have been admitted initially to VA hospitals, the proposed authority for providing contract nursing home care would not seem to be justified in view of the sound and equitable method of alleviating the need for attendant-type care now provided by our program of increased pension payments designed to help veterans with severe non-service-connected conditions to secure such care, whether in an institution or at home.

Section 3. Payments for nursing home care to State homes: Section 3 would authorize the Veterans' Administration to pay each State, at a rate of \$3.50 per day, for each war veteran who is furnished nursing home care in a State home for the first time after January 1, 1964, not to exceed, however, one-half the cost of the veteran's maintenance in such home.

Existing law authorizes payment of \$2.50 per day, but not to exceed one-half the total cost of his maintenance, for each war veteran receiving hospital or domiciliary care in a State home who would be eligible for such care in a VA facility.

This section would eliminate a provision in existing law for reducing the Federal payment by one-half the amount of pension or compensation payments collected from the veterans by the State home, and by the total of other types of collections if wives or widows of war veterans are not admitted and maintained in such home.

The program of partial Federal payments to State soldiers' homes rests on the sound premise that there is a basic responsibility on the part of the States to assist in the care of our aging veterans. We agree with this proposal to extend Federal aid on a sharing basis with State homes to provide nursing care for war veterans.

There is no apparent reason, however, for increasing the rate of the Federal payment to \$3.50 for such care while retaining the \$2.50 rate for hospital or domiciliary care. We feel that a uniform rate of \$2.50 for hospital, domiciliary, or nursing care provided in State homes would represent an adequate and equitable Federal contribution.

As noted in the Administrator's formal report on the bill, we have suggested certain amendments to section 3 which would retain the \$2.50 per diem rate and would continue the sound provisions for offsetting the Federal payments by part or all of the amounts collected from the veteran by some States. Of course, our favorable position with regard to enactment of this section is on the assumption that our suggested amendments will be adopted.

Section 4. Grants to States for veterans' nursing home facilities: Section 4 would authorize Federal grants to assist States to construct nursing home facilities for war veterans. Appropriations of \$5 million each year for the period of the next 5 fiscal years, a total of \$25 million, would be authorized. Not more than 10 percent of an appropriation for a fiscal year could be used to assist any one State; and the number of nursing home beds for war veterans could not exceed 50 percent of the estimated construction cost for a State facility.

This grant-in-aid program would correlate with the proposed per diem payments under section 3 for maintenance of veteran nursing home patients in State homes. It would undoubtedly assist those States having resources to share the financial requirements in expanding their State home programs to include nursing home forms of care.

In his report the Administrator noted, as bearing on the policy as-

pects of this matter, the recommendations of the President for increasing the basic authorizations for funds to advance the general program under the Hill-Burton Act of aid to the States in constructing nursing home facilities for the general population, including veterans.

We are engaged in special studies concerning the precise extent of our veterans needs for nursing home care and the availability of existing community facilities to meet present and foreseeable needs. When these studies are completed, we will be in a much better position than at present to appraise the situation from the standpoint of whether additional Federal assistance is indicated to help the States share their responsibility for meeting the needs of our veterans in the nursing home area.

These studies will be even more informative as we gain experience in the operation of beds for nursing home patients within the Veterans' Administration system pursuant to the President's recent authorization.

Under the circumstances, the Administrator has concluded that he cannot recommend enactment at this time of the special program of matching grants for nursing home facilities for war veterans which is proposed by section 4 of this bill.

Section 5. Discontinuance of aid and attendance allowances during hospitalization: Section 5 would provide that where a veteran is hospitalized by the Veterans' Administration, his pension payments based on need for regular aid and attendance or the additional compensation paid on the basis of such need in certain service-connected cases, shall not be discontinued earlier than the first day of the second calendar month beginning after the date of the veterans admission to the hospital.

Under existing law these allowances generally are discontinued immediately upon the veteran's admission to the hospital on the theory that continued payment would be unwarranted since the necessary aid and attendance services are provided directly by the Government during VA hospitalization.

The limited liberalization proposed by the bill has much to commend it. It should minimize the possibility that many seriously disabled veterans receiving the additional aid and attendance allowances will not apply for needed short periods of hospitalization because of financial problems which would result from the discontinuance of such allowances immediately upon hospitalization. It also would provide a more reasonable period for financial adjustments of outstanding obligations by the veteran who must enter the hospital for a long period of care.

There is precedent for the proposed extension. A recent amendment provided that the special \$200 additional allowance paid to the veteran who needs aid and attendance and who is receiving the maximum basic rate of disability compensation, shall not be discontinued during Government hospitalization until the first day of the second calendar month beginning after the date of the veterans admission.

We agree that it would appropriate, and more equitable, to permit continued payment of these allowances in all cases for the relatively short period specified. Accordingly, we favor enactment of section 5.

Section 6. Therapeutic and rehabilitative devices for certain veteran pensioners: Section 617 of title 38 now authorizes the Veterans'

Administration to furnish an invalid lift, if medically indicated, to any veteran in receipt of pension based on the need of regular aid and attendance. Section 6 of the bill would expand this existing authority to furnish an invalid lift so as to permit the furnishing of any type of therapeutic or rehabilitative device, as well as other medical equipment and supplies (excluding medicines), to a veteran who is eligible for such an invalid lift or who would be eligible but for the fact that he has such a lift.

While there are certain exceptions, some of which I will discuss later, our outpatient program, including the furnishing of prosthetic appliances, is generally restricted by law to veterans needing such care for service-connected disabilities.

In his report the Administrator has reaffirmed his view that the policy of restricting outpatient care to service-connected conditions is basically sound and has concluded that section 6 of the bill would not be justified as an exception to that policy. He recognizes that Congress has already seen fit to provide for the furnishing of invalid lifts, where medically indicated, to veterans receiving pension for non-service-connected disabilities based on the need of regular aid and attendance. Apparently, this was because of the unusual severity of the veteran's condition which makes it highly desirable that he have an invalid lift to assist him as a bedridden patient.

It is recognized, also, that these seriously disabled veterans frequently need rehabilitative and therapeutic devices as well as other medical equipment and supplies of the character which would be furnished pursuant to section 6.

However, this need for various types of appliances and equipment is not restricted to those who qualify for the invalid lift. Many other veterans receiving pension for aid and attendance might show an equal need for various types of appliances, devices, equipment, and supplies. As pointed out in the Administrator's report, the bill could therefore lay the foundation for broadening this authority beyond those entitled to the invalid lift to include many others who can demonstrate a need for this form of assistance for non-service-connected disabilities and who are receiving pension based on the need for regular aid and attendance.

This could in turn lead progressively to broader extension of the outpatient program so that the policy of confining it to service-connected disabilities would no longer be effective. We are most sympathetic with the severely disabled and handicapped veterans who would be benefited under this section of the bill but feel that it presents a very real question of basic policy.

Here again, the Administrator has emphasized that the pension program, by providing substantial increases for veterans requiring regular aid and attendance, is intended to accord a substantial measure of relief to those whose severe disabilities produce special problems. This is also an important factor in the Administrator's conclusion that he is unable to favor section 6 of this bill.

Section 7. Posthospital outpatient treatment for certain veterans receiving aid and attendance benefits: Section 7 proposes another exception to the general policy that outpatient services will be limited to service-connected disorders. In 1960, the Congress authorized outpatient medical services for a non-service-connected disability where

the veteran has been granted hospital care, and outpatient care is reasonably necessary to complete treatment incident to such hospital care. This program and the program of prebed care, which was authorized at the same time by Public Law 86-639, was designed to permit a more effective utilization of VA hospital beds through a more rapid rate of patient turnover and was not intended to authorize additional outpatient benefits on a continuing basis for veterans with non-service-connected disabilities.

Consistent with this intent, the Veterans' Administration has applied administrative measures to contain the completion of bed occupancy care program within reasonable limits, including the current limitation of 1 year on the period of outpatient treatment following an episode of hospitalization.

Section 7 of H.R. 8009 would amend the law to permit the Administrator to furnish certain veterans, with specified non-service-connected chronic conditions who have received post hospital care for not less than 1 year, further care as reasonably necessary for the disease or disorder. The group of veterans comprises those who are so seriously disabled that they receive the higher rates of pension or compensation based on the need of regular aid and attendance.

The disease entities are "(A) cardiovascular-renal disease, including hypertension, (B) endocrinopathies, (C) diabetes mellitus, (D) cancer, (E) a neuropsychiatric disorder, or (F) tuberculosis."

As the Administrator states in his report, careful analysis of section 7 has led us to the conclusion that it would, for the group involved, go well beyond the purposes of the limited posthospital program of outpatient treatment, which was established as an exception to the sound general policy that outpatient services will be limited to service-connected disorders.

The bill selects a specific group of chronic disease entities as a basis for further exception and would permit treatment for a much longer period than that reasonably designed to round out the antecedent hospitalization.

There are, no doubt, many other veterans receiving aid and attendance benefits whose disabilities are severe but not within one of the specified categories. To avoid discrimination, it would doubtless be urged that this extensive outpatient authority should be broadened to include all of those receiving aid and attendance payments who need further treatment for non-service-connected conditions. Such a substantial change of the legislative policy restricting outpatient care to service-connected disabilities might in turn set the stage for a large scale outpatient program for veterans whose ailments are not of service origin and without regard to whether they had been furnished hospitalization by the Veterans' Administration.

For the foregoing reasons and because the pension program provides a substantial measure of assistance, including increased allowances for those requiring regular aid and attendance, to needy war veterans with severely disabling conditions of a continuing nature, the Administrator has recommended against enactment of section 7.

Conclusion: By way of summary, Mr. Chairman, the position of the Veterans' Administration on this bill, as set forth by the Administrator in his report, is unfavorable as to the first and second sections of the bill; favorable to section 3 concerning payments to State homes

for nursing home care, if amended as suggested; unfavorable as to the provisions of section 4 concerning matching grants for construction of State nursing home facilities; favorable to section 5 providing a reasonable delay in discontinuing aid and attendance allowances for VA-hospitalized veterans; and unfavorable on sections 6 and 7 of the bill.

There is attached to the Administrator's formal report a section-by-section analysis of the cost effects of the bill.

Senator YARBOROUGH. Are there questions?

Senator METCALF?

Senator METCALF. Thank you, Mr. Chairman. I am not going to belabor this with too many questions.

As I understand your first position that you set forth in the first part of your statement, you say that because there is pending the King-Anderson bill, or the bill for general aid, the so-called medicare bill, you feel that this legislation should not be enacted?

Mr. FABLE. We have a number of specific reasons for our opposition to the various sections of this bill we are unable to favor. But we do point out, sir, that the bill itself—

Senator METCALF. I know.

Mr. FABLE. Yes, sir; we are pointing that out, sir, by way of general reference, that we feel that any bill in the veteran area that takes up the subject of nursing home care benefits should consider at the same time that this problem is not limited to the veteran, but also gets to his wife and his widow. It affects the entire aging population.

Senator METCALF. Well, at one time, I served on the Ways and Means Committee in the House of Representatives. I was a cosponsor of the Forand bill. I voted for that bill, I was one of the eight members of that committee who voted for it. I also voted for the Kerr-Mills bill, rather reluctantly, because it did only part of the job. But it did a part of the job, and I feel that if we cannot get a whole package of legislation, we should perhaps take some part of it to take care of some of the needy people who are in need of hospital and nursing home care.

Mr. FABLE. Senator, that is certainly a most reasonable position, and I do not think anyone would quarrel with it.

Senator METCALF. Well, I only have one other question. It seems to me in your last conclusion, where you refuse to support section 7—I am asking for information now.

Mr. FABLE. Yes, sir.

Senator METCALF. You say that support of this section 7 would set a precedent as to non-service-connected chronic conditions in this specially itemized list of diseases. Did you not earlier in your statement say that there is nursing home care that is to take care of non-service-connected people who have certified that they are in need?

Mr. FABLE. There is no program of nursing home care, as such, carried on by the Veterans' Administration at this time. We have received an authorization to put into operation 2,000 nursing home-type beds. But as we point out here, we have not yet submitted a request for appropriation, so that is off in the future.

Senator METCALF. Well, suppose we said that cardiovascular disease and so forth—you have itemized them on page 12 of your statement—suppose we said these various diseases would be taken care of on an

outpatient basis for non-service-connected chronic conditions, if there were a basis of need. Would you qualify your disagreement then?

Mr. FABLE. Well, Senator, if I may, section 7 is designed to provide outpatient care for these specific diseases for a period of time which is not limited.

Senator METCALF. Again, I am just asking for information. I am not clear enough on what the application would be.

Mr. FABLE. Well, certain of our problems, Senator, in this area are, first of all, we feel that it would be not intellectually justifiable to limit the benefit to these disease entities, because there are other veterans who also have non-service-connected conditions whose physical condition is just as severe, just as serious, and just as appealing.

For example, I do not believe—

Senator METCALF. Now we get back to the same philosophical discussion that we had at the very beginning; if we cannot take care of everybody, then we do not care to take care of anybody.

Mr. FABLE. At that point, sir, with respect to this particular question, we then move to the next point, that these cases are cases which are receiving benefits based on non-service-connected disabilities. And we come to the fundamental policy question of how is the Government best going to meet its responsibilities to the war veterans who have severe, non-service-connected disabilities?

It is the Administrator's position, sir, that the pension program, which is paid to everyone who qualifies for a benefit, is a more realistic and a more equitable way of providing the assistance, as opposed to moving into a new field in the outpatient program and making that available to those who are fortunate enough to reside in proximity to VA hospitals, regional offices, or facilities. If we keep this within the pension program, we are sure that everybody who is entitled to the benefit will get it, regardless of where he lives geographically. But if we purported to give outpatient help in VA facilities, we limit that to those who are in physical proximity to those facilities.

Senator METCALF. I think I understand now the position of the Veterans' Administration, without agreeing or disagreeing.

Mr. FABLE. Thank you, sir.

Senator METCALF. Thank you.

Thank you, Mr. Chairman.

Senator YARBOROUGH. Are there any further questions?

Senator METCALF. No, sir.

Senator YARBOROUGH. The thing that disturbs me, Mr. Fable, is that every time we have a major program here to help veterans readjust, or care for their problems caused by their service or resulting from it, the Veterans' Administration comes in and answers by saying, "Well, that would just be for veterans; we ought to do this for everybody." That is the fight the VA made on the cold war GI bill, that we ought to have scholarships for everybody. The result of that fight is that, since 1955, 9 years have gone by and scholarships have resulted for nobody, Federal scholarships on the undergraduate level, and we are missing out on educating our people.

Now, on this program here, it is pointed out that if this is done, it would be for veterans only and we ought to have hospital care for all the aged. I fear that if you take that attitude, there will be hospital care for none.

Senator Metcalf pointed out his fight going back to the Forand bill, to try to get medical care for the aged. Do you not think that if we had a medical care program for veterans, the good example of that would cause this care to be spread to the nonveteran segment of the population, instead of waiting for legislation, which I favor, Senator Metcalf favors, for hospitalization for the aged, for education for all of our youth? Do you not think that if this bill were passed, it would be easier to pass a bill for veterans rather than for all the population? First, because it costs less, and second, because the country knows it owes a special duty to those veterans?

Would it not be a good thing if the Veterans' Administration would help in getting these broader concepts that the administration says it is for—education for everybody and hospitalization for the aged?

Mr. FABLE. Senator, I have my limitations. I am a lawyer, not a historian. But as I look back over the past years, I cannot see that the fine medical and hospital program which the Congress has provided for veterans, and which is presently in existence, has resulted in a movement from that out to a broader base of the general population. So, therefore, if I am to judge the future by the past, I would have to assume that to give special benefits to veterans would not have the effect of going down the path of making those same benefits available for the general population. I am afraid, sir, that there are two separate and distinct problems.

Now, I am very conscious of the point you make, Mr. Chairman, that if it cannot be done for all, that is no argument for not doing it for some. That is certainly a statement of truth which cannot be quarreled with. The basic question, however, is to determine whether or not the same, the group that is going to be benefited, is carved out realistically.

I would like to say particularly, sir, that section 1 of this bill, which has gotten the greatest attention, is a section which should be looked at most closely, because we feel that it does just the reverse from what it has been stated it will do.

As an outstanding lawyer, sir, you are conscious of the fact that to attempt to interpret law when you do not have law to interpret is extremely hazardous. All we can do is look at the language in the bill and try to think in terms of the legislative intent that has been projected up to that point in time and speculate as to what the future holds. But in view of the committee report put out by the House Veterans' Affairs Committee, and the language in the section itself, which uses the phrase, and I want to make sure I have it precisely, "not more than 2,000 additional hospital beds for the furnishing of nursing home care" we feel, sir, that that will produce an unfortunate restriction on the present generous authorization which the Congress has seen fit to give in this area of hospital and domiciliary care and, of course, domiciliary care does include nursing-home-type care.

Senator YARBOROUGH. Well, I sit on the Special Committee for the Aging, and we are working on those problems there, we think diligently, for the general population. And, of course, there we have agencies in HEW speaking for the nonveteran segment of the population, and indeed for all. Things based on care for the aging alone would include veterans as well as nonveterans. True, this bill would apply only to veterans. As you point out, there would be special care for veterans under that.

The whole genesis of the laws pertaining to veterans was that these veterans served in times of great stress, they were put under great stress, they underwent ordeals that the general population did not undergo, and the result is they are going to need more treatment.

The night before last, Saturday night, I was in Dumas, Tex., a city of about 9,000 population in the 1960 census. The commanding officer of the VFW post came to see me—this was not a veterans meeting; this pertained to agricultural problems, a meeting of the agricultural interests there. He said he had about 30 or 40 members of the VFW post at Dumas and had had for several years. But, within the past few years, that membership had grown to 212. He said the reason that it grew is that veterans of World War II are reaching the age where some of them around here are coming apart at the seams. He said no one, doctors even, knew when a veteran who had had some injury, maybe under the stress of combat—he was not so old now, but maybe it was World War II—when something went wrong, he just—they used the expression—“came apart at the seams.” They had just used up so much of the body’s resources back there in those years of stress, and as they got older and injury or disease overtook them, they did not have the reserve forces in the body to pull them through—to keep them in working shape.

They had others who had injuries who came out to their post—this was just human experience—came out fully recovered, had jobs and were doing well, and, all of a sudden, just broke down, some mentally, some physically, but thinking that they had been doing well. Not old men; these were the veterans of World War II. Some of them thought they were in the prime of life—middle age.

So some of them had undergone experiences that have disadvantaged them and set them as a class apart, not because of any needs a particular veteran has, but because of the service he has rendered to protect the whole economy, the whole freedom, the whole people. So there is a difference in basic philosophy of the treatment of veterans and nonveterans.

I share with you this concern for the education of all youth. We are losing half of the youth in the land. Half of the youth in the land that makes the best grades in high school, that are of the top 30 percent in grades, half of those will never see the inside of college because of the cost of going to college.

I sit on the Education Subcommittee. Last week, there were very disturbing figures indicating that college tuition has gone up so fast that half of all the cost of college tuition in America, 50 percent, is being borne by the students. The other 50 percent is borne by States in some instances, some local government aid, some Federal Government aid.

I agree with you that there is need for help in this direction for all, but that is no reason for taking the veteran out of life, who lost the years of opportunity to get schooling earlier, years of building up seniority in his jobs, years of youth that he might have been building up bodily resources, instead of losing inherent bodily resources of the mind and spirit, flesh and blood, and going through great stress and strain to preserve us all.

I think the difference between the two categories of population should be borne in mind in considering the major legislation, whether

it be hospitalization legislation or whether it be a GI bill for educational legislation for youth. I think it is necessary for the VA to protect the needs of the veterans more especially. Of course, as all Americans, we are concerned with the whole population, but the VA is specially charged with seeing that the veteran is not neglected.

Do you not think that the VA has its highest obligation to the veterans?

Mr. FABLE. Mr. Chairman, I could not agree with you more. I would like to emphasize, sir, some of the points that came to my mind while you were speaking, and there is nothing you have said with which I do not agree wholeheartedly. The points I would like to stress are these:

First of all, although I feel that we have a special obligation to war veterans, no war veteran, because he is a war veteran, should be denied any of the other privileges of citizenship. I think we would all agree with that.

Secondly, it occurs to me that at the present time, there are over 1 million war veterans on the pension rolls and over 40,000 who are veterans receiving the additional pensions for aid and assistance. Now, it occurs to me that the needs of all of those 40,000 and all of those million must be considered and that a solution does not lie in 1,000 or 2,000 or 3,000 beds, physically located in such a way as to be unavailable to the large mass with which we are dealing and to whom we have a real responsibility and obligation.

That, sir, is why the Administrator's position is that he feels that the pension program is the area in which this problem should be attacked, because the pension program will assure that the benefit reaches each and every one who is eligible, and not make the granting or denial of the benefit contingent on a facet of geography.

Senator YARBOROUGH. And I presume that anyone that it reaches through the pension method, the Veterans' Administration, bearing in mind a very real human equation none of us has stated here, that that pension has a reasonable enough amount in it that if the man has relatives who are physically able to do it, if he has a pension check to help out with the groceries and the medicine and so on, very often, there would be some relative who would keep him there at less expense to him and to the Government than if he had to go into a hospital or live alone.

Mr. FABLE. That is certainly a factor in many cases, sir.

Senator YARBOROUGH. Particularly in families of limited means.

Mr. FABLE. Yes, sir.

Senator YARBOROUGH. Where their average per capita income is very low. They would reach a state where families would put out a great deal of effort to care for such a person if they had a check there to help out with groceries, medicines, and other things they need.

Mr. FABLE. That is a fact of human nature, sir, which I think we have all seen illustrated.

Senator YARBOROUGH. Particularly in rural areas; particularly areas distantly removed from hospitals.

Now, with reference to section 1 of the bill, you have the statement that this is unnecessary and would lead to an undesirable limitation. That is beginning with the second paragraph. Now, the memorandum from President Kennedy that you referred to, of August 8, 1963, au-

thorizing 2,000 nursing home type care beds within the VA system—I believe you did state that passage of this bill would cut down or would limit the number of beds that would be available to veterans.

Now, considering the House action in cutting, in the original bill, the number of beds from 4,000 to 2,000, and added to the 2,000 authorized by the President, do you think that that indicates the intent that there should be a minimum of 4,000 nursing care beds in the VA system? Was not that the purpose of some of the people in the House in passing that, that instead of this being an overall limitation, there be a minimum of 4,000 nursing care beds in the VA system?

Mr. FABLE. That is correct, sir.

Senator YARBOROUGH. It was their intention?

Mr. FABLE. Yes, sir. In the debate on the floor, it was clearly brought out that the 2,000 beds referred to in section 1 would be on top of the hospital program as added to by President Kennedy's 2,000 beds. But although we have the greatest respect for the legal ability of those who gave that interpretation, we feel that we would be remiss if we did not bring to the attention of this subcommittee the fact that the legal interpretation of the bill itself, if it were to become law as presently drafted, would have to be made in the light of the circumstances that then exist, because legislation speaks prospectively unless there is a clear indication that it is to be interpreted in some other way. Since section 1 talks about 2,000 additional nursing home beds, it would be in addition to what? It is our thought, sir, that since there appears to be little likelihood that at the time this bill would be subject to interpretation as a law, the 2,000 nursing home beds authorized by the President would be in existence, we would have to regard, in our view, the word "additional" as referring to additional to what in fact existed; namely, the hospital program with no nursing home beds.

Senator YARBOROUGH. Well, the word "additional" carries with it the connotation that there are nursing home beds; you are adding something. It would be utterly meaningless unless it was added to something else.

Mr. FABLE. Mr. Chairman, originally, when this section was drafted, it was 4,000 additional nursing home beds. At that time, I think it was clear that the "additional" referred to the beds that were already in existence in the VA.

Now, our conclusion, sir, is further buttressed by the explanation which the House Veterans' Affairs Committee itself gave the bill in their committee report.

If I may, I would like to read that into the record at this time. I am reading now from page 2 of the House Report 680, dated August 14, 1963, to accompany H.R. 8009:

Section 1 of the bill as reported provides that the Administrator may, subject to the approval of the President, establish and operate not more than 2,000 additional nursing home care beds for veterans eligible for such care in facilities over which the Administrator has direct and exclusive jurisdiction. An administrative ceiling of 125,000 hospital beds was established during the Eisenhower administration, as indicated on pages 30 to 37 of this report.

While the cited authority is discretionary let there be no doubt or misunderstanding as to the intent, purpose, and desire of the committee. The 2,000 additional nursing home care beds are to be provided in the immediate future and to be fully operated at the earliest practicable date.

The net increase provided by this bill shall be not less than 2,000 and whether or not the new hospital ceiling is 127,000 or the nursing care beds are included

in the domiciliary allotment (which is not governed by any ceiling other than the availability of funds), is of no concern to the subcommittee, so long as intermediate or nursing home care beds are provided in the additional amount indicated.

This would seem to indicate very clearly that the full subcommittee in its report contemplated that the 2,000 in section 1 was the only 2,000 that was going to be thrown into the situation, because you will notice that they said, "Whether or not the new hospital ceiling is 127,000."

The base up to that point has been 125,000.

Now, Mr. Chairman, when the bill was being debated on the floor of the House, it was suggested there:

Should this legislation be approved and ultimately become law, we'll have 2,000 beds authorized by Presidential memorandum, plus 2,000 beds authorized by statute, for a total of 4,000 nursing home care beds as contemplated by the Special Subcommittee on Intermediate Care.

May I suggest, sir, that section 1 is an authorization? Since I have a daughter who is in high school and who has been taking algebra and geometry, as I have thought about this problem, and how best to express it, some of the school problems which I have discussed with her have come to mind. We have a statutory authorization today which is unlimited. It is an infinite authorization. Any numerical authorization which is put in section 1, whether it is 2,000 or 4,000 or, as was suggested, 5,000, will be numerical limitation in addition to the infinite authorization and that makes me think of an algebraic formula: infinity plus x equals infinity.

The legislative committees of the Congress have already been as generous as it is possible for them to be in making authorizations. We have an unlimited authorization. The only question is one of dollars and appropriation, of getting the money and the authority to spend it.

Senator YARBOROUGH. All right, now, in this equation you have, infinity is the Presidential power?

Mr. FABLE. No, sir; infinity is the authority given the Administrator and the President by the Congress in section 5001 of title 38.

Senator YARBOROUGH. Now the x you have added is this 2,000 or 4,000 beds equals infinity?

Mr. FABLE. Yes, sir.

Senator YARBOROUGH. In other words, you are not limited. In the equation you have given, this 2,000 or 4,000 does not limit the authority you started with. The President could still, by Executive order, make it 6,000, 8,000, 10,000 or 12,000; is that right?

Mr. FABLE. Not quite, sir. We could be unlimited with respect to hospital beds or domiciliary beds, but in this little segment of nursing care beds, we would be restricted by the express—

Senator YARBOROUGH. That is what we are talking about, nursing care beds. I thought your equation was clarifying this thing, that you have this little segment that Congress says put up 4,000, but infinity is still out there.

Senator METCALF. If the chairman will yield, in the peculiar mathematics of the Veterans' Administration, infinity plus x equals x .

Mr. FABLE. I hope that will not be so, sir.

There are two problems that we have with section 1. One is we feel is unnecessary. That was the point I was trying to make with my formula. The second is we feel it would be an unfortunate limitation on the Executive authority which presently exists.

Senator YARBOROUGH. Can you tell us what progress has been made by the VA in the operation of nursing care beds under the President's memorandum of August 8, 1963?

Mr. FABLE. Dr. Zink, would you care to answer that question, please?

Dr. ZINK. Mr. Chairman, we have been engaged in a study of where and how best to develop these beds as authorized by the President last August. At the present time, we are receiving from the field and evaluating the projects submitted from the hospitals, which will provide this space, and is rapidly as these can be reviewed, verified, and totaled up, we shall be submitting to the Bureau of the Budget for a supplemental to do the necessary work to provide for the additional facilities. And as Mr. Fable said earlier, the President will probably ask for a supplemental appropriation to get on with the alterations, renovations, and so forth, that would be required. But it takes quite a while to develop these various projects to modernize or refurbish existing space. And as you know, we were not authorized to build any additional space.

Senator YARBOROUGH. Did you say that there are some of them available now? I did not quite get that.

Dr. ZINK. No, I did not, sir, but some of them could be made available much quicker than others. In some of the places, there will be much less alteration required, and those, of course, could come in faster.

Senator YARBOROUGH. In other words, none of that 2,000 has yet been made available?

Dr. ZINK. That is correct, sir.

Senator METCALF. When do you anticipate you will get some of them prepared?

Dr. ZINK. We have not any firm date yet, because we have not the money to go ahead with our work.

Senator METCALF. Are you asking for a supplemental appropriation?

Dr. ZINK. We have not yet, and as the Administrator explained to the Subcommittee on Appropriations of the House, when we have our plans completed and come in for the supplemental, he will be able to answer those questions.

Senator YARBOROUGH. In the last paragraph—excuse me.

Senator METCALF. Go ahead. I am sorry I interrupted.

Senator YARBOROUGH. I wish you would, Senator, any time, because I was about to change slightly to another subject. I wish you would ask questions at any time in order to clarify things.

I was starting to ask a question about your statement, where you say that the discriminatory feature of the bill, the limit of nursing care benefits to persons who have been admitted initially to VA hospitals—my question is, Do you think it would be fair to open this up so that the veteran could be admitted directly to a nursing care home without having received the maximum medical hospital benefits in a VA hospital first? Say taken directly off the street if he needs this type of domiciliary or nursing home care and did not need the medical treatment first?

Mr. FABLE. Mr. Chairman, an amendment of that sort would overcome the obvious discrimination which the section now has, but it

would be our feeling, sir, that relief of this sort should be within the framework of the pension program, as opposed to embarking on a new program in this area.

Senator YARBOROUGH. Mr. Fable, does VA have data there about the average nursing home care cost in the United States per month?

Mr. FABLE. Mr. Rosen, who is the Director of the Reports and Statistics Service of the Department of Medicine and Surgery, has that information, sir.

Mr. ROSEN. The cost of this kind of care, sir, varies, as you are aware, widely all around the country. There are low costs in the different parts of the country, \$100 a month, but going as high as \$500 a month in other areas.

Senator YARBOROUGH. Is there a so-called national average of about \$225?

Mr. ROSEN. In that area, yes, sir, but a national average can be misleading for planning purposes.

Senator YARBOROUGH. Mr. Fable, what are the prerequisites under the existing law and the Veterans' Administration regulation to obtaining aid and attendance benefits? Would you summarize the regulation for us in that?

Mr. FABLE. Yes, indeed, sir. In this particular area, Mr. Chairman, those veterans who are either in need of nursing home type care or who are receiving for such care—their entitlement would be covered by VA Regulation 1352. If I may, I would like to summarize and read the transmittal sheet which indicates in nontechnical language the current rule—

Senator YARBOROUGH. If you would, and then we shall put the whole thing into the record.

Mr. FABLE. Thank you, sir. [Reads:]

This revision is dated May 19, 1961.

(The document referred to follows:)

VETERANS' ADMINISTRATION,
Washington, D.C., May 19, 1961.

VA REGULATIONS—COMPENSATION AND PENSION (TRANSMITTAL SHEET 213)

Remove pages 123 and 124.

Insert pages 123-R and 124-R.

Paragraph revised: 1352 title (A).

Paragraphs added: None.

Paragraphs canceled: None.

EXPLANATION

The purpose of the following comment on the changes included in this amendment of VA Regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Paragraph 1352 (A) is revised to emphasize entitlement of a claimant who because of a physical or mental condition requires someone to protect him from hazards of daily living. It is expected that this will result in some liberalization in the granting of the regular aid and attendance allowance where evidence shows the need for a custodian. The interpretation in VA Information Bulletin IB 8-74, paragraph 5, is superseded. It is not necessary that the claimant reach a state of vegetative existence. Thus nursing home care or its equivalent will generally qualify.

By direction of the Administrator:

W. J. DRIVER, *Deputy Administrator.*

Distribution in accordance with VA Form 3-3040.

(P. 123-R)

1352 (§ 3.352). Determination of [permanent] need for regular aid and attendance and "permanently bedridden"

(A) *Basic criteria.*—The following will be accorded consideration in determining the need for regular aid and attendance: inability of claimant to dress or undress himself, or to keep himself ordinarily clean and presentable; frequent need of adjustment of any special prosthetic or orthopedic appliances which by reason of the particular disability cannot be done without aid (this will not include the adjustment of appliances which normal persons would be unable to adjust without aid, such as supports, belts, lacing at the back, etc.); inability of claimant to feed himself through loss of coordination of upper extremities or through extreme weakness; inability to attend to the wants of nature; or incapacity, physical or mental, [which requires care or assistance on a regular basis to protect the claimant from hazards or dangers incident to his daily environment.] "Total blindness" as well as "bedridden," will be a proper basis for the determination. For the purpose of this paragraph "bedridden" will be that condition which, through its essential character, actually requires that the claimant remain in bed. The fact that claimant has voluntarily taken to bed or that a physician has prescribed rest in bed for the greater or lesser part of the day to promote convalescence or cure will not suffice. It is not required that all of the disabling conditions enumerated above be found to exist before a favorable rating may be made. The particular personal functions which the veteran is unable to perform should be considered in connection with his condition as a whole. It is only necessary that the evidence establish that the veteran is so helpless as to need regular aid and attendance, not that there be a constant need. Determinations that the veteran is so helpless, solely by reason of service-connected compensable disease or injuries (38 U.S.C. 310 and 331) or without regard to service connection (38 U.S.C. 511 and 512) as to be in need of regular aid and attendance will not be based solely upon an opinion that the claimant's condition is such as would require him to be in bed. They must be based on the actual requirement of personal assistance from others. If the claimant is able to be out of bed and can walk around entirely unassisted by others, he cannot generally be regarded as meeting the requirements of the law and VA regulations; however, the other enumerated types of personal assistance must be considered (May 19, 1961).

(B) *Hospitalization at veteran's expense.*—Where a beneficiary is hospitalized at his own expense in a private institution, the same criteria will be necessary in determining the need for regular aid and attendance as would be required were he at his home, and the hospitalization will not be considered as a fact indicating the existence of the need (Feb. 24, 1961).

(C) *Attendance by relative.*—The performance of the necessary nursing or attendant's service by a relative of the beneficiary or other member of his household will not prevent the granting of the additional allowance (Feb. 24, 1961).

(p. 124-R)

1353 (§ 3.353). Determinations of incompetency and competency

(A) *Definition of mental incompetency.*—A mentally incompetent person is one who because of injury or disease lacks the mental capacity to contract or to manage his own affairs, including disbursement of funds (Feb. 24, 1961).

(B) *Authority.*—Rating agencies are authorized to make official determinations of competency and incompetency for the purpose of existing laws, VA regulations and VA instructions. Such determinations will be controlling for purposes of insurance (38 U.S.C. 722), the discontinuance and payment of amounts withheld because of an estate in excess of \$1,500 (VA Regulation 1556(B)), and direct payment of current benefits, unless the claimant is under legal disability. Where the veteran is rated incompetent the Chief Attorney of jurisdiction will be informed of the necessity for the appointment or recognition of a fiduciary. The Chief Attorney will develop information as to the veteran's social, economic and industrial adjustment. If the Chief Attorney upon review of this evidence concurs in the rating of incompetency he will proceed to effect the appointment of a fiduciary, or if the veteran is married, to recommend release of payments to the veteran's wife as provided in VA Regulation 5057 (38 U.S.C. 3202(f)). If the Chief Attorney is of the opinion that the veteran is capable of administering the funds payable, the evidence on which that opinion is based

will be referred to the rating agency with a statement as to his conclusions. The rating agency will consider this evidence together with all other evidence of record in determining whether its prior decision should be revised or continued. Reexamination may be requested as provided in VA Regulation 1327(D) if necessary to properly evaluate the extent of disability (Feb. 24, 1961).

(C) *Medical opinion.*—Rating agencies will make no determinations of incompetency without a definite expression regarding the question by the responsible medical authorities. The expression of medical opinion will be in accordance with the principles in VA Regulation 1353(A). Determinations relative to incompetency should be based upon all evidence of record and there should be a consistent relationship between the percentage of disability, facts relating to commitment or hospitalization and the holding of incompetency (Feb. 24, 1961).

(D) *Presumption in favor of competency.*—Where there is doubt as to whether the veteran is capable of administering his funds such doubt will be resolved in favor of competency (Feb. 24, 1961).

1354 (§ 3.354). *Determinations of insanity*

(A) *Definition of insanity.*—An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basic condition, exhibits, due to disease, a more

Senator YARBOROUGH. Now, I believe in this statement, you said that the maximum amount under the new pension program for aid and attendance will be \$170 per month? Is that on page 5—this can amount to as much as \$170 per month?

Mr. FABLE. That is correct, sir. That is in a case where there would be dependents. Public Law 86-211 provides that if a veteran is in need of regular aid and attendance, the monthly rate payable to him shall be increased by \$70. So that \$70 is on top of what he would receive by virtue of being on the pension rolls based on need including family status. The maximum amount which is paid to such veterans without dependents is \$155. The average pension under this program, where there is need for aid and attendance, has been about \$150.

Senator YARBOROUGH. That includes the \$70?

Mr. FABLE. That is correct, sir.

Senator YARBOROUGH. Is not that total there, which goes up to a maximum of \$170, considerably less than the average actual cost of nursing home care in the United States?

Mr. FABLE. That is correct, sir.

However, I should point out that pension is payable to veterans who have other income. For example, taking a veteran who is unmarried—and I am now referring to the new pension system—if he has income from other sources up to \$600, he would get \$85, and then, if he were eligible, the additional \$70 for regular aid and attendance.

If his outside income were between \$600 and \$1,200, he would receive basic pension of \$70, and then another \$70 as aid and attendance. Veterans whose income is between \$1,200 and \$1,800 receive \$40 in pension, and if eligible, the \$70 for regular aid and attendance.

Senator YARBOROUGH. What if his outside income is over \$1,800?

Mr. FABLE. Then there would be no pension payable, sir.

Senator YARBOROUGH. That would be it?

Mr. FABLE. That is correct, sir.

Senator YARBOROUGH. If his income were \$1,900 a year?

Mr. FABLE. That is correct.

Senator YARBOROUGH. Then he had better get it back to \$1,700 in a hurry, had he not?

Mr. FABLE. Incidentally, Mr. Chairman, the figures I was giving to you have to do with the veteran who has no dependents. There are

similar scales for veterans with dependents. There pension is payable up to a maximum of \$3,000 of outside income.

Senator YARBOROUGH. I do not mean that he should morally cut it back, but I am talking about the realities of life to families of that income, who have a marginal existence at best.

Mr. FABLE. I am firmly convinced that a veteran is just as much entitled to take advantage of the technicalities of law as a taxpayer is, and if a taxpayer is going to arrange his manner of living to suit the income tax structure, I see no moral injunction against the veteran doing the same thing.

Senator YARBOROUGH. That is a sound policy, because if the taxpayer has the money to get aid from an income tax accountant or anybody to help him with the income tax returns, they are out of their minds if they do not take all the deductions they are entitled to. That is the basic American policy. I do not mean cheating, I am talking about lawful deductions.

Mr. FABLE. Equal justice under the law.

Senator YARBOROUGH. Do you have any statistics on the number of veterans who need nursing home care but cannot qualify for aid and attendance?

Mr. FABLE. Mr. Chairman, I think that the answer to that would be no, but my impression would be that in view of the instruction put out in May 19, 1961, which was designed and provides specifically that nursing home care or its equivalent will generally qualify, it would be minimal.

Senator YARBOROUGH. Now, let us turn to section 3 for a minute. These State nursing homes—quite a number of States have them. They are mainly leftovers or came into existence for caring for veterans of the Civil War. Is not that where most State veterans homes began, after the Civil War?

Mr. BLAND. This federalized program started in 1888, Mr. Chairman, and I would suppose that would be true. They were an aftermath of the Civil War.

Senator YARBOROUGH. Yes, that was really the first of the generally State veterans homes.

Now, section 3 would increase rates from \$2.50 per day to \$3.50 per day for furnishing nursing care for war veterans. What is the difference in cost between domiciliary care and nursing care? Do you have any figures for nursing care as to nursing, or domiciliary care, such as the Civil War veterans homes?

I recall one in my State, a man did not have to be ill, he just went there for domiciliary care if he had no place to live or no one to care for him.

Dr. ZINK. We do not, of course, in the VA yet have any figures, because we have not the nursing care beds in operation. But we certainly estimate there will be a higher cost in operating nursing beds than domiciliary care.

However, the point is made here that we are paying also \$2.50 for hospitalized veterans in State homes, and the cost of that is generally in excess of nursing home care. We paid \$2.50 per diem for both hospital and domiciliary—

Senator YARBOROUGH. You have the same rate whether it is paid for in the State veterans' home as a nursing patient or just a domiciliary patient?

Dr. ZINK. Right, so we are suggesting that this new form of payment for nursing home also be at the standard rate for both hospital and domiciliary care at the nursing home.

Senator YARBOROUGH. Do you not think the fact that many of the States are willing to construct and staff nursing homes and are willing to keep those homes, but need some help on a matching basis from the Federal Government, is significant? Do you not think that this willingness to accept part of the burden would be a benefit to the taxpayer and to the Federal Government, and the fact that they are willing to bear a part of the cost should be encouraged in that respect? It is generally the older States and generally the richer States that have those homes.

Dr. ZINK. As Mr. Fable said before, we certainly also feel that the veteran should not be denied the benefits of any citizen which he has in the State. And, of course, this is the basis on which we are currently defraying \$2.50 or not more than half of the cost.

Senator YARBOROUGH. I believe in section 6 that you stated that providing these rehabilitative devices under conditions outlined in this bill, H.R. 8009, would create a bad precedent. Has not Congress already authorized some of these devices to non-service-connected cases, such as the seeing eye dogs for the blinded veterans, and invalid lifts to certain others? Has not that precedent been set, if you are setting precedents?

Mr. FABLE. There certainly is a precedent, Mr. Chairman, with respect to the invalid lift, because that is available to a war veteran who needs it. With respect to the aids to the blind, that is provided by section 614 of title 38, and if I may, I shall read that:

The Administrator may provide seeing eye or guide dogs trained for the aid of the blind to veterans who are entitled to disability compensation—

which would be service connected, sir—

and he may pay all necessary traveling expenses to and from their homes and incurred in becoming adjusted to such seeing eye or guide dogs. The Administrator may also provide such veterans—

again entitled to compensation—

with mechanical or electronic equipment for aiding them in overcoming the handicap of blindness.

Now, it is my understanding that this has been regarded as basic authority for making provision to veterans who are on the compensation rolls, even though perhaps some of the mechanical or electronic equipment which has been given him has been given him for a disability which is not service connected.

In any event, sir, it is clear that there must be compensation or a service-connected disability as a condition for the basic eligibility under this section.

Senator YARBOROUGH. Is that true of the invalid lift, also?

Mr. FABLE. No, sir; it is not. The invalid lift is made available to those who are medically in need of it. It would be a precedent.

Senator YARBOROUGH. Is not the test really whether the nature of the disability or illness is such and the veteran lacks the income to furnish it himself as to justify that action?

Mr. FABLE. It is a matter of degree, Mr. Chairman, and the question comes, once you start to go outside the pension program and start to give services either in kind or in materials, as this would do, how far do you go and where do you stop, and perhaps is it not sounder to do

it all within the area of the pension program? That is the fundamental policy question that is involved.

Senator YARBOROUGH. The fundamental policy of the VA is to try to do it through the pension program?

Mr. FABLE. That is correct.

Senator YARBOROUGH. You mention the 127,000-bed limitation under President Eisenhower. Is that still the top limitation of the VA, still under the Executive order?

Mr. FABLE. I happen to have with me, Mr. Chairman, a copy of the budget of the United States. I notice on page 401, and I would like to read from this if I may; it says:

Approximately 22.1 million living war veterans, including some 3 million with service-connected disabilities, comprise the largest single group of eligibles, although for ailments not related to service, hospital care is provided only to the extent that VA hospital facilities are available. Under the basic policy of limiting its hospital system to 125,000 beds, the Veterans' Administration meets approximately half of the hospital care requirements of veterans with non-service-connected ailments.

That is the President's budget which came up just recently.

Senator YARBOROUGH. Well, are those 125,000 beds kept relatively full all the time?

Mr. FABLE. Of course, you run into the situation where the average daily patient load last January in VA hospitals was 112,000. That compared with January a year ago, when it was roughly 112,000. There was a waiting list at that time, in January of this year, of 18,500, and the waiting list a year ago was 20,727.

Senator YARBOROUGH. The waiting list means those who already have certificates for admission; they have been found to be entitled to use the hospital facilities?

Mr. FABLE. That is right, and not scheduled for admission.

Senator YARBOROUGH. How many of those 125,000 beds are occupied by veterans who have received the maximum hospitalization available?

Dr. ZINK. About 3,700 were estimated by our hospitals in late 1962 as patients with long-term allergies and disabilities who could be discharged to nursing homes.

Senator YARBOROUGH. They have received the maximum benefits, but you just do not throw them out on the sidewalk because there is no place for them to go and nobody to care for them?

Dr. ZINK. Right; no feasible arrangements have been made.

Senator YARBOROUGH. So if you had this 2,000 provided by this bill and 2,000 more beds, as provided in the President's memorandum, you would have 4,000 in the hospital that ought to be moved out—you have 3,700 there who have received the maximum hospital benefits, and ought to be moved into these nursing beds?

Dr. ZINK. Yes; approximately 3,700 who need to be placed in nursing homes.

Senator YARBOROUGH. If you were hardhearted enough to carry out that exact letter of the law you would throw them out on the sidewalk, but you are humane enough not to do that, and I commend you for that. But to make these hospital beds available for treatment, it would take almost the 4,000 now to move that 3,700 out, would it not?

Dr. ZINK. That is right.

Senator YARBOROUGH. If you did, those on the waiting list would be cared for at a faster rate.

How much waiting time is there after the veteran gets on the eligible list before he can get into the hospital? That varies by areas?

Dr. ZINK. It varies by areas, and also categories of condition. Of course, in some areas, in the psychiatric—and a majority of this is in the psychiatric area, of course—it moves rather slowly.

Senator YARBOROUGH. They have to wait months sometimes?

Dr. ZINK. Sometimes.

Senator YARBOROUGH. And the psychiatric conditions, unless they get treatment, deteriorates materially?

Dr. ZINK. A great majority of those on the list are already hospitalized in some other hospital, sir.

Senator YARBOROUGH. Do you have information there as to the nature of the afflictions of the 3,700 who have received the maximum hospital benefit? If you do not have it readily available, I am going to ask you to look it up and put it in the record.

Dr. ZINK. We can get it for the record, sir.

(The material referred to follows:)

Diagnostic composition of the group of 3,700 patients who could be discharged to nursing homes

Diagnostic conditions which accounted for stay in hospital:	Percent of patients
All patients.....	100.00
Tuberculosis.....	1.49
Psychoses.....	30.65
Psychoneuroses.....	25.04
Neurological.....	22.59
Cancers and tumors.....	4.08
Heart and circulatory.....	5.64
Respiratory.....	3.13
Orthopedic conditions and the sequelae of accidents.....	2.83
All other.....	4.54

Senator YARBOROUGH. Do you have any statistics as to the number of veterans now in private nursing homes in the country?

Dr. ZINK. No, sir; we do not.

Senator YARBOROUGH. Out of the total number of veterans of all the wars now living, how many are over the ages of 65 years at this time?

If you do not have this readily available, I shall ask you to supply it.

Dr. ZINK. We certainly will.

(The material referred to follows:)

Age distribution of estimated number of living veterans

Age	Thousands of veterans as of June 30—		
	1963	1970	1980
Under 35.....	4,235	279	-----
35 to 44.....	9,533	6,512	313
45 to 54.....	4,803	8,987	6,491
55 to 64.....	1,286	2,963	8,014
65 or older.....	2,309	1,960	3,023
Total.....	22,166	20,701	17,841
Average age.....	44.2	49.8	58.0

Senator YARBOROUGH. Do you think if we implement this nursing home program, the information received from, I assume those in charge, would diligently study it statistically for the problems coming for every aging person, for a population whose age limits are going upward all the time. Do you think that would be a very valuable force in our studies over on the Subcommittee of Aging, on this whole problem of an aging population?

Do you think it would be a very valuable benefit for the whole Nation?

Dr. ZINK. I would suspect so, sir.

Senator YARBOROUGH. When you add these figures about the number of veterans 65 years or over, I wish you would give us also the statistics of how many there will be in 1970, assuming a death rate on your present curve, and how many of those living now will be 65 years of age by 1970 and how many by 1980, assuming a death rate on present actuarial statistics—not the insurance company actuarial statistics but the VA actuarial statistics, what you are actually finding out about this.

You stated earlier, Mr. Fable, that you thought this needed further study. It seems to me that there is a need, and I am going to ask, how long has the VA been studying this problem? Has it been under study some time or not? Has it just come up with this proposed legislation last year?

Dr. ZINK. We have proposed a study which was to have begun during this current fiscal year, sir, but because of the lateness in the appropriation and working under the restrictions, up until that time, we were unable to get started.

We are currently developing a study which we hope will be completed in the next year, which will really give us some information. This is one of the studies referred to by Mr. Fable before. We are now getting underway on that. We had hoped to have more of it done, but we were unable to.

Senator YARBOROUGH. Senator Metcalf, do you have any questions?

Senator METCALF. No.

Senator YARBOROUGH. Does counsel for the minority have any questions?

Mr. STRINGER. No.

Senator YARBOROUGH. Does counsel for the majority have any questions?

Mr. JOHNSTON. No, sir.

Senator YARBOROUGH. We have some other witnesses who want to testify, all of them representing some veterans' organizations. All of them, I think I have been advised by counsel, do not have any statements ready at this time, so we shall have to have further hearings on the bill. I assume that the representatives of the veterans organizations have been conferring over the years with the Veterans' Administration about this. Before this subcommittee has an executive session—of course, it will take some time to print this testimony up, and before we have an executive session and under the program ahead of us, it is harder to get days when we can have these hearings, it seems to me that it might be beneficial some day for VA to sit down with the representatives of those organizations that have been studying on this the longest.

We could have a roundtable session in here and discuss that, particularly on section 1, where you say you are putting a limitation on

governmental power to care for these veterans instead of creating something new. Some of these, where there is such a wide divergence of opinion, perhaps we ought to have a discussion session up here sometime, just an off-the-record session. It would not be an executive committee meeting and would not be testimony.

We could see if we might, by thrashing that out, reach some conclusions or get some information that might be of more aid to this subcommittee on this legislation, because with the Bureau of the Budget and the Veterans' Administration opposing it as strenuously as they do, as shown by these statements, and organizations representing the veterans being very strongly for it, there has not been a meeting of the minds—quite the contrary. There is very, very strong disagreement on that.

We might, in our roundtable discussion, obtain some results. I do not mean in the form of what is written in the bill. We might have beneficial sessions on this. I say that as a former judge, who, sometimes, when the lawyers could not, were bogging down in a lawsuit, called them in chambers and had them sit down across the table, when they were not talking to each other much, and discuss the lawsuit.

Sometimes progress could be made in the case. That might be possible here, I do not know. You gentlemen have been working on this a long time, as has the Veterans' Administration. You can think of it. There is nothing mandatory about it. I will be talking to the other members of the subcommittee as to whether they can set the time and whether it will be beneficial. Get all the evidence, have the other hearings, wind it up, and have this executive session.

There are different points of view to the bill, and I think it would be illuminating to the members of the subcommittee just to have a roundtable conference about it with the members of the Veterans' Administration and these other people, off the record, so that we can hear them argue back and forth with each other to see whether we might come up with some sounder conclusions of our own, as well as those of the conflicting positions here.

If you gentlemen have any other papers you wish to present, you are at liberty to file them, and so are other persons who have already testified on the bill.

If they want to file supplemental statements after seeing the position of the Bureau of the Budget and the Veterans' Administration, you are at liberty to do so.

I want to ask counsel, Mr. Johnston, if you know when these parties will be ready to file their final testimony? They could not be ready before next week?

Mr. JOHNSTON. It would be the latter part of next week.

Senator YARBOROUGH. We are running into Easter. If you run into the latter part of next week, you have Good Friday and the Easter recess. It would have to be not later than next Wednesday or Thursday morning, or possibly after that.

Gentlemen, we shall recess the subcommittee subject to call. We do not know what date the parties can get together. I shall be available Tuesday, Wednesday, or Thursday morning of next week, for another session if the parties will have their testimony ready at that time.

This subcommittee stands recessed subject to call.

(Whereupon, at 10:40 a.m., the subcommittee was recessed, subject to call of the Chair.)

NURSING HOME CARE AND FACILITIES FOR VETERANS

MONDAY, MARCH 30, 1964

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

The subcommittee met, pursuant to notice, at 10 a.m., in room 4232, New Senate Office Building, Senator Lee Metcalf presiding.

Present: Senator Metcalf.

Committee staff members present: Stewart E. McClure, chief clerk; Charles M. Johnston, counsel to the subcommittee, and John D. Stringer, associate minority counsel.

Senator METCALF. The Subcommittee on Veterans' Affairs will come to order.

This morning, we resume hearings on H.R. 8009, the nursing care for veterans bill. This will be the last public hearing. All witnesses who have indicated a desire to be heard will have been heard at the conclusion of this hearing.

Our time is a little tight this morning, so we shall get right on with the testimony.

Senator WILLIAMS of New Jersey has been very active and interested in all matters dealing with veterans' affairs since he came to the Senate. We are happy to have his statement this morning.

STATEMENT OF HON. HARRISON A. WILLIAMS, JR., A SENATOR FROM THE STATE OF NEW JERSEY

Senator WILLIAMS. Mr. Chairman and members of the subcommittee, I wish to thank you for the opportunity to appear before you today and present my views on H.R. 8009, a measure to improve the medical and nursing care for the aged and chronically ill American veteran. I would also like to commend the subcommittee for its prompt action in holding hearings on this extremely important measure.

Few, if any, subjects in recent years are more deserving of careful consideration than that of providing adequate medical and nursing care for our Nation's veterans.

The problems facing this group of Americans are many and serious. These problems will grow worse as our veteran population ages, and the waiting list for VA hospitals grow longer. In my own State of New Jersey, we have approximately 2 million veterans.

At the present time there are about 85,000 World War II veterans between the ages of 65 and 70. By 1975, there will 889,000 veterans aged 65 to 69, plus an additional 255,000 veterans between the ages of

70 and 75. The President's Council on the Aging recently reported that more than half our population over age 65 will be composed of veterans, their wives and widows by the end of the next 45-year period.

Mr. Chairman, a dramatic shift in the age and distribution of our veteran population is underway, and each of us must make every effort to see that our veterans programs are able to cope with this expected population shift.

The measure before the committee today (H.R. 8009) will be of direct assistance to the growing numbers of our aging veterans who need the special nursing care which is not generally available to them under our present program of hospital, domiciliary, and outpatient care.

If I may, Mr. Chairman, I would like to make a few remarks about each of the provisions of the bill (H.R. 8009).

Section 1 authorizes 2,000 additional nursing care beds for existing Veterans' Administration hospitals. This addition will benefit veterans who have received the maximum benefits of hospitalization, but who have not been placed in community facilities because of inadequate financial resources, lack of family ties, or because such facilities were not available. Keeping these patients in complex and costly medical facilities imposes a severe burden on the present 125,000 VA hospital bed limitation.

These reasons were cited by the late President Kennedy in his August 12, 1963, memo to the VA which read in part:

In order to relieve this situation, I authorize you to activate and operate facilities and beds for 2,000 nursing-home-type patients in addition to the 125,000 hospital beds presently authorized. This will provide arrangements more consistent with patient requirements and improve utilization of acute care facilities. The higher patient turnover will also defer the need for increasing present bed levels. Existing buildings best suited for this purpose and appropriately located throughout the country according to your judgment, should be utilized.

The need for additional nursing care beds is clear and I hope that the Administrator of the VA will take action consistent with the August memorandum.

Section 2 authorizes the Administrator of the VA to transfer to a public or private nursing home any long-term patient who has received maximum hospitalization benefits from the VA hospital, but needs further care in a nursing home.

This additional care would be paid for by the VA, but would be limited to one-third of the cost of care furnished in a VA hospital. This provision is similar to the existing VA social work service program and is designed to assist the long-term patient make a smooth transition from a hospital to his eventual place in the community.

Without this assistance many veterans lacking resources to pay for nursing home care would be forced to turn to relief to secure the funds necessary to accomplish this transfer. Our American veterans should not be forced to turn to welfare to secure adequate nursing care.

Two important goals will be achieved by placing these veterans into private nursing homes. First, by freeing beds presently occupied by veterans who could be placed in private nursing homes, we will be making critically needed beds available for other veterans. Second, the care available in private nursing homes can be obtained at one-third the cost of that in VA hospitals.

Section 3 provides that no veteran shall have his pension reduced because he received an aid and attendance allowance during the first 2 months after he is admitted for VA hospitalization.

Under existing law such allowances are generally discontinued when the veteran is admitted to the hospital on the theory that, since the necessary aid and attendance are being provided by the Government during VA hospitalization, continued payments are unwarranted.

By modifying existing law, section 5 will encourage veterans receiving aid and attendance pensions to reenter hospitals for brief stays without fear of losing their pensions. This will encourage veterans to seek needed medical and hospital care early, and thus prevent longer stays and perhaps further serious illnesses and complications. It would also enable them to adjust any outstanding financial obligations before entering the hospital for an extended period of care.

Section 4 authorizes the VA to furnish therapeutic, rehabilitative, and medical equipment supplies to veterans eligible for an invalid lift. This provision provides a form of outpatient care to veterans with non-service-connected disabilities similar to the existing outpatient program for veterans with service-connected disabilities.

There is great merit in providing severely disabled veterans, who are eligible for invalid lifts, with needed rehabilitative and therapeutic devices. Frankly, I cannot agree with the reasons against extending benefits which have been limited to veterans with a service-connected disability. Certainly we owe a deep obligation to the service-connected disabled; we must be aware, however, that victory was won not only by the men who fell and died at Okinawa, but also by the men who survived injury and continued to fight until victory was achieved. For these reasons, I favor providing such severely disabled veterans with needed prosthetic appliances or devices.

Section 5 provides outpatient treatment and services to veterans with non-service-connected disabilities involving cardiovascular renal disease, hypertension, endocrinopathies, diabetes, mellitus, cancer, a neuropsychiatric disorder, or tuberculosis.

The provision authorizes outpatient treatment, to round out hospital care, for a period not to exceed 1 year. While I certainly approve of the proposed extension of outpatient authority, I would suggest that the subcommittee consider a further modification which would authorize this outpatient care to other veterans whose diseases have a similar debilitating effect on the veteran.

Clearly, we must keep abreast of the medical needs of the veterans. It is unrealistic to establish a narrow category of illnesses which cannot be modified promptly to meet the changing medical needs of veterans or advancements in medical science.

In conclusion, Mr. Chairman, I strongly endorse H.R. 8009. This is sound and humane legislation. Given the countless sacrifices made by the American veteran, and the many heartaches suffered by their families, relatives, and friends, this bill is but a token tribute to the great debt that every American owes the gallant men who fought and died to make this Nation great.

Senator METCALF. Our next witness this morning is Mr. Charles L. Huber, national director of legislation for the Disabled American Veterans.

Mr. Huber, it is a pleasure and an honor to have you here before the subcommittee this morning and have you back with us again. You may come to the witness table and identify your companion for the record.

STATEMENT OF CHARLES L. HUBER, NATIONAL DIRECTOR OF LEGISLATION, DISABLED AMERICAN VETERANS; ACCOMPANIED BY WILLIAM J. FLAHERTY, ASSISTANT NATIONAL DIRECTOR OF LEGISLATION

Mr. HUBER. Thank you. I am accompanied this morning by Mr. William J. Flaherty, assistant national director of legislation for the Disabled American Veterans.

Gentlemen, on behalf of the Disabled American Veterans, I wish to express appreciation for the opportunity to appear before your subcommittee to present our views concerning H.R. 8009, a bill to provide certain veterans with urgently needed nursing home care and nursing care facilities while reducing the cost to the United States of caring for such veterans, and for other purposes.

Mr. Chairman, we think it appropriate to reiterate that the Disabled American Veterans was founded on the principle that the Government's primary obligation to veterans is to those whose disabilities were incurred in the defense of our Nation and to the dependents of those who died as a result of wartime military service.

Accordingly, we would respectfully recommend that H.R. 8009 contain a stipulation that priority of transfer to nursing homes, over which the Administration has direct and exclusive jurisdiction, be given the service-connected disabled veteran.

Senator METCALF. May I interrupt you?

Mr. HUBER. Yes, sir.

Senator METCALF. That is in accordance with the present law, is it not?

Mr. HUBER. On admission to hospitals, yes, sir.

It is an acknowledged fact that the number of aged veterans in our country is increasing and will continue to increase; and because sickness and disability are more prevalent among older persons, the need for medical attention and care will increase proportionately. Our Nation, we believe, has a duty to strengthen its resources and services to these veterans.

The Veterans' Administration operates 158 hospitals situated throughout the country with an administrative 125,000-bed ceiling set by Executive order. Approximately 10,000 patients now occupying beds in these VA hospitals have received maximum hospital benefits and are now in need of a form of care which is provided in nursing homes.

The Administrator of Veterans' Affairs in testimony before the House Veterans' Affairs Committee admitted that finding outplacement facilities for these veterans is often hopeless, especially where the veteran's income is extremely limited. Because of this, these veterans must be retained as patients and this limits the availability of beds in the general hospitals for the care of other veterans who require acute hospital treatment.

We feel that the Veterans' Administration has the responsibility to provide nursing home care for the long-term aged veteran. We also feel that every effort should be made to remove him from the general hospital to a more suitable environment. To keep him in a general hospital is an extravagance, a waste of both human and financial resources.

The general hospital has more pressing problems than that of providing long-term care for the aged patient. The primary interest of hospital personnel is in the acutely ill patient. If the patient does not present an acute medical problem, he will, very often, find himself in a situation where his needs are overlooked or neglected.

The VA hospital system has an impressive, longstanding record of high quality medical services. We feel that this record can and should be perpetuated by developing a comprehensive, long-range plan for the health care of the aged veteran in accordance with VA established criteria.

Without question, the VA has the ability needed to make this service function smoothly in the best interests of the chronically ill patient.

As tangible evidence of the recognition of the need for increased emphasis on developing a nursing home program within the VA medical structure, President Kennedy in a memorandum to the VA Administrator August 12, 1963, stated, in part—

that the changing characteristics of our veteran population, particularly those who served during the First World War, are resulting in an adverse effect on the acute medical programs administered by the Veterans' Administration. Nearly 1 million war veterans are age 70 and over.

The number will increase 50 percent by 1966. Older veterans account for one-third of the hospital admissions and they comprise the bulk of the long-term-care patient load. Many have attained maximum benefits of hospitalization but attempts at community placement have been unsuccessful because of the lack of facilities, inadequate financial resources, absence of family ties, and other reasons.

Retention of these patients in facilities designed for acute care is costly and places an undue strain on the 125,000 hospital bed limit under which the VA is now operating.

In order to relieve the situation, the President authorized the Administrator to activate and operate facilities and beds for 2,000 nursing-home type patients in addition to the 125,000 hospital beds presently authorized. The President declared that this will provide arrangements more consistent with patient requirements and improve utilization of acute care facilities.

There is no denying that the authorization proclaimed by the President will serve a necessary and useful purpose. However, it represents only a partial accommodation because the major portion of patients presently in need of nursing-type care would still be retained in VA general hospitals. The objectives set out in H.R. 8009 offer an opportunity to come to terms with the remaining problems.

SECTION 1

In a recent appearance before this subcommittee, Mr. Robert C. Fable, General Counsel for the Veterans' Administration, pointed out that section 1 of H.R. 8009 would specifically authorize the Administrator, subject to approval of the President—

to establish and operate not more than 2,000 beds for the furnishing of nursing home care to eligible veterans in facilities over which the Administrator has direct and exclusive jurisdiction.

Mr. Fable declared that section 1 is unnecessary because section 5001 of title 38 already gives an authorization which has no numerical limitation. He then recited the language of section 5001 which provides—

the Administrator, subject to the approval of the President, shall provide hospitals, domiciliaries, and outpatient dispensary facilities for veterans entitled under this title to hospital or domiciliary care or medical services.

Mr. Fable concludes, in his testimony, that—

it is clear that nursing home beds "may" be regarded as facilities for providing a form of domiciliary care and that the existing statutory authorization for domiciliaries is fully and completely adequate to provide for an unlimited number of nursing home care beds.

At this point, Mr. Chairman, we wish to mention that the DAV has the greatest respect and admiration for Mr. Fable. We admire him, for he is a gentleman, is articulate, and as a lawyer he has a wealth of background experience in interpreting law. However, we are moved to suggest that Mr. Fable's comments with respect to section 1 of H.R. 8009 may not be quite satisfactory.

When the DAV appeared in this matter before the House Veterans' Affairs Committee, we pointed out that—

the Veterans' Administration has an authorized ceiling of 125,000 beds in its general hospital operation. It is our feeling that this bed capacity is the very minimum needed for care of the acutely ill veteran.

We believe this bed capacity should be maintained for that purpose. However, since the proposed nursing care program would provide a medical service not previously included in the VA hospital system, we recommend that a separate minimum bed ceiling for nursing care be established under the program.

Our testimony continued—

we also believe that the VA domiciliary system should be resumed, and that appropriate steps should be taken to officially end the situation by which the membership capacity is currently being reduced. If necessary, a minimum bed ceiling should also be established for the domiciliary program.

We would accept Mr. Fable's declaration that section 5001 of title 38 furnishes a ground for providing nursing home care beds of "unlimited" number. However, we are skeptical of this so-called broad authority in its application to a nursing care program. Mr. Fable described it as "an infinite authorization" and attempts to prove his point by reciting a mathematical formula; that is, "infinity plus X equals infinity."

In this connection, we would point out that between one and none there also lies infinity; and thus the broad authority many work both ways. The fact is that the VA, under authority of section 5001, can, and has, reduced the number of domiciliary beds. The DAV is most anxious for assurance that this will not occur in regard to the proposed nursing home care program.

There seems to be a divergence of view concerning the number of beds authorized in section 1 of H.R. 8009. Although the bill, as it finally emerged, sets out in distinct terms "for not more than 2,000 additional beds," it is worthy of note that the House committee in its report states that "the net increase provided by this bill shall be not less than 2,000."

We think this serves to establish the intent of the House committee. In any event, Mr. Chairman, your subcommittee has the opportunity for correcting or clarifying the issue. We suggest that this can be accomplished by merely striking from section 1 the words "not more than 2,000 additional beds" and inserting in lieu thereof the words "not less than 4,000 additional beds."

This modification would make certain that the 2,000 beds authorized by the President's memorandum and the 2,000 beds contemplated in the bill, as passed by the House would be definitely authorized and that no ceiling would be set on this bed category.

Mr. Chairman, I am constrained to point out that although the late President Kennedy's memorandum dated August 12 authorized 2,000 nursing care beds in addition to the 125,000 administrative hospital bed ceiling, as of this date not one of these beds has been activated. This, despite the fact that the Veterans' Administration has released a list of nursing care beds to be operated at several Veterans' Administration hospitals throughout the country. If there is any money in the budget to operate these beds it has been well concealed, and so far as I am advised, there has not been a supplemental appropriation requested for this purpose.

Senator METCALF. May I interrupt you? That is my understanding, too. But there is no money in the budget for this, and there has not been any supplemental appropriation. This is merely an authorization.

Mr. HUBER. Yes, sir.

I understand that if and when the 2,000 nursing care beds are put into operation they will have to be operated within the limits of the funds provided for medical care in the 1965 budget. To a budget already strained to the breaking point, this means only one thing—there will have to be a reduction in beds at some stations or the possible closing of Veterans' Administration hospitals.

The Disabled American Veterans would be very much opposed to the closing of any Veterans' Administration installations in the medical field because of the well-demonstrated need for the existing installations to care for our disabled veterans. If my understanding is correct, I hope that the Veterans' Administration will take appropriate action by providing for a specific appropriation for the nursing care beds above and beyond the 1965 budget.

Failing in this field, the Disabled American Veterans, and I am sure other organizations, would want to bring this matter to the attention of the Congress to see that corrective action is taken.

Senator METCALF. I wonder if you would just halt a minute so that I may clarify in my own mind just what you said. I was somewhat taken aback by the testimony of the Veterans' Administration when Mr. Fable claimed that it had unlimited authorization and attacked this section 1 on the basis that it limited authority of the Veterans' Administration. As I understand your point, you are perfectly right to take the Veterans' Administration's interpretation at its own face value, but you want to be sure that at least 4,000 beds are authorized?

Mr. HUBER. Yes, sir, and by adding to this wording, it would not place a limit on the number of beds, as they could go beyond this, but the suggested amendment would make sure that at least we would have 4,000 beds.

Senator METCALF. So if in the opinion of the subcommittee, after consideration and recommendation of counsel and the staff, the contention of the Veterans' Administration is sustained, that it does have an unlimited authorization to authorize an unlimited number of beds for such care, nevertheless, we should say that not less than 4,000 beds would be authorized.

Mr. HUBER. That would be my suggestion.

Senator METCALF. Thank you.

SECTION 2

Mr. HUBER. This section authorizes the Administrator to transfer patients from VA hospitals who have received maximum hospital benefits to privately operated nursing homes. The Veterans' Administration would pay the cost of such care so long as it applies to a general hospital operated by the Veterans' Administration.

This nursing home care would generally be limited to 6 months. Section 2 also authorizes the VA chief medical director to prescribe and establish such standards for nursing home care facilities in privately operated facilities as he may determine.

The Veterans' Administration opposed this section on grounds that pension payments, which include additional rates for aid and attendance, are sufficient for a veteran to secure nursing care in private institutions.

Currently, the average pension payments to veterans in need of aid and attendance is approximately \$150 per month. It is obvious, on the basis of these figures, that the aid and attendance pension payments are inadequate to cover the cost in a skilled nursing home.

This very often results in a veteran being placed in a private institution where the standards of care are of poor degree. The veteran's welfare suffers in consequence.

I am somewhat appalled by the Veterans' Administration's strong objection and the even greater opposition on the part of the Bureau of the Budget to section 2 of this bill which authorizes the Veterans' Administration to contract for nursing care in certain cases so long as the cost does not exceed \$9 a day.

The Veterans' Administration, in its general opposition over the years to any type of nursing care, has raised the warning signal that to get into the nursing care operation might lead to degeneration of the Veterans' Administration medical system into a nursing care operation and nothing else.

No one opposes this more vigorously than the Disabled American Veterans. I suggest that section 2 is a reasonable approach to prevent the Veterans' Administration hospital system from degenerating into only a nursing care operation.

The Bureau of the Budget presents some astronomical cost figures on this section which we are not in a position to question if one goes along with the basic assumptions of the Bureau. I would be remiss in my duty, however, if I did not point out that the Bureau of the Budget cannot have it both ways. It cannot go down the line in wholehearted support of medical care for all segments of the population, and certainly this includes nursing care, and at the same time view with horror the extension of nursing care to disabled veterans.

Of course, inherent in the Bureau's opposition is that veterans should be treated the same as all other citizens and taken out of the preferential character which veterans today enjoy. The Disabled American Veterans reject this philosophy in its entirety.

SECTION 3

This section establishes a new rate of \$3.50 per day for any veteran who is admitted to a State home for the first time and who receives nursing care there. Presently the Veterans' Administration pays not more than \$2.50 for each day of care to any veteran in a State home if he is entitled to receive hospital or domiciliary care in a VA facility.

Section 3 also repeals the so-called offset provisions in the law which permit a reduction by one-half of any amount from any payments of compensation or pension made to the veterans to be used for the support of the State home.

The DAV subscribes to these provisions for the reasons that veterans who are placed in State homes for nursing care purposes would require a specific type of medical service that is more costly than that required for domiciliary care.

We believe that because of local circumstances, or personal preference; or because VA or private facilities are too far removed, a veteran's welfare may sometimes be better served in a State home. We suggest, however, that members of the VA medical staff make regularly scheduled visits to insure that necessary administrative procedures are being complied with to conform to veteran laws.

Senator METCALF. I wonder if you would pause there. I do not know about the location of various State homes in the States of the Union, but I know that in the State of Montana, the home at Columbia Falls is almost a day's travel by car from the VA facility. It would be almost 2 days of travel if you came from Miles City, a day from Fort Harrison. It would seem to me that the veteran's welfare might be better served by a visit by a local physician, and the Federal Government would save money thereby. Do you not think an alternative should be put in there?

Mr. HUBER. I believe that is quite true. What we are actually recommending here is that the VA look in on the State home once in a while to see that the standards of care are established, although they are prevented from supervision, of course, by another portion of the bill.

Senator METCALF. I think that is a good idea. I think the standard should be maintained, States rights notwithstanding. This is a question of States rights, because these are State homes.

Mr. HUBER. Certainly we would have no objection to the veteran's personal physician to drop in and see him, either, as you suggest.

Senator METCALF. It would seem to me that what you are talking about would save money. I do not know if other homes are as remote from the veterans facility as they are in Montana.

Mr. HUBER. In my own State of Iowa, the veterans home is about 50 miles from the VA Hospital. In Wisconsin, it is a couple of hundred miles. It varies considerably in different States.

Senator METCALF. Go ahead.

SECTION 4

Mr. HUBER. Section 4 authorizes funds, on a matching basis, to assist States in the construction or expansion of State nursing home facilities at \$5 million per year for each of the next 5 years.

We recommend enactment of this section since it would offer encouragement for the 28 States already maintaining State homes to expand, remodel, or modify these structures specifically for nursing care purposes.

Additionally, it would act as a stimulus for constructing nursing homes in the other 22 States which, at the present time, have no State homes in operation.

In testifying before this subcommittee, the Veterans' Administration recalled that the President had recommended a hospital and nursing care program for the aged chronically ill citizens of the Nation. The statement was made that providing relief for a special segment of the general population would not solve the problem.

It is the feeling of the Disabled American Veterans that disabled veterans are indeed a special group to which our country owes a special duty. What greater reward can we give to our Nation's defenders than to provide them with a bed in the hour of sickness, infirmity, and old age?

Certainly, the funds expended for nursing care will go to those beneficiaries in the greatest need of assistance and not to those who have the resources to provide for their own care.

SECTION 5

Section 5 provides that additional pension for aid and attendance shall not be reduced earlier than the first day of the second calendar month beginning after the date of the veteran's admission to a VA hospital.

Under current law, veterans receiving aid and attendance allowance based on service-connected disabilities have their compensation continued until the first day of the second month which begins after they are hospitalized. We see no reason why this rule should not also apply to aid and attendance pensioners. We, therefore, support section 5 of the bill.

SECTIONS 6 AND 7

Section 6 authorizes the Administrator of the Veterans' Administration to furnish therapeutic, rehabilitative, and medical supplies, if medically indicated, to a veteran who is eligible to receive, or who has received, an invalid lift. The appliances would consist of the type and variety required in everyday care and which would be provided if the veteran was hospitalized in a VA hospital.

Section 7 would lift the 1-year administrative restriction for outpatient care in the completion of bed occupancy care program (CBOC) for the six most common diseases affecting older veterans.

The Veterans' Administration has testified that section 6 could lay the foundation for broadening the authority for those entitled to the invalid lift and section 7 could lead progressively to broader extensions of the outpatient program so that the policy of confining it to the service-connected disabled would no longer be effective.

Mr. Chairman, there is nothing magic in tying the disbursing of therapeutic and medical supplies to veterans who are eligible for the invalid lift. Under section 6 this was included as a limitation because it would apply to many of the veterans who receive aid and attendance pension and who are most seriously in need. If there is any more workable alternative in the form of a reasonable limitation there is no reason why it should not be authorized.

We must keep in mind the people we are endeavoring to assist here are those who are so helpless or blind as to need the regular assistance of another person. The devices to be supplied are devices which they need in their everyday lives to make their existence a little more comfortable.

The cost is small, and by one means or another, often these supplies are furnished through the Veterans' Administration. There is no great principle at issue here. It is simply an extension of an existing practice.

The same may be said of section 7, which would lift the 1-year restriction on outpatient care under the CBOC program. Outpatient care beyond the 1-year period is today given by the simple device of bringing the man into the hospital for another period of hospitalization and beginning a new 1-year period under the existing regulations. Section 7 is aimed at administrative simplicity. We support the adoption of both sections 6 and 7.

SUMMARY

The Disabled American Veterans recognizes that chronic illness among the aging veterans is a grave health problem on which action is urgently needed. Our Nation, we believe, has an obligation to strengthen its resources and services to these veterans.

The nursing home care program proposed by H.R. 8009 would make available the 125,000 VA hospital beds for occupancy to those patients in need of active care, and for the first time, authorize 4,000 additional nursing care beds in the VA system. It will provide the vehicle by which the 10,000 patients now receiving nursing care in VA hospitals could be transferred to nursing care beds within the VA system, the State soldier homes, or private nursing homes at a savings to the Government of not less than \$18 per day per patient.

It will assure that appropriate standards of care and uniformity of treatment are established in private nursing homes for those who are eligible for this care. It will provide a modest increase in per diem rates which will cover more closely the cost of a veteran's nursing care in State soldiers homes, as well as increased aid to State homes by providing for a 5-year program of capital outlay.

It will encourage veterans who are receiving aid and attendance allowances to reenter hospitals for brief stays without loss of their pensions, thus preventing longer stays and more serious illnesses. It will furnish prosthetic and therapeutic devices and extend outpatient care to certain aid and attendance pensioners. It will keep prospective nursing care patients in their own homes and in their own environment as long as possible.

The Veterans' Administration through the years has developed experience, knowledge, and technical proficiency in relation to its hos-

pital program. It is clear that the necessity for nursing care services is steadily increasing due to the growing aged veteran population, the rising costs of medical care, and changes in the practice of medicine and public health.

We feel that these changing times offer a compelling reason for the Veterans' Administration to begin concentrating its energies more fully on the chronic illness and health problems of aging veterans. We believe that it is the obvious duty of the Veterans' Administration to utilize this lower cost nursing care program when the care provided meets the adequate needs of the veteran.

The Disabled American Veterans recognizes that there is a need for proper health service to the general aging population and that the Federal Government may, indeed, have a responsibility in this connection. However, we believe that the Government has a special responsibility for the health care of the disabled veterans who served our country in time of war. We believe that it is a matter of greatest urgency that H.R. 8009, with our suggested amendment, be enacted into law to fulfill this special responsibility.

Mr. Chairman, we appreciate the opportunity to present our position on this most important measure.

Senator METCALF. Well, I want to say on behalf of the committee that we appreciate your appearance here. I want to say personally that as a member of the Disabled American Veterans, a life member, I personally know of the contribution your organization has made to the welfare of the disabled veterans in America. I especially appreciate your analysis of the Veterans' Administration testimony here, and when the time comes to go into executive session on this bill, your testimony will be most helpful and informative.

Thank you for coming.

Mr. HUBER. Thank you very much, sir.

Senator METCALF. The next witness is Mr. Francis W. Stover, director, National Legislative Service of the Veterans of Foreign Wars.

Mr. Stover, glad to have you here. Will you identify your companions for the record, please?

STATEMENT OF FRANCIS W. STOVER, DIRECTOR OF THE NATIONAL LEGISLATIVE SERVICE OF THE VETERANS OF FOREIGN WARS, WASHINGTON, D.C.; ACCOMPANIED BY DR. ROBERT BELL, MEDICAL CONSULTANT TO NATIONAL REHABILITATIVE SERVICE; NORMAN D. JONES, DIRECTOR OF THE NATIONAL REHABILITATIVE SERVICE; AND COOPER T. HOLT, EXECUTIVE DIRECTOR, WASHINGTON OFFICE, VETERANS OF FOREIGN WARS

Mr. STOVER. Thank you, Mr. Chairman. I have with me, on my extreme right, Dr. Robert Bell, our medical consultant to our national rehabilitative service, and on my immediate right, Mr. Norman Jones, the director of our national rehabilitative services.

I would like to introduce also the new executive director of the Washington office, Mr. Cooper T. Holt, who is sitting out there in the audience. Mr. Holt succeeded the late Omar Ketchum who was the head of our Washington VFW office for many years.

Senator METCALF. Mr. Holt is an old friend of mine from the time when George Mahan of my State was a national commander of the Veterans of Foreign Wars.

You were succeeded, or—

Mr. HOLT. John was my junior vice commander in chief, Senator.

Senator METCALF. At that time, I remember meeting you. We are delighted to have you here, sir.

Go ahead, Mr. Stover.

Mr. STOVER. Thank you very much, Mr. Chairman.

Mr. Chairman and members of the subcommittee, thank you for the courtesy and privilege of this invitation to appear before your subcommittee to present the views of the Veterans of Foreign Wars of the United States with respect to H.R. 8009, the nursing home care bill. My name is Francis W. Stover and I am the VFW national legislative director.

The Veterans of Foreign Wars has made this particular piece of legislation one of our key legislative objectives for 1964. From our commander in chief on down, all members are dedicated to the successful passage of this legislation, which means so much not only to present veterans needing nursing home care, but especially those who in the future will need the care and facilities proposed in this bill.

Nursing home care is a term which is loosely defined and has many meanings and definitions. It is not a term of art which has a well-settled and commonly accepted meaning. What is meant then when the term nursing home care is referred to?

According to the best available information so far as the care of veterans is concerned, the term "nursing home care" is one of recent vintage, having been first used only during recent times. It is significant to note that the term is unknown in veterans' laws. In title 38 of the United States Code, which is the code for all veterans' benefits coming under the jurisdiction and operation of the VA, there is no mention of nursing home care. Veterans' Administration regulations do, at least in one place, refer to nursing home care in its regulation No. 1352, which pertains to the granting of the regular aid and attendance allowance for those veterans receiving a pension who are so helpless as to need the help of another person. The transmittal sheet accompanying this regulation states, in part:

thus nursing home care or its equivalent will generally qualify for aid and attendance.

Even then, the regulation does not define nursing care in any precise terms.

To put it in a negative way, it is known that a veteran who requires only nursing home type care is not in need of hospitalization or is not admitted for hospital care in a VA facility under present VA practices.

What is nursing home care? What is a nursing home? Dr. W. S. Middleton, Chief Medical Director of the VA's Department of Medicine and Surgery was asked these questions last year when he went before the Subcommittee on Appropriations of the House Appropriations Committee. He answered as follows:

The nursing home occupies an entirely different position as Mr. Gleason indicated.

Mr. Gleason meaning Mr. John S. Gleason, Jr., the Veterans' Administrator.

A nursing home is a proper residence for an individual who has ill, who cannot take care of himself, who does need continued attention but he is past the point where there can be medical gain in his care. Mr. Gleason has made a perfectly clear issue that we have these four different categories: First is the medical and the medical responsibility, which we are attempting to discharge, second is the restoration center that has obviously for its objective the rehabilitation of an individual who has come to a certain plateau of improvement and yet not quite able to get over the hump and take over, and third, of course, the nursing home, where there is no prospect for this individual by and large. He is going to be an invalid, perhaps confined to his bed or wheelchair for the rest of his days. The fourth is the domiciliary, the old soldiers' home that provides for the care of the individual dislocated from society.

Under present law the President is authorized to establish the number of hospital beds to be operated by the Veterans' Administration. At present, the ceiling on these beds is set at 125,000. The nursing home beds contemplated in H.R. 8009 would not come within this 125,000. Neither could the 2,000 additional beds authorized last August in President Kennedy's memorandum be interpreted to mean they would be included in this number (125,000).

The late President Kennedy stated in his memorandum to the Administrator of Veterans' Affairs on August 12, 1963:

Retention of these patients in facilities designated for acute care is costly and places an undue strain on the 125,000 hospital bed limit under which you are now operating.

In order to relieve this situation, I authorize you to activate and operate facilities and beds for 2,000 nursing home type patients in addition to the 125,000 hospital beds presently authorized.

It seems a fair and unambiguous conclusion from this memorandum that the President intended that the additional 2,000 beds authorized in his memo would be outside the present ceiling of 125,000 beds.

Domiciliary care is another type of care rendered by the Veterans' Administration. At last count there were approximately 16,000 veterans in domiciliary beds being cared for by the VA. These domiciliary beds are not part of the authorized maximum 125,000 VA hospital beds mentioned previously. There is no statutory limitation on the number of domiciliary beds that may be operated.

The domiciliary program appears to be the outgrowth of the soldiers' homes, which were established in the late 19th century to take care of veterans of the Civil War. Apparently, regulations for admission to these soldiers' homes were generous and veterans needing only a minimum of care were admitted when a bed was available.

Somewhere along the way this type of care came to be known as domiciliary care. In 1955 the Veterans' Administration issued a regulation which precluded admission to a VA domiciliary home except in those cases where the veteran was ambulatory and able to feed, clothe, and otherwise take care of himself. Obviously, this regulation is too narrow and restrictive to intend veterans needing nursing home care.

Recently, the Veterans' Administration inaugurated a new program of attempting to restore veterans to normal and useful lives and in pursuance thereof, have planned or established several restorative centers. These centers are intended to restore veterans to useful lives whose conditions and other factors make such treatment feasible.

Again, when we speak of nursing home care, generally we are talking about a veteran whose condition is a chronic, long term one, for

which there is little or no hope that he will ever be restored to a normal life as contemplated in the type of care rendered in a restoration center.

Other assistance provided by the VA is through its program of aid to State homes, where the VA pays for up to one-half of the veteran's care not to exceed \$2.50 per diem. The care provided in these homes include in some instances full hospital, nursing, and domiciliary care. Unfortunately, only 28 of the 50 States have State homes and generally, such a program does not even begin to take care of the veterans in those States where these homes are maintained and operated.

At the present time, therefore, the VA is authorized to provide a wide range of medical care, from complete full hospital care for the acutely ill, to restorative centers, domiciliary facilities, and under President Kennedy's memorandum, nursing home care up to 2,000 beds.

What, therefore, is the purpose of H.R. 8009 and why do veterans and veterans' organizations wholeheartedly support the proposals contained in this bill? Presently, there are 1 million war veterans aged 70 or over. The number is estimated to increase by 50 percent in only 2 years (1966). Presently, older veterans count for one-third of all hospital admissions and among this group are most of those needing long-term care for chronic conditions.

Also in this group are the estimated 9,700 veterans in VA hospitals who have received maximum hospital benefits, but because of no family or home, or lack of suitable facilities in their hometowns, continue to occupy VA hospital beds despite the fact that there is a considerable waiting list of veterans needing full hospital care.

Further, retention of these veterans who have received full hospital benefits is unduly costly, since they occupy beds which were intended to be used for veterans needing full-time care. In addition, the 125,000 hospital bed limit is not being fully utilized, since the 9,700 are, in effect, reducing this overall limit to 115,000 or whatever the number of nursing care patients happens to be who are occupying these beds.

These are a few of the reasons which the VFW feels demonstrates the need for increased facilities for the nursing home care veteran patient. There presently isn't a considerable amount of vigor on the part of the VA to implement President Kennedy's memorandum of August 1963, to establish and put into operation 2,000 additional hospital beds for nursing type patients. Even at this late date, over 7 months having elapsed, these beds are still in the future. On the 16th of March, a VA spokesman stated to this subcommittee:

Manifestly, the 2,000 nursing home care beds authorized by the President have not yet been either established or placed in operation.

Senator METCALF. You understand, do you not, that this is an authorization bill?

Mr. STOVER. Yes, sir.

Senator METCALF. Even though this bill were passed, and I hope it is, still we would have to go through the same appropriation process that we are undergoing to get the 2,000 beds. There is no guarantee that the passage of this bill will secure a single additional nursing home bed. Is that not correct?

Mr. STOVER. That is the way we understand it; yes, sir. In other words, the Congress can pass the law, but the President does not have to carry it out.

Senator METCALF. No, we have to pass these things twice. We authorize them and then the Appropriations Committee and the Bureau of the Budget get busy and refuse to appropriate any money. This is the authorization legislation. This will permit the Appropriations Committee to act, but as far as the 2,000 nursing home beds are concerned, the Veterans' Administration insists that they already have the authority.

The President has made an Executive order and we still do not have an appropriation. So there is no guarantee that if this bill passes, there will be a single additional bed. There will be additional beds authorized, perhaps, but we still have to go through the appropriation process.

Mr. STOVER. And Mr. Chairman, to take that a step further, I am thinking now of the VA hospital in Bay Pines, Fla. Even though the Appropriations Committees in the Congress appropriated the money, there is no way of forcing the President, sometimes, to spend the money. In other words, Senator Holland—

Senator METCALF. I am sure that in this administration, they will spend the money, even though there is a declared economy. I have been as critical as some of the others of the failure to spend the money in the defense areas, and so forth. But I do not think we need fear that if there is an appropriation, the Veterans' Administration will not spend it.

Mr. STOVER. Thank you, sir. The best available information also indicates that this year's budget as submitted by President Johnson to the Congress does not include or contemplate any money to either establish or operate these 2,000 nursing home beds. The VA has announced the several facilities where these beds will be finally established. But, beyond that point there seems to be no target date or solid effort to implement President Kennedy's order. Even after the cost of establishing these beds has been estimated, it will be necessary to come forward for a supplemental appropriation which, in itself, takes considerable time.

These facts are mentioned, Mr. Chairman, so the record will show why we need this legislation. The VFW is extremely disappointed concerning this inactivity and lack of effort in getting the nursing home care program started. It seems reasonable that after 7 or 8 months an estimate could have been submitted and definite plans formulated and agreed upon to go forward in carrying out President Kennedy's memorandum.

H.R. 8009 has been objected to by the administration on several grounds. One objection seems to be because H.R. 8009 will not take care of all veterans and therefore the VA shouldn't take care of anybody. It should be emphasized that under no conditions is the existing VA hospital system designed or intended to take care of all war veterans. Basic entitlement to hospital care for war veterans with non-service-connected disabilities is accorded only when there is a bed available and the veteran is unable to pay for the service.

According to the President's budget message under the present policy of limiting the hospital system to 125,000 beds, the VA meets approximately half the hospital care requirements of veterans with non-service-connected ailments.

For example, at the end of January there were over 18,000 veterans who were on the waiting list for admission to a VA hospital. This, alone, indicates the present system is not designed to take care of everybody and so it would be with H.R. 8009, which will take care of only a limited number of veterans who qualify under the provisions of this bill.

Another objection raised against H.R. 8009 refers to the pension program for veterans who are permanently and totally disabled which disabilities make the veteran substantially unable to follow a gainful occupation. Besides meeting these requirements, a veteran who receives a pension must meet strict income limitations.

For those veterans who are receiving pension payments and where that veteran is so helpless as to need the regular aid and attendance of another person, his pension payment is increased by \$70 a month. This so-called aid and attendance rate has been referred to as the proper vehicle to solve the problem of nursing home care.

Even with a veteran whose income is less than \$600 per year, who would receive \$85 a month plus \$70 for aid and attendance, it is obvious that his total (\$155 monthly) income would be insufficient to meet the cost of hiring someone to take care of him during this period of his life.

According to the best estimates, the cost of nursing care varies widely throughout the country from as low as \$100 a month in some sections and going as high as \$375 a month. It is obvious that the greater bulk of veterans who are receiving pension payments and who, by the way, are found in the lower income brackets, do not receive sufficient funds to begin to pay the average national cost of nursing home care. Being single and without dependents it is a logical inference that most of them have no home to go to, which is another reason the VFW is urging the Senate to approve H.R. 8009.

While on the subject of pensions, it should be pointed out that it has been the policy of this administration to oppose any and all liberalizations of the pension program, including aid and attendance allowances for those veterans so helpless and blind as to need the aid and attendance of another person. On April 3, 1963, the Veterans' Administrator appeared before the House Committee on Veterans' Affairs, at which time Mr. Dorn, of South Carolina asked the following question:

Mr. Chairman, I would like to ask the Administrator if the President or the administration are in favor of any pension bills?

Mr. Gleason, the Veterans' Administrator replied, "No, sir."

At that time there were several proposals pending before the Veterans' Affairs Committee to increase the aid and attendance allowance for pension purposes. This is mentioned only to have the record show that the administration is unqualifiedly opposed to any liberalizing pension proposals, including aid and attendance allowance for pension purposes.

The record also shows that previous administrations have opposed legislation for aid and attendance allowance on the now familiar grounds that such allowance should be provided for all similarly situated citizens.

To liberalize the aid and attendance allowance rate for pensioners as the answer to the nursing care problem has a very serious and fatal

flaw. Many veterans who will need nursing home care will not necessarily be on the pension rolls. As it is now, many veterans are admitted to VA hospital facilities for hospital treatment even though under no circumstances could they possibly qualify for pension payments.

This is especially true of younger veterans who may be struck down with degenerative diseases at an early age and continue in an invalid status for many, many years. To sum up, the question of attacking the need for nursing home care could not possibly be solved by trying to transfer this responsibility to the pension program. It is a part of the overall obligation of the VA to take care of veterans who are in need of hospital and medical care and unfortunately, H.R. 8009 is necessary to make this a fuller program.

Referring to the bill, itself, section 1, has been construed as meaning that a restriction of 2,000 beds is authorized by the language of the bill. In no event has it been the understanding of the VFW that this section was to work as a restriction of any kind. Rather, the intent and purpose of this section was to establish not less than 2,000 more beds in the VA system for nursing home care facilities. It is suggested, therefore, that the bill be amended to read that the VA should establish and operate not less than 2,000 additional beds in place of the language which now states "not more than 2,000 additional beds."

It is also the view of the VFW that the 2,000 beds contemplated in H.R. 8009 will be in addition to the 2,000 authorized in President Kennedy's memorandum of last August. This will mean a total of not less than 4,000 nursing home care beds. Furthermore, the VFW is vigorously opposed to these 2,000 beds being established and operated out of existing funds which were appropriated to operate the 125,000 authorized bed program. It is conceded that the VA has the authority to authorize and operate these beds, it has unlimited authority. But an expression on the part of Congress is most necessary to provide the impetus to get this program started.

Lastly, we are equally opposed to having any of these nursing home care beds deducted from or offset against existing domiciliary beds. As the bill states, we want these beds to be in addition to existing facilities, whether the facilities be hospital, domiciliary, or restorative.

Section 2 of the bill in many respects is the heart of H.R. 8009, since it would provide authorization for the VA to take care of veterans in other than VA facilities in their own hometowns. There are built-in safeguards one of which is, the VA cannot pay more than one-third of the cost of care being furnished by the VA to the veteran in a general hospital. Another feature would be setting standards in determining what is meant by nursing home care, since the VA will have to draw up contracts to carry out this section.

Another safeguard would be the limitation of 6 months in which the veteran could remain in the nursing home, except in some instances where the Administrator can authorize a longer period. This section would permit the VA to soon unload and transfer all patients, such as the 9,700 now occupying VA beds, and at the same time reduce the cost of caring for these patients by two-thirds. Nationally speaking, this section would serve as a pilot experience for other Federal and State programs which seem to be extremely limited in any definition or standards for nursing care and nursing homes.

Perhaps most important of all, only veterans who have been in VA hospitals can benefit by the terms of section 2, which would mean that only those veterans who were unable to defray the cost of their hospitalization could be eligible for this treatment and thereby eliminates any possible abuses.

Mr. Chairman, the average age of veterans today is 56. Section 2 alone is justified and needed on the basis that it will relieve the great pressures which will be brought to bear on the VA hospital system in the years to come. Presently, the VA hospital system in its association with medical schools is operating one of the finest hospital systems ever created. The easiest and quickest way to wreck the VA hospital system will be to load it up with patients needing only nursing home care. Thus, it cannot be emphasized too strongly the great necessity of section 2 of this bill to permit veterans to be taken care of outside the VA but under VA jurisdiction.

The VFW strongly supports section 3 in its present form; i.e., that the VA pay up to a maximum rate of \$3.50 per day for one-half the cost of a war veteran's maintenance for nursing home care in a recognized State home. It is realized this adds a dollar a day to the authorized amount for nursing home care or domiciliary care. Nevertheless, the increased allowance is in keeping with VFW policy that the \$2.50 is an inadequate amount and that the per diem rate of \$2.50 should be increased. By recognizing this in the case of veterans needing nursing home care, it is hoped that the rate will likewise be increased for veterans needing other types of care at these State homes.

Section 4 of the bill would authorize a program of matching grants to enable States to construct State home facilities to furnish nursing home care to war veterans. This is in keeping with VFW mandates urging the expansion and modernization of State facilities, as well as the establishment of new State facilities for those institutions which provide this service to war veterans. This Federal-State grant and aid program would go hand in hand with the increased per diem payment of \$3.50 and would be of invaluable assistance to those States desiring to take advantage of such a program. The VFW wholeheartedly supports section 4 of the bill.

It is noted that the administration favors section 5 of the bill which provides that where a veteran is hospitalized by the VA the amount of his pension payment based on need of regular aid and attendance shall not be discontinued before the first day of the second calendar month beginning after the date of the veteran's admission to the hospital. The VFW concurs and recommends favorable consideration of this section by this subcommittee.

The present requirement of discontinuing this allowance immediately upon the veteran entering the hospital is too harsh. As proposed in section 5 a reasonable period is allowed where the veteran can make this transition and does not fear the sudden loss of income, which presently deters some veterans from entering the hospital.

Section 6 of the bill would provide therapeutic and rehabilitative devices to any veteran on the pension rolls who is now eligible to receive an invalid lift. Section 6 is referring to a small group of very seriously disabled veterans. The argument that this establishes a bad precedent is without merit.

Invalid lifts are presently made available to those who are medically in need thereof, whether the condition is service-available to those who are medically in need thereof, whether the condition is service connected or not. Section 6 simply recognizes that there is more to the care and treatment of this particular group of invalids when it would authorize additional devices and medical equipment. The VFW strongly recommends your approval of section 6.

Section 7 would extend outpatient medical care to include non-service-connected disabled veterans for six specific conditions. Again, we are talking about six disabilities which are of the most serious nature and, in effect, treatment of these veterans on an outpatient basis would be more economical for the VA and more beneficial to the veteran. Section 7 would be an extension of the CBOC program which provides for posthospital care on an outpatient basis of veterans discharged from VA hospitals up to a period of 1 year. This select group of extremely seriously disabled veterans with chronic diseases would be simply an expansion of this program to take care of a very small group. Again, taking care of these veterans on an outpatient basis would be freeing and making available more beds for veterans suffering from acute conditions.

Mr. Chairman, the Veterans of Foreign Wars completely disagrees with the philosophy that existing and future programs for the general population should be utilized by veterans with non-service-connected conditions, especially those who may be needing nursing home care.

It is the policy of the Federal Government through the Veterans' Administration to provide hospital care for veterans suffering from non-service-connected conditions. It is also known that existing programs for the general population at all levels are woefully inadequate to take care of even a small percentage of those in need. In the report of the White House Conference on Aging, it is stated:

It is widely known that such care—
meaning nursing home care—

is inadequate with respect to services, personnel, physical plant, and financing. According to Olive Randall, vice chairman, National Committee on Aging, "There is probably no community in any one of the States in which the demands for this group (sick, elderly) are fully met quantitatively or qualitatively."

The number of people 65 and over requiring and seeking nursing home care will continue to grow. Estimates are that there are at least 2 million men and women over 65 outside of institutions who "are completely limited in their activities because of chronic illness."

Further on in the report of the President's Council on Aging, it states:

More than 10,000 Americans are over 100 years old; more than 2½ million are over 80. By 1970, there will be 3.7 million men and women in the 80 and over age group * * *.

Nor are the aged the only ones whose need for nursing homes is increasing; illness at all ages of a long-term nature requires the type of care provided by nursing homes.

Unfortunately, there is a national shortage of nursing homes. According to a recent Public Health Service inventory, the Nation has about 23,000 nursing and rest homes. They can accommodate less than 600,000 persons. Only 9,700 of these homes are staffed and equipped to give skilled nursing care and they have room for only 388,700 patients.

At least half a million more beds are needed right now for long-term patients according to the total estimate of need made by the States. As lifespans continue "to lengthen, as higher nursing home standards remove the dread which

still prevents many older people from deciding to enter a nursing home, and as health insurance is extended to cover nursing home care, the demand for good nursing homes will grow apace."

With respect to future programs, this observation comes to mind. Present pending so-called medicare legislation which would place all Americans under the social security system contemplates a maximum of 6 months of care for veterans and, at the moment, I am specifically referring to the mentally ill veteran, many of whom spend long periods of time in our VA hospitals.

In addition, the medicare program would blanket in all beneficiaries, whether or not they have been under the social security system. This means an initial allocation of money estimated to be around \$1 billion just to get the program started. The Bureau of the Budget objects to H.R. 8009 among other reasons because—

The policies and precedents created by this bill within a few years could easily cost the Federal Government at least half a billion dollars annually and over the next 45 years could result in Federal expenditures conservatively estimated at over \$10 billion, of which \$6 billion would be for nursing home care.

Considering the magnitude of the problem of the aging and nursing home care, it seems that the price of \$6 billion over a period of 45 years is indeed a bargain. All the VFW is asking is approval of the Congress to take care of a small number of veterans who wore the uniform during wartime and received an honorable discharge for services rendered. H.R. 8009 would be a step in this direction and at the same time preserves and continues the finest hospital system anywhere. Without H.R. 8009, especially the provision dealing with sections 1 and 2, there is the grave possibility that the hospital system which has evolved since World War II and so admired by all will eventually end up being taken over by veterans who will be needing nursing home care in the years to come. There are already almost 10,000 patients with long-term illnesses as stated previously who could be discharged today with maximum hospital benefits. Approval of H.R. 8009 will guarantee the integrity of our present hospital system and at the same time relieve the present need for nursing home care.

For these reasons the Veterans of Foreign Wars urges this subcommittee, the full committee, and the Senate to approve this bill without delay.

Thank you for this opportunity to appear here today on behalf of the 1,300,000 members of the Veterans of Foreign Wars.

Senator METCALF. Thank you very much, Mr. Stover.

Do your companions desire to make any statement? Dr. Bell or Mr. Jones?

Mr. JONES. Not unless there are questions, Mr. Chairman.

Senator METCALF. I have no questions.

On behalf of the subcommittee, I appreciate your appearance here. I especially appreciate your comments on the Veterans' Administration testimony, your suggestions with respect to it and your analysis of it, and it will be very helpful when this committee goes into executive session to consider the bill. Thank you very much for coming.

Mr. STOVER. Thank you, Mr. Chairman.

Senator METCALF. The next witness was to have been Mr. Joseph F. Barr, executive director of the Jewish War Veterans. In his

place will be an old friend of mine and the chairman's, Mr. Felix Putterman, the national legislative director of the Jewish War Veterans.

Mr. Putterman, I am especially pleased that you will be the final witness. You may proceed as you wish.

STATEMENT OF FELIX M. PUTTERMAN, NATIONAL LEGISLATIVE DIRECTOR, JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

Mr. PUTTERMAN. Thank you, Senator. I think before reading my statement, I would like to make two pertinent statements. Maybe they are not quite wholly germane, but they are pertinent.

Senator METCALF. The germaneness rule does not start until shortly after the morning hour.

Mr. PUTTERMAN. As you know, the veterans' organizations have for some years now tried to aid and abet many Senators in the U.S. Senate in the institutionalization of the concept of Senate Veterans' Affairs Committee. To date, of course, we have not been very successful. However, I would like to say that in its place, at least, we have a very fine subcommittee here, and I think that we speak for all of our community, that we appreciate the very fine works of your chairman, Senator Yarborough, of Texas, who has been very kind to us.

I also want to commend the subcommittee and the Senate for having now, on the subcommittee, yourself as one who has had a great deal of varied experience in the House with all types of legislation and has had a splendid record as a legislator and as a veteran of World War II.

The other remark that I would like to make is that our statement compared with many others that have been made before this subcommittee is relatively short and I hope succinct. We have not made an analysis, or at least presented an analysis for the committee, because we think there is much on the record. There is much in it now. Time is short.

I know that as the Acting President pro tem, you want to get over to where you can help the Senate write, on the books of the United States, a law which will once and for all square with the moral preachments of our synagogues and churches.

Having said that, I shall read my statement.

Mr. Chairman, my name is Felix M. Putterman. It is my privilege and honor to appear before you as national legislative director of the Jewish War Veterans of the United States of America, our Nation's oldest active war veterans' organization.

At the outset, I believe it is singularly appropriate that the Jewish War Veterans is supporting, wholeheartedly, favorable consideration of H.R. 8009 as a minimum approach to the problem of care for the aging war veteran. Our organization has included veterans of the Civil and Spanish American Wars, as well as those who served in both World Wars and the Korean conflict. Unfortunately, too many of our comrades have known the despair of infirm old age and the lack of proper institutional facilities for providing necessary care.

Before further discussion of our position, I think your committee should know that our organization, by resolution of its last two conventions, has endorsed the concept of medicare—hospital insurance

financed through the social security system. By so doing, we have recognized the manifest need among the general population of America's aged for an efficient and equitable scheme to bring order to the chaos so typical of present hospital care for the less affluent aged members of our society.

We believe that the Congress of the United States must recognize that this problem brought to its doorstep by the lengthening of the span of life and by the wonderfully effective drugs that keep so many alive who, in a prior generation, would have gone on, has the effect of creating situations which were not present or as prevalent before World War II.

In those days, many families had a place by the fireside, at the table, and a bed for the older generation. The present influx into urban communities and the trend toward smaller homes and apartments means that these comforts—places by the fireside, at the table, and room for rest—no longer exist in the majority of American homes.

What are we then to do with our infirm aged? I realize the place to ask this question in general, is elsewhere in another committee; but what about the aged veteran? We have had, in our offices, a parade of aged veterans, their wives and children asking for assistance.

In our files are a series of letters from the VA denying admission to VA hospitals because nursing home cases are not hospital cases, nor are they domiciliary cases, because the nursing home veteran is unable to dress and feed himself.

To put these men into insane asylums or to institutionalize them far from their homes, so that their wives and children are not able to see them is, in our judgment, unthinkable. To provide for 2,000 beds, more or less, when we know the need is for 9,000 beds—and that this number will increase rapidly—is at best myopic. The only real solution is to provide beds in the number needed and to provide the care these people need.

Years ago, our then national commander, Joseph F. Barr, answered affirmatively to the Bradley Commission, when asked whether there was a differentiation between the veteran and nonveteran which gives the former privileges the latter would not have. He expressed then, and we say now, that so long as our war veterans are selected for service on a hit and miss basis; that some, because of exemption from military service will be permitted to profit from the benefits of war, while others give life or limb or whatever. When the man who has been selected for service turns to his government for assistance, which he might have been able to assure himself had he not been called upon for service, he is entitled to that assistance.

Having said this, I return to consideration of H.R. 8009 as a measure for meeting the unique needs of many American veterans. The bill faces squarely the problems of caring for geriatric, paraplegic and other cases requiring specific care of a technically less demanding standard than that provided by veterans' hospitals.

From prior testimony presented to this subcommittee as well as from Veterans' Administration records, in our judgment, it is crystal clear and incontrovertible that we shall face an accelerated increase year by year, decade by decade, in the complex problems of aged veterans who, even now, make up the bulk of the long-term-care patient load in veterans' hospitals. There is a wealth of medical authority to substantiate the fact of increasing long-term illness for aged veterans

in the fields of heart disease, arthritis and rheumatism, high blood pressure, neuropsychiatric disorders, visual impairment, and the impairment of the legs and hips that are so characteristic of old age.

Surely the subcommittee would agree that many VA hospital patients, upon completion of hospital care, are left with disabilities that make intermediate care at home difficult or impossible.

For the approximately 10,000 such patients in the present VA hospital system there are no suitable facilities to continue the type of care required. Undoubtedly, this figure would be much greater if it included patients in neuropsychiatric hospitals who no longer require professional treatment. If intermediate care facilities were provided, more beds could then be made available for the acutely ill patients requesting admission to neuropsychiatric hospitals.

A review of the VA medical program indicates clearly that some manner of nursing care is presently provided to over 20,000 patients who for reasons of no available alternative are filling beds that could be used for veterans in need of acute medical care. In our view, H.R. 8009 fits in the broad program of care already provided without substantial increases in the cost of many other programs already in existence, since it would in the main, offset such present expenditure.

We reject much of the criticism leveled by the Bureau of the Budget as part of tarnished yet persistent attacks on veterans' benefits. The adjustments in the proposed legislation would benefit veterans for whom to quote President Kennedy's words of last August—

Community placement has been unsuccessful because of the lack of facilities, inadequate financial resources, absence of family ties, and other reasons.

This bill is not designed to provide care for millions of veterans, rather, it is focused specifically on the 22,000 long-term patients occupying VA beds—patients with no place to go.

Earlier I informed the subcommittee of our position in favor of medicare. In our judgment, H.R. 8009 would provide an excellent basis of experience as a pilot project, just as have many important facets of the VA medical program, for the ensuing benefit to a program for the general aged population.

The long-term patients, those presently in hospital beds, as well as the greatly increasing number to come, require our attention now. By your favorable report on H.R. 8009, you would provide the means for meeting the present need as well as creating an opportunity for obtaining invaluable experience in a program so vitally related to the general welfare.

Senator METCALF. Thank you very much, Mr. Putterman. I am personally especially grateful for your analysis of the comparison between this and the medicare program. Previously, Mr. Huber from the Disabled American Veterans suggested that there is a need for proper health service to the general aging population, and the "Federal Government may indeed have a responsibility in this connection."

I would strike that word "may" and suggest that the Federal Government does have a responsibility in that connection. But I think that your statement has very eloquently done two things to put the contention of the administration in perspective.

First, you have come forthrightly out for a statement that we do need to take care of the medical needs of the generally aging population. Medicare may be only the first step in the solving of that.

Secondly, however, you have set forth very eloquently special priorities that both the Veterans of Foreign Wars and Disabled American Veterans did this morning which you said are the needs in our society of veterans who have worn the uniform, as you say, on a hit or a miss basis, have been deprived of the benefits of the war and have had to succumb to all the detriments.

So let me congratulate you on a fine answer to one of the contentions that the Veterans' Administration has made.

Mr. PUTTERMAN. Thank you very much.

Senator METCALF. Of course, I personally thank you for the introductory comments that you made.

If there are no questions, thank you, Mr. Putterman, for your appearance and your testimony. It will be helpful to the committee.

Mr. PUTTERMAN. Thank you very much, Senator.

Senator METCALF. There are several letters and communications to the chairman which, without objection, will be incorporated in the record at this point.

(The communications referred to follow:)

STATE OF CONNECTICUT,
EXECUTIVE CHAMBERS,
Hartford, November 19, 1963.

HON. RALPH W. YARBOROUGH,
*U.S. Senate,
Washington, D.C.*

DEAR SENATOR YARBOROUGH: I am informed that the Subcommittee on Labor and Public Welfare will conduct a hearing on H.R. 8009, nursing home care for veterans, on December 5, 1963.

The potential benefits to the State of Connecticut are such that I earnestly request the members of the Subcommittee on Veterans' Affairs of the Committee on Labor and Public Welfare to act favorably on this legislation and to assist in its early enactment by the Congress.

Sincerely,

JACK DEMPSEY, *Governor.*

STATE OF DELAWARE,
EXECUTIVE DEPARTMENT,
Dover, November 15, 1963.

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

DEAR SENATOR HILL: Now pending before the Subcommittee on Veterans' Affairs of the Senate Labor and Public Welfare Committee is H.R. 8009. This bill would provide urgently needed nursing facilities to veterans.

There is a strong need for passage of H.R. 8009 by the Senate and I ask for your favorable consideration of this legislation.

Cordially yours,

ELBERT N. CARVEL,
Governor of Delaware.

STATE OF GEORGIA,
EXECUTIVE DEPARTMENT,
Atlanta, November 19, 1963.

HON. RALPH YARBOROUGH,
*Chairman, Subcommittee on Veterans' Affairs,
U.S. Senator,
Senate Office Building, Washington, D.C.*

DEAR SENATOR YARBOROUGH: I ask your support of the veterans' nursing care bill, H.R. 8009, passed by the House, and now being considered by the Senate Labor and Public Welfare Subcommittee on Veterans' Affairs.

This resolution provides (1) Federal matching funds for the operation of State veterans' homes and (2) Federal matching funds for construction, alteration, or expansion of State veterans' homes.

As you know, the State of Georgia, with the Department of Veterans' Service as administrative agency, operates a war veterans' home in Milledgeville. The Federal Government, through the Veterans' Administration, contributes \$2.50 per day per patient, or \$250,000 annually. Under H.R. 8009 the payment would be \$3.50 per day per patient for nursing care, and \$2.50 per day for patients needing domiciliary care.

Before the general assembly established the home the type patient there now would have routinely been admitted to Milledgeville State Hospital at 100-percent State expense.

The resolution specifically states that the State is to continue to supervise its own home. It also limits the total appropriation of capital outlay to \$5 million for each of the next 5 years.

Need for expansion of the home is almost upon us. Therefore, the Federal matching funds for alteration and construction would be especially meaningful to the Georgia taxpayer, as well as to veterans.

We now can take care of about 300 patients. Our World War I veteran population, about 39,000, is growing older—67 is the median age. Within the next decade, Georgia's 245,000 World War II veterans will begin needing this same type care.

I ask your support of the bill because (1) its aims are in the finest traditions of humanitarianism, (2) it is a means of relieving the State treasury of a necessary expenditure, (3) our aging veterans' population needs and deserves this type facility, and (4) this 50-50 responsibility is a sound approach to a problem which has no geographic borders.

With best wishes and kindest personal regards, I am,

Sincerely,

CARL E. SANDERS, *Governor.*

STATE OF IDAHO,
OFFICE OF THE GOVERNOR,
Boise, December 6, 1963.

HON. RALPH W. YARBOROUGH,
*Senator, State of Texas,
Senate Office Building, Washington, D.C.*

DEAR SENATOR YARBOROUGH: I take the liberty of calling to your attention the fact that Idaho is one of the States that provides veterans' housing and hospitalization for the veterans of the wars who are currently living in this State.

I take this opportunity to urge you, not only to support H.R. 8009, but to ask that you arrange for hearings on this important measure at an early date in the next convening session. H.R. 8009 would materially aid in the care of eligible veterans in the State of Idaho. It is my understanding that all of the major national veterans' organizations are supporting the passage of this most important measure. I should like to add my voice to the many others regarding the early passage of H.R. 8009.

Sincerely,

ROBERT E. SMYLLIE, *Governor.*

STATE OF IOWA,
OFFICE OF THE GOVERNOR,
Des Moines, December 5, 1963.

HON. RALPH W. YARBOROUGH,
*Chairman, Subcommittee on Veterans' Affairs,
U.S. Senate,
Washington, D.C.*

DEAR SENATOR YARBOROUGH: As Governor of the State of Iowa, I would like to urge the enactment of H.R. 8009.

We in Iowa are well aware of the staggering problems facing the aging veteran throughout our Nation and in our State. This legislation would assist in the relief of these problems by providing additional housing, care, and facilities for our aging citizens who have served their country in times of crisis.

We feel that, in addition to fulfilling a critical need, the legislation proposed in H.R. 8009 would succeed in reducing the cost of the veterans program to the Federal Government and to the individual States.

Favorable consideration of this measure will be deeply appreciated.

Very sincerely yours,

HAROLD E. HUGHES, *Governor.*

THE COMMONWEALTH OF MASSACHUSETTS,
EXECUTIVE DEPARTMENT,
Boston, December 11, 1963.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: The Governor has requested that he be recorded as being in favor of H.R. 8009, which would provide certain nursing home care and nursing care facilities for veterans.

Kindest personal regards to you and your staff,

RICHARD R. CAPLES,
Legislative Secretary to the Governor.

EXECUTIVE OFFICE,
STATE OF MISSOURI,
Jefferson City, December 3, 1963.

Hon. RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I wish to inform you that H.R. bill 8009 has my full and enthusiastic support. This, of course, is the act to amend title 38, United States Code, to provide certain veterans with urgently needed nursing home care and nursing care facilities while reducing the cost to the United States of caring for such veterans, or for other purposes.

The State of Missouri operates an institution, the State Federal Soldiers' Home of Missouri at St. James, Mo., that comes under the general term of State veterans' home. Of course, the provisions of H.R. 8009 would most certainly be of assistance to veterans not currently in, or eligible to be admitted to, a State veterans home and would provide a welcome increased per diem rate for nursing type care for our State veterans.

I will certainly appreciate it very much if you will give this bill your most favorable consideration.

With kindest regards, I am,

Sincerely yours,

JOHN M. DALTON, *Governor.*

STATE OF NEBRASKA,
Lincoln, November 21, 1963.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs, Committee on Labor and Public Welfare, U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: I understand your committee is to consider in the near future H.R. 8009 which has been passed by the House. This bill provides money to assist States in building facilities to care for veterans at the State level. This money is proposed on a 50-50 matching basis. It also raises the VA per diem on veterans in need of nursing care from \$2.50 to \$3.50 a day.

I am sure you will recognize that this is not a give-away project. Actually, the passage of this bill will be economical to the National Government. The money that they put into these projects would be far less than if they were to build facilities and care for these veterans at Federal expense.

In view of the fact that many of our veterans are aging and in need of care of this type, I urge you to work for the passage of this bill as a benefit both to the veterans and the Federal Government while, at the same time, helping States in meeting the increased obligations.

Sincerely,

FRANK B. MORRISON, *Governor.*

STATE OF NEW JERSEY,
OFFICE OF THE GOVERNOR,
Trenton, November 27, 1963.

HON. RALPH W. YARBOROUGH,
*Senate Office Building,
Washington, D.C.*

DEAR SENATOR: I am writing to you in support of H.R. 8009, a bill passed in the House and concerned with nursing care facilities for veterans.

Earlier, when the measure was up for consideration in the House, I expressed my support for it to New Jersey's Representatives. I have since communicated with Senators Case and Williams, requesting that they urge you to hold hearings on this bill. It is my understanding that hearings are to be held and are set for Thursday, December 5, 1963.

New Jersey shares the concern for increasing nursing care facilities for veterans in view of the fact that we have more than 850,000 living within our borders. I would hope that your Subcommittee on Veterans' Affairs will give speedy and favorable consideration to this bill so that its passage may be expedited in the Senate.

Thank you for your help in this matter.

Sincerely yours,

RICHARD J. HUGHES, *Governor.*

STATE OF NEW HAMPSHIRE,
Concord, November 26, 1963.

CHAIRMAN OF THE SUBCOMMITTEE ON LABOR AND PUBLIC WELFARE,
U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: The State of New Hampshire respectfully urges the Senate of the United States to enact H.R. 8009 providing Federal aid for nursing home care for aged veterans.

Sincerely,

JOHN W. KING, *Governor.*

STATE OF NORTH DAKOTA,
OFFICE OF THE GOVERNOR,
Bismarck, November 15, 1963.

HON. RALPH W. YARBOROUGH,
*Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.*

DEAR SENATOR YARBOROUGH: I would like to express my interest and support of H.R. 8009, relating to providing for certain veterans with needed nursing home care with an increased per diem rate.

I understand that this bill was unanimously approved by the House of Representatives on September 17, 1963, and that the next step is for your subcommittee to hold hearings on H.R. 8009. It is my sincere hope that your subcommittee, as well as the full Senate Committee on Labor and Public Welfare, will act favorably on this proposed legislation.

Sincerely,

WILLIAM L. GUY, *Governor.*

STATE OF ILLINOIS,
OFFICE OF THE GOVERNOR,
Springfield, December 11, 1963.

HON. RALPH W. YARBOROUGH,
*Senator from State of Texas,
Senate Office Building, Washington, D.C.*

DEAR SENATOR YARBOROUGH: I am writing to let you know of our interest in H.R. 8009, which was introduced on August 8, 1963, by Chairman Olin E. Teague, of Texas, of the House Committee on Veterans' Affairs. The bill resulted from extensive hearings conducted by the HCVA Subcommittee on Intermediate Care under the chairmanship of Representative Robert A. Everett, of Tennessee.

This bill is of particular interest to us because of the Illinois Soldiers' and Sailors' Home, Quincy, Ill. If passed, it would result in increased Federal financial participation in the cost of operation for that institution. The provisions of the bill which are of interest to us and which we favor are, as follows:

(a) "Section 3 continues this (per diem for State soldiers' homes) \$2.50

per day rate for those veterans who are currently in the home but establishes a new rate of \$3.50 per day for any veteran who is admitted to the home after enactment of this bill, for the first time and who receives nursing home care there. It is estimated that approximately 70 percent of those now in the homes are receiving domiciliary care."

(b) "Section 3 also repeals the so-called offset provisions in the law today which permits a reduction by one-half of any amount which is retained by the home from any payments of pension or compensation made to such a veteran and, unless wives or widows of veterans are admitted and maintained by such homes, by any other amounts collected in any manner from such veteran and used for the support of such State home." (Had this section been repealed last year it would have meant \$61,000 additional income for the State.)

(c) "Section 4 authorizes, on a matching basis, \$5 million, for each of the next 5 fiscal years to assist the States in the construction of new buildings, or the expansion, remodeling, modification, or alteration of existing structures in order to provide nursing home beds in their State homes."

If you agree that this legislation is desirable, we would appreciate your support during its consideration. Thank you.

Sincerely,

OTTO KERNER, *Governor.*

STATE OF OREGON,
OFFICE OF THE GOVERNOR,
STATE CAPITOL,
Salem, November 27, 1963.

HON. RALPH W. YARBOROUGH,
*Senate Office Building,
Washington, D.C.*

DEAR SENATOR: My attention has been called to H.R. 8009, which is now before the Subcommittee on Veterans' Affairs of the Senate Labor and Public Welfare Committee, to provide nursing care facilities for veterans in need of such service.

Oregon is in need of additional facilities and any assistance you can give to this proposed legislation will be appreciated.

Sincerely yours,

MARK O. HATFIELD, *Governor.*

Senator METCALF. We have a letter here from my good friend, Hon. Barratt O'Hara, Congressman from the Second District of Illinois, transmitting a letter from Mr. Sam Black, adjutant, Columbia Camp No. 2, Department of Illinois, United Spanish War Veterans, dated October 11, 1963. Without objection I order Mr. Black's letter printed at this point in the record.

HEADQUARTERS DEPARTMENT OF ILLINOIS,
UNITED SPANISH WAR VETERANS,
Chicago, Ill., October 11, 1963.

HON. BARRATT O'HARA,
*Member of Congress,
Washington, D.C.*

DEAR COMRADE BARRATT: Typical of the need for nursing home care I submit the following case:

Charles Graham, aged 94 years, member of Columbia Camp No. 2, located at 1500 Pershing Boulevard, Clinton, Iowa, has been refused admittance to the hospital or domiciliary at Clinton.

Reason: He has prostatic cancer and because of his advanced age they cannot operate, and is therefore no longer a "medical case" in their opinion.

He has no income except his pension and has been living with his niece at the above address, but since she makes her living as a music teacher in her own rented home, he has become quite a burden.

I do not know whether or not President Kennedy's Executive order is in effect as yet, but if it is at all possible I would like to see something done for this old charter member of Columbia Camp.

Sincerely in F. P. & H.,

SAM BLACK,
Adjutant, Columbia Camp No. 2.

Senator METCALF. We have received thousands of letters from veterans' organizations, auxiliaries, and interested citizens. I have asked the staff to pull out a cross section of those letters at random to be included in the record. I order that they be printed at this point in the record.

SAN PATRICIO COUNTY,
Sinton, Tex., January 16, 1964.

Re H.R. 8009.

Senator RALPH YARBOROUGH,
U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: The adjutant of the American Legion Department of Texas, tells us that H.R. 8009 is in trouble, as result of the President's economy drive.

We do hope cutbacks will not be made on the wrong end of the Federal agencies, as is so often the case. Hospital beds of all kinds are a "critical item," and the veterans' programs have never been "overfinanced" as far back as I can remember.

Please do everything possible to get approval of H.R. 8009.

Thanking you for your kind consideration and assistance, I remain,

Yours very truly,

PERCY A. HARTMAN,
Veterans' County Service Officer.

P.S.—District 6, VFW, meets in Alice Tex., Saturday and Sunday, January 18 and 19, 1964, at home of Post 8621.

P.A.H.

VETERANS INFORMATION CENTER,
Quanah, Tex., January 14, 1964.

Mr. RALPH YARBOROUGH,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I am writing this letter in support of H.R. 8009 which is now pending in the House.

I have been a service officer for over 44 years, and am now on my 20th year as veterans' county service officer of Hardeman County, I feel justified in stating the present situation as to getting a veteran in hospital.

I have a bed patient here in the Quanah Hospital and I called McKinney, and Armarillo, last Friday and they stated that they did not have a bed for this veteran. This veteran is a diabetic in the worst form, and it is uncontrollable, and is the kind that should have a place to go and spend his remaining days. This is not account of being helpless.

Thanking you for every consideration in behalf of the veterans of Hardeman County and the State of Texas.

Yours very truly,

HARRY I. BOOTHE,
State Hospital Chairman for the American Legion of Texas.

CHILLICOTHE, TEX.

MILTON GILES FORT POST No. 464,
THE AMERICAN LEGION,
Weslaco, Tex., January 15, 1964.

Senator RALPH YARBOROUGH,
Chairman, Senate Veterans' Affairs Subcommittee,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: The veterans' nursing care bill H.R. 8009 has been brought to our attention.

We as Legionnaires strongly urge your support of this bill, which will be for the good of all veterans.

Although at this time, we would like to take this opportunity to thank you for the fine work you have done in the past years for our State. We hope you will continue to serve the State of Texas even better in 1964 than you have in the past.

Yours very truly,

WILLIAM B. HENRY,
Adjutant, the American Legion, Weslaco, Tex.

U.S. SENATE,
Washington, D.C., December 13, 1963.

HON. RALPH W. YARBOROUGH,
*Chairman, Subcommittee on Veterans' Affairs,
Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.*

DEAR SENATOR: I enclose a letter received from Mr. John Ott, 37 Bush Street, Bloomfield, N.J., which is, I believe, self-explanatory.

I have advised Mr. Ott that I am referring his suggested amendment to H.R. 8009 to you for your consideration.

Sincerely,

CLIFFORD P. CASE, *U.S. Senator.*

NOVEMBER 4, 1963.

Senator CLIFFORD P. CASE.

HONORABLE SIR: I read that H.R. 8009 was passed on to the Senate. It will provide nursing care for non-service-connected veterans.

Could you amend this to provide nursing care at home (limiting care to one shift or one-half of what nursing care would cost)?

I believe such a bill would cost less and help a lot of men to get home instead of being confined to the hospital or nursing home, if the amendment is possible. Thank you.

Respectfully,

JOHN OTT.

HOMESTEAD, FLA., *January 17, 1964.*

CHAIRMAN OF THE SUBCOMMITTEE ON VETERANS' AFFAIRS.

SENATOR RALPH YARBOROUGH: Mr. Chairman and members of the Senate Veterans' Affairs Subcommittee, relative to the bill, H.R. 8009, veterans nursing care, now before the Senate. I speak as a veteran of World War II, and a member of the American Legion post, Sidney Coulling No. 133, Tazewell, Va. I pray for the passage of this bill, because of the thousands of veterans who have done so much to preserve the wonderful United States of America, and the democracy we live under.

Yours truly,

KENNETH HANKINS.

PHILADELPHIA, PA., *January 15, 1964.*

To the Honorable RALPH YARBOROUGH.

DEAR SIR: I am writing to you in favor of bill, H.R. 8009, to support the veterans home nursing care. It would be a fine idea as there is a lot of good it would do. I am a volunteer in the veterans' hospital and I belong to the Geo. T. Cornish American Legion Auxiliary 292, 4812 Fairmont Avenue. I have 3,000 hours of service at the hospital and these fellows need care.

Sincerely yours,

ANNE JONES.

The COMMONWEALTH OF MASSACHUSETTS,
Dorchester, Mass., January 13, 1964.

Senator YARBOROUGH,
*Senate Office Building,
Washington, D.C.*

DEAR SENATOR YARBOROUGH: I pray that you will peruse favorably the vitally needed legislation concerning certain veterans.

H.R. 8009 should command your earliest attention and careful consideration.

Believe me, sir, I know. I'm a vet of War Two who, because of existing U.S.

laws for veterans, had to be discharged from a VA hospital after medical treatment, but who certainly needed further nursing care in a nonexisting VA establishment.

Sincerely,

JOHN E. MORIARTY.

WOODSIDE, N.Y., *January 14, 1964.*

Hon. Senator YARBOROUGH,
The Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: As a member of the Woodside Unit No. 886 of the American Legion Auxiliary I am interested in seeing bill H.R. 8009 passed. Thus I ask that you see that this bill comes out of committee as soon as possible for a vote on the Senate floor.

Thank you for your cooperation in this matter.

I remain,

Sincerely yours,

EDNA B. DOOLEY.

LEMONT, ILL., *January 14, 1964.*

Hon. RALPH YARBOROUGH,
U.S. Senator (Texas), Chairman, Senate Veterans' Affairs Subcommittee, Senate Office Building, Washington, D.C.

DEAR SENATOR: Your efforts in calling prompt hearings on subject bill is greatly appreciated.

We sincerely hope your committee can get the bill passed in the Senate at this session of Congress.

There seems to be confusion at the veterans' hospitals about how far their responsibility goes in taking care of chronically ill veterans under the present laws.

It is my opinion that hospitals and nursing homes should be built in different sections of the country for the chronically ill wheelchair and bedridden veterans with the protection and care guaranteed by law, which will do a lot to improve morale.

Part of the costs could be absorbed by the veteran paying a certain percentage of his compensation.

Respectfully yours,

J. J. LYNCH.

NASHUA, MONT., *January 14, 1964.*

Senator RALPH W. YARBOROUGH,
Senate Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: As a member of the American Legion Auxiliary and vitally interested in the welfare of all veterans, I urge your support for H.R. 8009 when it comes up for action in the Senate.

We must take care of our aging and handicapped veterans who have done so much for their country.

I also urge your support for the creation of a Senate Veterans' Affairs Committee whenever Resolution 89-63 is up for action in Congress.

May I have a reply please?

Mrs. FRED LEADER,
Nashua, Mont.

DES MOINES, IOWA, *January 10, 1964.*

Senator YARBOROUGH,
Senator EDWARD KENNEDY,
Senator LEE METCALF,
Senator BARRY GOLDWATER,
Senator LEN B. JORDAN,
Chairman and Members of the Senate Veterans' Affairs Subcommittee, Senate Office Building, Washington, D.C.

HONORABLE DEAR SIR: I am writing to request your vote on the veteran's nursing care bill, H.R. 8009. I am a veteran of World War I, 28 months in service: 6 months WAAC; 22 months WAC. My deceased husband was a World War I veteran; was a chronic arthritic case; also lung and heart ailments.

Spent 1 month in veterans' hospital in 1958. Took a series of gold shots for about a year or so and ended up with an ulcer on his leg. Gold affected his eyes.

He was on salt free diet too long. Was dehydrated. Was back in the hospital 2 months in 1960; home a few months; back to hospital and released in 10 days. Could do no more and recommended nursing home care. The nursing homes we have in Des Moines are nothing to write home about but I was forced to put him there; funds were low. Price was \$150 per month; care not good. He had a sleeping porch for a room; too cold for him with arthritis. He was there 3 weeks and he died. Seems a shame, just 3 weeks more in the veterans' hospital could have been a lot better for him; so if we do need these facilities extended in some manner so they have adequate care then I recommend passage of this bill as swiftly as possible since there are many who need this care.

Sincerely,

FERN E. RINGELBERG.

AMERICAN LEGION AUXILIARY,
WALTER RILEY UNIT 307,
Nashwauk, Minn., January 12, 1964.

DEAR SENATOR YARBOROUGH: We favor the veterans' nursing care bill, H.R. 8009, because—

1. The need for long-term nursing care increases every day.
2. In many cases it is less costly and more convenient for a man to be cared for in his home. It is important to his family that the husband and father be at home with them if at all possible. Nursing care allowances at home might help.
3. If a veteran can be cared for in a local or neighboring hospital, it makes it possible for his family to visit him often. This is essential to the morale of any sick person.

Sincerely,

JANE DOWNES, *President.*

CANON CITY, COLO., December 10, 1963.

Senator RALPH W. YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SIR: I would like to request your sincere attention to H.R. 8009—a bill sponsored by American Legion and their auxiliaries. It is an act to provide eligible veterans with urgently needed nursing home care and nursing facilities.

I understand the fate of this bill, H.R. 8009, is in the hands of five Senators, of which you are one, so ask you please to give it your support. Thank you.

Sincerely,

EDYTH E. SPRIGGS,
Chaplain, Wary McKinstry Legion Auxiliary, Unit 13, Publicity Chairman.

THE AMERICAN LEGION,
DEPARTMENT OF TEXAS,
Austin, Tex., November 26, 1963.

HON. RALPH W. YARBOROUGH,
U.S. Senator, Senate Office Building,
Washington, D.C.

DEAR SENATOR: I appreciate receiving your letter of November 18, 1963, advising that hearings on H.R. 8009 commenced on November 20. The Department of Texas is very much interested in this bill and we urgently request your support of this measure.

As an individual who has been closely associated with nursing care patients for many years, I would like to report that the matter of hospitalizing and discharging nursing care patients upon receiving maximum hospital benefit has caused more friction and unfavorable publicity in our VA hospitals than any other subject matter. Dependents of veterans who require nursing care only cannot understand why VA hospitals desire to release such patients from the hospital upon attaining maximum hospital benefits. If the hospitals did not release these patients, the hospital would soon have all of their beds frozen with such patients and veterans with acute illnesses cannot obtain admission.

We feel that the care of such patients is a VA responsibility and the provisions of H.R. 8009 are a definite step in the right direction.

With kindest regards, I remain,
Sincerely yours,

W. H. MCGREGOR,
Department Adjutant.

TOLEDO, OHIO, *December 12, 1963.*

Senator RALPH W. YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR: I am legislative chairman of my unit of the American Legion Auxiliary, South Side Post No. 531. Our members are actively supporting enactment of H.R. 8009. An important piece of legislation. We ask you to give this bill your full support.

Thanking you very much.

Sincerely yours,

Mrs. ERNEST WINGER.

MONROVIA, CALIF., *December 12, 1963.*

Re bill No. H.R. 8009.

Senator RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: We are very much in favor of approval of bill H.R. 8009, releasing beds in hospitals for emergencies and for extra moneys for nursing and private nursing for veterans.

We hope you will give this bill favorable consideration.

Your reply will be appreciated.

Sincerely,

Mr. and Mrs. R. R. GOODRICH.

PARKERSBURG, W. VA.,
December 10, 1963.

HON. RALPH YARBOROUGH,
Veterans' Affairs Committee,
Senate Office Building,
Washington, D.C.

DEAR SIR: I call to your attention here H.R. 8009, which would provide some assistance to the non-service-connected totally disabled veteran, and which is now before the Subcommittee on Veterans' Affairs of the Senate Committee on Labor and Public Welfare.

You know the merits of this H.R. 8009, I am sure. I am equally certain that you are familiar with many of the problems of the disabled veteran, whether his disability occurred in service or out of service, consequently, your having this knowledge will enable you to examine this bill with all the facts.

It is my sincere desire that this H.R. 8009 be passed by the Senate and become a part of the legislation governing veterans' benefits. I hope you will look with favor upon it.

Yours very truly,

HAROLD O. YOUNG.

RHAWNHRST-CASTOR MEMORIAL POST No. 754,
THE AMERICAN LEGION,
Philadelphia, Pa., January 6, 1964.

Senator RALPH YARBOROUGH,
Chairman, Senate Veterans' Affairs Subcommittee,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: At the January 6, 1964, meeting of post 754 a motion was made and passed that you be requested to support H.R. 8009. This bill has already been passed by the House of Representatives. Its purpose is to increase nursing care facilities of both the VA and State institutions for war

veterans who are aged and chronically ill; that is, medical care has not returned them to good health. This nursing service is limited to those veterans now eligible and for whom the need for such a service is apparent.

Thank you for your consideration of this bill, H.R. 8009.

Sincerely yours,

FRANCIS PAUL KAISER, *Commander*.
E. P. WALSH, *Adjutant*.

NEW LONDON, WIS., January 3, 1964.

HON. SENATOR YARBOROUGH,
Chairman, Senate Veterans' Affairs Subcommittee,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: I am writing this letter as a veteran of World War II and would like to add my support for H.R. 8009, the veterans' nursing care bill.

It is my opinion that this bill could reduce the demands made on the Veterans' Administration for custodial and hospital care and give a humane care to the veterans who are bedridden or housebound and helpless in their own homes or in State homes for veterans. It would seem to me that this law carefully administered would actually save money rather than cost extra funds.

Respectfully yours,

ORMOND W. CAPENER,
Attorney at Law.

CHRISTIAN POST No. 278, THE AMERICAN LEGION,
Detroit Mich., December 17, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: Christian Post No. 278, the American Legion, Detroit districts, Department of Michigan, wishes to offer its endorsement of H.R. 8009 which has been referred to the Senate Committee on Labor and Public Welfare and the Subcommittee on Veterans' Affairs.

It is our opinion that nursing home care and nursing home care facilities are very much needed today because of limited facilities for such care in overcrowded veterans' hospitals.

We also believe that veterans who would qualify for care such as this could be more economically cared for in nursing homes or even in their homes.

DONALD B. KOPPIN, *Adjutant*.

DECEMBER 29, 1963.

HON. RALPH W. YARBOROUGH,
Senate Office Building,
Washington, D. C.

DEAR SENATOR YARBOROUGH: Greetings to you for a Happy New Year and every success in the legislative work ahead of you.

We in Oregon are most fortunate in that we do have a domiciliary center—a home for the veteran with no home nor family. There at White City, near Medford, Oreg., the elder veteran can live out his life with dignity.

Of equal importance in our world of today is H.R. 8009, the bill to provide nursing home care for those veterans who may be in need of it.

This important legislation is now before your Subcommittee on Veterans' Affairs. Will you lend your wholehearted support to get it to the Labor and Public Welfare Committee and thence to the agenda of the U.S. Senate where it is hoped you will be instrumental in securing the affirmative passage of this bill.

Veterans who need this care and are not financially able to provide for their own care and the families who cannot provide it for them will be blessed by the affirmative enactment of this bill as such legislation would materially assist them. The fulfillment of their needs for nursing home care will make it possible for our older citizens to be "at ease" in a crucial time of his or her life.

Sincerely,

Mrs. ELAINE DICKIE.

PORTLAND, OREG.

NOONAN, N. DAK., November 5, 1963.

SENATOR YARBOROUGH,
Senate Office Building, Washington, D.C.

DEAR SENATOR: As the commander of Legion Post 243, of Noonan, I am writing in regards to H.R. 8009 which is now before your subcommittee.

I urge you to support this bill in the best interests of our veterans' welfare.

Respectfully yours,

ROBERT A. BRANDT,
Commander, James Lumsden Post No. 243.

MID-SOUTH PARALYZED VETERANS' ASSOCIATION,
Memphis, Tenn., October 30, 1963.

HON. RALPH YARBOROUGH,
*Chairman of Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.*

DEAR SENATOR YARBOROUGH: The members of the Mid-South Paralyzed Veterans Association respectfully urge your full and favorable support of H.R. 8009, which would provide nursing home care and other benefits for the totally disabled veterans.

We also request that this bill be favorably acted on and taken from subcommittee for further Senate action.

Sincerely,

CONRAD M. STANDINGER, *President.*

EASTERN PARALYZED VETERANS ASSOCIATION,
New York, N.Y., September 24, 1963.

HON. RALPH W. YARBOROUGH,
*Committee on Labor and Public Welfare,
Washington, D.C.*

DEAR SIR: The members of this organization urge your full and favorable support of H.R. 8009 which would provide a nursing care program and other benefits for totally disabled veterans. It is our belief that there has been an urgent need for this type of service within the VA program of medical and rehabilitation care for many, many years.

We sincerely hope that H.R. 8009 will be reported out of your committee at the earliest opportunity.

Yours very truly,

HARRY A. SCHWEIKERT, Jr.,
Executive Secretary.

DEPARTMENT OF TEXAS,
VETERANS OF FOREIGN WARS OF THE UNITED STATES,
Austin, Tex., September 24, 1963.

HON. RALPH W. YARBOROUGH,
*Senator from Texas,
Senate Office Building, Washington, D.C.*

DEAR COMRADE YARBOROUGH: H.R. 8009 was approved by the House without an opposing vote on Tuesday, September 17. This bill would provide nursing home care for aged, chronically ill veterans.

On Thursday morning, August the 29th at the 64th National Convention, Veterans of Foreign Wars of the United States, our rehabilitation and welfare and service committee presented Veterans of Foreign Wars Resolution No. 238 to the delegates and this resolution was properly approved on convention floor. Veterans of Foreign Wars Resolution No. 238 strongly commits our entire organization to the fullest support of H.R. 8009. H.R. 8009 is now in the Labor and Public Welfare Committee of the Senate. Your support on this bill will be appreciated as thousands of chronically ill war veterans urgently need nursing care beds.

Your fine cooperation and dedicated service to the veterans of this Nation is sincerely appreciated by your comrades of Texas.

With my kind personal regards, I am,

Sincerely yours in comradeship.

JAMES F. STARKEY,
Department Commander.

PARALYZED VETERANS OF AMERICA, VIRGINIA CHAPTER,
Richmond, Va., October 1, 1963.

HON. RALPH W. YARBOROUGH,
U.S. Senate, Washington, D.C.

DEAR MR. YARBOROUGH: The Virginia Chapter of the Paralyzed Veterans of America would appreciate your support of H.R. 8009.

We are especially interested in section 5 and section 6 of this bill. Our membership is made up entirely of severely disabled veterans (paraplegics and quadriplegics). These two sections would greatly benefit these deserving veterans.

Thank you very much for your consideration.

Yours very truly,

LEONARD B. KENNEDY, *President.*

WAR VETERANS ASSOCIATION, WAYNE COUNTY,
Goldsboro, N.C., September 20, 1963.

HON. RALPH YARBOROUGH,
Chairman, Public Welfare Subcommittee on Veterans' Affairs, Senate Office Building, Washington, D.C.

DEAR SENATOR: H.R. 8009 has been favorably considered by the House of Representatives and will now come to the attention of your committee.

This legislation which will provide certain veterans with urgently needed nursing care is long past due.

Each of the better than 1,000 veterans who are members of this organization urge you to give this bill all support possible.

Very truly yours,

IVEY B. HARRIS,
By W. B. Chaffin.

IOWA SOLDIERS' HOME,
Marshalltown, Iowa, September 23, 1963.

Senator RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: It has been brought to my attention that on September 17, 1963, H.R. 8009 was considered under suspension of the rules and passed the House of Representatives. It is my understanding that the measure has been forwarded to the Senate Labor and Public Welfare Subcommittee on Veterans' Affairs for your consideration.

As commandant of the Iowa Soldiers' Home and on behalf of the veterans residing here. I respectfully urge speedy consideration and report on this measure. This legislation is of tremendous interest and benefit to the veterans of Iowa, and certainly a comprehensive approach to the establishment of a constructive program providing for the care and treatment of the needy aged and aging war veterans.

With kindest personal regards, I am

Very truly yours,

WARD M. LOFTUS, *Commandant.*

SERVICE DEPARTMENT, THE AMERICAN LEGION,
DEPARTMENT OF INDIANA,
Indianapolis, Ind., September 20, 1963.

HON. RALPH YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs, Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: I know you are aware of the historical efforts of the American Legion to accomplish the purpose and intent of H.R. 8009. Not only because of this support for many years, but rather in recognition of the urgent and increasing need for such legislation, I ask that you favorably consider this bill now referred to your Subcommittee on Veterans' Affairs.

Although President Kennedy has authorized 2,000 beds for use of nursing home type patients, this will fall far short of the current requirement. It will afford a sound basis from which statistics, cost, and other requirements can be estimated and projected.

I feel that the reduction in cost for care alone would be adequate reason to support H.R. 8009. In addition, this bill would provide substantial benefits to a group of our most deserving, chronically ill, and aging veterans.

The problems encountered by veterans in the category included in this bill are too numerous to relate, but it is easy for us who are constantly reminded of this problem, to recognize that most of these problems would be minimized or removed entirely by favorable action in the Senate.

I sincerely urge your support for favorable action.

Sincerely yours,

KENNETH E. TRUEBLOOD,
Director of Rehabilitation.

THE AMERICAN LEGION,
DEPARTMENT OF LOUISIANA,
Thibodaux, La., September 20, 1963.

Senator RALPH YARBOROUGH,
*Senate Office Building,
Washington, D.C.*

DEAR SENATOR YARBOROUGH: On September 17, 1963, H.R. 8009 was considered, under suspension of the rules, and passed the House of Representatives. The measure will now be forwarded to the Senate Labor and Public Welfare Committee on Veterans' Affairs for their consideration.

As a member of this committee you will play a vital role in the success or failure of this measure.

It is respectfully requested that you give this your consideration and will feel inclined to vote favorably on its adoption.

The American Legion is vigorously supporting this legislation and would appreciate your interest in it.

With kindest regards, I remain,

Yours very truly,

PAUL G. AUCOIN, Jr.,
Member, National Rehabilitation Commission.

UNITED VETERANS COUNCIL, SANDUSKY COUNTY,
Fremont, Ohio.

HON. RALPH W. YARBOROUGH,
*Senator, Chairman, Labor and Public Welfare Subcommittee on Veterans' Affairs,
Old Senate Office Building, Washington, D.C.*

DEAR SIR: The following resolution was adopted by this council:

"RESOLUTION

"Whereas H.R. 8009, a bill to amend the United States Code (title 38) to provide certain veterans with urgently needed nursing home care and nursing care facilities, passed by the House of Representatives on September 17 and was forwarded to the Senate; and

"Whereas the Senate Labor and Public Welfare Subcommittee on Veterans' Affairs now have said bill, H.R. 8009, for consideration; and

"Whereas said bill provides for operation of 2,000 additional nursing care beds by the Veterans' Administration; and

"Whereas said bill provides for transfer to a public or private nursing home of any veterans who have reached maximum hospital benefits but still require a period of nursing care; and

"Whereas the transfer from veterans' hospitals to nursing homes of veterans who still require nursing care will relieve the overcrowded and heavily burdened condition now existing in our veterans' hospitals; and

"Whereas this transfer of veterans to nursing homes will provide hospital care and service for many veterans now on waiting list: Therefore

"Resolved, That it is the sense of the United Veterans Council of Sandusky County, Ohio, in regular session at Fremont, Ohio, to solicit and request immediate approval of said bill H.R. 8009 and present said bill to the Senate for early action.

"Resolved, That copies of this resolution be forwarded to: Hon. Ralph W. Yarborough, chairman, Labor and Public Welfare Subcommittee on Veterans' Affairs; Hon. Edward M. Kennedy, Hon. Barry Goldwater, Hon. Len Jordan, Senate Office Building, Washington, D.C."

Adopted by unanimous vote this 12th day of November 1963.

ROY CRISPEN, *Vice President.*

GIBSONBURG, OHIO.

Correct, attest:

FORREST E. BINGMAN,
Secretary-Treasurer.

CLYDE, OHIO.

This council is composed of all 14 veterans' organizations in Sandusky County and represents 6,500 veterans.

AMERICAN LEGION AUXILIARY, COMAL UNIT No. 179,
New Braunfels, Tex., February 21, 1964.

HON. RALPH YARBOROUGH:

Will you kindly support and vote for H.R. 8009, a bill pending in Senate Labor and Public Welfare Committee to provide a nursing home care program in the Veterans' Administration.

Will appreciate an early answer.

Thanking you kindly, I remain,

Sincerely,

Mrs. MAMIE LAWRENCE, *President.*

13TH JUDICIAL DISTRICT OF TEXAS,
Corsicana, Tex., February 5, 1964.

HON. RALPH W. YARBOROUGH,
U.S. Senator, Washington, D.C.

DEAR SENATOR YARBOROUGH: It has come to my attention that H.R. 8009 has passed the House and is now in committee in the Senate. Some veterans in this area understand that you are either chairman, or are on the committee of which this bill is presently pending. They also have been informed that you are for the bill, and they want you to know that they appreciate your support of this pending legislation, which deals with hospitalization, and so on, relative to veterans.

Mr. Bill Smith, who is very active in veterans' affairs in this community, is also highly interested in this bill. Mr. Smith, you might say, is service officer for Navarro County, although he does not officially hold this title, but he does do a great deal of work, which benefits veterans, and he wants to thank you, too, for your interest in this matter.

With best regards, I am,

Your friend,

JAMES C. SEWELL, *District Judge.*

EL CAMPO, TEX., *March 3, 1964.*

HON. RALPH YARBOROUGH,
*Senate Office Building,
Washington, D.C.*

DEAR SENATOR YARBOROUGH: We earnestly request that you work and vote for House bill H.R. 80C9. We understand it is still in the committee, but should be voted out in the next few days.

We are grateful and commend you for the great work you have done since going to the Senate on behalf of all veterans.

Sincerely,

NAOMI CLARKE CHAPPELL,
Chairman, El Campo Legion Auxiliary, Craig Harris Post, No. 251.

Attest:

Mrs. MACK J. WEBB, *President.*

P.S. We have 130 members.

Senator METCALF. There are also various other statements that have been contributed, and they, too, will be incorporated in the official record of this subcommittee.

(The statements referred to follow:)

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., February 24, 1964.

HON. RALPH YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs, Committee on Labor and Public Welfare, U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: In behalf of the American Medical Association, I would like to present our views with respect to the nursing home care provisions of H.R. 8009, 88th Congress, which is presently under consideration by your subcommittee.

As we understand the bill, section 1 would authorize the Veterans' Administrator to establish and operate up to 2,000 "additional beds" for the furnishing of nursing home care to eligible veterans in facilities over which he has direct control. Section 2 would authorize the transfer of certain veterans from a Veterans' Administration hospital to a public or private institution which furnishes nursing home care and which meets certain standards. Section 3 would authorize the payment to a State home of \$3.50 per day for each veteran of any war receiving nursing home care in the State home. Section 4 would authorize a 5-year, \$25 million program of matching grants to States for the construction of State home facilities for the furnishing of nursing home care to "war veterans."

It is section 4 of the bill that cause the American Medical Association its greatest concern.

The American Medical Association believes that the establishment of a program of the nature envisaged in section 4 is unnecessary in view of: (a) the programs authorized in sections 1, 2, and 3; (b) the number of skilled nursing home beds which are currently in operation; and (c) the growth of public and private nursing homes which has been stimulated under the Hill-Burton program and under the FHA mortgage insurance program which the American Medical Association originally sponsored.

The operation by the Veterans' Administration of a limited number of nursing home care beds in facilities under its direct control as provided in section 1 would seem appropriate, although it would not allow for the flexibility that would be possible under section 2.

The program contemplated under that section would allow the utilization of the more than 330,000 skilled nursing home beds currently in operation in all parts of the country. The magnitude of the future increase in the number of such beds can be anticipated by a review of the existing Hill-Burton and FHA programs.

During its first 10 years of operation, some 17,675 nursing home beds were constructed under the stimulus of the Hill-Burton program. As of January 31, 1964, an additional 8,015 beds, or almost one-half the number previously built under that program, were under construction.

An even more impressive result has occurred under the FHA mortgage insurance program. In the first 5 years of its operation, 7,000 nursing home beds were constructed. Currently, more than 11,000 additional beds are under construction; and it has been estimated that the FHA program will produce, in the next 5 years, 100,000 new beds and will be indirectly responsible for an additional 100,000 beds financed entirely from private sources.

With these impressive figures in mind, it would be well to look at the number of veterans with which the four sections are concerned.

According to House Report 680, 88th Congress, the total number of patients in Veterans' Administration hospitals with long-term illnesses and disabilities who could be discharged with maximum hospital benefits amounts to 9,740. Of this number, 3,703 could be discharged to nursing homes.

Thus, it may be seen that existing facilities and the anticipated growth will be more than adequate to meet the demands of this program. The American Medical Association, therefore, strongly recommends that section 4 be deleted from the bill.

I will appreciate your making these comments part of the official record of your hearings.

Sincerely yours,

F. J. L. BLASINGAME, M.D.

AMVETS,

Washington, D.C., March 24, 1964.

HON. RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs of the Senate Committee on Labor and Public Welfare, Old Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: AMVETS support the principle of H.R. 8009 now before your committee, an act to provide nursing home care and related benefits to seriously ill and disabled veterans.

On June 25, 1963, the then national commander, Don Spagnolo, testified before the House Veterans' Affairs Subcommittee on Intermediate Care and presented AMVETS position on this particular legislation. I am enclosing a copy of his testimony which clearly outlines AMVETS position.

AMVETS strongly urge your favorable consideration of H.R. 8009.

With kind personal regards, I remain,

Sincerely,

EDMUND M. GULEWICZ, *National Commander.*

TESTIMONY OF DON SPAGNOLO, AMVETS NATIONAL COMMANDER, ON MEDICAL AND NURSING CARE FOR THE AGED AND CHRONICALLY ILL VETERANS, JULY 25, 1963

Mr. Chairman and members of the committee, we of AMVETS are pleased to have the opportunity and privilege of appearing before you today to present our views on medical and nursing care for the aged and chronically ill veteran.

No one, I am sure is more aware of the problems we are facing in the field of care for the aged and chronically ill veteran than is this committee—AMVETS commend this committee for its prompt action in holding hearings on this important issue.

The problem of care for this group is indeed a complicated one. They cannot economically be cared for in facilities designed to give maximum care to the acutely ill—nor can they be adequately cared for in the present domiciliary setup. The need, therefore, for special legislation to care for the aging veteran suffering from chronic long-term illnesses is quite apparent. The question still remains, "How?"

At our 18th National Convention in New York City—AMVETS unanimously adopted two resolutions on this subject. One urged the continuation and acceleration of long-range studies on how to handle the problems of the aged and chronically ill veteran in the hopes of finding a solution before the World War II group reaches their later years. The other supported special legislation to provide for the immediate needs of the World War I veteran in a nursing home situation who cannot now qualify for hospital or domiciliary care.

The pilot projects and studies now being conducted by the Veterans' Administration may well provide the answer for the future. In AMVETS' opinion—there is still time to study and prepare for the time when World War II and Korean veterans will swell the ranks of the aged and chronically ill. In the not too distant future—the relatively large number of World War II and Korean veterans and the snowballing size of our senior citizen population will virtually preclude the separate consideration of duplicate medical care problems of veterans and nonveterans on the score of cost alone. We of AMVETS feel that for the future—the Veterans' Administration should work hand in hand with other agencies working to solve the problems of all our aging or senior citizens, for in the process of growing old or becoming chronically ill—the veteran will in no sense of the word be unique.

Then too, there is time for the World War II and Korean veterans to prepare themselves for the eventualities of old age, and AMVETS question the advisability of legislation that might tend to smother their initiative and encourage reliance on Federal aid when retirement age is reached.

Time will not stand still, however, for the World War I veteran while we await the reports and results of these studies and pilot projects. Their problem is immediate, and prompt action is necessary. While our membership embraces but few World War I veterans, it is our considered opinion that special legislation should be enacted to provide medical and nursing care for the aged and chronically ill World War I veteran. Nursing care for these veterans unable to secure treatment at Veterans' Administration hospitals or domiciliaries is a must in our opinion since the cost of this type of care to themselves or their families is all but prohibitive.

In testimony before this committee spokesmen for the Bureau of the Budget said in effect that since veterans are better educated, have better jobs and higher incomes, there is no economic justification for citing them out for additional special benefits. While this reference to better education and higher incomes may hold true for the World War II and Korean veteran, it certainly does not hold true for the World War I group, and this is the group that is so badly in need of assistance in this field.

The World War I veteran did not return to an elaborate system of readjustment benefits as did his counterpart of World War II, and then just as his readjustment to civilian life was taking shape, along came the great depression further hampering his chances of providing for the necessities and problems of old age.

The spokesman for the Bureau of the Budget also said in effect that this group of veterans are in the same category as any other citizens who are infirm, chronically ill, or without income. He implied that if the condition did not arise out of military service this Government owed no obligation.

AMVETS submit that this argument is no more valid today than it was in the days of King Arthur and the Knights of the Round Table. The veteran has historically held a special place in society and received consideration not given to all the population. While AMVETS feel that we owe a special obligation to the service-connected disabled, we are also aware that final victory was not won only by the men who fell wounded at Belleau Wood, or Omaha Beach, or on the islands of the Pacific—though God knows how they did their share and more, victory was achieved by the men who somehow survived the holocaust to continue the fight till our colors flew over the enemies' homeland. The fact that many of these men returned home with no visible scars of battle does not make them less a veteran—nor, is it sufficient reason to say that in their hour of need their well-being is not the responsibility of this great Nation.

AMVETS' position on this matter is basically simple. In our opinion, a veteran who meets the income requirements for non-service-connected pension under either the old or the new law cannot bear the financial burden incident to long-term chronic illness requiring nursing care.

A single World War I veteran receiving \$85 per month under Public Law 86-211 has a total yearly income of not more than \$1,620. Should it become necessary for him to enter a nursing home—his total income for 12 months would not provide 6 months of care. Medical expenses are a financial burden even under the best of circumstances. To a World War I pensioner, they become unbearable.

In testimony before this committee spokesmen for the Veterans' Administration testified that this legislation would open the door for more liberal benefits for millions of war veterans in the years ahead, thereby establishing a dangerous precedent. AMVETS seriously doubt the validity of this argument. The so-called precedent set by the Spanish-American War pension has not opened the door to the same type of pension for World War I. The precedent set by the World War I bonus has not secured a bonus for World War II. All benefits of the World War II GI bill were not passed on to the Korean veterans, and we venture to predict that with our ever-growing social reforms the vast majority of World War II and Korean veterans will never draw nonservice pensions when they reach retirement age. We might add that if the legislation passed by Congress for their rehabilitation and training does the job it apparently is doing and was meant to do this will be as it should be.

But, dwelling on past precedents and the effect that this legislation may have on future benefits will not solve the problem of the aging veterans now in need of nursing home care. AMVETS are sure that this distinguished committee, as it has in the past, will decide this issue on the facts before it; namely, the present-day needs of our veteran population and will not be influenced by past precedents or unfounded fears of the future.

AMVETS feel that immediate steps should be taken to provide some nursing care in present Veterans' Administration facilities through restoration of bed capacity in areas where facilities have been closed or curtailed. Immediate steps should be taken to revitalize and expand the domiciliary program rather than curtail the system as has been proposed in some sources. The Veterans' Administration's restoration centers can do much for the veterans capable of rehabilitation and returning to work—but it is not the answer for the veterans over 65 years of age.

Consideration should be given to providing direct grants to State soldiers' homes so they might expand their facilities in this field. Perhaps it may be advisable for State and local governments to assume some of this responsibility under a system of Veterans' Administration supervision, veterans' priority and preference, and backed by supplemental or matching funds.

In the interim, or until adequate care can be provided, AMVETS would suggest that the allowance for aid and attendance under Public Law 86-211 be increased so as to provide some immediate financial relief.

AMVETS have faith in the future of this great Nation. We are confident that when our veterans of World War II and Korea reach retirement age—the problems of all our aged and senior citizens will have been solved. The President has proposed this type of care for all of our citizens. Medical and nursing care for our aged veterans would provide these benefits to one segment of our population and would therefore, in our opinion, be in keeping with the President's program. Veterans' legislation has been the forerunner of many of our social reforms; if our ultimate goal is to provide this type of care to all our senior citizens we can pick no better place to start.

Again, I would like to thank the committee for the privilege of presenting our views.

Thank you.

STATEMENT BY JOHN E. ERICKSON, NATIONAL LEGISLATIVE DIRECTOR, ON THE MATTER OF NURSING HOME CARE, THE VETERANS OF WORLD WAR I, U.S.A., INC., WASHINGTON, D.C.

We would like to express our appreciation for the privilege of submitting to the distinguished chairman and committee, a statement in respect to nursing home care and nursing home facilities.

The veterans of World War I have long realized the tremendous need and the expansion of that need as the aging veteran reaches and goes beyond the allotted time of three score and ten. The Veterans' Administration has recognized and established the fact that having reached the age of 65, the veteran is considered disabled insofar as gainful employment and the ability to care for himself is concerned. With the mounting problems of our aging veterans ever before us, and the increasing need for hospitalization and nursing home care, we have passed resolution after resolution in our conventions asking for a lifting of the present ceiling of 125,000 beds to meet these needs commensurate with the veteran population of this country through hundreds of cases and experiences of our older veterans having reached the maximum medical care at the VA facility, that has been required to leave the hospital to become a burden upon their family. In most cases, these veterans, unable to care for themselves, are in dire need of some type of nursing care.

With your kind permission, we would like to submit an example in the case of Mr. Henry Nilson, of Minnesota. Mr. Nilson, a veteran of apparent good health, slipped on a piece of ice and broke his hip, and was hospitalized at the veterans' hospital in Minneapolis. Surgery was performed upon him, and during his convalescence from surgery, he contracted pneumonia. Immediately after partial recovery from pneumonia, he suffered a stroke which permanently and totally incapacitated him. After all possible medical treatment had been exhausted, the Veterans' Administration notified his wife, Mrs. Bloomie Nilson, that she would have to take him home. Mrs. Nilson then had him transferred from the veterans' hospital to his home, and made arrangements with the Kenny Institute for further treatment for him at her expense. After a course of treatment at the Kenny Institute, with no appreciable improvement, Mrs. Nilson was notified that no further treatments could be given. Mr. Nilson is totally helpless, and requires aid and attendance at all times. Not being in a financial position to hire a nurse or to place him in a private nursing home, Mrs. Nilson must necessarily assume that burden herself, which precludes her obtaining necessary

employment in order that she may maintain her home and nursing care for her totally invalid husband. Here is an example of dire hardship which is placed upon a person who is not in a financial position to meet the high cost of nursing care and such convalescent and medical care as may be required. We feel very strongly that the existence of a Veterans' Administration operated nursing home is desperately needed in order that so many of these hardship cases can be properly cared for. This is only one of the many, many similar situations involving veterans and their families who are forced to exhaust their life savings to care for an invalid veteran. This situation deprives the other members of his family who may be dependent, such as wife or children, from any security whatsoever, not only against possible illness or accidents, but also the procurement of a decent standard of living.

While the President's directive created 2,000 additional beds for nursing home care, and while the pending bill before this committee, H.R. 8009, calls for an additional 2,000 beds, we certainly feel that this is just the beginning of a program that will require more attention and expansion as our veterans reach the time in life when they are no longer able to care for themselves, and in a large measure, find it impossible to meet the ever rising cost of private medical care and hospitalization.

The story of medical costs can be summed up in the cost of hospitalization at the Washington Hospital Center, for example. A bill for \$1,415 for 26 days; another for a 3-month period of \$2,640; and one for \$5,421.85, and in addition, the doctor's fees, laboratory work, and X-rays. Hospitalization fees have become so high that veterans retired on a small fixed income cannot seek medical care in hospitals. They linger and put off medical attention due to lack of funds. The same holds true to visiting their local doctor, and soon their ailment becomes serious, and in many cases, fatal.

The basic needs of overaged, ill veterans, cover all of the major aspects of living. The Department of Health, Education, and Welfare has found it essential to base the development of programs upon an understanding of the nature of people, of their fundamental needs. The need for security first developed in infancy and childhood within the family. The need for security manifests itself throughout life. All of us share the need for security from lack of medical care, especially after the three score and ten years of life. Disabling illness, fear of being without shelter, friends, funds, and nursing home care in our last few years of life is a tragic play to see, or story to read. Newspaper accounts that arouse pity or terror by a series of sad events, misfortunes to the overaged, chronically ill, helpless veterans who defended this Nation never will start a nursing home system. Congress must start a nursing home program for its veterans at once, before all the Indian War, Spanish-American War, and World War veterans die, unattended.

Senator Abraham A. Ribicoff, as Secretary of the Department of Health, Education, and Welfare, in urging legislation before the Committee on Ways and Means, said, "You have the opportunity to equal the landmark action taken by the 74th Congress, which passed the Social Security Act in 1935. They sought to promote freedom from fear, the fear of economic insecurity. To a large extent they succeeded.

"Today, the later years of millions of Americans are plagued anew by fear. With lifespan lengthened, with medical science breaking into undreamed realms of discovery, the Nation's aged now face another aspect of insecurity, how to meet the mounting costs of medical care."

The great need is for improvement of services and operations in nursing homes, including establishment and enforcement of safety and health care standards; technical assistance and consultation to nursing home operators to improve the scope and quality of services, policies of patient admission, rehabilitation, and discharge, and methods of nursing home administration, and provision of training courses for nursing home operators and staff.

We feel that the provision of H.R. 8009 will not meet the full requirements for nursing home care. The Veterans' Administration has stated that because of the large list of veterans who would be eligible for this nursing home care, it will be necessary to establish stricter eligibility requirements and only those veterans will be admitted who are bed patients and are in the most desperate need. The eligibility to nursing home care will be made only for those who have received the maximum medical care from the Veterans' Hospital, and have been discharged, but those who are now desperately trying to care for themselves will have to be readmitted as a bed patient in the VA hospital in order to gain eligibility.

According to the VA, at the end of fiscal year 1963, there was a total of 19,477 patients on the waiting list. Also, during fiscal year 1963, the figures for admittance had materially increased. It is safe to assume that approximately one-quarter of these on the waiting list would eventually qualify for nursing home care, to say nothing of the many thousands of bed patients in the VA facilities at the present time who will stand in need of such care.

Under the provisions of the present bill before the committee, the Veterans' Administration is asked to provide these nursing homes within the present facilities, and in addition to that, there are provisions made for subsidies to State homes. The veterans of World War I feel very strongly that the entire nursing home program should be adjacent to and a part of the Veterans' Administration itself. Nevertheless, we feel that H.R. 8009 is a step in the right direction.

We recognize the fact that in a general, medical, and surgical hospital, doctors and nurses are usually oriented toward emergency treatment, while in a nursing home, doctors, and nurses are oriented to a longer range of treatment and professional staffing can be much less complete because patients require the physician only at extended intervals, but in order to maintain the highest quality of medical care, we feel that nursing homes should be closely associated with the general, medical, and surgical hospital.

While it is possible for the VA to find facilities within the confines of the present VA hospitals, we are of the opinion that this will have a tendency to reduce the needed facilities for the urgently ill hospital patients, and their care, and we again reemphasize our statement that nursing care should be adjacent to and not within the hospital itself. The veterans of World War I has always held that the Veterans' Administration should put into use, all of the available 125,000 beds for those patients who are in need of medical and surgical treatment.

Yet, H.R. 8009 is broad enough to assist existing soldiers' homes and to provide nursing care homes within the requirements of good medical practise under the supervision of the Veterans' Administration. It is for these reasons then, that the Veterans of World War I of the U.S.A. endorse and will support the enactment of H.R. 8009 into law, with the reservation that we will maintain the privilege of offering amendment to these bills to correct such phases of the program which may fall short of the desired and ultimate goal in treatment of our nursing home care patients.

The interpretation of the veterans of World War I in nursing home care is merely that of an adequate convalescent period to restore this veteran to a better and normal, healthier life.

STATEMENT BY JOHN SAGRAY, PAST COMMANDER, DEPARTMENT OF TEXAS, VETERANS OF WORLD WAR I, U.S.A., INC., SAN ANTONIO, TEX.

The Department of Texas expresses its deep and sincere appreciation for the privilege granted allowing our representative, John C. Sagray, to appear and present a statement before the distinguished chairman and committee in reference to nursing care and facilities.

The veterans of the State of Texas realize the great importance of care for the convalescing veterans. After completion of medical treatment rehabilitation is very often delayed due to the great distance they live from Veterans' Administration hospitals and their inadequate home environment and other local facilities. From a medical recovery point of view, there has been glowing objectives on unrelated subjects about care for the incapacitated, and if you look today at some of the ramblings of counterproponents of the aid and assistance proposed program, they are simply beautiful in their eloquence. Now let us assume we are inspired, but if you consider that it is most important that the people who represent the veterans also understand the role of the lawmakers in the passage of bills, particularly that for aid and assistance.

The homebound, chronically ill patient may require one or more of a broad range of supportive services. Some examples are social services, nutritional guidance or food service, physical therapy, occupational therapy, speech therapy, dental care, equipment and appliance loan service, pharmaceutical service, laboratory and X-ray service, and vocational education.

Because of the lack of adequate controls over programing and construction, certain types of facilities have been overbuilt, with resulting unnecessary duplication of services and uneconomic use of community resources. These develop-

ments, coupled with related problems of unsuitable locations, particularly to south Texas, the lack of access to needed professional competencies and skills, and consequent gaps in service, have inhibited the development of a balanced, comprehensive program of services for the area.

Many are poorly housed, poorly fed. Many are forced to turn to their children or to public charity for the medical care they need. Many have been shoved into a dull, meaningless existence because the opportunities to remain active, to use their skills and talents, are not available.

About 1,250,000 elderly people are invalids who, though not in institutions, are unable to get along without help from others. Tragically, many of those with serious conditions would be in better health if known preventive and restorative services had been promptly used.

Statistics show the average older person is incapacitated 5 weeks of the year by illness or injury, with 2 of these weeks spent in bed.

One out of every six older Americans will go into a hospital during a year. The average hospital stay for an older person is 2 weeks, twice as long as for the average younger person.

Of the one in six aged persons who is hospitalized in a year, the hospital bill—not including doctor's and other expenses—averages about \$525.

Nursing homes are concerned with the broad range of long-term care; medically oriented facilities; the need for better standards and licensure programs; the need for more and better restorative, rehabilitative, and social services in the nursing homes.

The Administrator of Veterans' Affairs in the appearance before this committee April 3, 1964, granted that there are presently in VA hospitals several thousand veterans who have received maximum hospital benefits and are now in need of a form of care which is provided in nursing homes or similar facilities. He stated that despite efforts to place these patients in suitable community facilities, it is often impracticable to do so, especially where the veteran's income is severely limited, and that this situation is progressive and is becoming more widespread. The Administrator further stated that as a result of inability to find a suitable place, these veterans must be retained as patients and this limits the availability of beds in the general hospitals for the care of other veterans who require definitive hospital treatment.

The cost of bed occupancy in a VA general hospital, we are told, is estimated at \$27 per day. By contrast, bed occupancy in a skilled nursing home is estimated at half this cost for care appropriate to the needs of the chronically ill patient.

A single World War I veteran receiving \$85 per month under Public Law 86-211 has a total yearly income of not more than \$1,620. Should it become necessary for him to enter a nursing home, his total income for 12 months would not provide 6 months of care. Medical expenses are a financial burden, even under the best of circumstances. To a World War I pensioner, they become unbearable.

We are sure that this distinguished committee, as it has in the past, will decide this issue on the facts before it; namely, the present-day needs of our veteran population, and will not be influenced by past precedents or unfounded fears of the future.

That immediate steps should be taken to provide some nursing care in present Veterans' Administration facilities through restoration of bed capacity in areas where facilities have been closed or curtailed. Immediate steps should be taken to revitalize and expand the domiciliary program, rather than curtail the system as has been proposed in some sources.

The Veterans of World War I of the State of Texas, urge the subcommittee to weigh all the factors including the present available Veterans' Administration bed facilities in the northern portion of the State, the distance of travel (well over 300 miles from the southern boundaries to a veterans' hospital), the home environment, the availability of medical treatment and supplies, and private nursing homes available at low cost to the limited income of the veteran are tantamount to the plight of the golden age class.

The nursing home care bill, H.R. 8009, can be a pivotal factor in the reclamation of the care needed for a convalescent veteran.

THE NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS,
February 28, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: The National Association of State Directors of Veterans' Affairs respectfully wishes to offer the following testimony in connection with the hearings being held on H.R. 8009, the nursing home care for veterans bill, which is currently before the Subcommittee on Veterans' Affairs in the U.S. Senate.

1. The National Association of State Directors of Veterans Affairs at their last national convention held at Atlantic City, N.J., August 27-30, 1963, unanimously endorsed this worthwhile legislation by resolution.

2. The national association feels that H.R. 8009 is perhaps the greatest step forward in beneficial legislation for the veteran in the United States since the enactment of the GI bill of rights.

3. The national association feels that this is a most humane piece of legislation, inasmuch as the legislation directly assists those most in need of help; the helpless.

4. The greatest single area of need as expressed by our directors engaged in service work over the past 10 years has been the patient discharged from Veterans' Administration hospitals to nursing home care, chronically ill, needing regular medication, and without sufficient income to even maintain himself and dependents even without the additional cost of the nursing home.

5. The national association further feels that this legislation would provide critically needed beds in Veterans' Administration hospitals throughout the Nation for the reason that the Veterans' Administration hospitals are currently caring for them on the humanitarian basis that they are unable to discharge them to an elderly wife unable to care for the veteran, or to place them in a nursing home because of insufficient income.

6. Finally, the national association feels that the care of the veterans continues to be a responsibility of the Veterans' Administration hospital, particularly where the veteran is so chronically ill as to be in continuous need of medical treatment and nursing care; it remains a fact that this care must be given, or the veteran will either die, or again become a patient of the Veterans' Administration Hospital or other eligible institution; there only remains whether the care will be given through a welfare, a charitable or church organization, or through a veteran source.

Mr. Chairman, we urgently endorse the provisions of H.R. 8009, the nursing home care for veterans bill, and respectfully trust that you and the members of your committee will see fit to act favorably and early on behalf of the Nation's veterans, who are so greatly in need even as of now.

Respectfully submitted.

JAMES J. MURPHY, Jr.,
President (Arizona).

WILLIAM B. HAINES,
Vice President (Ohio).

PETER WHEELER,
Secretary-Treasurer (Georgia).

RICHARD C. MANNING,
Judge-Advocate Historian (Maryland).

STATE OF NORTH DAKOTA, DEPARTMENT OF VETERANS AFFAIRS,
Fargo, N. Dak., February 24, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: I hope that this airmail letter reaches you in time because on February 27 the president of the National Association of State Directors on Veterans Affairs, Mr. James J. Murphy, will be appearing before your Subcommittee on Veterans' Affairs on behalf of House bill H.R. 8009, the nursing home care for veterans bill.

The National Convention of the National Association of State Directors unanimously endorsed H.R. 8009 last August at our national convention at Atlantic City, N.J.

As you know, the forementioned bill has already been passed by the House of Representatives and enacted into law would mean a great deal to our veterans in the State of North Dakota, as well as in other States.

H.R. 8009 authorizes a seven-point program and its passage would help to solve some of the more serious problems that face us today, especially with regard to nursing care beds by the Veterans' Administration. Here in North Dakota, even though we are not as thickly populated as many States, there is a dire need for many, many more nursing-care-type beds within the Veterans' Administration. Another feature of the bill which would greatly benefit North Dakota is the proposed per diem rate of \$3.50 for nursing care of certain veterans in State homes.

I will not bring out the other favorable points of this bill as I am sure you are well aware of the contents, but I would like to reemphasize that we are very concerned that this bill passes, and we urge that favorable consideration be given this bill and to the remarks that will be presented to your committee on Thursday, February 27, by the president of our national association.

Sincerely,

LLOYD F. ZANDER, *Commissioner of Veterans Affairs.*

SOUTH DAKOTA VETERANS DEPARTMENT,
Pierre, S. Dak., February 24, 1964.

HON. RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: It is our understanding that your committee has before it H.R. 8009, the nursing home care for veterans bill, and that a hearing on the bill will be held by your committee on February 27, 1964.

Although no beds for such care have been allocated in any of the three Veterans' Administration hospitals in South Dakota, it is our sincere wish that your committee will give the proposed piece of legislation favorable consideration, and that ultimately it will pass the Congress and receive the approval of the President.

The service provided in H.R. 8009 is greatly needed for our aging veterans, who do not have the means to provide for themselves nursing home care in private institutions, and whose condition does not require treatment and care in the present Veterans' Administration hospitals, which are presently overcrowded in caring for veterans who are actually in need of medical and surgical services.

We trust that you are heartily in favor of H.R. 8009 and will use your efforts and influence in its enactment and approval.

Yours very truly,

ERNEST A. JONES, *Director.*

STATE OF INDIANA, DEPARTMENT OF VETERANS' AFFAIRS,
Indianapolis, February 24, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: Many aging veterans are being discharged daily from Veterans' Administration hospitals, having reached maximum hospital benefits and are sent home in a helpless condition to wives that are as old as the veteran, who like the veteran sick and are unable to provide care needed, either physically or financially.

President Kennedy issued an executive order setting up 2,000 beds to provide this type care and so far as this writer knows, none of these are operating.

The House passed H.R. 8009 on a voice vote last September and the bill is now before your committee. It would provide 2,000 beds for nursing care. These are but "a drop in the bucket" so far as the total needed is concerned, but this is definitely a step in the right direction.

This department earnestly solicits your favorable consideration of H.H. 8009, which will provide a much needed care for the helpless veterans who are unable to care for themselves. Most of them are terminal cases waiting only for death and they have no place to go, and such a short time to live.

We hope you will give a favorable report soon on H.R. 8009.

Yours very truly,

WILLIAM F. O'NEILL, *Director.*

THE NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS,
Columbus, Ohio, February 24, 1964.

HON. RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: At our national convention, August 27 to 30, in Atlantic City, this association unanimously endorsed H.R. 8009, the nursing home care for veterans bill. We had the honor and privilege of having you as our principal speaker at our banquet, in which address you indicated your support for this legislation.

It would be redundant to emphasize how greatly enactment of H.R. 8009 would benefit many wartime veterans of the State of Ohio.

May I, therefore, assure you of our interest in this bill and urge its favorable consideration in your subcommittee.

Sincerely,

WILLIAM B. HAINES,
Vice President (Chief, Ohio Division of Soldiers Claims).

OFFICE OF NEW MEXICO VETERANS' SERVICE COMMISSION,
Santa Fe, February 25, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: The New Mexico Veterans' Service Commission join me in supporting the passage of H.R. 8009, the nursing home care for veterans' bill.

We act as legal guardian for almost 300 incompetent veterans and in several instances we have had trouble in finding proper homes for wards of this commission when relatives cannot take care of such veterans. Another factor in placing such veterans in proper nursing homes is the limited funds available from pension and/or social security benefits.

Your efforts on behalf of these helpless people will be appreciated by all concerned.

Sincerely yours,

MANUEL A. ARMijo, *Director.*

ILLINOIS VETERANS' COMMISSION,
Springfield, Ill., February 24, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: As administrator of the Illinois Veterans' Commission, I would like to go on record in favor of House bill H.R. 8009, the nursing home care for veterans' bill.

I feel that this bill will be of great benefit to the veterans of Illinois.

Sincerely,

EDWARD B. AKIN, *Administrator.*

STATE OF MISSISSIPPI,
STATE VETERANS' AFFAIRS COMMISSION,
Jackson, Miss., February 25, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: House bill H.R. 8009, the nursing home care for veterans' bill, which is presently before the Subcommittee on Veterans' Affairs, was endorsed by the directors of State veterans' affairs at the national convention in Atlantic City in August 1963. We feel that this is certainly worthwhile legislation and that it will help the aging veterans to no small degree. We earnestly hope that your subcommittee will give a favorable report on this legislation.

Cordially yours,

HOOKER M. COEN, *Commissioner.*

STATE OF MAINE,
DEPARTMENT OF VETERANS' SERVICES,
Augusta, Maine, February 24, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: During the convention of our National Association of Directors of Veterans' Affairs last August in Atlantic City, Mrs. Washburn and myself had the pleasure of making your acquaintance. We both agreed that your fine and informative speech was not only the highlight of the conference banquet but of the whole convention.

You are no doubt cognizant of the fact that our association strongly supports H.R. 8009, the bill to provide nursing home care for veterans.

Here in Maine we have had a situation for several years of a substantial waiting list of veterans for admittance to the Veterans' Administration hospital at Togus. Oftentimes this number exceeds 100.

It is my hope that the implementation of H.R. 8009 would not only provide needed care for this worthy group of veterans and also help alleviate the problem of this waiting list.

Your support on this bill has been and will be most sincerely appreciated by our association and me personally.

Sincerely,

ROBERT R. WASHBURN, *Commissioner.*

COMMONWEALTH OF PENNSYLVANIA,
DEPARTMENT OF MILITARY AFFAIRS,
Harrisburg, February 24, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: As the director of veterans' affairs for the Commonwealth of Pennsylvania, and a member of the National Association of State Directors of Veterans' Affairs, I was privileged to hear your address at our convention of the 30th of August of last year. At that time, you indicated your interest and strong support of House bill 8009, the nursing home care for veterans bill.

Since this bill is now in the Senate, I would like to respectfully urge your continued support of this bill. I am certain that your enlightened endeavor for an early passage will bring about the fruition of legislation which is needed now but which will be more greatly needed in the ensuing years as the veterans' population transitions into the category of the aged. As a rehabilitationist, I am well aware that in the twilight of life human being needs fall less in the area of definitive medical care and more in the area of nursing needs. Not only will

nursing home care be necessary at the Federal level, but nursing type homes will be needed as supplementaries at the State level. I strongly urge your good offices in the early passage of this bill.

Most respectfully,

ANTHONY R. FLORES,
*Lieutenant Colonel, MSC PARNG,
Deputy Adjutant General.*

STATE OF TENNESSEE DIVISION OF VETERANS' AFFAIRS,
Nashville, Tenn., February 24, 1964.

Senator RALPH W. YARBOROUGH,
*Chairman, Subcommittee on Veterans' Affairs,
U.S. Senate, Washington, D.C.*

DEAR SENATOR YARBOROUGH: The veterans of Tennessee are vitally interested in H.R. 8009, which passed the House of Representatives during the first session of the Congress and is now, I understand, before your committee for consideration.

We are very interested in this legislation. We have felt for many years that there was a need for treatment of this particular type veteran; that is, for the veteran who has reached maximum hospitalization but who is unable to care for himself and is, very often, a terminal case. In a great majority of cases, the facilities in the veteran's home are inadequate to take care of his needs. We feel that H.R. 8009 would meet the requirements of a great majority of these cases. We are fully aware of the fact that the 2,000 additional beds for nursing care will not be adequate to take care of the needs, and that section of the bill which provides that the director of the hospital may authorize nursing care in a private facility for a period of no more than 6 months will be of great value to the veterans of Tennessee.

I would like to urge that your committee act favorably on this legislation and that it be sent to the Senate as soon as practicable.

With best wishes, I remain,

Yours very truly,

JOE F. HUDGENS, *Director.*

RALEIGH, N.C., February 26, 1964.

HON. RALPH W. YARBOROUGH,
U.S. Senate, Washington, D.C.:

The North Carolina Veterans Commission asks that you inform your Subcommittee on Veterans' Affairs of its endorsement of H.R. 8009, relating to nursing home care for veterans.

COLLIN MCKINNE,
Director, Veterans' Commission, State of North Carolina.

MONTGOMERY, ALA., February 24, 1964.

Senator RALPH W. YARBOROUGH,
*Chairman, Subcommittee on Veterans Affairs,
U.S. Senate, Washington, D.C.:*

Speaking for all veterans in Alabama it is respectfully requested that you and your committee give your full and sympathetic support to H.R. 8009.

WALTER C. HEAD, Jr.,
Director, Department of Veterans' Affairs, State of Alabama.

TRENTON, N.J., February 24, 1964.

Senator RALPH W. YARBOROUGH,
*Chairman, Subcommittee on Veterans' Affairs,
Senate Office Building, Washington, D.C.:*

I would appreciate your full support for the passage of H.R. 8009, veterans' nursing care bill now before Subcommittee on Veterans' Affairs. Great number New Jersey aged veterans desperately need nursing home care benefits. State administration in favor of H.R. 8009.

ANTHONY J. VOLPE,
Director, Division of Veterans' Affairs, State of New Jersey.

OKLAHOMA CITY, OKLA., February 26, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
U.S. Senate, Washington, D.C.:

We urge the support of each member of your committee on H.R. 8009. Your favorable consideration and ultimate passage would have an immediate effect upon our State veterans' homes.

O. C. BALL,
Director, War Veterans' Commission, State of Oklahoma.

ROANOKE, VA., February 26, 1964.

Hon. RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
U.S. Senate, Washington, D.C.:

We urge strong support House bill 8009, nursing home care.

HARRY F. CARPER, Jr.,
Director, Division, War Veterans' Claims, State of Virginia.

ST. PAUL, MINN., February 25, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
U.S. Senate, Washington, D.C.:

Minnesota veterans are anxiously watching the progress of H.R. 8009 presently before your subcommittee; it is our feeling that this bill would be of benefit to a group of veterans who are in dire need. In addition it would alleviate some of the pressure in our veterans' hospitals, thus enabling them to do a better job. Urgently request your active support of the passage of this legislation.

ROBERT G. HANSEN,
Commissioner of Veterans' Affairs, State of Minnesota.

BATON ROUGE, LA., February 24, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans' Affairs,
U.S. Senate, Washington, D.C.:

On behalf of the veterans of Louisiana I ask you to support H.R. 8009. It would increase our hospital bed space by 60 rooms and cut cost of maintaining this number of patients now being cared for in regular hospitals to about one-half.

HAL A. BURGESS,
Director, Veterans' Affairs, State of Louisiana.

NEW YORK, N.Y. February 25, 1964.

Senator RALPH W. YARBOROUGH,
Chairman, Subcommittee on Veterans Affairs,
U.S. Senate, Washington, D.C.:

On behalf of the 2,350,000 veterans of the State of New York, I urge the speedy passage of H.R. 8009. Nursing home care is essential to the well-being of our older veterans.

FRANK V. VOTTO,
State Director of Veterans' Affairs, State of New York.

Senator METCALF. Without objection I order printed at this point in the record a series of articles relating to nursing homes, printed in the January, February, March, and April issues of Consumer Reports.

BY RUTH AND EDWARD BRECHER



Nursing Homes

BEGINNING A NEW SERIES

PART 1: *The Many Kinds of Care*

An estimated 350,000 Americans are being cared for today in nursing homes and an additional 250,000 in related facilities—boarding homes, rest homes, convalescent homes and hospitals, and so on.* The average age of the men and women in the nursing homes is 80; many are in their 90's. Their average stay is more than a year; many stay on year after year. Two-thirds are women; very few are married couples. Only half can walk by

*The meanings of these and similar terms differ from state to state and even from home to home. The basic distinction is between "skilled nursing homes," where registered professional nurses (R.N.'s) or licensed practical nurses (L.P.N.'s) are on duty, and "homes for the aging," which offer residential or personal care but not fully skilled nursing service. Some homes, of course, provide both kinds of service, in separate units or wings under one roof.

Only facilities for the aging and aged are covered in this article; nursing homes for infants, children, and other specialized groups raise problems of different kinds.

themselves, even with the aid of canes or crutches. Many are bedridden, incontinent, out of touch with reality. Others, in relatively good health and spirits, are lodged in nursing homes because they have no place else to go—or because the minimal services they need are not available elsewhere in their communities. The cost of nursing-home care to the residents, their families, and American taxpayers exceeds half a billion dollars a year.

What kinds of care are these nursing-home residents receiving? How can the quality of their care be improved? And how can an aged man or woman in need of nursing-home care—or more commonly, his family—shop for and find a home of the appropriate type where the quality of care is high, where the cost is moderate, and where the resident will be happy, or at least contented?

This month CU presents the first of a major series of reports on this extremely important corner of the Ameri-

can medical care and social care structure. CU's findings should interest readers in three separate respects:

As family members, many of us already have close relatives in nursing homes. Many more of us will be faced during the years ahead with the need to find a suitable nursing home for a parent or grandparent, an aunt or uncle, a brother or sister. Few people have even the foggiest notion of how to start shopping for a nursing home. CU will offer concrete practical suggestions.

As aging citizens ourselves, many of us will need nursing-home care for months at a stretch, or even year after year, during our own later years. We all thus have a direct personal interest—however remote it may seem to us at the moment—in the development of a nationwide pattern of high-quality care.

As taxpayers, all of us are helping to pay the cost of nursing-home care for the indigent and the medically indigent (roughly half of all nursing home residents are receiving public assistance from tax funds). All of us thus have an interest in getting our money's worth for our tax dollars, and we also share responsibility for the sometimes woefully sub-standard quality of nursing-home care.

CU has drawn for these reports on data of many kinds from many sources. CU researchers visited representative nursing homes. They talked with state inspectors and others whose professional task it is to make the rounds of nursing homes; these informants were asked what they looked for when they visited a home, and what they saw. Both Federal and state health and welfare officials were interviewed, along with the owners and managers of proprietary nursing homes and the administrators of voluntary and public homes. Officials of the American Association of Homes for the Aging, the American Nursing Home Association, and the National Council on the Aging were consulted. The Office of Aging in the U.S. Department of Health, Education, and Welfare supplied much additional data. Many thousands of pages of official and unofficial reports, surveys, investigation findings, hearings, and statistical tabulations on nursing homes and other facilities for the aged were assembled and intensively gone through. Forty states also supplied data on nursing-home conditions within their borders. Finally, the text of CU's articles was reviewed by authorities especially qualified to advise on the major aspects of nursing-home care.

The good and the bad

The authorities agreed that there has been a notable improvement in nursing-home conditions during recent years, and that many excellent homes are now in operation. But, as might be expected, some shocking conditions were also reported. Here are some examples:

■ Some nursing homes in some states are filthy, fetid, unsafe, overcrowded—unfit for human habitation. Many are understaffed. Their residents are ill-kempt, neglected,

undernourished, and in extreme cases maltreated. We were told by trustworthy informants of homes where residents were forbidden to leave their own rooms, of homes where residents were kept in bed, regardless of their ability to get up and move about, and of patients subjected needlessly to physical restraints. We heard of the excessive use of sedatives and tranquilizers as a sort of "psychic strait-jacket." We were told of homes where the food was of woefully inferior quality, badly prepared, sloppily served, and where residents were given neither time nor help enough to eat properly. We heard of homes where incontinent patients were left unchanged for hours, and of one home where the residents were locked up at night like criminals, with no one at all left in attendance.

■ State licensing regulations are designed to prevent such abuses and close down the worst homes. All 50 states have licensing laws. Yet some homes that fail to meet even minimum licensing requirements continue to operate unlicensed in some states. More amazing still, some state and local welfare agencies continue to lodge residents in these substandard, unlicensed, "bootleg" homes at public expense. Thus while health departments in these states make feeble efforts to reform or close down the worst offenders, welfare officials go right on pumping state and Federal funds into them to keep them open. "We have to have some place to lodge these people," welfare officials argue. "We can't just put them out on the street, and we haven't funds enough to buy them decent care."

■ A few local welfare departments still "auction off" nursing-home applicants to the lowest bidder; the nursing home that quotes the lowest rate gets the body. The effect of this practice on standards of nursing-home care can be easily imagined.

■ Families often turn to their family physicians for advice on selecting a nursing home; but some physicians are not objective counselors because, unknown to their patients, they share in the profits of the nursing homes whose services they recommend. The ownership of a nursing home by a physician is quite unobjectionable and may even be beneficial in some cases—where the physician is actually the administrator of the home, for example, or where he supervises its medical program and his financial interest is fully known to his patients. But secret participation by physicians in nursing-home ownership or profit-sharing is an evil, for it gives the physician a financial incentive to refer his patients to the home in which he has a stake. Some physicians have no doubt been attracted to nursing-home investment by reports of high profits—sometimes 30% or more a year—on such investments. Nursing homes welcome physician-investors for obvious reasons. "All you have to do to keep a nursing home profitably full," CU researchers were told, "is to cut a physician or two in on the profits." The 1959 Code of Ethics of the American Nursing Home Association pro-

Ruth and Edward Brecher, onetime members of the Editorial staff of CONSUMER REPORTS, contribute to the REPORTS regularly. They were major contributors to "The Consumers Union Report on Smoking and the Public Interest" (a 15-

page excerpt from which appeared in the June, 1963 REPORTS), and they write for Harper's, Reader's Digest, and other publications. They won the 1963 Albert Lasker Medical Journalism Award for outstanding medical writing.

NURSING HOMES continued

vides: "No financial inducements of any kind shall be offered to any personnel or organization for the purpose of attracting patients to a nursing home"—but this clause is apparently not applicable to sharing the profits of the home with physician-investors. No one knows how many physicians and physicians' wives are involved, since the true ownership of proprietary nursing homes is readily masked by corporate subterfuges. This is a festering scandal that warrants prompt attention from the American Medical Association, county medical societies, and state licensing officials.

■ Geriatric authorities agree that sound nursing care for the aged includes keeping them up and about, encouraging them to remain as active as their physical condition will permit rather than confining them to bed. Many nursing homes charge more for the care of bed-ridden patients; hence they may keep patients in bed unnecessarily month after month (with the deterioration of body and mind

that almost inevitably results) in order to earn the higher bed-care rate. Other nursing homes may do the same as a matter of convenience. Some homes—including licensed homes in some states—have no place where patients can meet, eat, or even sit and talk except for their beds and bedside chairs. Day rooms, dining rooms, and other social facilities either do not exist or else have long since been filled with beds.

Such details could be multiplied; indeed, the sad plight of nursing-home residents has been a common target of muckraking newspaper exposés. CU researchers can affirm that such conditions do exist.

But to emphasize the worst nursing homes is to provide a seriously misleading picture. For standards have unquestionably been rising. In some states even the worst homes provide tolerable conditions. CU researchers visited a number of nursing homes where good care was being provided in pleasant surroundings at a cost that state and local welfare departments were able to pay. This bizarre mixture of outstanding homes, mediocre homes, and intolerable homes operating side by side is one of the most striking features of the nursing-home picture today.

How the nursing homes got where they are

A generation ago, as part of the New Deal efforts to end the Great Depression, the Social Security Act of 1935 revolutionized the economic status of the aged in the United States. In addition to assuring modest monthly social security payments to the employed and their dependents upon retirement, the Act provided Old Age Assistance (OAA) as a matter of right to all those past 65 who were in need. Thus many who had long been penniless found themselves suddenly in receipt of a small but dependable monthly income.

A supply for the demand

Boarding houses, naturally enough, sprang up to shelter these new beneficiaries. Typically, they were run by widows or unemployed couples who hoped to save their own homes and independence by taking in half a dozen residents older and worse off than they were. An unwise proviso in the 1935 Act, moreover, hastened this trend. It withheld OAA payments from residents of state and local public institutions (poorhouses, county farms, tax-supported chronic disease hospitals, mental hospitals, etc.). The purpose, of course, was to prevent the states and localities from unloading their responsibilities onto the Federal OAA program—but the effect was precisely the reverse. Soon the aged, the sick, the halt, and the blind were streaming out of the state and county institutions in order to qualify for those coveted monthly payments. More widows—and aging nurses as well—opened more homes to shelter them.

As the years rolled by, the average age of these boarding home residents increased; the residents slowly grew sicker and less able to care for themselves. Thus boarding homes inevitably became nursing homes. Inflation raised

the costs of caring for the aged sick faster than OAA payments rose. The nursing homes were pinched. Residents needed more care and often got less. Two or three pensioners were crowded into a bedroom intended for one. The parlors were converted to bedrooms, and then the dining rooms. World War II prevented the building of new homes and cut down further the labor force available for nursing-home employment.

Meanwhile pneumonia—"the old folks' friend"—and other infections often fatal in old age were being curbed by the sulfa drugs and penicillin, so that even the very sick lived much longer. More and more residents survived into their 80's and 90's, crowding the homes still more. Thus was ushered in the blackest era in American care for the aged—an era that deserved but never received the attentions of a Dickens or a Steinbeck to awaken the public to its horror. The Social Security Act had provided the aged with some dollars, but not with the facilities or services they needed at a price they could pay.

Then, in 1950, amendments to the social security laws started the country on the long road back to decency. First, OAA payments were extended to the residents of public medical institutions (except TB and mental hospitals); this encouraged the states and counties to reopen such institutions, and to enlarge them or build new ones. Second, the amendments required each state to establish a standards-setting or licensing agency; this stimulated all the states to establish minimum standards for nursing-home care and to attempt to enforce them through licensing laws. Higher welfare payments, together with rumors of enormous profits from nursing-home operation, attracted new capital (and with some of it came new ideas and good

business methods). A boom in nursing-home construction followed. Federal loans and subsidies have further encouraged new construction. States have been required to prepare statewide plans to qualify for Federal Hill-Burton hospital and nursing-home funds.

Thus the years since 1950 have been marked by a general rise in standards, a closing down of some (though far from all) of the substandard homes. Most important,

health and welfare officials, and to a growing extent the public as well, no longer view these homes as dumping grounds where people go to die. Many new programs have been instituted for the benefit of the residents. Efforts are being made in an increasing number of homes to preserve human and democratic values—to regard and treat each resident as an individual. These welcome trends are beginning to spread through the land.

Preventive programs: alternatives to nursing homes

Health and welfare officials are also beginning to realize that the nursing home is not the panacea for all the problems of aging. Other programs for the aging, designed to help them maintain themselves independently outside of a nursing home, are at least equally important. These programs have been called "preventive" in the sense that they prevent or at least delay the need for nursing-home care.

By all means check on the availability of such preventive programs in your community before deciding that some aged member of your family needs nursing-home care. Here are the main examples:

DAY-CARE SERVICES. Many old people who enter nursing homes might well live on in their own homes or with friends or relatives for additional years if they had supervised care during the day. Hence day-care centers for the aged have been established in a number of cities, sometimes in conjunction with nursing homes. These day-care programs more than pay for themselves by reducing the number of applicants for day-and-night-care homes which cost much more. They bring interests and sociability into otherwise drab and lonely lives. But there are still relatively few day-care programs.

ORGANIZED HOME CARE. Illnesses occur much more frequently, and last much longer, among the aged. Hence they use far more than their share of general hospital services, at \$30 to \$40 or even more per day. During prolonged hospital stays they tend to deteriorate and to lose their capacity for independent living; many must therefore be transferred to nursing homes instead of returning to their homes. In many cases, they could be cared for at home in lieu of hospitalization, or after only a short hospital stay for acute illness, if an organized home-care program were available, with visiting nurses to carry out the doctor's orders, plus physical therapy, occupational therapy, rehabilitation service, meals-on-wheels, homemaker service, social casework, or whatever else may be needed. The cost of this organized home care per patient per day is a fraction of the cost of care in a general hospital. The patient is often happier, and his recovery more complete. Organized home care has proved its worth in Greenwich, Conn., Rochester, N. Y., Detroit, Mich., and a dozen other cities—yet its spread to the rest of the country has been lamentably slow. Fewer than 5000 patients, it is estimated, are receiving organized home care on any one day in the entire United States.

HOUSING FOR THE AGED. Many aged men, women, and couples, even those in their 80's or early 90's, can of course continue to live independently in private homes and apartments. But the time comes for some when continued independence can best be secured by moving to a housing development specifically designed for older people, with the services they need readily available. Many pioneering housing projects for the aged have abundantly proved their worth. The best of them offer private apartments at low cost, all on one floor, or in buildings with elevators. They have especially designed kitchens and bathrooms, plus a central dining room serving three meals a day for those who need or want it. Such housing can be located close to shopping centers, parks, and the center of the city so that residents need not feel cut off from the mainstream of life. It can be built for elderly people only, or as one unit in a project that also houses younger families. Transportation can be supplied, along with work-and-play programs, counseling services, opportunities for socializing, and other needed facilities. Home medical care and organized home care can be provided efficiently, and a very large project may even have an infirmary to care for those who are intermittently ill but not in need of general hospital care.

Some housing developments for the aging are being built with Federal and state funds by local governments and non-profit organizations; others are being built privately with FHA mortgage guarantees. But the quantity falls far short of the need, and some projects provide only a minimum of the desirable services.

FOSTER HOME CARE. Some aging men and women, though they cannot live alone, can live very well in a family and be more happy in one; but they may lack a family of their own willing and able to care for them. Programs to help the aging find foster homes have been tried and have in some cases been notably successful. There is need for more such programs and for much additional experimentation to make the programs work well.

SHELTERED WORKSHOPS AND OTHER WORK OPPORTUNITIES. Two common curses of life following retirement are idleness and boredom. Some elderly men and women, though forced to retire, can secure new jobs in which their capacities are fully used. Still others may live lives filled with family and social activities, intellectual interests, volunteer work, hobbies, travel, and so on. But this still leaves a substantial number whose lives are completely empty and who

NURSING HOMES continued

appear to be unemployable. If left without help or guidance, they will inevitably deteriorate. What can be done to help them?

Recreational programs and occupational therapy can help many. But some cannot feel happy or hold their heads high unless they are at least in part "earning their keep" as part of the production process. With sufficient ingenuity, work can be found for many of them. One way is through "sheltered workshops" where they can earn money performing such functions as sorting, assembling, sewing, hat making, and so on. These workshops differ from occupational therapy in providing "real" work instead of "busy" work—an important distinction for many of the elderly. Sheltered workshops can be set up independently or attached to a day-care center, a housing center, or a home for the aged. The aged and aging can be effectively used, too, in a variety of volunteer programs—listening to children read, addressing envelopes, visiting in hospitals or homes for the aged, teaching skills like knitting or sewing, and so on. The urgent need is for organizations that will bring the work to the aged or the aged to the work (with suitable safeguards to avoid their exploitation).

INFORMATION AND REFERRAL CENTERS. Of crucial importance is a single center in each community to which the aged and their families can go for unbiased information on what facilities are available. Such centers can also evaluate the applicant and advise on the facilities most likely to meet his needs and wants. Centers designed to serve this informational and counseling function have been established, though in some cases only on a small scale, in Chicago, New York, Philadelphia, Baltimore, Md., Providence, R.I., and Worcester, Mass.

In communities that lack such a referral center, patients may end up in a high-cost, low quality nursing home despite vacancies in a low-cost, high quality home nearby. They may end up in a home that does not provide services they urgently need, or does provide (and charge for) serv-

ices they don't need. Worst of all, they may end up in a nursing home despite the availability of preventive services, which would enable them to continue an independent, happier life outside.

The greatest single step

To what extent could we solve our nursing-home problem by expanding these preventive services? Estimates vary. The proprietor of one nursing home told CU researchers frankly that 40% of his residents, currently paying \$325 per month and up, could live perfectly well outside—at lower cost and with far greater independence—if such services were available. One difficulty is that there's a profit in nursing homes but none in these preventive services. Hence most of the money, both for construction and for operating expenses, is going into nursing homes. No doubt the greatest single step most communities could take toward improving the quality and cutting the cost of services to the aged would be a broadscale expansion of the preventive services described above.

These preventive services, let us stress again, are not pie-in-the-sky dreams of ivory-tower theorists. They have repeatedly proved their worth in actual operation. Indeed, all of them have already been accepted by Congress as integral parts of our national program for the aging. On recent visits to Washington, CU researchers found the U.S. Department of Health, Education, and Welfare a beehive of activity relating to these programs. The Housing and Home Finance Agency, the FHA, the Small Business Administration, and other agencies, too, have programs for the aging in operation. But the curse of most of these activities is "tokenism."

Congress has authorized the programs, and has thus given Senators and Congressmen an exciting list of developments to point to when campaigning for re-election. But it has for the most part voted only token appropriations, and has thus limited most of the programs to a scale wholly inadequate to national needs. Many states, too, have failed to take full advantage of the Federal funds available to them for such preventive services.

Types and levels of care

Even if an unlimited array of preventive services were available, of course, many of the elderly would still need—and some would prefer—the kinds of care available in homes for the aging or skilled nursing homes. These homes fall generally into three broad categories from the point of view of sponsorship and administration.

Three types

Public homes are owned and operated by state and local government departments. The latest (1961) Public Health Service survey of nursing homes and related facilities reported that 12% of all beds were in public homes.

The public homes are in some cases the direct descendants of the traditional poorhouses, county farms, and other

tax-supported dumping grounds for the aged, the disabled, and the paupers. A few have changed little through the years. But some cities, counties, and states have built and now maintain excellent nursing-home facilities—often financed in part with Federal funds and offering good care to residents able to pay their way in whole or in part as well as to the indigent and the medically indigent. When shopping for a nursing home, don't write off the public homes before investigating them.

Voluntary homes are owned and operated by religious groups, fraternal organizations such as the Masons, a few labor unions, and other voluntary non-profit associations. The voluntary homes run by Catholic and Jewish organizations, and by several Protestant denominations, are of par-

ticular importance as pace-setters and as centers for experimentation with new services and new patterns of care. The PHS survey reported 16% of all nursing-home beds in voluntary homes, which have these advantages:

Funds for their physical plant are often donated in whole or in part, so that capital costs may be lower.

They usually need pay no taxes.

They can draw on many hours of voluntary help to provide additional services without additional cost.

They can tap without cost the abilities of community leaders on their boards of directors.

They need not add a profit margin to their schedule of charges—in fact, they can set their charges below their costs and meet their deficits through contributions.

These factors combined mean that the typical voluntary home can offer considerably more service per dollar than a proprietary home charging the same rates. In addition, the voluntary homes are more likely to be managed and staffed by men and women sincerely dedicated to the welfare of their residents without regard for personal gain.

But these inherent advantages do not necessarily add up to a net superiority of all voluntary homes over all proprietary homes. Voluntary home managements, however dedicated and well-meaning, may be misguided, set in their ways, overly protective of their residents, ignorant of progressive trends. In extreme cases a voluntary home may be run more for the benefit and convenience of its management and staff than for its residents. The worst of the voluntary homes have been described by the Reverend C. A. Becker—administrator of a church-associated nursing home in Wisconsin—as “mausoleums of the living dead, a disgrace to church and God himself.” When shopping, accordingly, it is well to judge each home—public, voluntary, or proprietary—strictly on its merits rather than on the motives of its owners or sponsors.

Proprietary homes are owned and operated for a profit by individuals, partnerships, and corporations. The PHS survey reported that 72% of all nursing-home beds were in these proprietary homes. They have gained this enormous numerical lead over public and voluntary homes in part because the profits of nursing-home operation have attracted many new investors, but in part also because our cities, states, counties, and voluntary organizations have been slow to assume responsibility and to seize opportunity.

The proprietary homes vary enormously from one another. Many are quite literally “homes”—private houses

that have been converted to nursing-home use, staffed by a widow or couple who take in half a dozen aged residents, with or without the help of a nurse or two. Sometimes the proprietress is herself a registered or a practical nurse. At the other extreme are strictly modern 100-or-more-bed proprietary homes, with motel-like architecture and 50 or more employees, often part of a corporate chain of similar homes. Some proprietary homes serve primarily or exclusively welfare recipients; in effect, they are contractors providing service to a state, county, or city. Others serve primarily or exclusively residents with private means; their charges are likely to run higher than those of the welfare homes—from \$325 per month to \$500 or even \$750. CU will report in more detail on these homes in a future issue.

Three levels

Nursing homes and related facilities also vary widely with respect to the type and extent of services they offer. Many classifications have been proposed, and many states have developed their own classification systems. One of the simplest is a Public Health Service classification, which recognizes three levels of care:

Residential care, defined as “primarily room and board, with limited services such as laundry, personal courtesies such as occasional help with correspondence and shopping, and a helping hand. . . .”

Personal care, defined as room and board plus personal services such as help in walking and getting into and out of bed; assistance in bathing, dressing, and feeding; preparation of a special diet (diabetic, low-salt, low-fat, high-protein, etc.); and supervision over medication (such as pills) that can be self-administered.

Skilled nursing care, defined as room and board plus “those nursing services and procedures employed in caring for the sick which require training, judgment, technical knowledge, and skills beyond those the untrained person possesses.” Staff includes registered professional nurses (R.N.’s) or licensed practical nurses (L.P.N.’s) or both. Some large skilled nursing homes provide an X-ray department, laboratory diagnostic facilities, and almost everything else (short of major surgery) needed for care of the ill. Some smaller homes secure these services through arrangements with a nearby hospital.

Combination homes

The Public Health Service also recognizes combination homes—those that give primarily residential or personal care but with skilled nursing care available when needed. The homes in the 1961 PHS survey were distributed by type as follows:

Residential care homes without skilled nursing	34,600 beds
Residential care homes with skilled nursing	12,400
Personal care homes without skilled nursing	124,000
Personal care homes with skilled nursing	83,100
Skilled nursing care homes	338,700
Total beds	592,800

The trend in recent years has been to add skilled nursing care to homes that previously provided solely residential or personal care. Indeed, this trend has proved unavoidable. A home that starts with patients in their 70’s, all of them well and able to care for themselves, will find itself a

CU WELCOMES YOUR SUGGESTIONS

Readers who have had personal experience with nursing homes are invited to forward their comments and suggestions to Nursing Home Project, Consumers Union, Mount Vernon, New York, for use in drafting subsequent articles in this series. Letters cannot be individually acknowledged, however—and questions about specific nursing homes or about the nursing home situation in particular states or communities cannot be answered.

NURSING HOMES continued

decade later with many patients in their 80's who need more and more nursing care. A resident who must move out because he needs more care than a home provides faces a harrowing experience. A resident may even try to hide his illness to forestall removal; this can make his recovery more doubtful. As a result, even homes that would like to limit themselves to hale and hearty residents are under constant pressure to add skilled nursing care. From the shopper's point of view, one of the most important questions to ask about a home for the aged is a simple one: "What happens to a resident who falls ill and needs nursing care?"

Specialized facilities

Closely related to the homes for the aged and nursing homes described above are four kinds of facilities offering specialized kinds of care. These are:

LONG-TERM-CARE UNITS IN GENERAL HOSPITALS. Many surveys have shown that the aged sick tend to occupy general hospital beds, at rates that may average \$30 a day, long after they have recovered from their need for the intensive kind of care general hospitals are staffed and equipped to provide. They stay on because they have no place else to go for even the minimal care they need. Hence some 500 general hospitals have established long-term-care units (sometimes called extended-care units) for such patients. Emphasis in these units is—or should be—on rehabilitation procedures designed to return the patient to life in his community or at least in a nursing home. The cost per day is generally much lower than in other parts of the hospital.

REHABILITATION CENTERS. These are precisely what their name implies—places where the disabled or chronically ill

can be restored either to good health or to a sufficient degree of health so that they can live independently or in nursing homes. Some centers serve outpatients only; others have residential facilities for patients in the process of rehabilitation. Victims of stroke are often good candidates for rehabilitation services.

CHRONIC DISEASE HOSPITALS. Some states and voluntary agencies have established special hospitals for the chronically ill, most of whom are aged. A number of these are outgrowths of the old tuberculosis hospitals and occupy buildings no longer needed for TB patients. Chronic disease hospitals vary enormously. Some are mere nursing homes under another name. Some offer excellent rehabilitation services and specialized medical services such as radiation and chemotherapy for cancer.

MENTAL HOSPITALS. Though in theory dedicated to the care and treatment of the mentally ill, these institutions—both state and private—actually house today many aged patients who cannot be distinguished in any way from many residents of nursing homes. Nursing-home patients, too, often suffer from mental confusion, depression, agitation, or other mild psychiatric conditions. The newer psychiatric drugs, and new understanding of the nature of these infirmities, make it possible for psychiatrically oriented nursing homes to care for many of them. As our nursing-home system expands, it seems likely that more and more elderly men and women with temporary or chronic mild psychiatric illness will properly be routed to such nursing homes rather than to mental hospitals. The fact that Federal OAA funds can be used for needy nursing-home residents, but not for mental hospital patients, will no doubt hasten this trend. Louisiana has already opened three 250-bed nursing-home units for the care of patients previously lodged in state mental hospitals.

What's wrong with the picture?

Viewing the entire spectrum of services for the aging and aged from day-care centers through geriatric housing projects to nursing homes and specialized institutions, what do we find?

First and foremost, few families have access to all of the facilities and services we have been describing. Thus aged residents must make do with whatever bits and pieces of a coherent program which happen to be available locally. *Second*, the quantity of service is grossly inadequate to the need. If all the states were to be as well supplied with long-term-care beds as the five leading states, an additional 500,000 beds would be required.

Third, the quality of service, especially nursing-home service, is still substandard in many respects. State standards for licensure, though slowly rising, are still too low in most states.

Finally, coordination is lacking—the kind of coordination that would channel both public and private funds into the most urgently needed services and would also offer to each person the kinds of services he needs. At present the

distribution of services is haphazard, not only from community to community but also within each community. One indigent patient ends up in the understaffed, under-equipped back ward of a state mental hospital; a neighbor in precisely the same mental, physical, and economic position goes to a substandard nursing home; a third is fortunate enough to be routed to a first-rate nursing home where he lives out his life in comfort or gets the kind of rehabilitation service he needs to return to his own home. Similarly, a patient with adequate financial resources may get outstanding care at \$300 or \$400 a month, or may waste his life savings lying in bed in a modern, plate-glass, \$750-a-month snakepit.

Next month CU will provide concrete, practical advice on how to shop for good nursing homes in your community, what to look for when you visit them—and how to evaluate what you see. The third installment will discuss nursing-home costs and charges and will make specific recommendations for the improvement of nursing-home care.

Accreditation: coming soon?

The most helpful tool for aging men and women, and for their families, in the search for a good nursing home would be a list of *accredited* homes in their vicinity—homes which they could be sure met reasonable standards in all important respects.

A list of accredited general hospitals is readily available. The Joint Commission on Accreditation of Hospitals sets minimum nationwide standards, then surveys each hospital periodically to determine whether it is living up to those standards. (Consumers can get a list of accredited hospitals from the Joint Commission at 200 East Ohio St., Chicago 11, Ill. Send stamped, self-addressed envelope and 50¢.) The Joint Commission's accreditation has had a welcome effect in raising hospital standards generally; for countless hospitals have improved their procedures and remedied their shortcomings in order to achieve and maintain their accreditation.

A similar service to the nursing home field could be of overwhelming value. Health and welfare officials have accordingly often asked why the Joint Commission should not similarly establish standards for nursing homes, survey the homes periodically—then publish lists of accredited nursing homes for the benefit of the aged, the chronically ill, and their families.

In November 1962, it looked as if this major step were on the verge of accomplishment. After two years of spade work the Joint Commission had unanimously recommended to its sponsoring organizations—the American Hospital Association, American Medical Association, American College of Surgeons, and American College of Physicians—that a nursing home accreditation program be launched. Tentative standards had actually been drawn up. Three of the four sponsoring organizations were all set to go. But actions of the Joint Commission must be unanimous—and in November 1962, the AMA announced its veto. As a result of this AMA veto, the urgently needed Joint Commission accreditation program died aborning.

What caused the AMA to sabotage the Joint Commission plan? The reason officially cited by Dr. Percy E. Hopkins, chairman of the AMA Board of Trustees, was that the Board had decided "after lengthy study and many conferences" that the plan "would not be feasible at this time because of the strong opposition by the American Nursing Home Association to the proposed program and because of certain other important factors."

CU asked Dr. Hopkins and the AMA for a list of these "certain other important factors," but the reply failed to mention even one.

Other outstanding authorities on nursing-home accreditation, however, did talk to CU researchers about the AMA's "other important factors." The three factors most frequently cited were these:

1. An increasing number of American physicians and their wives, as CU noted last month, have been investing, openly or secretly, in commercial nursing homes. The American Nursing Home Association (ANHA), while it has some non-profit homes in its membership, is the recognized spokesman for the proprietary homes, including many owned in whole or in part by physicians. Hence, when the ANHA voiced its "strong opposition" to the Joint Committee accreditation programs, the AMA Trustees,

it was alleged, paid attention—and pulled out of the program.

2. The American Medical Association at the time of the nursing-home decision was waging a bitter campaign against President Kennedy's medical-care-for-the-aging program. That program included a reference to a national nursing-home accreditation program. The AMA Trustees, it was alleged, somehow or other associated the Joint Commission accreditation program with what they considered the evils of medicare, and so voted against it.

3. One prime mover in the effort to launch the Joint Commission nursing-home accreditation program had been the American Hospital Association. The AMA Trustees were irked with the American Hospital Association because it had refused to join in the anti-medicare campaign, and they dumped the accreditation program, it was alleged, as a reprisal measure against the AHA. The trade publication *Modern Hospital* seemed to sum up this phase of the matter in a headline:

AMA AND NURSING HOME ASSOCIATION DEAL AHA OUT OF ACCREDITATION PROGRAM

While CU's researchers know of no documentary proof of these allegations, the AMA's next step did tend to confirm them. Along with vetoing the Joint Commission program, the AMA Board of Trustees authorized a new accreditation program, independent of the American Hospital Association and the Joint Commission. This new accreditation program was to be under the joint auspices of the AMA and the American Nursing Home Association! The AMA, moreover, supplied nine-tenths of the "seed money" for the new program.

Thus, motives aside, the AMA record of action is clear and distressing. Instead of going along with a rational, objective, patient-oriented program under the impeccable auspices of the Joint Commission on Accreditation of Hospitals, the AMA Board of Trustees chose instead to lend the AMA's prestige, and to contribute its funds, to the kind of accreditation program desired by commercial nursing-home proprietors and the corporate nursing-home chains in the American Nursing Home Association.

Ask your own doctor about this the next time you talk with him—or tell him about it if he has not heard. Perhaps he can use his influence within the AMA to urge a reversal of the AMA Trustees' decision. For the issue is still an exceedingly live one.

On November 7, 1963, representatives of 13 organizations concerned with nursing homes met in Chicago at the call of the American Association of Homes for the Aging to discuss an accreditation program which might be launched independently of the AMA and ANHA. Surprisingly, AMA and ANHA representatives attended the meetings, and indicated that their organizations might reconsider their earlier decision to "go it alone together" and might after all join with the 11 other professional organizations in a multilateral accreditation program. No decision was reached; but the representatives present agreed to check back with their organizations and meet again on February 20, 1964. Thus the AMA and the ANHA have another chance to accept a patient-oriented accreditation program. CU will report the outcome of the February meeting.

Nursing Homes

BY RUTH AND EDWARD BRECHER

PART 2: *How to Shop for a Nursing Home*

Each year, half a million American families face the complex and troublesome task of selecting a nursing home, home for the aged, or some similar facility for an aging family member. Since a nursing home stay may extend over several years, and cost several hundred dollars per month, many thousands of dollars may be involved in such a decision—plus the health and happiness of the patient, perhaps for the rest of his life.

This month we present suggestions for choosing a nursing home, based on the findings of CU's researchers and the advice of a number of experts in the field.

The overwhelming majority of American families with aging relatives gives little thought to nursing home selection until the day of crisis arrives. Then, when a decision can no longer be postponed, there is a hurry and scurry to find some place to send the patient. Under such conditions, no one has time to shop thoroughly or sensibly; and besides, at the time the crisis arises, the range of choice is limited to those homes in your vicinity (if any) which happen to have a vacant bed. The patient by then may be in no physical or mental condition to make a decision for himself; he must accept whatever decision his family, attorney, friends, or the Welfare Department makes for him.

The best way to avoid these last-minute crises is for Americans over 65 or so—especially those in good health who do *not* need nursing-home care at the moment—to

shop for themselves in advance of the need, and to learn as much as possible of the local nursing-home situation. They will find themselves warmly welcomed as visitors at well-run nursing homes. If they stay to make friends with a few of the lonelier residents, they are bound to get a more intimate view of the institution. And even if it turns out that they never need a nursing home, their time may not be wasted, for they will be in a position to advise their friends and neighbors who suddenly do need nursing-home accommodations.

Elderly men and women should also consider the use of a good nearby nursing home for *temporary* shelter—when younger members of the family are taking their annual vacation, for example, or when some other family member is sick and needs home care. During such a temporary stay, the visitor will learn what living in a nursing home is really like, without the burden of anxiety and depression which so often complicates transfer to a nursing home in time of illness or other crisis. Some nursing homes welcome such short-term, exploratory stays.

Note, too, that some outstanding nursing homes, especially "voluntary" homes under religious or other non-profit auspices, offer well-planned day care programs and other services for non-residents. Enrollment in one of these programs is one way of learning about a nursing home, and of easing the transition from home to nursing home.

Preparing a shopping list

As matters stand, lacking guidance from an impartial Joint Commission accreditation program (see story opposite), consumers must make their choice of a nursing home with the aid of less authoritative guides. For convenience, CU suggests that you divide the selection process into two distinct phases:

First, prepare a list of homes likely to be worth visiting and inspecting.

Second, actually visit half a dozen or more of these homes, inspect them closely, then reach a decision primarily on the basis of what you have found out for yourself.

There are many ways of building up your preliminary list. A few communities, as CU noted last month, maintain a central "information and referral center" for the aging. If there is one near you, by all means go there first. But, there are many sources of information and

useful steps to take beyond that, even if you are lucky enough to have access to a referral center.

HOMES LICENSED BY YOUR STATE. Most state health or welfare departments publish a list of licensed nursing homes in the state. Send for a copy, then limit your shopping to homes that are licensed. Despite compulsory licensing laws in all 50 states, unlicensed homes in some states are still being permitted to operate with impunity.

Make sure, moreover, that the home you select is *fully* licensed. Some states give "provisional licenses," "temporary licenses," or other quasi-licenses, to homes which fail to comply with official regulations.

AHA REGISTRATION. In 1958, the American Hospital Association established minimum standards for skilled nursing homes, and it now "registers" homes meeting these standards. While AHA registration falls considerably short of

NURSING HOMES continued

a full-dress accreditation program, it is helpful in identifying well-run homes. Thus, the AHA registration list is another good place to locate skilled nursing homes likely to be worth inclusion in your shopping list.

To get a copy of the AHA list, send your request and a stamped, self-addressed envelope to the Bureau of Registration and Approval, American Hospital Association, 840 N. Lake Shore Drive, Chicago, Ill. 60611.

Note that the AHA list includes only homes which offer skilled nursing care facilities. Also there has been some opposition to AHA listing on the part of proprietary nursing homes, so that some good homes are missing from the AHA list. But in the opinion of CU's nursing-home consultants, the hunting is likely to be better among AHA-registered homes than among those which lack this distinction.

LOCAL ACCREDITATION. A few state and district nursing-home organizations—notably those in California and in Erie County (Buffalo), N. Y.—have joined with local medical societies and others to establish local accreditation programs. If there is such a program in your state, it will no doubt pay you to ask about it and to secure a list of locally accredited homes.

CONSULT NURSING HOME RESIDENTS YOU KNOW. If you have a friend in a nursing home, or if your friends have friends there, by all means make inquiries.

CONSULT YOUR CHURCH. Your priest, rabbi, or minister may know of non-profit, church-associated homes under the auspices of your own denomination where you may be entitled to priority. As CU noted last month, non-profit homes can in general give more and better service per nursing-home dollar—though they may not always live up to their opportunities.

CONSULT YOUR DOCTOR. Ask any doctors you trust to suggest additions to your list, and to weed out homes they consider substandard. But remember that some doctors have a financial stake in a particular home, and may be helping to keep it full. (If your doctor resents the implication that his recommendation might be self-serving, ask him tactfully whether he has taken any steps to secure

the outlawry of improper doctor-nursing home relationships by his county medical society or by the AMA. While the doctors with secret financial stakes in nursing homes are no doubt a small minority, they appear to be a growing minority—and the rest of the profession is standing idly by while this scandal festers.)

CONSULT YOUR HOSPITAL'S SOCIAL WORKER. Many patients are admitted to nursing homes upon discharge from general hospitals; finding good nursing-home accommodations for these patients is one of the standing functions of the hospital's medical social worker.

HOSPITAL-AFFILIATED NURSING HOMES. Some nursing homes are formally affiliated with nearby general hospitals. Experts interested in improving nursing-home standards believe that this kind of affiliation is essential for bringing the nursing homes into the mainstream of modern medical progress. If any of the nursing homes in your vicinity have such an affiliation, place them high on your list.

SHOPPING FOR WELFARE RECIPIENTS. About half of all nursing-home residents, as noted last month, have their bills paid in whole or part by welfare departments under the old-age assistance (OAA) or medical assistance for the aged (MAA) programs. In such cases, welfare officials commonly pick the nursing home; and the welfare recipients and their families are likely to accept the selection as if it were binding on them—but it is rarely binding. In most states, welfare recipients and their families retain (in theory at least) the right to make their own choice among nursing homes willing to take welfare patients.

A minority of homes, it is true, refuse to accept welfare patients at all; others set a quota for them or have rates so high as to exclude welfare recipients. But, subject to these limitations, you can and should shop for a welfare recipient as you would for a self-paying patient.

SELECTING THE RIGHT TYPE OF HOME. As noted last month, the term "nursing home" can be used to cover anything from a boarding home for the elderly to a fully staffed and equipped "skilled nursing home" offering almost every type of health service for the aged and the chronically ill except surgery.

Limit your shopping to those homes which provide at least the services your family member now needs or is likely to need during the months ahead. Ask your physician for a list of these needed services, then check to determine which homes on your tentative list are staffed and equipped to provide them. Even if the patient for whom you are shopping requires only simple residential services at the moment, make sure that the home has some practical arrangement to care for residents when they fall ill.

A growing number of states have nursing home classification systems, and set minimum requirements for the homes in each classification. Homes fully staffed and equipped to handle bedridden, seriously ill patients needing skilled nursing attention, for example, may be classified as Group I or Class A; homes offering only residential care may be classed as Group IV or Class C. Your state health or welfare department can tell you whether your state has such a system; if it does, get acquainted with

A BASIC QUESTION

Are you sure a nursing home is the answer? As CU noted last month, many elderly people are shunted into nursing homes who might continue to live happily and independently on the outside with the help of suitable programs: organized home care, meals-on-wheels, day care centers, foster homes, housing projects for the aged, etc. Carefully review these possibilities—discussed in last month's REPORTS—before deciding on a nursing home. (Copies of the January issue are still available; send 50c to Back Issue Dept., Consumers Union, Mount Vernon, N. Y.)

it—and strike from your tentative list those homes which are classed below the level the prospective patient requires.

LOCATION OF HOMES. Place high on your list those homes whose locations will be convenient for visiting by yourself, other relatives, and friends. The more convenient the location, the more visits the resident will receive—and few medicines can do as much for nursing-home residents as frequent visits from those they care for.

Consider, too, the relative advantages of a central city location where residents can watch familiar traffic on street and sidewalk, stroll or take a bus to the park, the library, a movie, or a ball game, and feel themselves still at the heart of things—as contrasted with a suburban or rural site where they can enjoy the trees, birds, flowers, and friendly neighbors. Remember that it is their tastes and preferences you should be considering—not your own.

What to look for on your shopping visits

On the basis of such considerations as are set forth above, you should be able to focus on those nursing homes which are fully licensed, are adequately recommended by people in a position to know, offer the needed services, and are appropriately located. Phone or write for the descriptive brochures that most nursing homes publish, study them, share them with the prospective resident, and then start on your rounds. Here are the main points to look for:

ARCHITECTURE. You will quickly discover the distinction between the older, smaller homes utilizing converted residences and the newer, larger fireproof structures—many of them as modern in design as the latest and most luxurious motels. You may feel an almost irresistible impulse to strike the older residences off your list and to choose a spic-and-span newly built home on the basis of architectural design alone. Resist that impulse.

THE SPIRIT OF THE PLACE. Appropriate architecture, to be sure, is a worthwhile plus for any nursing home. But there is one factor which outweighs both architecture and most other considerations. "The only nursing home whose patients I really enjoy visiting," a Maine physician told CU researchers, "is a 19th century architectural monstrosity, so unprepossessing that you might turn up your nose and pass it by without entering if you were on a shopping trip. The front porch sags; it badly needs a coat of paint; the state officials sigh when they renew its license. But the spirit's a joy to behold.

"Everybody's happy there, and active, and busy. The place is really run for the residents—and in large part by them, too." Here are some tips on how to evaluate this elusive characteristic, spirit, when you visit a home.

First of all, look at the *patients*. "An amazing number of shoppers," one nursing home administrator remarked, "look at me, and at the bathrooms, check for dust in the corners and inspect the potted plants—but ignore the patients altogether. Yet the proof of nursing-home quality is in the feelings and attitudes of the patients."

You should not, of course, expect too much when evaluating nursing-home spirit. Old age and illness take their tolls; men and women in their 80's and 90's with multiple physical impairments can't be expected to be spry and gay. Hence it's wise to withhold judgment on this count until you have visited three or four homes at least, to have a basis for comparison. Remember, too—in this as in all other respects—that it isn't yourself you are shop-



ping for; it's the prospective resident's tastes that should be accommodated. Above all, discount the sales pitch of the front-office man or woman who shows you around. Any nursing home can hire or train a good salesman, capable of handling *shoppers* suavely. Be on the alert for the interactions between staff and *residents*.

STAFFING. Adequate staffing in a nursing home depends on three main things:

- There must be enough employees.
- They must have the needed skills.
- They must have proper attitudes toward residents.

A fully staffed skilled nursing home should have at least one registered professional nurse (R.N.) on duty around the clock seven days a week. There will be, in addition, a licensed practical nurse (L.P.N.) in each wing or unit, plus an adequate supply of nurses' aides, orderlies, maids, and other employees. There should also be an occupational therapist, a physical therapist, a recreation director, and other specialized professionals on duty full time or part time, depending on the size of the home. There may also be a consulting psychiatrist who makes periodic visits. In all, such a home is likely to have one full time employee for every two residents. Its charges will necessarily be high.

Such homes, however, are rare. Most nursing homes will taper off from this high standard to the level where there is an R.N. on duty only 40 hours a week, or where the nursing supervisor is a licensed practical nurse instead of an R.N., and so on down.

The only way to find out about staffing patterns is to ask—and hope that the answers apply to actual employees rather than to some ideal pattern which the home hopes

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to attain some day. Don't rely *too much* on simple observation; some states tolerate "nurse masqueraders"—women who wear the distinctive uniforms and caps of the R.N. without having the training the costume symbolizes.

But by careful observation you can gauge the attitudes of the staff toward the residents. These attitudes are set in part by the administrator, and in part by the working conditions; a home that pays less than the going wage and makes undue demands on employees is likely to be unmasked by a prevailing surliness. On the other hand, don't be misled by syrupy staff attitudes, and be particularly vigilant to avoid homes where the administrator makes such remarks as, "We treat them just like babies, poor things." Few old people really want excessive "sweetness and light"; like the rest of us, they prefer to be cared for with dignity.

THE SMELL OF ILLNESS. "I can tell almost as much on a visit to a nursing home with my nose as with my eyes," one state inspector told CU. Many patients in the typical home are incontinent. A well-run home restores control functions to as many residents as possible through specific rehabilitation procedures—and keeps the incurably incontinent patients clean and neat.

Some homes seek to mask the odors of incontinence by means of incense, perfume, pine oil, or modern masking aerosols. This is *not* recommended practice, no matter how pleasant the result. For the presence of a strong masking odor means that staff members are not promptly alerted to a resident's need for attention. Some good homes refuse, on principle, to use deodorants; others make sparing use of them for temporary unpleasant odors.

Kitchen and dining room odors, too, can tell a visitor much about ventilation and cleanliness.

THE CURSE OF DEPERSONALIZATION. Humans dread large institutions, and especially long stays in them, in considerable part because of their depersonalizing effect. Everyone is treated the same, subjected to the same rules and regulations, and even may be fed the same food and dressed the same. We demand to be ourselves, with our own separate identities; and this demand lasts long after most other demands have been muted by age and illness.

The best nursing homes understand this, and make intensive efforts to avoid depersonalization. Residents, for example, may be encouraged to bring their own furniture to the home, so that each room is individually furnished in the style of its occupant. The comfort a resident draws from living on surrounded by his familiar *lares* and *penates* can hardly be overemphasized. Where complete self-furnishing is not permitted or feasible, good nursing homes permit at least token memorabilia of a more vigorous past—favorite pictures and photographs, a well-worn easy chair, a crocheted bedspread, a shelf of precious books. Be on the lookout for such personal treasures as you make your tour of a home.

Clothing, too, is important in avoiding depersonalization. Notice the clothes of the residents; are they all



dressed pretty much alike, or are personal tastes respected? A gay scarf, a piece of jewelry, a jaunty necktie—such small things bespeak encouragement of individuality.

Finally, notice grooming. Are the men clean-shaven? Have the women had their hair done? Are nails clean and manicured? Ask about the arrangements for barber and beauty shop service.

PRIVACY. Though geriatric authorities stress the need of the elderly to maintain social activities and interpersonal relationships to the fullest possible extent, they also recognize the need for privacy.

"Peepholes or glass panels in doors, and lack of curtains or screens for privacy around beds in multiple bedrooms are affronts to dignity," one CU consultant writes. "In congregate toilet rooms, the absence of doors or curtains on stalls is similarly an affront. It tells you something about the attitude of the home."

The ultimate in nursing home privacy, of course, is a private room for each resident. Some authorities recommend private rooms; others oppose them as likely to lead to psychological isolation and depression. A higher rate is generally charged for private accommodations—though some studies suggest that a nursing home designed with private rooms may be as economical to run as one with double or quadruple rooms. No doubt the desirability of or need for a private room varies from resident to resident; but leaving the decision to each resident may not be an ideal solution, since a resident may want a private room for reasons of prestige or because she has had no experience with doubles and fails to appreciate the advantages. Other things being equal, you are probably wise to choose a double room in a first-rate home rather than sacrifice advantages for a private room in a less desirable home.

SEX SEGREGATION. Some nursing homes accept women residents only; others accept both women and men but segregate them as much as possible. CU's nursing-home consultants report that homes that encourage socializing among their male and female residents develop a much warmer spirit and are happier places to live. Everyone dresses a little better, takes a little more time with personal grooming—and makes a little greater effort to be pleasant and socially active.

RACE SEGREGATION. Many nursing homes admit only white residents; a minority admit only Negro residents; but a

trend toward integration is visible. Many state and county homes are already successfully integrated, and so are some voluntary and proprietary homes. CU's researchers visited several predominantly white nursing homes, including one in the mid-South, that admit Negro applicants and reported no difficulties whatever.

CALL SYSTEMS. A phone or intercom in every room is a gracious convenience, and a safety precaution as well—but room phones are rarely found except in the newer and more expensive homes. At the very minimum, there should be some kind of flashing light or buzzer system with which a bedridden patient can summon nursing aid without delay. Check for call buttons in the bathrooms, too.

VISITING HOURS. A few outstanding nursing homes have unlimited visiting hours—day and night. Many more have quite generous visiting hours—eight or ten out of every 24. A home with generous visiting hours is to be preferred for several reasons. This encourages visiting—and nothing does more for the morale of the residents. Also, a home with generous visiting hours is likely to keep itself presentable throughout the open period. Further, limiting visitors to two or three hours a day is likely to create a disturbing hubbub when the doors are opened—and residents who do not have visitors are likely to feel conspicuously left out of things.

FOOD AND FOOD SERVICE. Try to arrange your shopping visits to overlap a dinner or supper hour. Better yet, try to arrange to eat a meal in each home.

- Is the food adequate in quantity and attractively served?
- Are the hot foods hot and the cold foods cold when they reach the residents?
- Is the dining room pleasant, and are most of the residents eating there—or being served on trays in their beds?
- Are residents given time to eat at their own pace?
- Are meals served at convenient times? (No more than 14 hours should elapse between the evening meal and breakfast.)
- Are snacks available between meals and in the evening?

A few outstanding homes—notably those run by the Carmelite Sisters for the Aged and Infirm, a Catholic order devoted to the care of the aging—have not only a snack bar but also an attractive cocktail lounge where residents may order drinks. If a resident wants a Martini before dinner or a highball before retiring, and if his doctor approves, he is fortunate indeed to find a home which provides such amenities.

Ask to see the menus of each nursing home; many states require the homes to prepare menus in advance and to keep them on file. Note whether the meal actually being served matches the formal menu; the menu may be window dressing to impress the state nursing-home inspector.

Ask about special diets—diabetic, low-salt, low-fat, etc.—prescribed for many nursing-home residents. Well-managed nursing homes have carefully worked-out plans for preparing the proper number of meals of each kind, and for routing the appropriate meal to each patient. Some homes save trouble by serving low-salt, low-sugar, low-fat meals to all patients, and letting those who want salt,

sugar, or fat add it for themselves. This procedure is generally frowned on by dietitians as likely to impair the palatability of the food, and to lead to errors.

Visit the kitchen. Is it clean, well-organized, well-ventilated? Are foods stored clean and dry, with adequate refrigeration capacity available?

SPECIAL SERVICES. The larger and more modern nursing homes will proudly show you many special features—for example: a dentist's office, fully equipped; a chiropody chair for foot care; an occupational therapy room where residents can work at weaving, ceramics, painting, sewing, etc.; a physical therapy room with parallel bars, stairs, walking aids, and other equipment.

The largest may even have a laboratory for diagnostic tests, an X-ray department, and an examining room for the use of visiting doctors.

All of these are valuable adjuncts to a nursing home—but in addition to noticing the equipment, watch for evidence that it is actually being used. It costs comparatively little to equip a home, but a lot to staff it adequately for the routine use of the equipment.

WORK PROGRAMS. Some expensive nursing homes stress their "complete personal service"; residents need not lift a finger to help themselves. Some other homes, in contrast, take advantage of work opportunities within the home to make residents feel useful and needed. Patients should never be exploited, of course—but in one of the best homes in the country, CU researchers saw a resident hard at work in the kitchen with the staff. "She got in the way at first, and was more trouble than she was worth," the nun in charge remarked, "but it was the only way to keep her happy—and now she really is helping." The administrator of another home remarked, "Morale went way up here when we permitted our ambulatory patients to make their own beds and clean up their own rooms." A few homes have sheltered-workshop units where residents can make objects for sale or earn money in other ways. Such possibilities have to date barely been explored; they offer much hope for the future. Give preference to a home which uses these or other devices to keep residents active.

ACTIVITIES. The best nursing homes have intensive recreational and activity programs—designed not just to pass the time, like radio and TV, but to secure active participation. Here are some examples:

- Birthday parties and celebrations of other special events.
- Games: cards, chess, checkers, bingo, etc.
- Croquet, shuffleboard, horseshoes, and other active outdoor amusements.
- Newspapers, magazines, books on the premises, library service available.
- Lectures, music programs, amateur theatricals, dances, etc.
- Hobby clubs for photography, stamp collecting, gardening, etc.

"I would rather see activity than spotlessness," one CU consultant writes, "but this doesn't mean that the residents have to be playing pingpong. Activity may mean green

NURSING HOMES continued

plants in the resident's room which he is caring for himself, or an afghan she is knitting."

Some outstanding homes permit and facilitate outside trips and expeditions. An attendant may take a group of residents shopping, or to the movies, or to a concert, the theatre, or a lecture. Residents able to get around town by themselves are encouraged to do so. A summer camp, or summer weekends in the country, may provide a welcome change for residents who are well enough. This freedom, in turn, acts as a powerful motivating force in persuading depressed or physically handicapped residents to follow rehabilitation procedures conscientiously in the hope that they, too, may soon be able to get around on their own.

SELF-GOVERNMENT. In a few homes visited by CU's researchers, residents had their own self-government which set rules, made recommendations, and negotiated with the administrator. Morale, of course, was high.

MEDICAL CARE. Nursing homes do not (with some notable exceptions) assume responsibility for the medical care of their residents. Instead, each patient in most homes is expected to continue under the care of his private physician. The wastes and inadequacies to which this system leads border on the incredible.

CU's researchers, for example, visited one suburban nursing home located 20 miles from the heart of the city supplying most of its residents. The proprietor proudly reported that each resident had completely free choice of his own physician; indeed, a total of 35 physicians were caring for the home's 104 residents! The cost of the time spent by those 35 doctors in driving to and from the home could have been used to supply the home with a full time resident physician.

A further effect of this anarchic system of medical care is that many patients seldom see their doctors, and some do not see one at all. A recent survey of 25 nursing

homes in Westchester County, N.Y., for example, revealed that in only seven of the 25 were all of the patients surveyed visited by a physician even once a month. Fifteen per cent of the patients saw a doctor every three months; 5% every six months; and 2% every "nine months or longer." Surveys in other areas have turned up patients who go year after year without ever seeing a doctor.

Finally, leaving each patient to his own physician means that some will continue under the care of physicians who have little interest in or experience with geriatric problems.

Pioneering homes for the aged and skilled nursing homes are seeking to improve this pattern of medical care—without depriving individual patients of their right to free choice of a physician—in several respects.

First, some homes have a sick-call system. A staff physician comes visiting at regular times once or twice a week, and any resident may ask to see him. Those residents who wish to may also name the staff physician as their private physician; others may continue under the care of their outside physicians if they so desire.

Second, some homes maintain tickler systems showing frequency of medical visits to each patient. If a patient has not been visited for an extended period—such as a month or two—the home phones the physician and reminds him that he has not been in to see his patient recently.

Third, some nursing homes have a physician-in-charge. Others have a staff committee of physicians who see that complete medical and nursing records are kept on all patients, and who meet periodically to review the records. Each patient's own physician is welcome at these staff meetings. If the medical staff notes that some patient is not receiving treatment that seems indicated, or is receiving treatment of doubtful value, the staff committee may consult the attending physician and make suggestions. This is the medical staff system commonly employed in general hospitals (and likely to be found in homes affiliated with general hospitals). Its extension to skilled nursing homes would contribute to both patients' welfare and the education of the medical profession in geriatric procedures.

Warning: heartbreak ahead

By conscientiously applying the shopping advice here offered, many readers should be able to get much more for their nursing home dollar than by picking a home blindly on the basis of someone else's recommendation or the ads in the yellow pages of the phone book. But many other readers are likely to find that CU's shopping advice leads only to bitter disappointment.

You may find a home which meets all or most of the specifications set forth—but at a rate you cannot afford

to pay. You may find that the only homes which provide high-quality care have waiting lists so long that the chances of admission within a year or two are negligible. (Here the advice to shop early in advance of need proves its worth; when you find what you want, you can get on the waiting list.) Finally, despite the most diligent search, you may fail to find a single suitable home in your area. Some of these problems seem presently unsolvable. Next month's article will try to deal with as many as possible.

Next month the concluding article in this series will tackle these crucial problems: How much does good nursing-home care cost, and how much should

it cost? How can and should the cost be financed? What can be done to raise the standards of care in nursing homes and in related facilities as well?

Nursing Homes

BY RUTH AND EDWARD BRECHER

PART 3: Costs, Charges, and Methods of Payment

How much are skilled nursing homes and homes for the aged actually charging these days? No nationwide survey of nursing home charges has ever been made; but from incomplete state surveys and from CU's own inquiries, the following rough data emerge.

The charge may be as low as \$75 or \$80 per month (and in rare cases even less) for minimal service to welfare recipients in substandard homes in some low-rate areas. At the other extreme, charges may run to \$500 per month or more—much more if private-duty nurses are added to the bill—for paying patients in skilled nursing homes in high-rate areas. Charges for comparable services, as noted in an earlier issue, are generally somewhat less in voluntary homes run by non-profit organizations such as religious denominations and fraternal orders.

Rates are also likely to vary within a particular home. Welfare patients, for example, are often charged less than paying patients for the same accommodations and services. There are likely to be "extra" charges for bedfast patients, incontinent patients, and so on. Charges may also vary with the type of accommodations occupied, as in this example from a well-run proprietary skilled nursing home in Maryland:

Semi-private room	\$325 per month
Four in a room	325
Group apartment	325
Semi-private apartment	495
Private room	595
Private apartment	750

"The above prices," shoppers are told, "include 24-hour nursing service, giving medications prescribed by the pa-

tient's physician, recreation, occupational therapy, shampoo, telephone at bedside, meals served in the dining room or in the individual room as desired." Personal laundry at this home is \$10 a month extra, hand-feeding \$45 a month extra, and care of the incontinent \$30 a month extra.

Monthly rates rarely include either medicines or doctors' services; these can, of course, add greatly to the patient's monthly expenses. A home with a good "sick call" system (described last month) can significantly reduce the cost and improve the quality of medical care. Under this system a staff physician comes once or twice a week, at a regularly scheduled hour, to see any patient in the home who wishes to consult him. A home with a part-time pharmacist who buys in quantity and who dispenses all medication at cost can also save patients substantial sums. Bear these money-saving services in mind when judging nursing homes. It is mostly voluntary homes that offer them.

When shopping, take time to understand the financial arrangements at each home. Ask for a written statement of them. "Rates must be stated when arrangements are being made to admit patients," says the 1959 Code of Ethics of the American Nursing Home Association. "All extras that must be charged for should be carefully noted, and refund policies [in case of death or discharge during a period paid for in advance] clearly stated so that there may be no misunderstanding later."

Also inquire about tipping practices. Many CU readers have written to complain that they are "blackmailed" for tips whenever they visit relatives in nursing homes. On the other hand, administrators complain that residents and relatives are responsible for the tipping evil; they often



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offer tips as bribes in an effort to get special favors. If tipping is generally practiced in a home, a resident who does not tip is obviously at a disadvantage; hence the customary level of tipping in a home should be determined in a frank talk with the administrator and should be added to the quoted rate to get the true cost. The obvious solution to the tipping problem is to pay employees a fair wage, then prohibit tipping altogether and enforce the prohibition. Some non-profit homes have adopted this policy. (The shockingly low wages paid by some nursing homes will be discussed next month.)

When you're choosing a nursing home, the balancing of quality considerations (reviewed last month) against the

rates charged is always a difficult problem. Your purse and your conscience must be your guide. (Remember that the cost of nursing home care is tax deductible, subject to specified limitations.) And the exercise of simple common sense may help matters.

Families often strain their resources to the utmost when a long-term patient is first transferred to a nursing home. Then, as month follows month, the financial load proves too heavy to bear. The cost per month may go up, moreover, as the patient grows older and sicker and needs more care, and as inflation raises nursing-home rates. As one of CU's nursing home consultants has pointed out, it is generally better to select at the beginning a home well within your reach rather than to start the patient out in a luxurious home only to find it necessary later to uproot him and shunt him to less desirable quarters.

Are nursing home rates too high?

Many letters complaining of exorbitant rates have come in to CU. From one point of view these complaints are no doubt justified. Let us suppose, for example, that the going rate in your area for good care in a skilled nursing home meeting acceptable standards is \$10 per day, \$300 per month, \$3650 per year. For a family earning \$10,000 or even \$15,000 a year this is clearly an exorbitant rate in the sense that it is more than such a family, if it has children, can afford to pay out of current income month after month or year after year. Nor can an aged man or woman dependent on Social Security afford such rates. But from the point of view of the *cost of services rendered*, the \$10-per-day rate may be quite reasonable.

To see where the money goes, let's take a look at the operating expenses of an actual skilled nursing home—an efficiently designed, well run, fully staffed, well equipped 100-bed proprietary home in a suburban area. More than half the cost of such a home goes for keeping the home staffed for four 42-hour shifts per week—168 hours in all.

"In a good 100-bed nursing home," the proprietor explains, "you will have approximately 64 employees. There will be 31 nurses' aides, 4 registered nurses, 3 licensed practical nurses, 5 kitchen helpers, 2 cooks, 1 chef, 3 maids, 1 porter, 1 maintenance man, 1 secretary, 1 bookkeeper, 1 director of nurses, 3 switchboard operators (2 part time), 1 administrator, 1 consultant dietician, 1 laundry worker, 2 occupational therapy assistants, 1 part-time chaplain, and a beautician and barber on commission basis." Here is the actual cost of staffing this home:

Nursing staff	\$ 91,456 per year
Food staff	24,980
Administrator	12,356
All other salaries and wages	27,000
Social Security and unemployment insurance	9,497
	\$165,289

The average pay per full-time employee in this home (even taking into account the \$237 per week for the ad-

ministrator) is less than \$50 per week plus meals—hardly a munificent rate. This home, moreover, is operating at 98% of capacity—a very high occupancy rate. Yet, despite low wages and few vacancies, the cost of staffing the home added up to **\$4.63 per patient per day**.

To this must be added the cost of raw food for meals, which in this home came to **\$1.05 per patient per day**.

Other operating expenses (phone, insurance, supplies, utilities, maintenance, repairs, laundry and linen, property taxes, etc.) came to **\$2.34 per patient per day**.

Finally, this 100-bed modern nursing home represents an investment of \$5200 per bed for land, building, and equipment, or \$520,000 in all. To earn a 6% return on this \$520,000 would add another **87¢ or so per patient per day**. In sum:

Salaries and wages	\$4.63 per patient per day
Raw food	1.05
All other operating expenses	2.34
6% on investment	.87
	\$8.89 per patient per day

This figure, of course, makes no allowance for depreciation. Moreover, it is for an unusually successful home, with only two beds out of the 100 vacant on an average day. Many homes operate at only 85% to 90% of capacity, which raises the daily cost per patient. And this home is in a state with relatively low wage levels.

Thus from the point of view of *costs*, \$9 or even \$10 per day may not be unreasonable, and may even be a bit low in some parts of the country.

This view is confirmed by the experience of Connecticut, where a rate of \$9.40 per day was set for *welfare patients* in Class A homes by the State Hospital Cost Commission. The rate was based on an analysis of the actual audited expenses of the state's Class A homes.

The conclusion is inescapable: *since the cost of nursing home care is greater than most families can meet, ways must be found to finance such care which do not depend primarily on current family income.*

Ways of financing nursing home care

Ours is a credit economy, built largely on the principle: "Buy now, pay later." This approach clearly won't work for nursing homes. So other ways must be found—and some have been found—to eke out current income as a source of funds for paying nursing home bills.

LIQUIDATION OF ASSETS. One common way to pay is through liquidation of assets. A grandmother dies at 80; the 85-year-old grandfather must go to a home for the aged or skilled nursing home. He sells his house and nets, let us say, \$10,000 over the mortgage. The problem here is that he cannot anticipate how many years longer he will live. He therefore can't know in advance at what rate he can afford to pay out his \$10,000.

One common solution is for him to take the \$10,000 and buy an annuity from an insurance company—the kind of annuity contract that assures a specified income per month for life no matter how long the annuitant may live.

Families, however, may be reluctant to enter into an annuity arrangement because they feel that the patient's life expectancy is shorter than the average for his or her age and that the annuity is therefore a poor buy.

Some universities and some charitable institutions will take an elderly man's or woman's \$10,000—or \$100,000—and guarantee a fixed income for life. There are sometimes substantial tax advantages in such an arrangement as compared with a commercial annuity; and the annuitant in addition has the satisfaction of knowing that any capital remaining after his death will be used for educational or charitable purposes.

Some homes for the aged have themselves taken on this annuity function by promising *lifetime care* in return for

a substantial lump-sum payment when the patient enters the home. Such arrangements were commonly made in the past by non-profit homes under charitable and religious auspices, and some are still being made. They have been getting rarer, however; for many non-profit homes that made these arrangements in the past found themselves stuck with annually rising costs of operation and with patients who lived far longer than expected in the carefree environment of a well-run home.

The more common approach nowadays, accordingly, is for the non-profit home to charge the entering resident a substantial entrance fee or "founders' fee" and in return to guarantee care for the rest of his or her life *at a fixed monthly rate*. Under such an arrangement the home still takes the risk of rising costs of care, but is freed of the risk that residents will live longer than anticipated without continuing their payments.

One drawback of most life-care contracts is that they deprive both the resident and the home of the welfare benefits to which the resident would otherwise be entitled. The state welfare department can and often does take the position that since the resident has such a contract, he has no need for welfare payments. But a life-care contract can provide, for example, that entering residents make a *deposit*, to be drawn on for monthly payments. The resident agrees to apply for welfare benefits when the deposit is exhausted, and the home agrees to keep the resident on at the welfare rate. If you are considering a life-care contract, explore this possibility with your lawyer and the lawyer for the home.

Life-care contracts of these or any other kinds are in effect insurance contracts and should therefore be under the strictest supervision of state insurance departments or other regulatory agencies to ensure equitable rates, adequate reserves, and sound financial practices. California and perhaps a few other states do regulate life-care contracts. But even in such states, *watch your step*.

A home may be advertised, for example, as under the auspices of a particular religious denomination. Families trusting the denomination may invest in the life-care contract without investigation. Later it may turn out that the home has only the loosest ties with the denomination and that it is in fact a separate legal entity for which the religious association has no financial responsibility. If the home should go bankrupt, the residents would be left without care and without recourse.

Note that life-care contracts are usually non-cancellable. If the resident doesn't like the home and wants to move elsewhere, he cannot count on getting the balance of his money back (though an equitable settlement can sometimes be negotiated).

Finally, beware of life-care contracts that do not cover skilled nursing care. If a resident later needs long-term nursing care of a kind not available under the contract, the "life-care" assurance may prove a mirage.

Most of the experts CU consulted approve in *principle* life-care contracts offered by financially responsible non-

ARE NURSING HOME BENEFITS INCLUDED?

More than six million Americans, it is estimated, have Blue Cross contracts or health insurance policies that will pay at least in part for nursing home care under specified conditions—for example, following hospitalization. Many of those entitled to nursing home benefits, it seems likely, are ignorant of this coverage and may fail to file claims, or may fail to take this coverage into account when deciding whether or not they can afford nursing home care. Hence CU recommends:

If you or any member of your family is contemplating nursing home care and has Blue Cross or health insurance coverage, check carefully to determine what portion of the cost of nursing home care, if any, will be paid by Blue Cross or the insurance company.

Some companies will pay limited nursing home bills as a matter of administrative decision even though this benefit is not specified in the policy; such payments are generally limited to cases where admission to a nursing home will cut the length of a hospital stay or make hospital admission unnecessary. If you are entering a nursing home in lieu of hospitalization, check this possibility with your health insurance company.

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profit organizations. But they warn, over and over, that investments in any such contracts—often involving many thousands of dollars—should not be entered into without competent legal advice, objective financial advice, and a complete medical evaluation of the patient's life expectancy.

These and other methods of paying for the care of the aged through liquidation of assets, moreover, all share a common limitation. They are available only to those elderly men and women who still have substantial assets left when the need arises—and the sad fact is that more than half of the elderly sick do not have adequate assets to liquidate. Hence the financing of nursing home care through liquidation of assets, like paying for it out of current income, is open only to relatively well-to-do families.

THE WELFARE APPROACH. Lacking either adequate current income or adequate assets to liquidate, more than half of all Americans in nursing homes today must turn to state welfare departments for help under the Federally subsidized Old Age Assistance (OAA) or Medical Assistance for the Aged (MAA) programs.

The shortcomings of these programs will be reviewed in detail in next month's concluding installment. The major shortcoming is the simple fact that both Congress and the state legislatures are unwilling to appropriate annually the vast sums needed to provide *adequate quality of care* for the hundreds of thousands of nursing home residents who must now depend in whole or in part on welfare funds. Nor is this unwillingness likely to be overcome in the foreseeable future. The result almost everywhere is that welfare rates for nursing home care are too low to provide good care, and so nursing home residents suffer.

THE BLUE CROSS INSURANCE APPROACH. Some Blue Cross plans and some commercial health insurance companies in recent years have begun dabbling in nursing home benefits. One reason for their interest is that their elderly policyholders who have hospital benefits tend to stay on at a very high cost per day in general hospitals despite the fact that they might be equally well cared for, and might even be more comfortable, in a skilled nursing home costing one-third as much. Hence Blue Cross and health insurance benefits are sometimes offered for limited nursing home stays following hospitalization or (more rarely) as an alternative to hospitalization.

CU welcomes this broadening of Blue Cross and health insurance benefits. Many advantages should accrue from the new programs, including less waste of costly hospital facilities on patients who don't really need them. But all

such plans have a built-in limitation that prevents them from solving the problem of long-term care of the aged. They are all financed on an annual basis; hence each year's premiums must be high enough to pay a year's claims. Continuing nursing home care at \$3650 per year or thereabouts is simply too costly a service to be financed on an annual basis. Premiums would have to be exceedingly high in the absence of very strict limitations on nursing home benefits—such as the limitation to 90 days' care per year or per illness found in some contracts.

To sum up, neither current family income nor liquidation of assets nor Social Security or welfare payments nor Blue Cross nor commercial health insurance nor a combination of these can really meet the needs of America's aged for high-quality long-term nursing care. Some other method of financing—dependent on neither current income nor current welfare appropriations—must be found.

THE SOCIAL SECURITY APPROACH. Fortunately an excellent approach stands ready at hand—an approach whereby every employed American can save a small sum each year throughout his earning years and the insurance fund thus accumulated can be used to pay the nursing home bills of all retirees and dependents who need skilled nursing home care. This approach, of course, would be the addition of nursing home care (along with other medical care costs) to the Social Security benefits now available.

By spreading the cost of this year's care over all the productive years of the entire working population, the Social Security approach can avoid the inherent shortcomings of the other methods of payment and can provide high-quality care with a minimum impact on the budget of any individual family.

The King-Anderson bill now pending in Congress, and other bills based similarly on the Social Security mechanism, are a step in this direction. They would add a small sum to the payroll deductions currently being made for Social Security and, in return, would make nursing home benefits, and some other medical benefits for the aged, available to retirees and their dependents. The benefits would be limited, it is true, at least at the beginning, but they would be more generous than those available through Blue Cross or most commercial insurance plans. Quality of care can—and should—be ensured by providing payments only for care in homes accredited under a nationwide accreditation program (discussed last month).

CU agrees in part with opponents of these medicare proposals, who make much of the limitations built into the bills now pending. But their shortcomings should not be a ground for defeating the pending bills. Rather, the bills should be improved by broadening amendments.

This series, originally planned for three installments, has been lengthened to four to make room for additional data. The fourth and final installment, to appear in the April issue of the REPORTS, will make concrete recommendations for improving the quality of nursing home care. Of the earlier articles in this series, the first (January) article asked the question "Are you sure the patient really needs nursing home

care?" and described many alternatives to, as well as types and levels of care available in, nursing homes. The second (February) article gave practical advice on how to shop for a nursing home; where to look, what to look for when you get there, how to judge what you see. Both January and February issues are still available; send 50c for each copy to Back Issue Dept., Consumers Union, Mount Vernon, N. Y.

Nursing Homes

BY RUTH AND EDWARD BRECHER

PART 4: *How to Improve Them*

Earlier articles in this series have sought to present a picture of nursing homes as they are, to stress the importance of a nationwide nursing home accreditation program similar to hospital accreditation, and to provide helpful tips for families shopping for nursing home care. This month CU concludes its nursing home reports with a review of proposals for improving the quality of nursing home care.

These proposals have been drawn from many sources, including interviews with nursing home proprietors and administrators and with state and Federal health and welfare officials. *Most of the reforms proposed, moreover, have already been tried out in one state, or in several states, and have proved their practical worth.* In the few cases where proposals have not already been tried and found useful, the fact is noted below.

Drive . . .

DRIVE THE SUBSTANDARD HOMES OUT OF BUSINESS. This can be done by closing down the unlicensed homes, by enforcing licensing standards, and by raising licensing standards in states where they are too low. The argument against such measures is superficially plausible but utterly without merit. "If we closed down the substandard homes," one state licensing official told CU researchers, "there'd be no place for their residents to go."

Indiana operated under that theory for a decade, from 1947 to 1957. The state had fairly good licensing standards, but the welfare department, which was responsible for the licensing, let homes that failed to meet the standards go right on operating, and even pumped Federal and state money into them to keep them in business, on the theory that the beds were desperately needed. This is still common practice in many states.

Then, in 1957, Indiana's licensing control was transferred from the welfare department to the state health department, which proceeded really to enforce the 10-year-old regulations. Pandemonium reigned. "Those nursing home operators who were operating in violation called us the Gestapo," a health official recalls. Many homes had to close down, and a shortage of beds seemed imminent.

But cleaning up the mess also attracted new capital into the business. Despite the closings, or perhaps because of them, the number of available beds in Indiana actually

increased from 8871 in 1958 to 9352 only two years later.

The Missouri experience was equally impressive. Following a disastrous nursing home fire in which 73 elderly residents burned to death, the state legislature in 1957 passed a new law and the state health department clamped down. Three hundred of the state's 750 nursing homes went out of business. But by 1960 the total number of nursing home beds in the state had risen from 14,000 to 17,000—with plans for an additional 2500 new beds in modern homes awaiting health department approval. In Pennsylvania, one-third of all the homes closed their doors during a clean-up campaign that began in 1956—yet the state now has 4000 more beds than it had before the clean-up, with another 5700 under construction or in the planning stage.

The proprietors of the better nursing homes, of course, support strict enforcement of the regulations, and so do the nursing home associations in some states. It is primarily the state legislatures that drag their heels. They fear that enforcing the licensing laws will raise welfare costs—and no doubt they are right. But it is hard to see how a state can hold up its head when the state welfare department is forced by inadequate funds to send residents to nursing homes that the state health department would like to close down for failing to meet even minimum licensing standards.

Raise . . .

RAISE WELFARE RATES FOR NURSING HOME CARE. Present welfare rates paid by many states for nursing home care are a disgrace—too low to buy good care and too low to attract new capital for the construction of modern nursing homes.

It is not only the welfare recipients, moreover, who are penalized by these low rates. On the contrary, *paying patients get less service than they have paid for because of the welfare underpayments.* A new nursing home, for example, may start out with only private patients in residence. Then some patients run out of money and are kept on at state welfare rates. Additional welfare patients are accepted to keep the beds full, or out of charity, or for other reasons. The income of the nursing home declines as the proportion of the patients on welfare rates increases. With less money coming in, the nursing home must either



raise its rates to private patients or else curtail its services to private and welfare patients alike. In either event, the burden of compensating for low welfare rates falls on precisely the group least able to carry that burden—the elderly sick who are paying their own way.

Raise . . .

RAISE THE AUTHORIZED MAXIMUM. Some nursing home residents have friends or church groups or charitable organizations willing to supplement the state welfare payments in order to secure for them the care they need.

Some states make this kind of supplementation utterly impossible by deducting from the state welfare payment any such outside "income."

An example of this policy arose in Cleveland last year. The maximum welfare payment for nursing home care there is \$170 per month. Local studies had shown that the minimum rate for which skilled nursing home care of good quality can be procured in Cleveland is \$250 a month. A charitable organization, the Benjamin Rose Institute, accordingly began to make additional payments for the nursing home care of selected patients in order to secure for them the care they urgently needed. The state welfare department's response was to cut the \$170-per-month state payment by the amount made available by the Benjamin Rose Institute. A state doesn't save any money by such tactics, of course, for the friends or agencies willing to put up the extra money for supplementation immediately withdraw their offer when they learn that it is not going to benefit the patients in whom they are interested.

The Cleveland incident is not an isolated case; it is standing policy in many states. It cannot be too roundly condemned as stupid and cruel. The only situation in which this rule against supplementation might be warranted is where the state welfare rate is itself adequate to secure high-quality care—and there are very few examples of such rates anywhere in the United States.

Commissioner Elias S. Cohen of the Pennsylvania Office for the Aging has aptly dubbed the rule against supplementation a policy of "equal deprivation for all." This policy holds, he explains, that if you allow friends or relatives to supplement welfare payments, "there will be others without friends or relatives who will be disad-

vantaged. Therefore, everybody must be equally disadvantaged, equally deprived. This is, to be blunt about it, cockeyed."

Some states recognize the stupidity of forbidding supplementation altogether and permit supplementation up to a stated maximum. Florida, for example, makes \$100-a-month welfare payments, but in addition permits supplementation up to a total of \$300 a month—no doubt a reasonable level. But other states that permit supplementation set a ridiculously low maximum on the amount of supplementation permitted. Delaware, for example, pays only \$75 a month and permits supplementation only up to \$150 a month. Kentucky pays only \$115 a month and permits supplementation only up to \$135 a month.

CU recommends that all states, at no cost to their treasuries, raise their supplementation ceilings to \$300 a month, as Florida has done, or to whatever level is needed to secure full care in a high-quality nursing home.

Repeal . . .

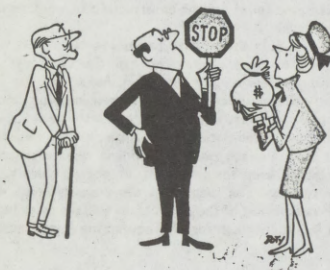
REPEAL RELATIVE RESPONSIBILITY LAWS. Most states provide that if a patient must go to a nursing home and the welfare department pays part of the bills, the department can try to get its money back in whole or in part from children or other relatives. These "relative responsibility laws" are a maze of inconsistencies, and they may be inconsistently administered even within a single state. Very little is actually collected under these laws. The cost of collecting is likely to be excessive. The amount of ill-will these laws stir up is enormous—especially when the state renders a bill to the sons and daughters after a patient has died. Several states have operated for years without any relative responsibility laws whatever. Leading welfare groups recommend the outright repeal of such laws, and so does CU.

Classify . . .

CLASSIFY NURSING HOMES. Many state welfare departments pay a single fixed rate for all nursing home care in the state, or in particular parts of the state. It would be hard to invent a system more effectively designed to force down nursing home standards, to penalize good nursing homes, to reward exploitation of patients—and to straitjacket the state itself in its efforts to solve its nursing home problems.

Massachusetts is a classic example of this evil. Its welfare department pays a \$6.85-per-day rate for all nursing home residents—with the following results:

- A home that can chisel its costs down to \$3 or \$4 per day by understaffing, underfeeding its residents, and cutting other corners can make a lot of money. Every dollar cut from service rendered patients means a dollar more of profit.
- Homes that provide good service lose money on their welfare patients and must recoup these losses from their paying patients or (in the case of voluntary homes) in other ways.
- Newcomers are discouraged from building new nursing



NURSING HOMES continued

homes. Those who do enter the field build as cheaply as possible. There is no incentive either for building a good home or for operating it at a level above the minimum needed to keep the license.

• Worst of all, raising the rates under this system may accomplish little or nothing. Suppose, for example, that the Massachusetts welfare rate were raised from \$6.85 a day to \$7.85 or \$8.85. Nursing home proprietors would be free simply to pocket the extra \$1 or \$2 per patient per day and go on delivering whatever substandard service they had delivered in the past. By common agreement, the state rate in Massachusetts is too low to cover the cost of decent nursing home service. Yet efforts to get the legislature to raise the daily rate in 1963 were defeated precisely on the ground that a raise would benefit only the nursing home proprietors, not the patients. A number of other states, it should be added, use the same or almost equally self-defeating methods of establishing welfare rates for nursing home care.

The solution is clear and is in actual use in several states, among them Washington and Connecticut. These states classify nursing homes on the basis of the services that they supply to residents, and pay higher rates to those homes that meet the requirements for the higher classifications. Thus each home has a hard cash incentive for improving and expanding its services. The failure of other states to adopt this sensible plan can be explained only by the general resistance of state legislatures to any steps that might raise standards and therefore costs. The better nursing homes and some state nursing home associations, it should be noted, enthusiastically support the classification system.

Require . . .

REQUIRE COST ACCOUNTING BY NURSING HOMES. Every state welfare department and some local welfare departments must set the rate they will pay for welfare patients. There is only one reasonable basis on which they can determine a fair rate—namely, the cost of providing the service. Yet incredible as it may seem, some welfare departments do not even try to collect cost accounting data from nursing homes—and some that try fail to get usable data from many homes. *No welfare bill should be paid to any nursing home that refuses to make complete audited cost-accounting data available to the welfare department.*

Ideally, a rate should be set for each home based on its own audited costs. This is the system used by many Blue Cross plans to reimburse hospitals. It discourages chiseling and encourages improvements in patient care. To date, so far as CU has been able to determine, not a single state welfare department has adopted this plan. Some departments have, however, successfully introduced plans for setting the rate for each class of homes on the basis of the average costs of the homes in the class. This, while not ideal, is a long step in the right direction. Welfare departments object that it is too difficult a task to set a fair

individual rate for each nursing home in the state. Maybe it is. But CU would be more impressed with the objection if even one state welfare department had actually tried the system to see how much work it would involve.

Make . . .

MAKE NURSING HOME OWNERSHIP A MATTER OF PUBLIC RECORD. The financial arrangements of some nursing homes resemble the intricacies of public utility financing in the wildest pre-SEC days. One corporation may own the stock of a second, lease a home to a third, enter into a management contract with a fourth, and so on. Excessive profits may get hidden in such intercorporate finagling, and responsibilities may be shirked. A full statement of all arrangements, showing the true names of the individuals actually in control and of all others sharing the profits, should be required on nursing home license applications and should be matters of public record. A further result of this requirement would be to unmask practicing physicians who hold secret interests in nursing homes to which they refer patients—an abuse discussed in earlier issues.

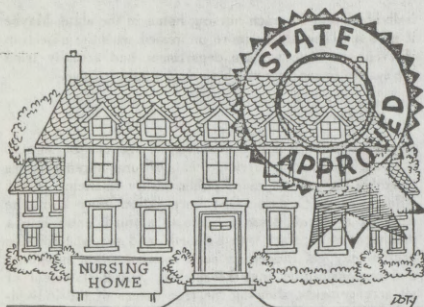
Stop . . .

STOP FUNNELING FEDERAL FUNDS INTO ANTIQUATED STATE WELFARE SYSTEMS. Of the estimated \$300 million poured into nursing homes by state welfare departments, more than half comes to the states from Federal appropriations. The Federal government thus has a \$150 million-a-year stake in seeing that these nursing home funds are well used. Both Congress and the U.S. Department of Health, Education, and Welfare have shirked that responsibility.

The Kerr-Mills Act, for example, was allegedly passed by Congress to provide more and better medical care, including nursing home care, for the aged. Massachusetts took its Kerr-Mills funds and used them to pay for nursing home care. But the net effect was to raise the state welfare payments for nursing home care by only 35¢ per day. The rest of the Kerr-Mills money—\$1.70 per patient per day—went to reduce the cost of nursing home care to state and local welfare departments. In short, the money supposedly appropriated by Congress to help the aged was employed instead primarily to help Massachusetts taxpayers. Other states used the same loophole.

A number of the reforms CU is urging—for example, curbing the use of Federal funds to pay for patients in unlicensed homes or substandard homes, raising the authorized maximums so supplementation can be provided, and establishing suitable systems of setting nursing home welfare rates—could be required by Congress or by the Department of Health, Education, and Welfare as a condition of Federal assistance.

The Bureau of Family Services in the U.S. Department of Health, Education, and Welfare knows the score on these and other points. The Bureau states that it "encourages states to establish rates which will meet the cost of nursing home care and to administer their nursing home programs in a manner to promote improvements in the quality of care. The Bureau of Family Services also pro-



vides consultation to state agencies on methods of setting rates for nursing home care. . . .

The problem is that most states do not accept the Bureau's "encouragement" to mend their ways, nor do they follow the Bureau's "consultation" advice. The Department of Health, Education, and Welfare and its Bureau of Family Services should call these abuses bluntly to the attention of Congress and should recommend legislation that would force the state welfare departments to reform on penalty of losing their Federal funds. In addition, the Bureau can use its *existing* powers to do more than merely "encourage" reforms. It could, for example, refuse to permit Federal funds to be used for unlawful purposes, such as payments to unlicensed nursing homes.

Clarify . . .

CLARIFY STATE RESPONSIBILITIES. In most states, three separate government units are concerned with nursing home problems. The state health department sets standards and issues licenses. The state welfare department routes particular patients to particular homes and pays the bills. The state commission on the aging publishes reports and makes recommendations—but has no power to act. A few states have in addition a rate-setting agency independent of the other three. This fractionation of responsibility leads, as might be expected, to many serious problems.

A case can be made for taking nursing home concerns out of welfare departments altogether and lodging them either in health departments or in state commissions for the aging. Welfare departments these days, and indeed the whole concept of welfare, are under intense political pressure from those who would abolish welfare programs altogether or else curtail them drastically. Welfare officials must therefore devote a major portion of their energies to defending existing procedures. Little strength is left over for improving those procedures. And in some states, at least, health departments or commissions on the aging might have better luck with state legislatures than welfare departments do in securing adequate appropriations for nursing home services.

Welfare spokesmen reply that this shuffling of services

from one department to another would accomplish little or nothing. The heart of the problem, they insist, is the failure of both Congress and the state legislatures to face up to the facts that 1) adequate nursing home care is costly care, and that 2) holding down welfare payments inevitably lowers standards for paying patients as well as welfare patients.

Our 50-state system is admirably designed to settle precisely such issues. Let a few states try centralizing nursing home problems in their health departments or commissions on the aging. If the system works, other states can then follow suit. If it doesn't work, it can be abandoned.

But unfortunately, CU researchers were told, present Department of Health, Education, and Welfare procedures tend to *discourage* such experiments, since the U.S. Welfare Administration deals only with state welfare departments. CU recommends that a few states challenge this roadblock—and that the U.S. Welfare Administration cooperate with them.

Raise . . .

RAISE MINIMUM WAGES. Employees who work in nursing homes and homes for the aged carry heavy responsibilities. A well-organized society would take necessary measures, accordingly, to attract to the homes a high calibre of employee. Nursing home jobs have no glamour nor other secondary appeal. Minimum wage levels might therefore be set a little higher for nursing home employment than for many other kinds of employment.

Far from using such measures to improve nursing home care, some states' regulations have actually *exempted* homes for the aged and nursing homes from the minimum wage and maximum hours laws applicable to other employment. The result is what you would expect. Men and women who can't get employment in any other line of work drift into the nursing homes.

A nursing home proprietor paying an average of \$50 a week plus meals to his employees pointed out the consequences. "Some of my competitors are paying \$25 a week plus meals and a room in the attic," he told CU researchers. "As a result, my rates must be higher than theirs. I find it hard to hold the line. Eventually I may have to cut back to \$25 a week, too, to meet competition. Ending the minimum-wage-law exemption nursing homes now enjoy in this state would penalize only the substandard homes; it would be a real blessing to the homes which are trying to give good service to their residents."

With an adequate wage level in nursing homes, the tipping evil (discussed last month) could be abolished.

License . . .

LICENSE NURSING HOME PROPRIETORS AND ADMINISTRATORS. At present nursing homes must be licensed, but not (except in Oregon) the men and women who run them. As a result, men and women wholly untrained and unsuited for this responsibility—garage mechanics, insurance salesmen, housewives, ex-athletes—are free to open nursing

NURSING HOMES continued

homes. Many nursing homes, moreover, are controlled by absentee owners or by nursing home chains. Some of the chains, it is true, have served to raise standards by introducing sound operating procedures. But others may hire a businessman capable of milking the last dollar out of a nursing home in preference to a qualified, concerned administrator. The entire tone of a home is set by the man or woman in charge; in particular, the "spirit of the place," discussed in detail in February, depends mostly on the administrator.

Oregon has met this problem by establishing minimum experience and training qualifications for licensed nursing home administrators; other states should take note of both the legislation and this state's experience under it.

Provide...

PROVIDE ON-THE-JOB TRAINING. No matter how well-meaning an administrator and his employees, these men and women also need specific skills, and these skills can be taught. A welcome harbinger on the horizon is the recent growth of training programs for both administrators and other personnel, including demonstration programs provided for the states by the U.S. Public Health Service.

Some of these programs are sponsored by state nursing home associations, others by state health departments. George Washington University has pioneered a three-year training program for prospective administrators. Several states have employed dietitians, nursing consultants, and other specialists to visit nursing homes and improve their methods. Pennsylvania holds training institutes, with free room and board as well as instruction for nursing home personnel who attend. A major expansion in these training programs for those employed in nursing homes is needed, however, in most states.

Change...

CHANGE FHA POLICIES. One important factor in the recent development of high-quality nursing homes has been the availability of FHA mortgage guarantees. Many excellent homes have been built with these guarantees. But incredible as it may seem, FHA-guaranteed loans are currently available only for *proprietary* nursing homes—those run for a profit. Non-profit homes, including denominational homes, are ineligible under FHA rules. CU enthusiastically applauds the principle that Federal mortgage guarantees be available for nursing home construction, nor can there

be objection to their use for proprietary homes—but certainly non-profit homes should be given access on at least equal terms to Federal credit facilities.

Bring...

BRING THE NURSING HOMES INTO THE MAINSTREAM OF MODERN MEDICAL PROGRESS. An increasing number of physicians are on the staff of at least one general hospital. There they make the rounds with senior associates. They attend staff meetings where cases are discussed and new techniques explained. Good medical records are insisted upon. Staff committees review the work of surgeons to guard against unnecessary operations; in some hospitals the medical care given patients is similarly audited. Hospitals have rules governing specific medical procedures. Thus the good word spreads. Something approaching a *system* of medical care is slowly being built up, with the general hospital at its heart.

The typical nursing home functions almost entirely outside this system. Patients transferred from a hospital to a nursing home are all too rarely accompanied by their essential medical records; and the same is true of patients transferred from nursing home to hospital. Medical and nursing records within the nursing home—one of the most important aspects of modern medical care—may be inadequate or non-existent; and it is nobody's business to improve them. Physicians visiting patients in nursing homes have none of the opportunities to learn from one another that a well-organized hospital staff provides, and are subject to none of the supervision, manuals of standing procedures, or other controls common in the better hospitals.

To solve this problem, health leaders have long recommended that nursing homes be integrated into the modern pattern of medical practice by affiliating each home with a nearby general hospital. Many benefits could accrue, both to the hospital and the nursing home. The hospital dietitian, for example, could take some responsibility for the adequacy of the diets fed nursing home patients. The hospital records librarian could review the nursing home records. Conversely, the nursing home could help by taking over patients no longer in need of hospital care.

CU strongly recommends all possible measures to encourage the affiliation of nursing homes with accredited general hospitals. It recommends to readers that, other things being equal, they give preference in their own shopping to nursing homes in their community that have joined the modern pattern of medical care through affiliation with a general hospital. But such homes may be hard to find; in 1962 it was estimated that only 7% of all beds were in skilled nursing homes that had such an affiliation.

This is the fourth and last installment in CU's series on nursing homes. CU regrets that it cannot acknowledge letters individually nor answer questions concerning particular nursing homes or nursing home conditions. And CU cannot, of course, recommend any individual nursing home. All us-

able data assembled by CU from readers' letters on the subject, however, have been included in these articles. Twenty-four page reprints of the series will be available after May 1st; send 25¢ for each copy (write for quantity rate) to Reprints Dept., Consumers Union, Mount Vernon, N. Y.

Senator METCALF. The record will be kept open for 1 week for submission of additional letters and statements to the chairman and such material will be screened by the staff and, without objection, put into the official record.

Before the hearings close, I want to make a comment about the chairman of the subcommittee, Senator Yarborough. He has been most diligent in securing hearings and requiring that this bill be given complete priority in the subcommittee. As the Senate is now meeting under a very difficult situation and it is a difficult period to secure times for hearings and to get various legislation allocated, Senator Yarborough has put this bill up as the highest and most important urgency and has himself, despite engagements in Texas that are most pressing, participated in hearings.

I feel the fact that we are now reaching the final point of the hearings and going forward into the executive session is because of his efforts and his energy and his diligence in the pursuit of this legislation.

Now, unless there is something else to come before the subcommittee, the subcommittee will stand adjourned.

(Whereupon, at 11:20 a.m., the hearings were concluded.)

APPENDIX



AID for*
Community Hospitals
and *
Other Health Facilities
*

FACTS FOR HILL-BURTON APPLICANTS



U S DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service



THE HILL-BURTON PROGRAM was initiated by the Public Health

Service following the passage of the Hospital and Medical Facilities Survey and Construction Act in 1946. The Act, sponsored by Senators Lister Hill of Alabama and Harold Burton of Ohio (later named Supreme Court Justice), authorized grants to assist in constructing needed hospitals and public health centers.

IN 1954 the program was broadened to provide grants

also for nursing homes, diagnostic and treatment centers, and rehabilitation facilities.

A 1958 amendment to the Act gives eligible sponsors the option to take a loan in lieu of a grant.

Funds for Facilities

The Hill-Burton Program makes Federal grants or loans available to assist in constructing and equipping public and other types of nonprofit hospitals and other health facilities for which a need is established.

Annual Appropriations

Since 1947 Congress has made annual appropriations from \$65 million to \$210 million for the construction of health facilities under the Hill-Burton program.

Eligible Facilities

General hospitals
Diagnostic centers
Chronic disease hospitals
Mental hospitals
Public health centers
Rehabilitation facilities
Tuberculosis hospitals
Nursing homes
State health laboratories
Diagnostic and treatment centers
Nurses' home and training facilities

Types of Projects:

- Construction of new buildings
- Expansion, remodeling, or alteration of existing structures
- Initial equipment for new or remodeled structures

Federal Share

The Federal share varies from State to State, ranging from one-third to two-thirds of the cost of construction and equipment. Applicants should obtain information concerning the Federal share applicable to their proposed project from their State administering authority.

Loans

Eligible applicants may accept a loan in lieu of a grant under the same requirements. Loans may be made for a maximum period of 40 years at a low interest rate determined at the time the project is approved.

Project Selection

Projects are selected by the State administering authority in accordance with the provisions of a State plan for hospital and other health facilities. This plan, developed by the

State authority and approved by the Public Health Service, contains an inventory of existing hospital and other health facilities and shows the community's remaining need. Priority for Federal aid is determined on the basis of the relative need of the various areas of the State for additional facilities and services. The State agency is responsible for selecting projects for approval and for forwarding applications to the PHS for final approval.

How to Apply

Consult your State agency concerning your community's needs for hospitals and other health facilities, the priorities for construction, and the eligibility of the proposed project.

The State agency will:

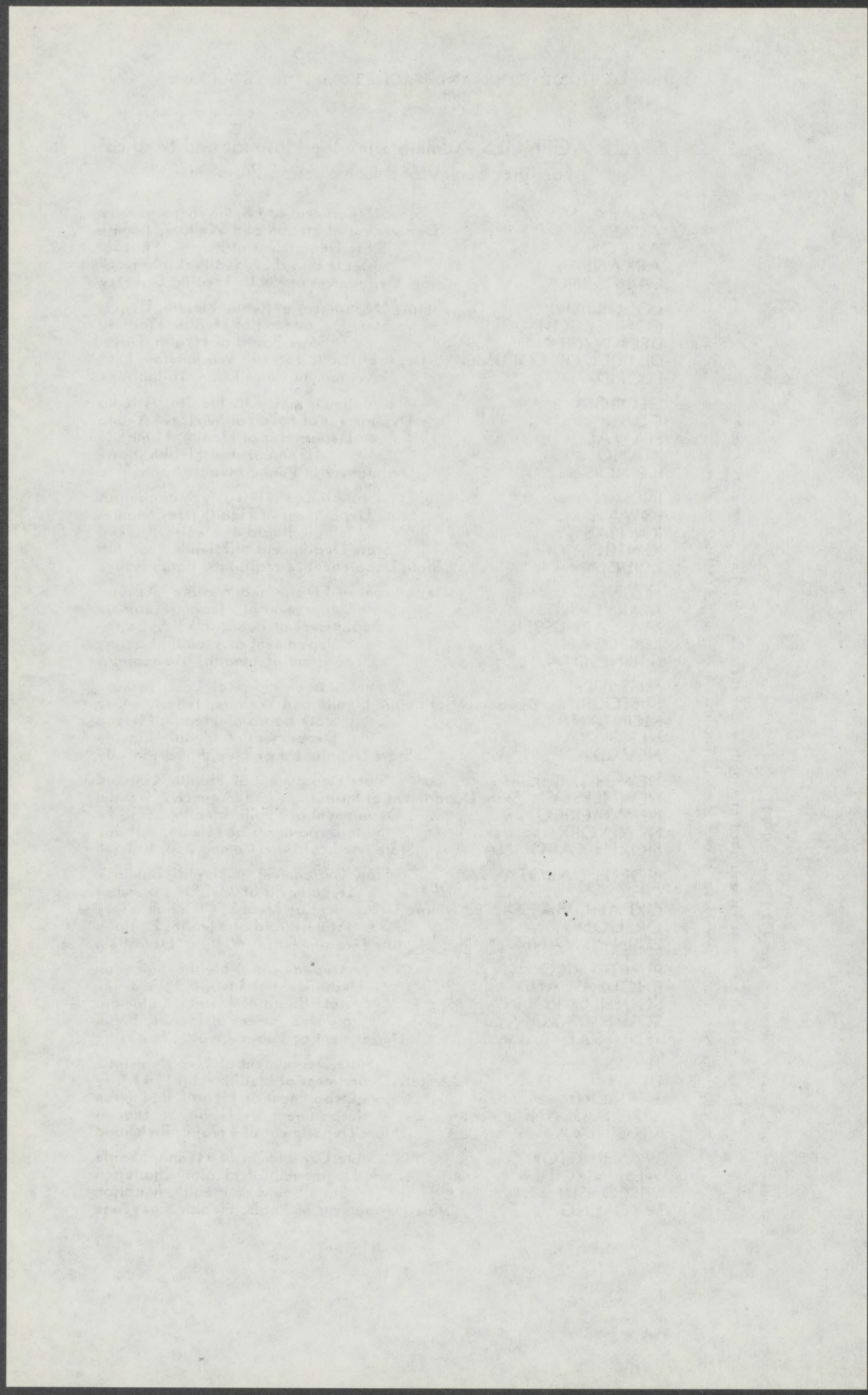
1. Advise as to the possibility of the project receiving Hill-Burton assistance
2. Furnish application forms
3. Give instructions on completing and submitting the application
4. Explain the applicant's responsibilities which include:
 - a. Raising the non-Federal share of the construction costs
 - b. Employing an architect to prepare plans and specifications
 - c. Submitting the application to the State agency for approval
 - d. Awarding construction contracts based on competitive bids and purchasing equipment in accordance with established procedures
5. Provide information regarding all State and Federal requirements

When Applicant Gets Payments

Payments of the Federal share of project costs are made on the basis of work completed as determined by inspections of the project by the State administering authority. The initial payment usually is made after 25 percent of the construction is completed. Additional payments are made as the project progresses.

STATE AGENCIES Administering the Hospital and Medical Facilities Survey and Construction Program

ALABAMA	State Department of Health, Montgomery
ALASKA	Department of Health and Welfare, Juneau
ARIZONA	State Department of Health, Phoenix
ARKANSAS	State Board of Health, Little Rock
CALIFORNIA	State Department of Public Health, Berkeley
COLORADO	State Department of Public Health, Denver
CONNECTICUT	State Department of Health, Hartford
DELAWARE	State Board of Health, Dover
DISTRICT OF COLUMBIA	Dept. of Public Health, Washington, D.C.
FLORIDA	Development Commission, Tallahassee
GEORGIA	Department of Public Health, Atlanta
GUAM	Department of Medical Services, Agaña
HAWAII	Department of Health, Honolulu
IDAHO	Department of Health, Boise
ILLINOIS	Department of Public Health, Springfield
INDIANA	State Board of Health, Indianapolis
IOWA	State Department of Health, Des Moines
KANSAS	State Board of Health, Topeka
KENTUCKY	State Department of Health, Frankfort
LOUISIANA	State Department of Hospitals, Baton Rouge
MAINE	Department of Health and Welfare, Augusta
MARYLAND	State Department of Health, Baltimore
MASSACHUSETTS	Department of Public Health, Boston
MICHIGAN	Department of Health, Lansing
MINNESOTA	Department of Health, Minneapolis
MISSISSIPPI	Commission on Hospital Care, Jackson
MISSOURI	Department of Public Health and Welfare, Jefferson City
MONTANA	State Board of Health, Helena
NEBRASKA	Department of Health, Lincoln
NEVADA	State Department of Health, Carson City
NEW HAMPSHIRE	State Department of Health, Concord
NEW JERSEY	State Department of Institutions and Agencies, Trenton
NEW MEXICO	Department of Public Health, Santa Fe
NEW YORK	State Department of Health, Albany
NORTH CAROLINA	State Medical Care Commission, Raleigh
NORTH DAKOTA	State Department of Health, Bismarck
OHIO	Department of Health, Columbus
OKLAHOMA	State Department of Health, Oklahoma City
OREGON	State Board of Health, Portland
PENNSYLVANIA	State Department of Welfare, Harrisburg
PUERTO RICO	Department of Health, San Juan
RHODE ISLAND	Department of Health, Providence
SOUTH CAROLINA	State Board of Health, Columbia
SOUTH DAKOTA	State Department of Health, Pierre
TENNESSEE	Department of Public Health, Nashville
TEXAS	State Department of Health, Austin
UTAH	State Department of Health, Salt Lake City
VERMONT	Department of Health, Burlington
VIRGIN ISLANDS	Department of Health, St. Thomas
VIRGINIA	State Department of Health, Richmond
WASHINGTON	State Department of Health, Seattle
WEST VIRGINIA	State Department of Health, Charleston
WISCONSIN	State Board of Health, Madison
WYOMING	State Department of Public Health, Cheyenne



Nursing Homes, Their Patients and Their Care

*A study of nursing homes and similar
long-term care facilities in 13 States*

Jerry Solon, M.A.

Dean W. Roberts, M.D., M.P.H.

Dean E. Krueger, M.A.

Anna Mae Baney, B.A.

A joint project of the
Commission on Chronic Illness
and the Public Health Service

The Authors

Mr. Solon, health program research analyst with the Division of Hospital and Medical Facilities, Public Health Service, was detailed as a research associate to the Commission on Chronic Illness for the purposes of this study. Mr. Solon is now associated with the Beth Israel Hospital in Boston, Mass., as director of its medical care studies unit.

Dr. Roberts, director of the Commission on Chronic Illness at the time of the study, is now executive director, National Society for Crippled Children and Adults, Chicago, Ill. The commission completed its activities in 1956, after 7 years of intensive educational and research work.

Mr. Krueger, research associate with the Commission on Chronic Illness, was detailed to the Commission by the Public Health Service. Mr. Krueger is now engaged in research studies at Columbia University School of Public Health and Administrative Medicine, on assignment from the National Heart Institute, Public Health Service.

Miss Baney is a health program research analyst with the Division of Hospital and Medical Facilities, Public Health Service, engaging in various studies in the medical care field.

Foreword

This study has demonstrated how effectively a voluntary organization, official State agencies, and the Federal Government may work cooperatively on a problem engaging their mutual interests and responsibilities.

The Commission on Chronic Illness, a national voluntary organization founded by the American Hospital Association, the American Medical Association, the American Public Health Association, and the American Public Welfare Association, spearheaded a drive to learn what role nursing homes and related types of facilities are filling today. The Public Health Service lent its personnel and other resources to help make the Commission's goal a reality. The 13 States which participated in the study served their own direct needs for information about nursing homes while adding important segments to the total study.

The survey methodology designed by the Commission on Chronic Illness and the Public Health Service served a triple purpose: it provided each of the surveying States with a ready-made device for conducting the study; it produced comparable data for the study States so that any one of them might evaluate its nursing homes in the light of the situation in other States; and it permitted the survey results of the 13 participating States to be consolidated and projected to a national appraisal.

That the cooperative roles of this partnership have blended so productively is a tribute to the spirit of the many individuals in the State agencies and national groups which participated in this study.

JOHN W. CRONIN
*Assistant Surgeon General
Chief, Bureau of Medical Services*

Agencies in the 13 Participating States Centrally Responsible for the Study

California

State Department of Public Health
State Department of Social Welfare

Colorado

State Department of Public Health

Connecticut

State Department of Health

Georgia

State Department of Public Health

Indiana

State Board of Health

Maryland

State Department of Health
Commission on Chronic Illness

Minnesota

Minnesota Department of Health

New Mexico

New Mexico Department of Public Health

New York

State Department of Social Welfare

Oklahoma

State Department of Health

Rhode Island

State Committee on Aging

Vermont

State Commission on the Chronically Ill and Aged
State Department of Health

Wyoming

State Department of Public Health

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Acknowledgments

In a widely cooperative study such as this it is not possible to extend acknowledgments adequately to participating individuals and organizations. The agencies centrally responsible for carrying out the survey in each of the 13 States which joined in the study are listed on page iv. To the many persons in these and other cooperating agencies in the study States go thanks for their essential part in the study.

Encouragement and promotion of the study came from many sources. Particular acknowledgment is due Dr. Jack Masur, George St. J. Perrott, Lucille M. Smith, Dr. Alice M. Waterhouse, and Maurice E. Odoroff, of the Public Health Service, and Peter G. Meek of the Commission on Chronic Illness.

The arduous task of day-by-day review, processing, and consolidation of the data flowing in from the various States was supervised by Ella H. Davis. Her thoughtful handling of the myriad details of this process made a major contribution to the study.

No acknowledgments in this type of study would be complete without reference to the administrators of nursing homes and other institutions who furnished the information on which this study is based. Their willingness to cooperate in this undertaking has demonstrated their good faith and deep interest in their chosen undertaking.

Introduction

Intelligent community planning for health facilities and services to meet the needs of the chronically ill requires a basic understanding of the nature of the nursing home and similar long-term care facilities. The lack of knowledge concerning the role of this type of institution in the total constellation of medical care facilities led the Commission on Chronic Illness and the Public Health Service to engage in a fact-finding study centered on the patients and their care.

As part of the overall hospital construction program, the Public Health Service has been responsible since 1946 for assisting communities, through officially designated State agencies, to plan and construct chronic disease hospitals. Numerous factors, including the mounting public interest in facilities for the aged and chronically ill, culminated in the enactment of the 1954 amendments to Title VI of the Public Health Service Act, generally known as the Hospital Survey and Construction Program. The provision of funds for construction of nonprofit nursing homes as well as other types of medical care facilities created additional need for basic facts by communities and State and national groups.

This intensified need led to an important byproduct of the study. In response to requests from States and communities outside the 13-State coverage of this study, the survey methodology has been made available for continued application through publication of a Guide to Making a Survey of Patients Receiving Nursing and Personal Care, which is available from the United States Government Printing Office. This guide, together with the present report, may stimulate more communities to take stock of the role of nursing homes and related long-term care facilities in the health picture of the community.

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I. Setting for the Study

Why a Study Developed

The nursing home is a new phenomenon in American life. It has grown out of a complex of social, medical, and economic changes in our society. It offers to meet problems aroused by those changes. In its very emergence, however, it poses its own problems.

As a relatively new type of facility, the nursing home is not yet clearly conceived and understood. Like most newly emerging social institutions, it was not established full-blown and definitive; it has found its way gradually, hesitantly, and to a great extent, expeditiously. What it offers, therefore, is not necessarily always the professionally appropriate answers to the problems it attempts to meet but rather responses dictated by immediate practicalities. It is not a homogeneous type of institution; it means different things in different localities or to different people. Those who administer nursing homes have not uniformly conceived the task and responsibility of operating such homes and caring for patients, and State and local governments have stepped in with certain minimum requirements in the interests of patients and the public. The agencies administering licensing programs have themselves been hampered by lack of broad information about the existing nursing homes and uncertainty about what should constitute proper requirements for approval.

The history of nursing homes is still very much in the making. Underlying the state of flux in their development is a lack of a philosophy of the nursing home role. Where does it properly fit into the organization and administration of medical care? What is its role in relation to hospitals? In relation to homes for the aged? What function should it perform from the human relations viewpoint, with an eye to the family and home which the patient leaves temporarily or permanently?

Because of its central concern with chronic illness and its key position in the public eye, the Commission on Chronic Illness was confronted with many such questions. But the answers were not available. So much had happened in the short span of a decade or two. From a negligible number in the thirties, nursing homes had multiplied to some unknown magnitude in the fifties, but a magnitude no longer to escape public awareness. And what were nursing homes harboring in the way of chronic illness? What were they doing about it?

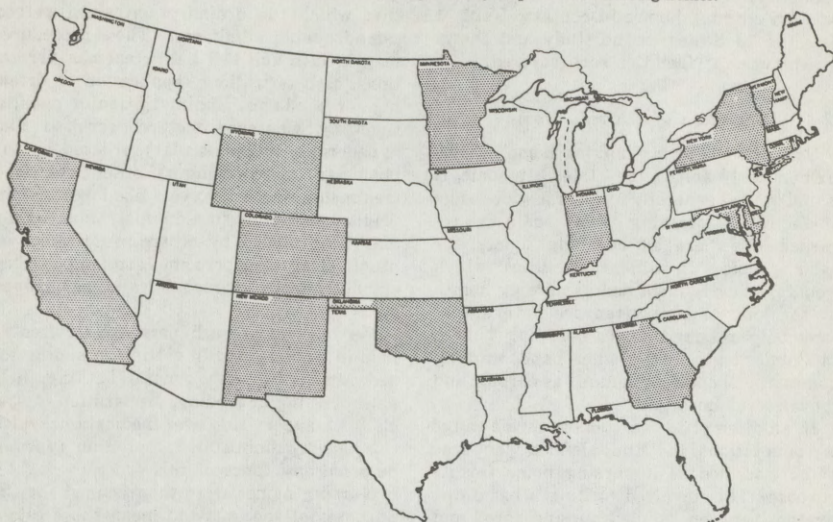
Concerned and pressed by these questions, and unable to discover the answers in available information, the commission set about to find some answers for itself. It developed a study designed to throw light on some of the basic questions confronting the commission and others concerned with the care of chronically ill persons. Obviously, not all the gaps in existing knowledge could be filled by a single study. The commission, therefore, chose for its attack a study of the characteristics of the patients in nursing homes and of the types of care these patients receive. Through this kind of information, the commission hoped to gain insight into the character of the nursing home as it operates in practice.

Method and Scope of the Study

A pilot survey during 1953 in one State, Maryland, served to develop, test, and sharpen the methods and tools of the study (1). The commission then invited interested States to repeat the survey, making available to such States its methodological materials, survey schedules, consultation, and other assistance (2).

The States participating in the patient study were thus self-selected. This procedure for achieving the survey coverage was employed for two principal reasons. First,

Figure 1. Thirteen States participating in study of patients in nursing homes.



it was doubtful that sufficient knowledge was at hand to guide a purposive selection of States to yield a representative sample of the Nation's nursing homes. Second, inviting States to join the study voluntarily assured an intensity of interest which was essential for a successful carry-through of the survey in those States.

Happily, the open-door policy brought a wide variety of States into the study. Figure 1 shows the broad geographic distribution of the 13 participating States. More States responded than had been anticipated, reflecting the widespread concern with nursing homes throughout the country. Although not constituting technically a representative sample of nursing homes in the United States, in the light of data which have become available since the initiation of the study, the 13 States in the survey come close enough to giving a general picture of the nursing home situation. From a practical standpoint, as appendix A reveals, the major results may be adequately presented for the country through direct consolidation of the findings of the 13 States.

The central focus of the study is the proprietary nursing home (3, 4). This was

recognized as the most numerous and the least understood among the variety of non-hospital care facilities. Every State that participated in the study therefore surveyed its proprietary nursing homes. In order better to understand the role of proprietary nursing homes, however, the survey was extended wherever possible to various other types of institutions which care for chronically ill or aged persons, such as nonprofit nursing homes, homes for the aged, county homes, chronic disease hospitals, and related types of facilities. In the pilot study in Maryland, the survey was also extended to long-term patients in general hospitals and to the visiting nurse service in Baltimore (5, 6, 7). Five States used the same procedures and materials also in covering children's convalescent homes.

The scope of the present report includes proprietary nursing homes, nonproprietary (voluntary and public) nursing homes, domiciliary care homes under all types of auspices, and chronic disease hospitals (excluding mental and tuberculosis hospitals) under all types of auspices. Proprietary nursing homes receive the main emphasis, and the other types of institutions are

studied primarily in order to view the proprietary nursing homes in context. Table 1 lists the 13 States in the study and shows which types of facilities each covered.

Definition of Nursing Home

Usage of the term "nursing home" varies tremendously among the States. In some, it is understood generally to cover a wide range of facilities, including what would be regarded elsewhere as boarding homes for older people. In others, facilities which would be clearly identified as nursing homes by the kind of care given are nevertheless commonly referred to as boarding homes. In Connecticut, on the other hand, nursing homes are officially designated as chronic and convalescent hospitals.

In an attempt to overcome the wide range of connotations, the study defined what was to be classified as a nursing home for its purpose. This involved making a basic distinction between "skilled nursing care" and "personal care," as follows:

Skilled nursing care—those procedures employed in caring for the sick which re-

quire some technical nursing skill beyond that which the ordinary untrained person can adequately administer. These procedures may include full bed baths, enemas, irrigations, catheterizations, application of dressings or bandages, administration of medications by whatever method (oral, rectal, hypodermic, intramuscular) ordered by the physician, and carrying out other prescribed treatments which involve a like level of complexity and skill in administration. They may be provided by either professional or practical nursing personnel, so long as they extend beyond personal care as defined below.

Personal care—such personal services as help in walking and in getting in and out of bed, assistance with general bathing, help with dressing or feeding, preparation of special diet, supervision over medications which can be self-administered, and other types of personal assistance of this order.

Nursing homes were then defined for the purposes of the study to mean those establishments which provide "skilled nursing care" as their primary and predominant function. Domiciliary care homes, which will

Table 1. Types of facilities included in survey by each State

State	Type of facility surveyed by each State			
	Nursing homes		Domiciliary care homes	Chronic disease hospitals ¹
	Proprietary	Voluntary and public		
Number of States surveying each type of facility.....	13	11	11	5
Total population of States surveying each type of facility: ²				
Number.....	41,261,000	29,471,000	32,266,000	10,852,000
Percent of total United States population....	25.9	18.5	20.3	6.8
California.....	X	X	X	
Colorado.....	X	X	X	
Connecticut.....	X	X	X	X
Georgia.....	X	X	X	
Indiana.....	X		X	
Maryland.....	X	X	X	X
Minnesota.....	X	X	X	X
New Mexico.....	X	X	X	
New York (upstate) ³	X			
Oklahoma.....	X	X	X	X
Rhode Island.....	X	X	X	X
Vermont.....	X	X	X	
Wyoming.....	X	X	X	

¹Excluding mental and tuberculosis hospitals.

²Represents 1954 civilian population, which numbered 159,084,000 for continental United States.

³Excluding New York City.

be treated later in the report, are those which provide personal services as distinguished from skilled nursing services.

Skilled nursing care available as an "adjunct" service in a home primarily for boarding and personal care would theoretically not qualify an establishment as a nursing home under these definitions. In actual practice, however, it was discovered that the prevalent looser type of interpretations exercised considerable sway over the classifications made of individual homes in the field. The end result, it must be recognized, is that the facilities classified as nursing homes in the study actually represent a combination of homes which provide skilled nursing care as their primary function and of homes which give a measure of skilled nursing care only incidentally to their prime function of personal care.

In two study States, New York and Wyoming, this combination can be subdivided clearly into the two component groups. How the two subgroups vary in these States in the types of patients and care found in the respective homes are examined in the next section (see pages 25-27).

Survey Procedures

The model survey plan which was developed out of the pilot study in Maryland was furnished in guide form, together with personal consultation, to the States which joined in the overall study. Carrying out the survey under the basic plan was the responsibility of the sponsoring agency in the State (see list on p. iv).

The general survey pattern involved a visit to the nursing home by a field agent, usually a nurse, who, with the assistance of the nursing home administrator and other staff members, completed a schedule of information on each patient in the home on that day. Patient records maintained in the nursing home were used as needed and available. Alternative methods allowed for completion of the schedules by the nursing home staff themselves. In any event, it should be recognized that a basic limitation of the survey data is that these data cannot go beyond what the nursing home administrator and his staff know and report about each patient.

Information gathered on the patients included personal data, date of admission to the nursing home, diagnoses as available, nature and extent of disability, nursing and personal services received, physician's care, charges, and source of funds for payment. Certain information about the homes themselves was obtained, including the length of time they had been in operation and the number and types of staff employed. (The physical characteristics of the homes, often studied in the course of inspections under licensing programs, were not covered in this study.)

Each State did its own field work, processed its own schedules and tabulated the results, using the uniform procedures, classifications, codes, and tabulations outlined in the standard guide. This guide has been published in essentially the form followed in the study (8).

With the continuing cooperation and participation of the responsible agencies in the 13 participating States, the Commission on Chronic Illness and the Public Health Service jointly processed and consolidated the survey findings, using a standard set of tables furnished by each State.

Time of Survey

The States joined the study at various periods during 1953 and 1954. The field data were gathered during those 2 years.

The time consumed in processing the schedules and machine tabulating the results varied among the States. The last of the State findings became available at the end of 1955, and consolidation of the data was completed during 1956.

Nursing Homes in the Nation

Stocktaking of existing nursing homes and related long-term facilities would assume more meaning if we knew the number of such homes in the country and the number of people they accommodate. Absence of reliable national figures on these elemental points was a major gap in information which hampered the Commission on Chronic Illness in its investigations. Because the Division of Hospital and Medical Facilities of the

Public Health Service was similarly hampered for lack of such information, this division conducted a national inventory of nursing homes and related facilities in 1954.

Reports (9-12) have been published which present in considerable detail the background, methods, and findings of that national inventory. Some of the resulting basic information is reviewed here as a helpful setting for the present analysis.

The National Inventory

The variety of facilities covered by the national inventory represented essentially all types of nonhospital facilities providing nursing or supportive services to chronically ill, convalescing, aged, disabled, or infirm persons. Specifically, it included nursing or convalescent homes, homes for the aged, boarding care homes for aged persons, public homes, children's convalescent homes, and special nursing homes for alcoholics, drug addicts, or mentally disturbed patients. Maternity homes and domiciliary facilities for children were excluded, as well as institutions for the blind and the deaf and institutions for the mentally deficient if they did not meet the study's definition of a nursing home by giving primarily "skilled nursing care."

The States and Territories submitted the survey data during the period April-October 1954. New field surveys were not requested for purposes of the inventory. Instead, the State agencies administering the Hill-Burton Hospital Survey and Construction Program were asked to furnish data on existing establishments, utilizing information already available to them or to other agencies and organizations or which was readily obtainable through such sources. The findings, therefore, lack some degree of accuracy and completeness. They are considered, however, to have sufficient scope and reliability to meet the current pressing needs for information.

The difficulties experienced with classification of homes in the patient study already described were analyzed carefully in developing the classification scheme of the inventory. The groupings of homes which came out of the patient study were essentially

those conventionally regarded as "types"—in effect the patient study took familiarly known types of homes and proceeded to observe their actual character as revealed through information about their residents.

The national inventory, in contrast, broke more sharply with conventional labels and established a classification structured more rigorously on rationale. It was built on the same basic definitions as were used in the patient study for "skilled nursing care" and "personal care" (see "Method and Scope of the Study"). In addition, it defined a third level of care: "shelter," representing room and board, minimum services of a custodial nature such as laundry, and personal courtesies such as occasional help with correspondence or shopping and an occasional helping hand short of the routine "personal care" defined earlier. Then, without regard to popular ways of designating homes—for example, nursing home, home for the aged, public home, boarding care home, and so on—the inventory classified facilities into four categories, based on the predominant level of care furnished: skilled nursing homes, personal care homes with some skilled nursing, personal care homes without skilled nursing, and sheltered homes.

Findings of the National Inventory

The national inventory revealed a total of about 25,000 homes with approximately 450,000 beds. These facilities range from the boarding home for aged persons, which gives only the simplest supportive services, to the professional type of nursing home providing highly skilled and intensive nursing care.

Table 2 shows the number of facilities in the different categories of the inventory classification. Skilled nursing homes account for 40 percent of the total beds of all types reported.

Most of the homes in each of the types of facilities are under proprietary auspices (fig. 2). However, because voluntary and public homes are typically larger than commercial homes, they provide more of the total nursing home beds than might be expected (table 1, appendix B). In the case of skilled nursing homes, 9 out of every 10 are

Table 2. Estimated number of nursing homes and related facilities in the United States, 1954

Type of facility	Homes	Beds	
		Total	Per 1,000 population
Total.....	25,000	450,000	2.8
Skilled nursing homes.....	7,000	180,000	1.1
Personal care homes with skilled nursing.....	2,000	80,000	.5
Personal care homes without skilled nursing.....	7,000	110,000	.7
Sheltered homes.....	9,000	80,000	.5

SOURCE: Inventory of nursing homes and related facilities (9).

operated under proprietary ownership; these provide, as a result of their generally smaller size as compared with voluntary and public institutions, 7 of every 10 beds in all skilled nursing homes.

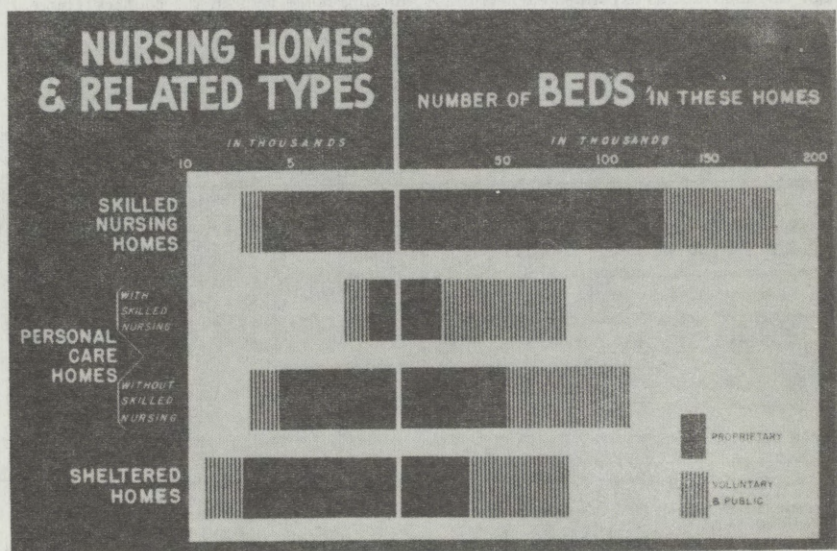
Relationship of National Inventory to Patient Study

A common tendency discovered among most of the States in the patient study was

to classify as proprietary nursing homes not only the type of facility which in the later terms of the national inventory was designated as "skilled nursing homes," but also the type identified in the inventory as "personal care homes with skilled nursing." In other words, in the patient study, most of the States did not distinguish between homes which provide skilled nursing care as their primary service and homes which function primarily for personal care but have some minor extent of skilled nursing services.

The basic definitions and classifications of the national inventory and the patient study had, to be sure, a close tie-in. However, in the patient study, the force of local custom and understanding often overrode the intended classification of homes. The definitions employed in the patient study narrowed the range of interpretation of the term "nursing home" but did not eliminate it.

The national inventory sought to draw sharper distinctions and to make clearer, more objective provision for categorizing homes into successive levels of skill. As a

Figure 2. Nursing homes and related types of facilities.

result, it was successful in achieving a classification of facilities which was less ambiguous than the patient study classification.

In general, then, differences between the number of facilities in the States involved, as reported by the national inventory and by the patient study flow from differences in classification and in interpretation of definitions, as well as from differing degrees of completeness of coverage. Differences in time period, where establishment or closing of individual homes may have occurred be-

tween reporting dates, would also have had a considerable influence; the rapid rate of accession of proprietary nursing homes will be observed later in the report.

The data of the national inventory have served as the principal means for gauging the proportion of the country's facilities represented by the 13 States in the patient study. Appendix A explains how projection of national estimates from the patient study was tested and developed through the inventory findings and other data.

II. Proprietary Nursing Homes

Survey Coverage

The burgeoning sector of the nursing home field represented by proprietary nursing homes is a difficult one to circumscribe, as was recognized earlier. General standardization of what is construed as a nursing home will come about slowly and doubtless somewhat painfully. At this stage of our knowledge and capacity to deal with the problem, the extent of the field is rather hazy but it is beginning to take some form.

For this analysis, as explained earlier, the facilities included as nursing homes may be

generally said to be those which provide skilled nursing care, either as a primary function or incidentally to provision of personal care. Even here, the inclusions were subject to each State's interpretations, so that there is a tendency toward conformity with the prevailing conception of nursing homes in the subject area.

With approximately 25 percent of the Nation's population, the study States were judged to have 30 percent of the proprietary nursing home beds in the country (table 1, appendix A). Projecting from this, there

Table 3. Survey coverage of proprietary nursing homes

State	Total			Number reported ¹			Percent of total patients reported ¹
	Homes	Beds	Patients ²	Homes	Beds	Patients	
Total, 13 States reporting.....	2,715	47,322	39,179	1,686	28,891	23,242	59.3
California ¹	464	8,356	6,784	120	2,635	1,687	24.9
Colorado.....	140	2,571	2,093	136	2,476	2,016	96.3
Connecticut.....	183	4,197	3,819	180	4,134	3,763	98.5
Georgia.....	53	1,235	998	51	1,136	918	92.0
Indiana.....	340	5,768	4,277	339	5,751	4,264	99.7
Maryland.....	102	2,385	2,029	95	2,203	1,874	92.4
Minnesota.....	199	3,335	3,202	187	3,087	2,964	92.6
New Mexico.....	32	333	254	32	333	254	100.0
New York (upstate) ¹	752	13,653	11,609	96	1,651	1,391	12.0
Oklahoma.....	248	3,166	2,291	248	3,166	2,291	100.0
Rhode Island.....	79	1,111	911	78	1,107	908	99.7
Vermont ²	95	980	754	95	980	754	100.0
Wyoming.....	28	232	158	28	232	158	100.0

¹California and New York used a planned sample of homes. (In the other 11 States complete coverage was the objective.) The analysis will provide for expansion of the samples to the corresponding totals for those States. This expansion will yield reported totals for the 13 States of 2,686 homes, with 46,614 beds and 38,557 patients.

²Partly estimated.

³Total in State not reported. In absence of other evidence, assumption made that reported group represents total.

are in the United States an estimated 160,000 beds in 9,000 homes of the type construed in this study as proprietary nursing homes. As table 3 shows, the 13 study States reported 2,715 such homes with 39,179 patients. The study States achieved nearly complete coverage in the survey except that California and New York employed a planned sample.

The information presented in this section is based on actual reports for 1,686 proprietary nursing homes with 23,242 patients. The samples employed in California and New York will be expanded to represent the totals for those States so that they will carry their proper weight in the 13-State summation. The resulting 13-State totals which will be cited in the analysis will therefore be 2,686 homes with 46,614 beds and 38,557 patients.

Personal Characteristics of Patients

Personal data gathered for the patients include age, sex, marital status, and race. The detailed findings by State are shown in table 2, appendix B.

Age

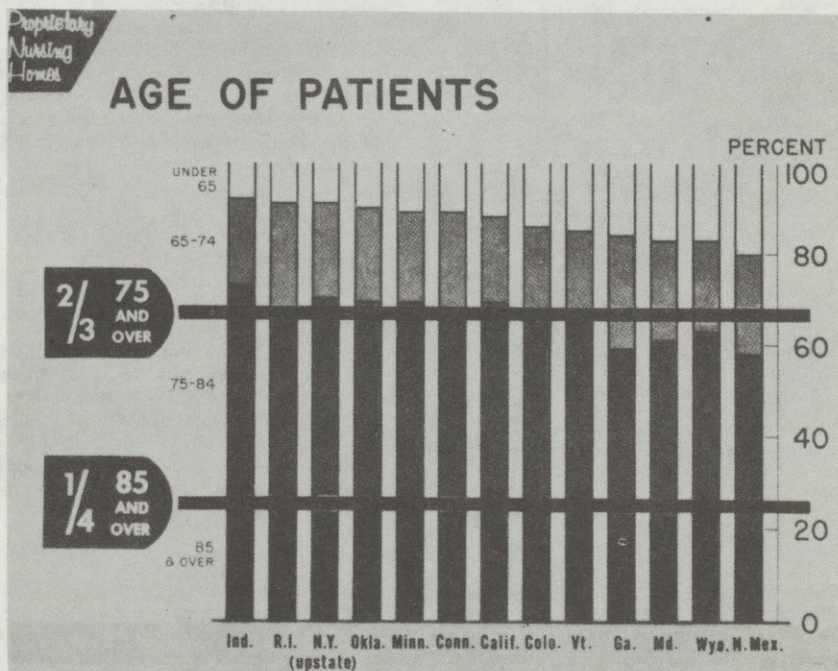
Nursing homes take their prime character from the age of their patients. The average patient is 80 years old.

Less than one-tenth of the patients in proprietary nursing homes are under 65 years of age (table 4). Very few indeed—little more than 1 percent of the total—are less than 45 years old.

Figure 3 emphasizes how extreme is the age characteristic. As many as one-fourth of the patients are 85 years of age or older.

The chart also depicts the striking similarity in the age of patients among the survey

Figure 3. Age of patients in proprietary nursing homes.



States. Whatever other characteristics may be found to vary from one State to another, the age makeup of the patient population is distinctly standard. Nursing homes in contemporary society, it appears, are characteristically a form of home for the aged. Some individual homes will depart from this pattern for one reason or another—in catering to short-term convalescents of any age or to patients in a younger age group—but the predominance of patients in the older ages is clear.

Table 4. Patients in proprietary nursing homes, by age, sex, and race

Age	Total patients	Sex ¹		Race ¹	
		Male	Female	White	Non-white
Number, 13 States...	38,557	12,468	25,943	37,031	745
Percentage distribution					
Total.....	100.0	100.0	100.0	100.0	100.0
Under 45.....	1.4	2.0	1.0	1.3	5.0
45-54.....	2.1	2.6	1.8	2.0	6.6
55-64.....	5.5	6.4	5.1	5.3	13.6
65-74.....	20.6	24.0	19.0	20.5	27.9
75-84.....	42.3	40.4	43.3	42.6	27.9
85 and over.....	26.2	22.5	28.0	26.5	13.6
Unknown.....	2.0	2.1	1.9	1.8	5.5
Median age (years)	80	78	80	80	73
Number per 100,000 general population in category ²					
Total.....	102	66	136	107	26
Under 45.....	2	2	2	2	2
45-54.....	18	15	21	18	17
55-64.....	62	47	77	61	60
65-74.....	365	289	432	367	183
75-84.....	1,870	1,278	2,347	1,889	581
85 and over.....	6,383	4,387	7,692	6,534	1,237
Under 65.....	10	8	12	10	7
65 and over.....	1,071	725	1,365	1,088	327

¹ Sex unknown, 146. Race unknown, 781.

² Based on 1950 population census.

NOTE: Figures in this and other tables are individually rounded and therefore do not necessarily add precisely to their totals.

The highly selective nature of the patient population of nursing homes stands out boldly when viewed in relation to the general population. For every 100,000 of the total population in given age groups, the number of patients in proprietary nursing homes mounts sharply with age, as table 4

shows. Of the population 65 years of age and over, 1 percent are in these homes. Little as this is, it is 100 times the corresponding rate for the population under 65 years old. The strong effect of age on the proportion of the population in nursing homes is similarly seen among persons over 65 years old—the proportion in nursing homes is one-third of 1 percent for those aged 65-74 years, but over 6 percent for the group 85 years of age or older.

Sex

Two-thirds of all patients in proprietary nursing homes are women. This is not merely a consequence of the large proportion of older women in the general population. The rates in table 4 demonstrate that of the total population of given ages, much larger proportions of women than of men are in proprietary nursing homes. This undoubtedly reflects the greater longevity of women in this indirect respect: Many more women than men are widowed. Widowhood, in turn, more strongly disposes to residence in a nursing home or other protected environment than if a marital partner is present.

This differential experience results in a somewhat older average age for women patients than for men patients—80 years compared with 78 years.

Marital Status

The significance of widowhood is emphasized by the fact that two-thirds of all patients in proprietary nursing homes are widowed. Those who are partnerless because they have never been married or have been divorced or separated make up an additional sizable proportion of the patients in these homes (table 5). Only one-tenth of the patients are married with the spouse living.

Proportionately more women patients than men patients are widowed—nearly three-fourths against one-half.

Race

About 8 percent of the general population in the 13 study States are nonwhite. Only 2 percent of the patients in proprietary nursing homes in these States are nonwhite.

This difference cannot be wholly accounted for by the fact that proportionately fewer nonwhites attain the advanced ages characteristic of nursing home residents. Even among nonwhites living into the higher ages, the rate at which they are found in proprietary nursing homes is substantially lower than the rate among white persons. For example, of the total population 85 years of age or older in the study States, the proportion in proprietary nursing homes is 6.5 percent among white persons and only 1.2 percent among nonwhites. Economic and social factors would seem to hold likely explanations and would merit more detailed study.

In net result, white and nonwhite patients in proprietary nursing homes are sharply distinguished in their average age—80 and 73, respectively.

A curious fact revealed in the study is that the nonwhite patient group is made up about equally of men and women while among the white patients there are twice as many women as men. Perhaps related to this is the fact that in the nonwhite population of the study States, equal proportions of the men and women are 65 years of age or older—5.5 percent in either group. Among the white population, however, of whom 8.7 percent are 65 years of age or older, the proportion for women is higher (9.3 percent) than for men (8.1 percent).

Table 5. Marital status of patients in proprietary nursing homes, by sex

Marital status	Total patients	Sex ¹	
		Male	Female
Number, 13 States	38,557	12,468	25,943
Percentage distribution			
Total.....	100.0	100.0	100.0
Widowed.....	65.3	51.5	72.1
Single.....	17.7	21.8	15.8
Married.....	10.5	16.3	7.7
Separated or divorced.....	2.7	5.7	1.3
Unknown.....	3.8	4.8	3.1

¹ Sex unknown, 146.

Medical Condition of Patients

Physical and mental status is at the heart of the description of the patients in this

study. Information available on this score relates to the extent of disability among the patients and the types of diagnoses reported for them.

Ability to Walk

Somewhat less than half of the patients can walk alone or with no more help than a cane or crutch. Others need some major mechanical or personal assistance for getting about, while nearly one-third do not walk or get about at all, even in a wheelchair (table 6).

Considerable variations appear among the States in the extent of disablement of nursing home patients. Figure 4 summarizes these variations by showing the range among the 13 study States in percentage of patients suffering given forms of disability. The proportion who cannot walk alone even with the help of a cane or crutch varies from two-fifths in Wyoming to two-thirds in California. (Detail for all 13 States is given in table 3, appendix B.)

Less relationship than might be expected appears between walking status and age of the patients (table 6). Surprisingly little variation shows among the different age groups in the proportion who can walk entirely independently or, on the other hand, in the proportion completely unable to walk. Consistent differences do appear among the age groups, however, in the proportions of patients able, but with some severe limitation, to get about. The proportion of patients who maneuver themselves about with the aid of major appliances such as walkers and wheelchairs decreases with age, while the proportion dependent on an attendant's helping hand increases with age. Thus, for those for whom it is difficult but possible to get about, increasing age brings greater reliance on personal help and decreasing ability to manipulate mechanical appliances.

Bed Status

Twenty percent of proprietary nursing home patients are completely bedfast. An additional 14 percent are in bed most of the time. Others are in and out of bed for portions of their time. Somewhat less than half are normally out of bed.

Table 6. Relationship of disability to age among patients in proprietary nursing homes

Condition of patient	Total patients	Age ¹				
		Under 55	55-64	65-74	75-84	85 & over
Number, 13 States.....	38,557	1,321	2,123	7,955	16,300	10,106
	Percentage distribution					
Total.....	100.0	100.0	100.0	100.0	100.0	100.0
Walking status:						
Alone or with cane or crutch.....	45.6	40.3	39.6	46.8	47.6	43.6
With walker, wheelchair, etc.....	8.0	16.4	11.0	9.3	7.4	6.2
Only with attendant's help.....	14.1	7.7	11.3	13.0	14.3	16.0
Does not walk or get about.....	31.4	33.5	37.4	30.1	29.9	33.2
Unknown.....	1.0	2.1	.7	.8	.8	1.0
Bed status:						
Out of bed except to sleep or rest.....	46.9	51.4	44.9	48.5	47.8	44.4
In bed part of the time.....	18.7	12.7	17.7	18.4	18.8	19.7
In bed most of the time.....	13.8	11.6	13.0	14.6	13.3	14.3
In bed all of the time.....	20.4	23.8	24.4	18.4	19.9	21.5
Unknown.....	.2	.5	.0	.1	.2	.1
Mental condition:						
Always clear.....	43.5	71.2	54.9	49.5	42.2	35.1
Confused part of the time.....	33.7	18.5	30.6	31.5	34.7	36.3
Confused most of the time.....	22.4	8.8	14.0	18.9	22.6	28.3
Unknown.....	.4	1.4	.4	.2	.4	.3
Continence:						
Continent.....	64.5	72.7	69.0	67.7	64.6	60.5
Incontinent, feces only.....	1.4	.8	.8	1.4	1.6	1.4
Incontinent, urine only.....	7.4	5.6	4.6	6.8	7.5	8.5
Incontinent, urine and feces.....	26.2	20.4	24.7	23.6	25.8	29.1
Unknown.....	.5	.6	.9	.5	.5	.4

¹ Age unknown, 752.

Again the situation varies from State to State, as figure 4 shows. The proportion completely confined to bed ranges among the study States from 12 percent to 35 percent of the patients.

We would expect that confinement to bed would increase with the age of the nursing home patients. As already observed above with respect to ability to walk, however, there is no strong pattern demonstrating that the older patients in nursing homes are more heavily disabled in this regard. This suggests perhaps that disability at any age is a large selective factor in bringing patients into the nursing home. Often the disability will have to be more severe to induce placement of a younger person than of an older person in a home. Some older people enter a nursing home not so much because of a severely disabling condition but rather because of general infirmity or because of social difficulties in housing arrangements. People not quite so old would be more apt

to be cared for at home particularly if a husband or wife is still living. It may be that by such selectivity, the patients in nursing homes would not show the extent of increasing disability with age which might ordinarily be expected.

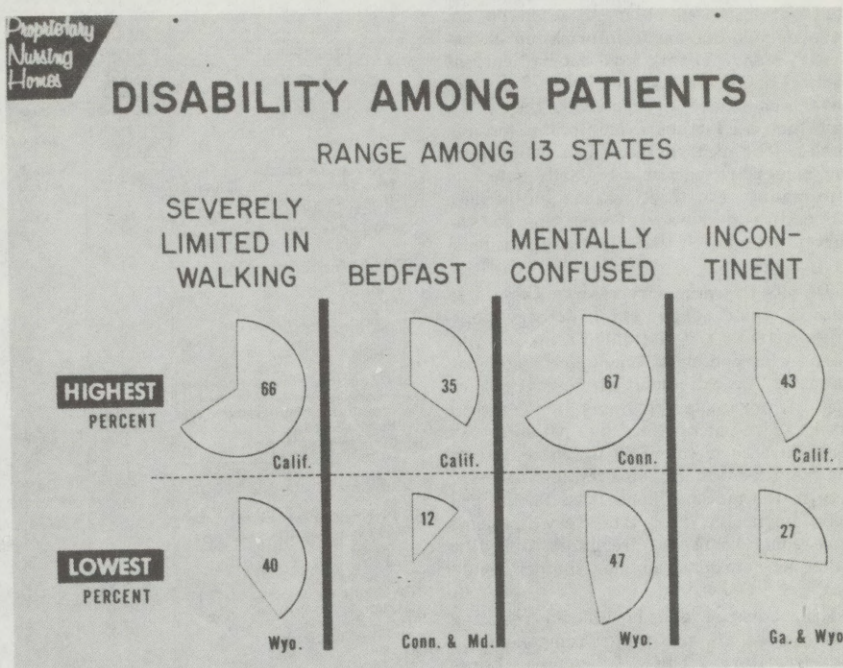
Mental Condition

More than half of the patients in proprietary nursing homes are disoriented, at least part of the time. About 1 out of 5 disoriented patients show this state of confusion most of the time.

All of the study States reported large proportions of patients as being confused. The range (fig. 4) is from about one-half to two-thirds of the patients in the different States.

In contrast to the physical disabilities discussed above, disorientation shows a decided relationship to age (table 6). The proportion of confused patients mounts sharply from about one-fourth of those under 55

Figure 4. Disability among patients in proprietary nursing homes.



years of age, to half of those aged 65-74, and on up to nearly two-thirds of the patients who are 85 and over.

Most of the mental confusion among the older patients stems from arteriosclerotic processes, while among the younger patients it is more likely to result from other diseases affecting the central nervous system and from mental disorders.

Continence

Large numbers of nursing home patients do not have control of elimination. Fully one-third are incontinent of either urine or feces or both. One-fourth lack both bladder and bowel control.

Although a range in the severity of this problem is exhibited among the different States, its extent is very impressive for all States. As figure 4 indicates, in none of the

surveying States is the proportion of incontinent patients less than one-fourth.

Incontinence may have its basis in either organic or psychological difficulties. The extent of its prevalence in relation to age of the patients may reflect its twin origins, for incontinence in patients in nursing homes shows an increase with the age of the patients to an extent which is between the observed increase in physical disabilities and in disorientation. Approximately 25 percent of patients under 55 years of age are incontinent, with increasing proportions among the older group, up to about 40 percent of those 85 years and older (table 6).

Diagnoses

The observable physical and mental limitations of the patients which have been discussed above have a degree of validity not

matched by the diagnostic information available. Nursing home administrators and staffs, it has been observed, often do not have reliable diagnostic information on patients. Many patients have not had current medical diagnoses made or, when diagnoses have been made by physicians, they often have not been transmitted to the nursing homes. The medical records in many nursing homes are particularly inadequate and unrevealing. For these reasons and because of possible inaccuracy of reporting for the survey, reliance on the diagnostic data must be guarded.

Despite this necessary reserve, these data permit some enlightening observations. They certainly reveal (table 7) that chronic diseases predominate among nursing home patients. They also point out how large loom the cardiovascular diseases among this group. Two out of every five patients have a cardiovascular condition which represents the main medical reason for their need for care in the nursing home (that is, the primary diagnosis). Fully 2 of every 3 patients have some heart or circulatory difficulty, either as a primary or contributory condition.

Heart disease and hemiplegia resulting from stroke are two major components in the circulatory group of diagnoses. Large numbers of nursing home patients are victims of these diseases. One in six patients suffers residuals of a paralytic stroke and, more than for any other type of diagnosis except multiple sclerosis, having this condition means having it as the principal pathology: In both types of diagnoses, more than 9 out of 10 patients who had the condition had it reported as their primary diagnosis.

About one-tenth of the patients are receiving care for fractures; in most cases, hip fractures. These fractures particularly assume a chronic rather than an acute character since the aged person with a hip fracture requires so prolonged a period of care.

Arthritis and rheumatism affect a goodly proportion of these aged people. Various forms of paralytic conditions, mental disorders, and diabetes were reported for more than 5 percent of the patients. Nearly as

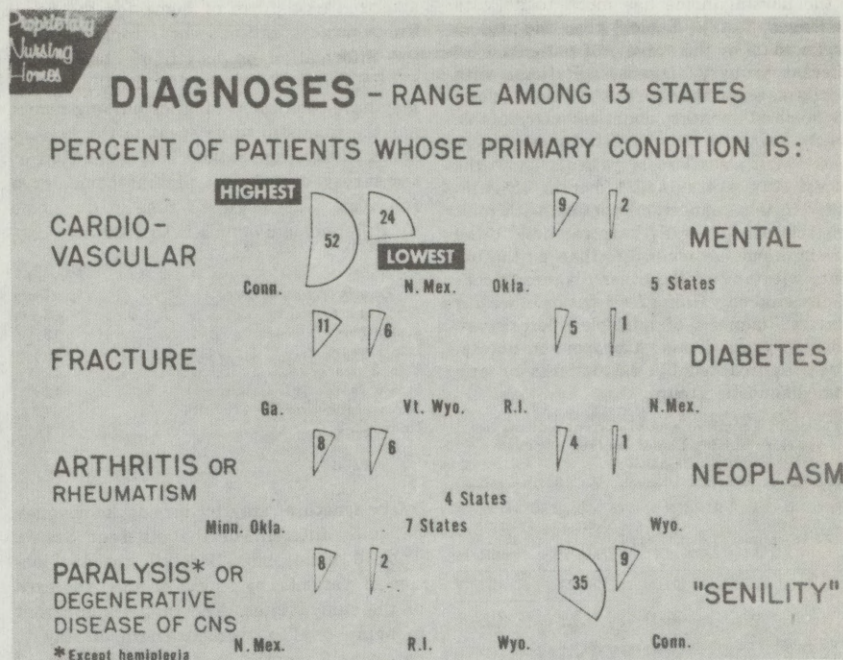
Table 7. Diagnoses reported for patients in proprietary nursing homes

Diagnostic group	All diagnoses	Primary diagnoses
Number, 13 States	61,867	38,557
	Percent of patients	
Total	100.0	
Cardiovascular diseases	65.6	40.3
Heart disease	17.2	11.6
Hemiplegia (mainly from stroke)	16.3	15.2
Other circulatory diseases	32.0	13.5
Senility	25.6	17.0
Fractures	11.3	8.8
Hip	8.0	6.4
Other	3.3	2.4
Arthritis and rheumatism	9.5	6.3
Paralyses (excluding hemiplegia) and degenerative diseases of central nervous system	5.8	4.9
Paralysis agitans	2.5	2.1
Multiple sclerosis	1.0	1.0
Other	2.3	1.8
Mental disorders	5.5	3.6
Psychoses	2.2	1.7
Psychoneuroses and other behavior disorders	3.2	1.9
Diabetes	5.3	3.4
Neoplasms	4.5	3.3
Genitourinary diseases	3.8	1.5
Gastrointestinal diseases	3.0	1.1
Total blindness	3.5	1.5
All other diagnoses	14.0	5.3
No diagnosis	2.2	2.2
Unknown	1.0	1.0

many were reported as having cancer or other neoplasms. One out of 30 patients is totally blind, although for less than half of them is blindness the main problem requiring that they be under nursing home care.

The frequency with which senility is reported points up a special problem. For one thing, the term "senility" is quite undefinative; it identifies the nature of the difficulty only in a vague and unsatisfactory manner. Moreover, the reported prevalence of senility undoubtedly reflects not so much the true prevalence of the condition as it does a failure to have any more definitive diagnostic information on the patients. If the patient is not attended by a physician, if the physician's diagnosis does not find its way to the nursing home, or if the nursing home does not employ adequate medical records then

Figure 5. Diagnoses of patients in proprietary nursing homes.



the blanketing term "senility" may be conveniently assigned.

Many of the patients have a multiplicity of diseases, so characteristic of older, chronically ill people. More than half again as many diagnoses were reported as there were patients.

Figure 5 shows for some of the diagnostic groups the variation among the States in the extent to which the given conditions are reported as primary diagnoses (see table 4, appendix B, for complete detail). It is interesting to observe that Connecticut, where relatively high standards of care prevail, reports the highest proportion of patients with cardiovascular diagnoses among the study States and the lowest proportion under the term "senility."

Men and women patients show a not very dissimilar picture on diagnoses (table 5, appendix B). A few differences come to light,

however, which are worth noting. More women suffer fractures, particularly of the hip. Disorders of the genitourinary and gastrointestinal systems seem to be more prevalent among men. On the whole, however, differences are quite few and minor.

Age has a more decided effect on diagnoses than does sex (table 5, appendix B). A sharp distinction may be seen between patients under 55 years of age and those over 55 in diseases of the heart and circulatory system; considerably fewer of the younger patients have these conditions. Certain other diagnoses, on the other hand, appear more frequently among the younger patients; outstandingly, multiple sclerosis. This may reflect the hypothesis offered in the earlier discussion relating disability to age: In the absence of severe identifiable conditions, younger individuals may be brought into the nursing home infrequently.

The condition which brings the patient to the nursing home has much to do with the length of stay. Table 8 gives the median stay, to date of the survey, of patients with different primary diagnoses. Patients with neoplasms show the shortest average time in the home, 7 months, doubtless attributable largely to the number of terminal cancer cases. Multiple sclerosis patients show the longest stay, averaging 21 months. Significantly in this connection, persons with multiple sclerosis generally have recourse to the nursing home earlier in life than do the patients with any of the other diagnostic conditions studied. Half of all patients with a primary diagnosis of multiple sclerosis are under 55 years of age, a proportion not remotely approached by the patients of any other diagnostic group.

Table 8. Length of stay of current patients in proprietary nursing homes, by type of primary diagnosis

Selected primary diagnoses	Number of patients	Median length of stay (months) ¹
Total patients, 13 States...	38,557	12
Multiple sclerosis.....	369	21
Total blindness.....	563	20
Arthritis and rheumatism.....	2,439	17
Semility.....	6,538	14
Paralysis agitans.....	826	13
Hemiplegia (mainly from stroke).....	5,854	12
Heart disease.....	4,488	12
Diabetes.....	1,298	12
Fracture of hip.....	2,464	11
Psychoses.....	662	11
Gastrointestinal diseases.....	408	11
Fracture (other than fracture of the hip).....	913	9
Psychoneuroses and other behavior disorders.....	729	9
Genitourinary diseases.....	595	9
Neoplasms.....	1,267	7

¹ In present home to date of survey.

Care of Patients

Care of the patients has many aspects: how long they are under care in this type of institution, what level of care they need, what types of nursing and personal services they receive, what kinds of personnel are available to provide these services, and the extent to which the patients are attended by physicians.

Length of Stay

From the standpoint of the advanced ages

of the patients, the nursing home was characterized as a form of home for the aged. This characterization seems strengthened by the information on length of stay in the nursing home. Not counting the time which may have been spent in other nursing homes nor the time still to be spent in the present home, the average patient had at the time of the survey been in the present home for a full year. The length of time in the home for different individuals is as follows:

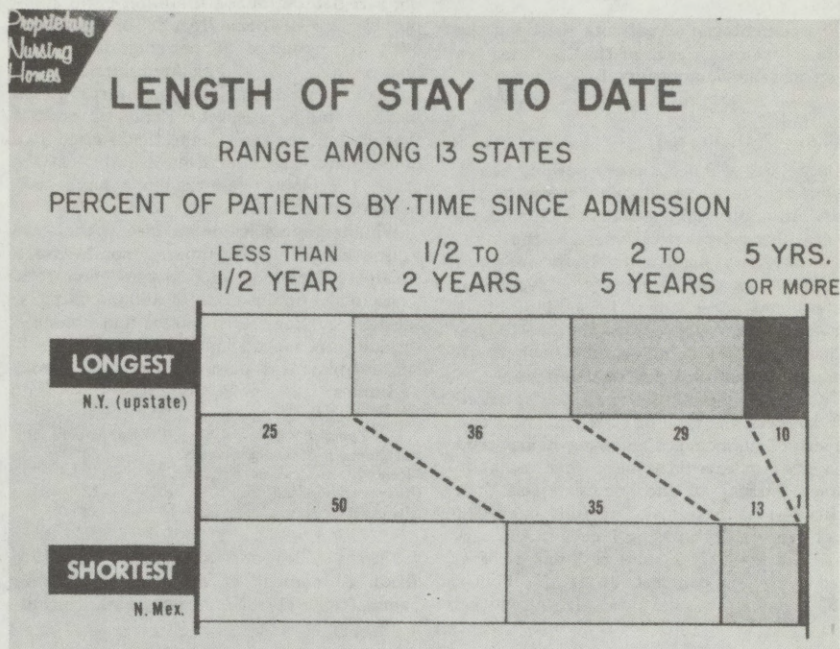
Length of stay to date	Percent of patients
Less than 6 months	32
6 months to 1 year	18
1 to 2 years	19
2 to 3 years	12
3 to 5 years	11
5 years and over	7
Unknown	1
Total	100

The length of stay in nursing homes may be quite different in the different States. Table 6 of appendix B details the distribution of patients, by length of stay, for each of the study States. The range is apparent in figure 6. The average length of stay to date was 6 months in New Mexico and 17 months in upstate New York. The length of time homes have been in existence in the various States has much to do with this difference and will be examined in the discussion of age and occupancy of homes.

Level of Care Needed

Information on the level of care needed as sought in the survey is of a highly subjective nature. The informant (nursing home administrator or staff member) indicated for each patient whether his needs could be expected to be met only in a nursing home or whether, with the supposed availability of a relative at home, he could conceivably have been cared for in his own home. In the 12 States reporting on level of care needed, the responses showed the following percentages of patients assigned to each of three levels of need for care.

Figure 6. Length of stay to date of patients in proprietary nursing homes.



Level of care needed	Percent of patients
Nursing care which one would not ordinarily expect could be given in a patient's own home, even with relatives available to help	48
Nursing care which might be given at home if patient had a home with relatives available to help	41
Mainly boarding care	11
Total	100

Reliance cannot be placed on the preciseness of these figures, in view of the range of interpretation which may be given to the concepts expressed in the levels of need. However, at a minimum, they indicate that a not inconsiderable number of persons are in nursing homes who really require less than skilled nursing care. This is not to say that they should not be in the homes where they are, but it is a commentary on the di-

verse nature of services provided by nursing homes.

Services Received

Some of the more common identifiable services received by patients are listed in table 9, which shows very significant differences among the groups of patients judged to have different levels of need. Except for those receiving help with tub bath or shower, the proportions who receive the specified services decline in consistent relationship to the expressed levels of need. Relatively fewer patients who require nursing home care receive help with tub bath or shower since they are commonly given bed baths.

About 3 percent of the patients were receiving none of the specified services. Here again there is a marked connection with the level of care needed. The great majority of those not receiving any of the services had

been identified as needing mainly boarding care.

The percentages of patients receiving the various services in each of the 13 States are given in table 7, appendix B.

Staffing of Homes

Only 2 out of 5 proprietary nursing homes have a registered professional nurse on the staff. An additional one-fourth of the homes have a licensed practical nurse as the highest skill-level represented. Thus, one-third of the homes employ neither a registered professional nurse nor a licensed practical nurse. (Two of the States in the study—Colorado and Wyoming—do not have provision for licensure of practical nurses.)

Table 10 demonstrates the close relationship between the type of staff employed and the size of the home. The larger homes tend to a greater extent to have professionally trained nurses. Of the homes of less than 10 beds—and these make up fully one-third of all proprietary nursing homes in the surveyed States—only 1 home in 5 has a registered nurse. In contrast, 3 out of 4 homes of 35 beds or more have a registered nurse.

With about 40 percent of all the homes having a registered nurse, the differential staffing by size of home results in somewhat over 55 percent of all patients residing in homes which have a registered nurse.

Sharp contrasts appear among the States in this staffing respect. Figure 7 reveals that at one extreme (Connecticut) almost all homes have a registered nurse, while at the other (Wyoming) almost none have such personnel.

Whether by choice or because of the state of the labor market, nursing homes use a considerable number of part-time employees. These make up one-sixth of all staff in nursing homes. Registered nurses and nonnursing staff are more commonly found on part-time employment than are practical nurses and aides:

<i>Type of staff</i>	<i>Percent on part time</i>
Registered professional nurses..	23
Licensed practical nurses.....	12
Other nursing staff.....	12
All others.....	22

Nurses aides and attendants constitute about 40 percent of all staff in nursing homes (table 11). Nonnursing staff (includ-

Table 9. Services received by patients in proprietary nursing homes, by level of care needed

Services received	Total patients	Level of care needed ¹		
		Could not ordinarily be given in patient's own home	Might be given in patient's own home	Mainly boarding care
Number of patients, 13 States.....	38,557	17,506	14,999	3,975
		Percent of patients		
Help in feeding.....	24	37	15	1
Help in dressing.....	48	60	45	10
Care of hair.....	62	79	53	15
Shaving.....	21	25	19	9
Help with tub bath or shower.....	42	32	52	48
Full bed bath.....	55	71	47	12
Rub and massage.....	64	78	59	16
Bedpan.....	39	53	32	4
Enema.....	26	43	14	4
Hypodermic injection.....	18	25	13	5
Dressings.....	7	11	4	1
Medication.....	66	76	64	38
Pulse, temperature, or respiration taken.....	46	57	40	15
Special diet.....	22	27	20	11
None of these.....	3	(¹)	2	21

¹ Information not available on 2,077 patients.

² Only 0.3 percent.

Figure 7. Skill-level of staff in proprietary nursing homes.

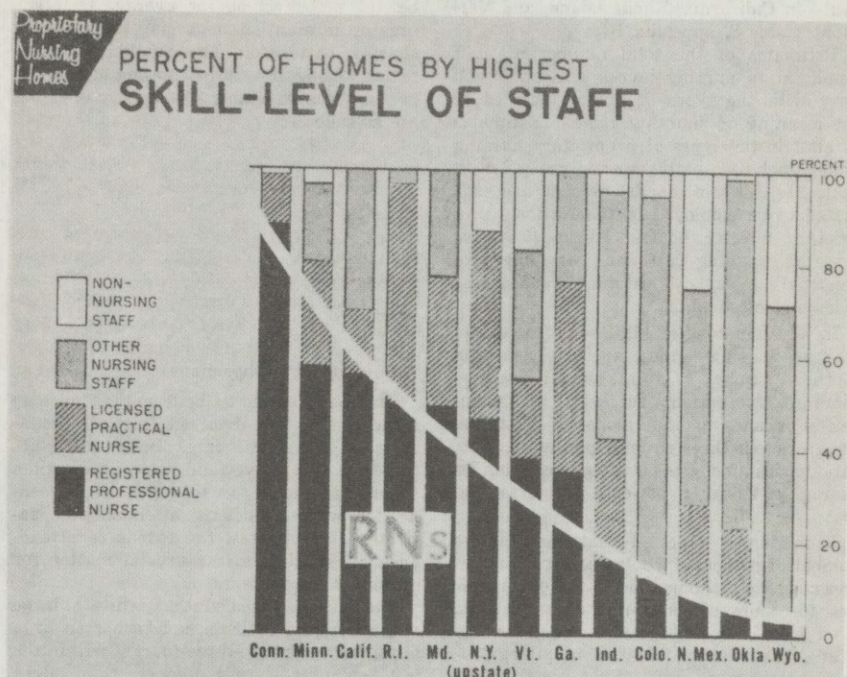


Table 10. Highest skill-level of staff in proprietary nursing homes, by size of home

Highest skill-level of staff in home	Total homes	Bed capacity of home					
		Under 10	10-14	15-24	25-34	35-49	50 and over
Number of homes, 13 States	12,674	855	503	737	343	161	75
Percentage distribution of homes							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Registered professional nurse	41.1	20.7	37.6	47.6	59.2	78.3	70.7
Licensed practical nurse	24.9	24.1	22.1	31.2	26.5	8.7	18.7
Other nursing staff	28.0	43.3	31.8	19.3	14.0	13.0	10.7
All others	6.0	11.9	8.5	1.9	.3	0	0

¹An additional 12 homes were not reported for staff.

ing cooks, custodial staff, office help, and so on) make up about 30 percent of the total; licensed practical nurses, about 20 percent; and registered nurses, 10 percent.

The extent to which registered nurses are

used in proprietary nursing homes varies widely among the States. Registered nurses represent only 1 percent of all staff in Oklahoma and Wyoming but up to 23 percent in Connecticut. The next highest proportion

represented by registered nurses is 12 percent—in California, Rhode Island, and Vermont (table 8, appendix B).

Estimates of the total number of staff employed in nursing homes nationally will vary with the types of homes included in the meaning of "nursing home." Estimates of staff in the types of proprietary nursing homes included in this survey are given in table 11. All told, 66,000 persons are estimated to be employed in the Nation's proprietary nursing homes. About 45,000 of these are nursing personnel, including professional nurses, practical nurses, and nurses aides and attendants.

In addition to the skill-level of available staff in nursing homes, a crucial question is their number. On an overall average, there are two patients for every staff member. For nursing staff alone, of all types, the average is three patients per nurse. This ratio varies among the study States from an average of 2.5 to 5.2 patients per nurse (fig. 8).

It might be expected that the relative number of personnel would decrease with increasing size of home, due to the opportunities for more efficient utilization. On the other hand, more extensive services may be offered in the larger facilities, requiring proportionately more staff. Whatever the indi-

vidual effects of these and other factors may be, the net effect on the average staff volume in different-sized nursing homes is not sharply patterned. The median bed/staff ratios among the 2,674 nursing homes reporting on staff (table 10), by size of home, are as follows:

<i>Bed capacity of home</i>	<i>Number of beds per staff member</i>
Total	2.7
Under 10	2.5
10-14	2.8
15-24	2.9
25-34	2.8
35-49	2.4
50 and over	2.5

Attendance by Physicians

There is reason to believe that nursing homes are rather divorced from the mainstreams of medical care. Information obtained in this survey did not do more than superficially touch on this question in connection with physicians' attendance of patients. Nevertheless, the extent of attendance by physicians is a crucial matter for nursing home patients.

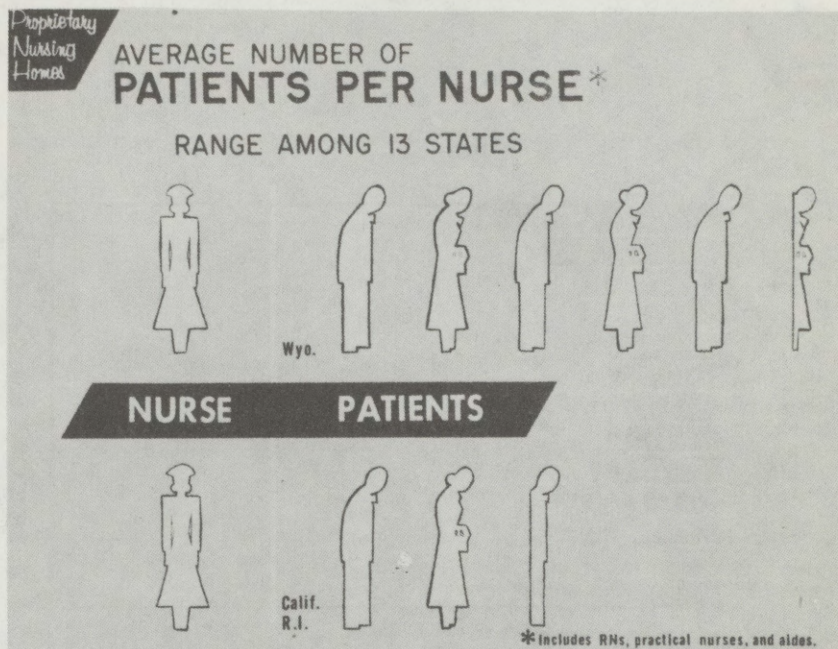
The survey revealed that while a large number of the patients had been seen by a physician recently—three-fourths within the last 3 months—larger numbers than might

Table 11. Personnel in proprietary nursing homes, by type of staff and full- or part-time status

Type of staff	Total personnel	Time involvement		
		Full-time	Part-time	Full-time equivalent ¹
Number of personnel, 13 States.....	19,763	16,503	3,260	18,133
Percentage distribution of personnel				
Total.....	100.0	100.0	100.0	100.0
Registered professional nurses.....	10.1	9.3	14.0	9.7
Licensed practical nurses.....	17.1	18.0	12.8	17.5
Other nursing staff.....	41.5	43.5	31.4	42.4
All others.....	31.3	29.2	41.8	30.3
National estimates				
Number of personnel, United States.....	66,000	55,000	11,000	60,500
Registered professional nurses.....	7,000	5,000	2,000	6,000
Licensed practical nurses.....	11,000	10,000	1,000	10,500
Other nursing staff.....	27,000	24,000	3,000	25,500
All others.....	21,000	16,000	5,000	18,500

¹ Full-time plus half the number of part-time personnel.

Figure 8. Average number of patients per nurse in proprietary nursing homes.



seem warranted for such a class of patients have been without attendance for long periods:

<i>Time since last physician visit</i>	<i>Percent of patients</i>
Less than 1 month	60
1 to 3 months	16
3 to 6 months	8
6 to 12 months	5
1 to 2 years	1
2 years and over	1
No visit since admission	4
Unknown	5
Total	100

Half of those who had not seen a physician since their admission to the nursing home had been in the home for as long as 6 months or more.

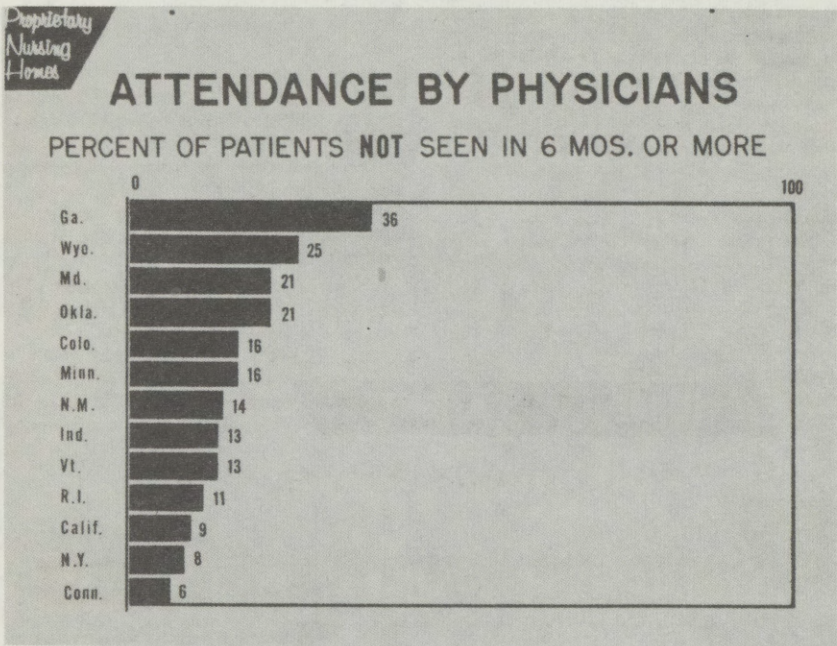
As of the time of the survey, 1 patient in 8 had not been attended by a physician in 6 months or more in the nursing home (including 3 percent whose last physician visit

date was reported as not known and who had been in the home at least 6 months). The average of 12 percent in this unattended group is surrounded by a wide range of differences among the States (fig. 9); in some States less than 10 percent of the patients are not seen by a physician for as long as 6 months, while in others the proportion is much higher, mounting to more than one-third of the patients in one State.

Whether or not patients were seen within 30 days of the survey does not seem to be related to the age of the patients:

<i>Age (years)</i>	<i>Percent attended by a physician within 30 days of the survey</i>
Total	60
Under 55	61
55-64	64
65-74	61
75-84	59
85 and over	59

Figure 9. Attendance by physicians in proprietary nursing homes.



It appears, however, that among those attended by physicians during the month, the younger patients tend to have been seen

more frequently (table 12). The differences among the age groups are statistically highly significant by the chi-square test.

Table 12. Patients in proprietary nursing homes who had been attended by a physician within 30 days of survey, by number of visits and age of patient

Number of physician visits within 30 days of survey	Total patients	Age ¹				
		Under 55	55-64	65-74	75-84	85 and over
Number of patients, 13 States	23,772	846	1,402	5,019	9,897	6,156
		Percentage distribution				
Total	100.0	100.0	100.0	100.0	100.0	100.0
1	49.7	42.2	46.9	46.2	50.9	52.2
2	16.9	9.9	15.4	16.0	18.2	17.0
3-4	17.4	23.6	19.8	20.5	15.9	16.1
5-6	2.3	4.1	1.7	2.4	2.6	1.6
7-8	1.2	2.0	2.2	1.3	1.1	.8
9 or more	8.9	13.7	10.8	9.6	8.1	8.7
Unknown	3.6	4.4	3.2	3.9	3.2	3.6

¹ Unknown, 452.

Sources of Funds and Charges for Care

Perhaps the outstanding fact which emerges from the study regarding the financing of care of patients in nursing homes is the role of public assistance funds. Fully half of all proprietary nursing home residents are recipients of public assistance, with these funds paying the full bill in 4 out of 5 of these cases. Table 13 details the various sources of funds and their combinations in paying for care of patients.

The extent of coverage by public assistance varies considerably among the States, as figure 10 shows, but is substantial in every State in the study. In none of these States is the proportion covered by welfare funds less than 25 percent of all proprietary nursing home patients. In several of the States the proportion is as high as 70 percent. Among the factors which may explain

differences among States are the varying provisions made for care of needy patients in public institutions which provide nursing care.

About as many patients pay their own way as are financed from public assistance funds. Other sources of funds may include community chest and other voluntary organizations and public programs such as workmen's compensation and rehabilitation. To some extent the home itself may furnish free care. These sources, however, play a minimal role.

Amount of Charges. In proprietary nursing homes, the average (median) monthly charge for care is about \$150. Average monthly charges range from about \$90 in New Mexico and Oklahoma to \$200 in California. The range among individual homes is of course much greater.

Figure 10. Public assistance recipients in proprietary nursing homes.

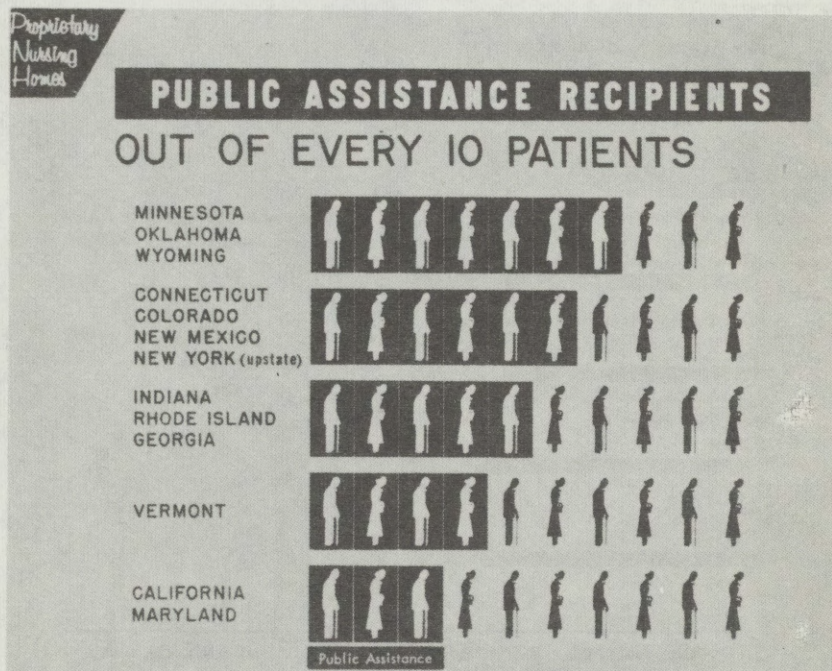
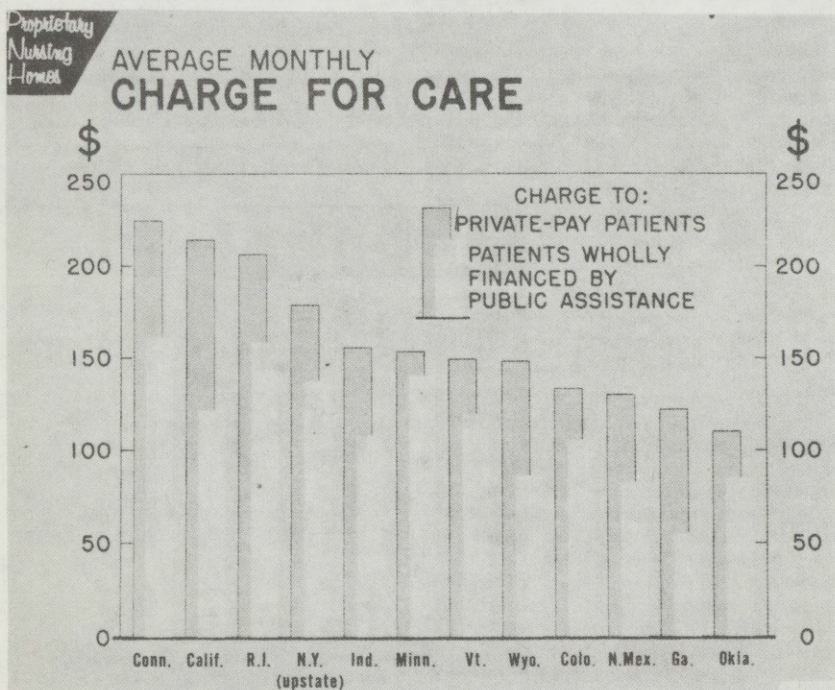


Table 13. Sources of funds for care of patients in proprietary nursing homes

Source of funds	Patients
Number, 13 States.....	38,557
	Percent
Patient (or family).....	54.8
In whole.....	45.4
In combination with other sources.....	9.4
Public assistance.....	51.3
In whole.....	41.7
In combination with other sources.....	9.6
Other agency ¹	1.8
In whole.....	.9
In combination with other sources.....	.9
Combinations of sources:	
Public assistance and patient (or family) ..	9.0
Public assistance, patient, and other agency ..	.1
Public assistance and other agency.....	.5
Patient and other agency.....	.4

¹Including free care from the home itself.

With the number of patients financed from public assistance, the amounts payable from this source assume an unusual importance. Statutory and budgetary limitations on the amounts payable through public welfare grants exercise a powerful influence on the field. In figure 11 we see, State by State, the varying degrees of discrepancy between average private and public payments. The comparison here is between the amount of the charges for patients who pay entirely out of their own funds and the amount of the charges for patients whose care is paid for entirely out of public welfare funds. While the comparison does not take account of the cost of luxury accommodations purchased by individuals paying for themselves, the main force of the comparison is not lost. The public assistance average payment is sufficiently below the private-pay average in most of

Figure 11. Charges for care of patients in proprietary nursing homes.

the States to highlight a difficult situation. The difference is at a minimum in Minnesota, where the private-pay average is \$153 and the public assistance average is \$140, or 92 percent of the private-pay average. The largest proportionate difference appears in Georgia, where the respective median payments are \$122 and \$55, the average public assistance payment being only 45 percent of the private-pay average.

In composite, the data produce national estimates for average private-pay and public assistance monthly payments of \$175 and \$128, respectively.

Charges tend to go up with the size of the nursing home:

<i>Bed capacity of home</i>	<i>Median monthly charge</i>
Total	\$154
Under 10	130
10-14	132
15-24	151
25-34	158
35-49	163
50 and over	187

Size of home of course reflects other related factors. As we have already observed, the larger homes tend to be the better staffed. Charges are higher for the more adequately staffed homes. The average charges for establishments with given bed/staff ratios are as follows:

<i>Number of beds per staff member</i>	<i>Median monthly charge</i>
Total	\$154
Under 1.0	305-310
1.0-1.9	184
2.0-2.9	162
3.0-3.9	132
4.0-4.9	112
5.0-5.9	110
6.0 and over	98

The average payment increases distinctly with the level of care the patients are judged to require. Those reported as needing mainly boarding care are charged an average of \$115 a month. Those whose needs are of the type that could conceivably have been met at home with someone to care for the patient pay about \$150 on the average. The median charge is about \$160 for patients who need nursing care of a type which could not be expected to be provided at home.

Table 14 presents the average (median)

charges for care in 12 of the study States as they vary with the physical and mental capacities of the patients. A difference of about \$20 a month is noted in charges for patients who walk independently and for those severely restricted in walking ability. Nearly the same difference is found between charges for the care of continent and incontinent patients, and approximately a \$10 variation between charges for the care of mentally clear patients and confused patients. Interestingly, a smaller variation appears between charges for patients who are out of bed and for those who are bedfast. Higher rates are generally understood to be charged for the bedfast patient. Welfare agencies, in fact, not uncommonly authorize larger payments for patients who are confined to bed. The failure of the study to reveal a more distinct difference in charges with extent of confinement to bed may reflect recognition in practice of the sometimes greater needs for services by the ambulatory or semiambulatory patient.

Age and Occupancy of Homes

The experience of licensing agencies gives

Table 14. Average amount charged for care of patients in proprietary nursing homes, by condition of patient

Condition of patient	Median monthly charge
Total, 12 States ¹	\$154
Walking status:	
Alone or with cane or crutch	\$143
With walker, wheelchair, etc.	164
Only with attendant's help	160
Does not walk or get about	159
Bed status:	
Out of bed except to sleep or rest	150
In bed part of the time	156
In bed most of the time	157
In bed all of the time	158
Mental condition:	
Always clear	148
Confused part of the time	157
Confused most of the time	159
Continence:	
Continent	148
Incontinent, feces only	154
Incontinent, urine only	166
Incontinent, both urine and feces	162

¹Maryland not included.

ample evidence that the growth of nursing homes during the past 25 years is continuing. Although there is some discontinuance of nursing homes with time, the influx of new homes seems to more than offset the losses. Information gathered in the survey for 12 of the 13 study States (Maryland not included) brings out the phenomenon of new accessions in almost startling relief: Half of the presently operating proprietary nursing homes have opened within the past 4 years; one-fourth have been in operation for less than 2 years.

The 2,590 homes in the 12 States for which this information was obtained were distributed as follows, according to their age, based on present ownership in present location:

<i>Age of home, less than—</i>	<i>Percent (cumulative)</i>
6 months	8
1 year	15
2 years	26
3 years	36
5 years	59
10 years	83

The picture is not the same for all States, as table 9 of appendix B brings out. Nursing homes have probably had a longer history in some States than in others and are more stabilized in some States than in others. Thus, in New York and Vermont, fully one-fourth of the establishments have been in existence for more than 10 years; the average home is 5 or 6 years old in these States. On the other hand, the average home is barely 2 years old in New Mexico, Oklahoma, and Wyoming; in these States as many as one-third of the homes have been operating for less than a year.

Rate of Occupancy. Eighty-three percent of the beds in the surveyed homes were occupied at the time of the survey. As in hospitals, the occupancy rate for nursing homes tends to increase with the size of the institution. Table 15 traces the average percentage of occupancy through the groups of nursing homes of different sizes.

Occupancy experience is not the same in all study States. Roughly two-thirds of the nursing home beds in Wyoming were occupied when the survey was taken while the

nursing home beds in Minnesota were all but fully occupied:

<i>State</i>	<i>Average percent occupancy</i>
Wyoming	68
Oklahoma	72
Indiana	74
New Mexico	76
Vermont	77
California	81
Colorado	81
Georgia	81
Rhode Island	82
Maryland	85
New York (upstate)	85
Connecticut	91
Minnesota	96

Table 15. Rate of occupancy in proprietary nursing homes, by size of home

<i>Bed capacity of home</i>	<i>Number of homes</i>	<i>Average percent occupancy</i>
Total homes, 13 States.....	2,686	82.7
Under 10.....	867	75.3
10-14.....	503	79.2
15-24.....	737	83.7
25-34.....	343	85.9
35-49.....	161	81.3
50-74.....	54	81.6
75-99.....	5	91.4
100 and over.....	16	92.1

Nursing Homes and Near-Nursing Homes

Early in this report we recognized that the facilities included as proprietary nursing homes did not always conform to the more confining definition which had been intended as the criterion for inclusion in the study. From the standpoint of that definition—involving the provision of a skilled form of nursing care as the primary purpose of the home—other facilities which were included might be regarded as “near-nursing” homes.

A closer look at this distinction can be taken very briefly in the case of New York (upstate) and Wyoming. In upstate New York, the licensure program officially distinguishes between “nursing homes” and “convalescent homes,” with the convalescent home giving a less skilled type of service. In Wyoming, the distinctions made in the national inventory (9) between “skilled nursing homes” and “personal care homes with

skilled nursing" were carried back through the patient study in a complete retabulation of the original data.

With the distinctions so clearly deliberate in these two instances, we shall see how the survey data emerge for the separate categories in the two States. From this, we may hope to gain some appreciation of the effect of delineating types of homes in a more exacting fashion than is generally done in most States.

Table 16 presents selected information on the characteristics and care of the patients in nursing and near-nursing homes in New York and Wyoming. A brief review of these items will give the general sense of the differences between the two types of homes.

Personal Characteristics of Patients

The two levels of nursing homes in both States show the same basic characteristic so

immediately apparent for nursing homes as a whole: their aged clientele. There are some differences, due to the small numbers of homes in Wyoming, but the fundamental sameness in respect to age of the patients is clear. Their median age in both types of homes is about 80 years, with about one-fourth past 85 years of age. The predominance of widowed patients noted earlier appears in both nursing and near-nursing homes. About two-thirds of the patients in each category are widowed.

Medical Condition of Patients

The close similarity between nursing homes and near-nursing homes ceases with the physical and mental condition of the residents. Clearly and consistently, the "true" nursing homes have a more heavily disabled group of patients. About half of their patients are unable to walk independ-

Table 16. Comparison between two component types of homes which compose the "nursing home" category in the study, upstate New York and Wyoming

Characteristics of patients, level of care needed, and services received	New York (upstate)		Wyoming	
	Nursing homes ¹	Convalescent homes ¹	Skilled nursing homes ²	Personal care homes with skilled nursing ²
Number of homes.....	606	146	11	17
Number of patients.....	10,467	1,142	70	88
Percent of patients				
Age:				
65 and over.....	91.0	89.9	77.2	87.5
85 and over.....	26.0	25.8	22.9	29.5
Median age (years).....	80	80	80	79
Marital status: Widowed.....	67.5	65.2	68.6	62.5
Medical condition:				
Severely limited in ability to walk.....	51.9	32.1	48.6	33.0
Completely bedfast.....	15.3	5.9	20.0	13.6
Mentally confused.....	51.9	30.3	52.9	42.0
Incontinent.....	32.3	12.8	38.6	18.2
Level of care needed:				
Could not ordinarily be given in patient's own home.....	18.0	.3	37.1	19.3
Might be given in patient's own home.....	71.5	50.3	58.6	55.7
Mainly boarding care.....	10.1	48.6	4.3	23.9
Unknown.....	.5	.7	0	1.1
Services received:				
Medication.....	69.0	35.2	55.7	23.9
Pulse, temperature, or respiration taken.....	39.1	6.6	47.1	4.5
Full bed bath.....	54.0	33.4	42.9	30.7
Bedpan.....	36.1	24.5	30.0	14.8
Help in dressing.....	43.3	23.8	62.9	25.0

¹ Terms used in licensure program in New York State.

² Terms used in the national inventory of nursing homes and related facilities (9).

ently even with aid of a cane or crutch, whereas about one-third of the patients in the facilities providing a lesser level of skilled care are so limited. Similarly, relatively more of the patients in facilities providing skilled nursing care are bedfast, mentally confused, or incontinent.

Level of Care Needed

The judgments of informants as to the kind of care each patient needs bear out sharply the other observations on nursing and near-nursing homes. Although the specific items inevitably received somewhat different interpretations in different States, the distinction between the two types of homes in New York and Wyoming comes through clearly. As many as one-fourth and one-half of all patients in the near-nursing homes were considered by the administrator or the staff of the home to need mainly boarding care. Only a fraction of this number were so classed in the skilled nursing homes.

Services Received

In both upstate New York and Wyoming, all nursing and personal services identified

for study were received by relatively more patients in the nursing homes than in the near-nursing homes. Selected services listed in table 16 indicate the differing proportions of care provided in the two types of homes.

Charges

The average charges for care reflect the different general levels of care provided in the nursing and near-nursing homes. In upstate New York, the median monthly charges are \$158 in the former and \$117 in the latter; in Wyoming, \$125 and \$87, respectively.

* * *

This brief documentation emphasizes the fact that the root of much of the confusion regarding nursing homes, what they are, and what they do, is in the varying conceptions of what constitutes a nursing home. Differing definitions, usually implicit rather than explicit, underlie many of the expressed differences of opinion of the role of the nursing home and of its practices. Many of the differences among the States revealed in this study stem from such variations in the ingrained conceptions of the nursing home in different parts of the country.

III. Other Nursing and Domiciliary Care Homes

Survey Coverage

Although the study centered on proprietary nursing homes, it was extended to other types of facilities at the option of the 13 participating States. Ten States carried the survey into nursing homes operated under private nonprofit auspices, and 5 of these 10 States plus one additional State included public nursing homes. A total of 11 States covered the nonproprietary nursing homes and the domiciliary care homes. With two exceptions, the same group of States surveyed both types of homes; Indiana did not include nonproprietary nursing homes and Colorado did not include domiciliary care homes. The domiciliary care homes include private boarding homes for older people, voluntary homes for the aged, and public homes giving a type of care of a lesser order than nursing care.

Because the number of these institutions is not large and the degree of coverage of all existing facilities of these types is quite doubtful, the data for the reporting institutions have been merged on a gross basis within each of two types—nonproprietary nursing homes and domiciliary care homes—with no pretense of representing them as a reliable sample of either sort. They are offered rather as illustrative of the types of differences which may be found between proprietary and nonproprietary nursing homes, and between these and domiciliary care homes, in the States involved. The magnitudes of the differences serve only as a vehicle for generalization without being interpreted too closely.

As table 17 indicates, 63 nonproprietary nursing homes were surveyed; 19 of these are public facilities and 44 are operated by

voluntary groups. Reports were received on 3,128 patients. The data are presented here on a basis of 80 homes with 3,773 patients, reflecting expansion of California's planned sample.

Of the domiciliary care homes, 737 were reported, with 14,868 residents. Among these institutions, 445 are proprietary, 183 voluntary, and 109 governmental. The analysis, allowing for projection of California's sample, will be presented in terms of 2,627 homes with 26,964 residents.

In this portion of the report, then, we will attempt to get the general drift of differences between proprietary nursing homes, voluntary and public nursing homes, and domiciliary care homes. The comparison will be made for the 11 States which reported the latter two types, overlooking the substitution of one State, and representing the proprietary nursing homes with comparative data for the same group of 11 States which reported nonproprietary nursing homes.

Personal Characteristics of Patients

We have seen that a description of the

patient population rather definitely "types" the general run of proprietary nursing homes. In order better to appreciate the character of these homes, we shall look for similarities and differences in the types of residents of nonproprietary nursing homes and domiciliary care homes. State-by-State data are given in appendix B, tables 10 and 11. The following discussion is based on merged data for the 11 States reporting the several types of homes (table 18).

Age

As noted earlier, an outstanding characteristic of proprietary nursing homes is the predominantly aged population for which they provide care. Much the same is true of the other types of homes. However, somewhat more patients who are under 65 years of age are in the nonproprietary nursing homes. Whereas about 90 percent of the patients in proprietary nursing homes and in domiciliary care homes are 65 years of age or older, only about 80 percent of those in the nonproprietary nursing homes are in the older age group.

Table 17. Survey coverage of voluntary and public nursing homes and domiciliary care homes

State	Number reporting ¹					
	Voluntary and public ² nursing homes			Domiciliary care homes		
	Homes	Beds	Patients	Homes	Beds	Residents
Total, 11 States reporting	63	3,768	3,128	737	21,660	14,868
California ¹	6	412	129	243	5,781	1,344
Colorado	6	301	268			
Connecticut	7	296	235	4	378	351
Georgia	1	67	66	21	1,146	975
Indiana				124	6,653	5,629
Maryland	6	434	413	15	1,464	1,187
Minnesota	24	1,667	1,545	99	3,972	3,706
New Mexico	2	202	193	47	187	129
Oklahoma	4	261	204	71	855	644
Rhode Island	2	32	14	38	302	248
Vermont	3	48	28	53	559	395
Wyoming	2	48	33	22	363	260

¹ In consolidating the data from 11 States for analysis, California's planned sample was expanded to the corresponding State totals. The analytical tables will consequently show reported totals for 80 nonproprietary nursing homes with 4,288 beds and 3,773 patients; and for 2,627 domiciliary care homes with 33,243 beds and 26,964 residents. The larger increase in number of domiciliary care homes

than in corresponding beds and patients as a result of expanding the counts for California is attributable to the small size of the homes. Nearly all these homes in California are proprietary, which are typically smaller than those under voluntary or public ownership.

² Nonproprietary.

Sex

The 2:1 predominance of women in proprietary nursing homes is matched in the domiciliary care facilities. In the nonproprietary nursing homes the ratio is more nearly 1:1. Thus, nonproprietary nursing homes seem to exercise some particular selectivity which brings more younger patients and relatively more men to them than are found in the other types of homes.

Marital Status

In keeping with the preceding characteristics, somewhat fewer of the patients in nonproprietary nursing homes are widowed—about half compared with about 60 percent in the proprietary nursing homes and domiciliary care facilities.

Race

Nine percent of the combined populations of the 11 States are nonwhite. Only 2 percent of the residents of proprietary nursing homes and of domiciliary care homes are nonwhite. Again, nonproprietary nursing

homes display a difference, with as few as 0.5 percent of their patients being nonwhite.

Medical Condition of Patients

In physical and mental condition, the patients in the three types of facilities are in progressively poorer shape as we move from domiciliary care homes to voluntary and public nursing homes to proprietary nursing homes. Respectively, the proportions who are unable to get about without some major mechanical or personal assistance range from little more than one-tenth to four-tenths to nearly six-tenths. The completely bedfast patients constitute, respectively, one-thirtieth, one-eighth, and one-fifth of the patients. One resident in 12 in the domiciliary care homes is disoriented most of the time; usually confused patients are relatively twice and three times as numerous in the nonproprietary and the proprietary nursing homes, respectively. Incontinence is found in about one-tenth of the residents of domiciliary care homes, in one-fifth of those

Table 18. Types of patients in three types of homes

Characteristics of patients and level of care needed	Proprietary nursing homes	Voluntary and public nursing homes	Domiciliary care homes
Number of patients, 11 States.....	22,684	3,773	26,964
	Percent of patients		
Age:			
Under 45.....	1.5	3.4	1.1
65 and over.....	87.7	78.6	89.6
Median age (years).....	79	78	79
Sex: Female.....	66.3	52.5	63.0
Race: Nonwhite.....	2.0	.5	2.4
Marital status:			
Widowed.....	63.3	49.5	58.2
Married.....	10.8	8.6	6.4
Medical condition:			
Severely limited in ability to walk.....	55.1	37.6	13.2
Completely bedfast.....	22.5	12.8	3.1
Mentally confused.....	58.9	43.4	29.1
Incontinent.....	37.3	21.4	8.8
Level of care needed:			
Could not ordinarily be given in patient's own home.....	63.4	45.7	13.3
Might be given in patient's own home.....	26.2	30.4	29.3
Mainly boarding care.....	9.7	23.5	57.4
Unknown.....	.7	.3	.1

in nonproprietary nursing homes, and in one-third of those in proprietary nursing homes.

The character of the differences among these facilities is verified by some of the diagnostic data available. Thus, the gradient observed with respect to extent of disability is repeated for certain characteristic diagnoses:

Primary diagnosis	Domiciliary care homes	Percent of patients in—	
		Voluntary and public nursing homes	Proprietary nursing homes
Hemiplegia	3	6	16
Hip fracture	2	5	7
No diagnosis	24	5	2

Care of Patients

Whether the differences in the types of residents of the several types of homes are paralleled by corresponding differences in care received can be seen readily from a few comparisons.

Table 19 demonstrates that the patients found in proprietary nursing homes are the most likely of the three groups to have each of the types of services provided. In turn, patients in voluntary and public nursing homes are more frequently in receipt of these services than are the persons in domiciliary care homes. The numbers of residents who do not receive any of these specified types of services are: 1 out of 40

patients in proprietary nursing homes, 1 out of 10 in the nonproprietary nursing homes, and at least 1 out of 3 in domiciliary care homes. These differences are not unexpected in view of the differing character of the patient populations.

The extent to which residents of the various types of homes are closely attended by physicians makes an interesting commentary on these previously observed differences. In respect to attendance by physicians, the voluntary and public nursing homes show the same pattern as the proprietary nursing homes, while the domiciliary care homes trail off, as expected. About 75 percent of the patients in the proprietary and nonproprietary nursing homes had been seen by a physician within the 3 months preceding the survey, and about 50 percent in the domiciliary care homes. Approximately 15 percent of the nursing home patients—again equally in proprietary and nonproprietary homes—had not been seen by a physician for as long as 6 months or more while in the nursing home; in domiciliary care homes, the corresponding proportion is 35 percent.

Tables 12 and 13, appendix B, present information on services and attendance by physicians for individual States reporting.

Length of Stay

The periods of time which patients have

Table 19. Proportion of patients receiving specified services in three types of homes

Services received	Type of home		
	Proprietary nursing homes	Voluntary and public nursing homes	Domiciliary care homes
Number of patients, 11 States	22,684	3,773	26,964
	Percent of patients		
Help in feeding	27	19	7
Help in dressing	51	32	17
Care of hair	65	44	26
Shaving	22	23	11
Help with tub bath or shower	41	44	34
Full bed bath	56	31	9
Rub and massage	65	37	11
Bedpan	41	27	6
Enema	33	20	5
Hypodermic injection	18	14	6
Dressings	8	6	2
Medication	67	67	30
Pulse, temperature, or respiration taken	52	43	11
Special diet	24	16	9
None of these	3	10	37

spent in the three types of homes reveal an apparently basic difference among the types of facilities. The typical patient in the proprietary nursing home had spent almost a full year in the home up to the time of the survey, but the typical stay was about twice as long in the other types of facilities. Specifically, the median length of stay to date for the 11 States was, respectively, for proprietary nursing homes, nonproprietary nursing homes, and domiciliary care homes, 11 months, 20 months, and 25 months.

This, together with the findings noted, forms a rather distinct picture of nonproprietary nursing homes. It seems as though the predominance of nursing care in these homes may have been overlaid on a domiciliary function—so many of the voluntary and public homes were in the beginning merely homes for the aged. It may also be that, to a greater extent than is true of the proprietary nursing home, the voluntary or public facility attracts many residents who need a sheltered environment rather than the intensive nursing care which these homes may provide. Thus, whether by custom or design, the voluntary or public nursing home is still characterized rather strongly by the features of a home for the aged. Nevertheless, the nonproprietary homes are closer in type of population to the proprietary nursing home than to the domiciliary care home.

This summary distinction would of course not hold for many individual institutions. Some voluntary and some public institutions are exclusively oriented to long-term patients in need of intensive nursing care.

Level of Care Needed

Judgments as to the level of care needed by each individual clearly affirm the increasingly disabled status of patients from one type of facility to the other, as has been noted. The domiciliary care homes would, by definition, be expected to have mostly boarding care cases, and in fact about 3 out of 5 of their patients need mainly boarding care. But while only 1 out of 10 patients is deemed a boarding care case in the proprietary nursing homes, 1 out of 4 is so classed in the nonproprietary nursing homes.

The differences observed between proprietary and nonproprietary nursing homes are quite apparently not mere happenstance. Most of the 80 nonproprietary homes in the 11 States are under voluntary auspices (61 voluntary and 19 governmental). Homes operated by fraternal orders and church groups may appeal to members of these groups as places to live even in the absence of an absolute physical need for close nursing attendance. Thus, people may enter these homes while they are younger and in better physical status than are those who seek admission to proprietary nursing homes.

Staffing of Homes

One of the key characteristics of proprietary nursing homes is that only 2 out of every 5 such homes have a registered professional nurse in attendance. A key characteristic of the voluntary and public nursing homes is that proportionately twice as many of those facilities have a registered nurse. This is all the more impressive in view of our finding that apparently not quite as many of the patients in the nonproprietary homes as in the other types of homes need skilled nursing care.

This difference in staffing is not merely a consequence of the typically larger size of voluntary and public homes, with larger homes tending to be staffed with better-trained personnel as a general rule. Even for equivalent sizes of homes, more of the voluntary and public homes have professional nurses than do proprietary homes.

Domiciliary care homes, as we would expect, only infrequently have the more highly trained type of nurse. About 1 home in 10 has a registered nurse, and an additional one-third of the homes have a licensed practical nurse. On the other hand, half of the establishments have no nursing staff as such at all, either professional or practical.

In overall number of personnel, nonproprietary and proprietary nursing homes both average about 2 patients per staff member; domiciliary care homes have about 3 patients per staff member. For every nurse on the staff (registered, practical, and

nurses aides), proprietary nursing homes average 3 patients; nonproprietary nursing homes, 4 patients; and domiciliary care homes, about 10 patients.

Sources of Funds and Charges for Care

The extensive part which public assistance financing plays for patients in proprietary nursing homes is fully paralleled for the residents of both nonproprietary nursing homes and domiciliary care homes. Public welfare funds pay in whole or in part for the care of about one-half of the patients in each of the three types of institutions (table 20).

As previously noted, funds from voluntary organizations and from governmental sources other than public assistance categories have a negligible part in paying for proprietary nursing home patients. Within voluntary and public nursing homes, these sources, including free care from the institution itself, naturally assume a larger role; they finance the care of about one-eighth of the patients, paying in full for 2 out of 3 of these and supplementing other resources in the rest. The care of approximately the same proportions of residents is paid for from these types of funds in domiciliary care facilities.

The relative parts played by public assistance funds or other categories of tax funds are subject very largely to the par-

ticular financing method employed by the individual States or by local governmental units for needy patients. Sometimes support is furnished through the medium of public assistance grants to the individual patient and sometimes it is provided directly in governmentally operated institutions. Even when care is furnished directly in public institutions, procedures vary; the institution may be maintained through direct appropriation of funds for operating purposes or through charges against public assistance grants made to the individuals receiving care.

Amount of Charges. About 15 percent of the residents of voluntary and public nursing homes are given free care by the institution. Among the remainder, the average (median) amount charged per month is about \$110 (based on 10 States, Maryland is not included). The comparable monthly charge in proprietary nursing homes in the same 10 States approaches \$160.

In domiciliary care homes, 5 percent of the residents are not charged for services. The rest pay an average of nearly \$90 a month.

As noted earlier in analyzing the rates in proprietary nursing homes, there is a sharp distinction between the average amount paid by patients who are financing their own way and the average amount paid for patients wholly financed by public assistance. The

Table 20. Sources of funds for care of patients in three types of homes

Source of funds	Proprietary nursing homes	Voluntary and public nursing homes	Domiciliary care homes
Number of patients, 11 States	22,684	3,773	26,964
	Percent of patients		
Patient (or family)	56	45	47
In whole	45	33	29
In combination with other sources	11	10	17
Public assistance	50	60	48
In whole	38	40	31
In combination with other sources	11	10	16
Other agency ¹	3	12	13
In whole	1	8	9
In combination with other sources	1	4	4

¹ Including free care from the institution itself.

NOTE: Figures individually rounded and therefore do not necessarily add precisely to their totals.

median monthly amounts in the 10 States are as follows:

	<i>Proprietary nursing homes</i>	<i>Voluntary and public nursing homes</i>	<i>Domiciliary care homes</i>
Private-pay	\$.187	\$.116	\$.100
Public assistance	.127	.98	.67

The average public assistance payment is two-thirds of the private-pay average in proprietary nursing homes and in domiciliary care homes. In the voluntary and public homes even the private-pay rates are set relatively low, bringing the average amounts from the two major financing sources closer together.

Age and Occupancy of Homes

Existing nursing homes under voluntary and public auspices tend to have been established longer than have homes under commercial operation. Nearly three-fifths of the nonproprietary nursing homes have been operating for as long as 5 years or more, whereas only about one-third of the proprietary nursing homes and domiciliary care homes have been in existence for that long. Only about one-tenth of existing nonproprietary nursing homes were opened within 2 years preceding the survey but as many as one-third of the other two types have been established that recently.

The stability of voluntary and governmental organizations assures greater continuity of institutions under their auspices than can be true ordinarily of the average home under proprietary ownership.

Rate of Occupancy. In voluntary and public nursing homes, nearly 9 out of 10 beds are occupied. At the time of the survey, these homes showed the highest rate of occupancy of the three types of facilities—88 percent, compared with 83 percent for proprietary nursing homes and 81 percent for domiciliary care homes.

However, this record is entirely traceable to the typically larger size of the nonproprietary nursing homes. In the 11 States reporting, the median size of these homes is 36 beds, whereas the proprietary nursing homes average 14 beds and the domiciliary care homes, only 7 beds. As with proprietary nursing homes, the rate of occupancy increases markedly with size of institution, and it is the concentration of larger homes in the nonproprietary group which brings up the occupancy average for the category as a whole. The fact is that, size for size, proprietary nursing homes usually have a higher occupancy experience than the nonproprietary nursing homes, as table 21 reveals.

Table 21. Rate of occupancy in three types of homes, by size of home

Bed capacity of home	Average percent occupancy		
	Proprietary nursing homes	Voluntary and public nursing homes	Domiciliary care homes
Total homes, 11 States	83	88	81
Under 10	76	67	70
10-14	82	76	77
15-24	86	80	85
25-34	85	71	79
35-74	81	89	86
75-99	91	87	88
100 and over	92	93	87

IV. Chronic Disease Hospitals

Survey Coverage

To round out their picture of facilities providing care to the chronically ill, five of

the surveying States studied the types of patients and care found in chronic disease hospitals.

As table 22 shows, reports were received on 19 hospitals with 3,186 beds and 2,751 patients. Seven of these hospitals are publicly owned and had a total of 2,277 beds at the time of the survey. Another 7 hospitals, with a total of 728 beds, are operated under voluntary auspices. The remaining 5 hospitals, having a total of 181 beds, are proprietary.

There are, as with the other types of facilities surveyed, varying conceptions as to what constitutes a chronic disease hospital. In view of the wide range of these variations, the coverage of chronic disease hospitals in this study is too small to permit treatment of the findings as representative of chronic disease hospitals in general.

However, the findings of the five States reporting on chronic disease hospitals have been merged, and while this yields a very gross summary, it serves adequately to point up how chronic disease hospitals in these States differ in general character from the other types of facilities surveyed. The results are cited without pretense at precision but rather as they lend themselves to generalizations. Comparisons with facilities in the nursing and domiciliary care categories will be made on the basis of data for the five States which surveyed all types of facilities described in this report.

Personal Characteristics of Patients

The survey has made clear the general character of nursing homes and domiciliary care facilities in light of the characteristics and conditions of the patients. A similar look will be taken here at the types of patients in chronic disease hospitals. On indi-

vidual items of information, considerable variation occurs among the five States, as may be observed in table 14, appendix B.

Age

The patients in chronic disease hospitals, as in the other long-term care facilities, are mostly aged people. Although a substantial minority, almost one-tenth, are under 45 years of age, the average (median) age is about 70 years. This means they are somewhat younger than the patients in proprietary nursing homes and domiciliary care homes, who average around 80 years of age.

Sex

Unlike the patients in proprietary nursing homes and domiciliary care facilities, where women predominate, or even the patients in nonproprietary nursing homes, where there are equal numbers of men and women, roughly 3 out of every 5 patients in the chronic disease hospitals are men. In only 1 of the 5 States (Oklahoma) are the men less than a majority. Among the other 4 States, the men patients outnumber the women patients; in Connecticut, as many as 4 out of 5 patients are men.

Marital Status

With respect to marital status, the characteristics of the chronic disease hospital patients differ from those of persons in proprietary nursing homes and domiciliary care homes and more closely resemble the characteristics of patients in nonproprietary nursing homes. About two-fifths of the patients in chronic disease hospitals and nonproprietary nursing homes are widowed, as

Table 22. Survey coverage of chronic disease hospitals, by type of ownership

State	Number reported, by type of ownership								
	All types			Proprietary		Voluntary		Public	
	Hospitals	Beds	Patients	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds
Total, 5 States reporting	19	3,186	2,751	5	181	7	728	7	2,277
Connecticut	4	579	502	0	0	1	101	3	478
Maryland	4	909	828	0	0	1	120	3	789
Minnesota	5	527	507	1	32	4	495	0	0
Oklahoma	5	161	133	4	149	1	12	0	0
Rhode Island	1	1,010	781	0	0	0	0	1	1,010

compared with about three-fifths of the patients in the other types of facilities.

One-fifth of the chronic disease hospital patients are married, in contrast to only about one-tenth in the other types of establishments.

Race

The chronic disease hospitals exhibited a complete reversal of the pattern observed in the other categories of care facilities in number of nonwhite patients. Although about 7 percent of the total population in these five study States are nonwhite, 11 percent of the chronic disease hospital patients are nonwhite. In these same States, only 3 percent of the residents of proprietary nursing homes and domiciliary care homes are nonwhite, and the nonproprietary nursing homes have roughly 0.5 percent nonwhites.

Medical Condition of Patients

Judging by ability to move about, patients in chronic disease hospitals would seem to be the most incapacitated of the patients in all of the types of homes studied. In the various types of facilities, the proportions of patients who are severely limited in ability to walk are as follows:

<i>Type of facility</i>	<i>Proportions with limited walking ability</i>
Chronic disease hospitals.....	Three-fifths
Proprietary nursing homes.....	One-half
Nonproprietary nursing homes.....	One-third
Domiciliary care homes.....	One-sixth

Significantly, however, relatively fewer of the patients in chronic disease hospitals are bedfast or mentally confused than in proprietary nursing homes. The sequence of facilities in descending order of prevalence of these disabilities is as follows:

<i>Type of facility</i>	<i>Proportions of patients—</i>	
	<i>Completely bedfast</i>	<i>Mentally confused</i>
Proprietary nursing homes	One-sixth	Three-fifths
Chronic disease hospitals	One-eighth	One-half
Nonproprietary nursing homes	One-tenth	Two-fifths
Domiciliary care homes.....	One-twentieth	One-fourth

The fact that the patients in chronic dis-

ease hospitals are somewhat younger than the group in proprietary nursing homes would partly explain the lesser extent of these disabilities. The differences may, however, also be an indication of the differential type of care and its related rehabilitative aspects in the two types of facilities. With more chronic disease hospital patients unable to walk, the fact that fewer of these patients are confined to bed must reflect positive efforts to move certain types of otherwise bedfast patients into a chair for periods of time. Regular lifting of helpless patients from bed to chair and back again can be a troublesome and time-consuming task. This service seems to receive more recognition and attention in chronic disease hospitals than in proprietary nursing homes.

Incontinence is as severe a problem in chronic disease hospitals as in proprietary nursing homes. In both types of facilities, one-third of the patients lack bladder or bowel control. In the nonproprietary nursing homes and domiciliary care homes, respectively, 20 percent and 10 percent of the residents are incontinent. The extent of incontinence among patients in the chronic disease hospitals is undoubtedly very largely a consequence of the large proportion of hemiplegia cases found in those institutions. In chronic disease hospitals in the five States reporting on this type of facility, 18 percent of the patients have a primary diagnosis of hemiplegia compared with 12 percent in the proprietary nursing homes. Possibly these patients are also generally in the more acute stage of paralysis in the hospitals than in the nursing homes.

Heart diseases also tend to be present relatively more frequently in chronic disease hospitals than in the other facilities, and probably these diseases are also usually in the more acute phases. Neoplasm is a primary diagnosis in 5 percent of the patients, a slightly higher rate than is found in the other institutions.

Hip fractures, interestingly, are proportionately only half as common in the chronic disease hospitals as in proprietary nursing homes, 3 percent against 7 percent. With the length of care involved in these cases, it may be assumed that they accumulate in

nursing homes over prolonged periods, whereas a stay in a chronic disease hospital may be limited to the early period following the injury, during which union of the fracture is hoped for.

A significant contrast between chronic disease hospitals and the other types of facilities is the infrequency with which senility is reported in the former. In chronic disease hospitals, senility is reported as the primary diagnosis for barely 4 percent of the patients in contrast to 14 percent in proprietary nursing homes. This is undoubtedly due to the readier availability of definitive medical diagnoses in chronic disease hospitals.

Care of Patients

From the foregoing we have some general concept of the types of patients found in chronic disease hospitals as compared with nursing homes and domiciliary care homes. Next we shall see whether there are any corresponding differences in the general character of care provided.

For most types of nursing and personal services, little difference appears between the proportions of patients receiving these services in chronic disease hospitals and in proprietary nursing homes. More patients in these hospitals and proprietary nursing

homes receive most of the services listed in table 23 than do residents of nonproprietary nursing homes and domiciliary care homes. Conversely, only 1 or 2 percent of the patients in chronic disease hospitals and proprietary nursing homes are not receiving any of the specified services. In contrast, as many as one-tenth of the patients in nonproprietary nursing homes and more than one-third of the residents of domiciliary care homes are without such services.

We should expect hospitalized patients to be attended regularly by physicians. About 90 percent of the hospital patients had in fact been seen by a physician within the 30 days preceding the survey. By comparison, somewhat over half of the nursing home patients and barely one-third of the residents of domiciliary care homes were seen by a physician within that period. While 3 percent of the patients in chronic disease hospitals had not been attended by a physician in as long as 6 months or more, the proportion in nursing homes was about 15 percent and in domiciliary care homes, 40 percent.

Variations between States with respect to recency of visits by physicians (table 15, appendix B) provide a revealing glimpse of a fundamental difference among chronic disease hospitals. In 3 of the 5 States reporting, all or virtually all of the patients had been

Table 23. Proportion of patients receiving specified services in four types of facilities

Services received	Type of facility			
	Chronic disease hospitals	Proprietary nursing homes	Voluntary and public nursing homes	Domiciliary care homes
Number of patients, 5 States.....	2,751	11,800	2,411	6,136
	Percent of patients			
Help in feeding.....	23	26	19	9
Help in dressing.....	49	56	32	20
Care of hair.....	64	69	46	30
Shaving.....	38	26	24	12
Help with tub bath or shower.....	67	45	38	34
Full bed bath.....	30	52	34	14
Rub and massage.....	41	63	31	14
Bedpan.....	37	38	26	10
Enema.....	27	27	15	7
Hypodermic injection.....	24	18	13	7
Dressings.....	11	8	7	4
Medication.....	73	70	64	35
Pulse, temperature, or respiration taken.....	59	55	45	22
Special diet.....	31	21	16	9
None of these.....	1	2	11	36

seen by a physician during the 30 days preceding the survey; in the other 2 States, only about half the patients had been attended that recently. In those same 2 States, 1 out of 10 of the chronic disease hospital patients had not been seen by a physician for at least 6 months. Obviously, the concept of a chronic disease hospital must vary tremendously in different States to produce such different practices in medical attention.

Length of Stay

At the time of the survey, the average patient had spent somewhat more time in the chronic disease hospital than had been spent by the average patient in his present proprietary nursing home—15 months against 12 months. To what extent movement from one nursing home to another, as opposed to perhaps more stability in a stay in a chronic disease hospital would be responsible for this difference is not known. Age may be a factor in that a higher mortality rate may characterize the generally older population found in the nursing homes.

The median length of stay in nonproprietary nursing homes in the 5 States was 19 months. The length of stay in domiciliary care homes—30 months—was much longer than that in nursing homes or chronic disease hospitals.

Really long hospitalization of, say, 5 years or more is not infrequent among patients in chronic disease hospitals; 1 out of 6 patients had been in the hospital for 5 years. This is nearly as many as had been in voluntary or public nursing homes for that long a period. Only 1 in 20 patients had been in the same proprietary nursing home that long. However, both chronic disease hospitals and nonproprietary nursing homes typically have been in existence for a comparatively long period, whereas many proprietary nursing homes are of recent origin.

Level of Care Needed

The disability patterns of the four types of facilities are verified by the judgment of the informants as to the level of care needed by each patient. About two-thirds of the patients in chronic disease hospitals and

proprietary nursing homes were judged to need a skilled type of care which could not ordinarily be given in their own homes. Roughly 5 percent of the patients in chronic disease hospitals and proprietary nursing homes were reported as needing mainly boarding care, about one-fourth in nonproprietary nursing homes, and about one-half of the residents of domiciliary care facilities.

Staffing of Hospitals

A hospital without a professionally trained nurse on its staff would hardly seem to be a hospital. All but two of the so-called chronic disease hospitals surveyed in the five States reporting on these facilities had registered professional nurses on their staffs. The exceptions were two relatively small institutions in Oklahoma which perhaps more closely resemble a convalescent type of facility than a true chronic disease hospital.

Nonproprietary nursing homes rank next in employing professionally trained nurses; less than one-fifth of these homes had no registered professional nurse available whereas more than half of the proprietary nursing homes did not employ even one such nurse. Less surprising, of course, is the finding that roughly three-fourths of the domiciliary care homes had no registered nurse.

In relative number of personnel, the chronic disease hospitals rank with both proprietary and nonproprietary nursing homes—all average about 2 patients per staff member. Nursing homes, however, have comparatively more *nursing* staff, averaging 3 and 4 patients per nurse (all skill levels) in proprietary and nonproprietary homes, respectively, as against 5 patients per nurse in the chronic disease hospitals. One may wonder, in view of this surprising finding, whether a looser criterion was perhaps applied in the nursing homes in classifying certain personnel as nurses.

Domiciliary homes, as we should expect, are less intensively staffed. They average about 4 patients for every staff member; for nursing staff alone, the ratio is 10 to 1.

Sources of Funds and Charges for Care

The relative role assumed by public welfare and other governmental and voluntary agencies in paying for the cost of care for patients in chronic disease hospitals differs markedly from the role of these agencies in other types of facilities (table 24).

Slightly more than 30 percent of the patients in chronic disease hospitals receive public assistance funds to meet the costs of care in contrast to proportions ranging from about 40 to 60 percent in the several types of homes. These data represent the findings of four States; Rhode Island did not report such information.

Conversely, compared with the other types of institutions, a relatively greater share of the hospital patient's bills is borne by voluntary agencies or by public funds other than assistance grants, largely reflecting the operation of chronic disease hospitals by voluntary and governmental groups. Bills for nearly 50 percent of the persons in chronic disease hospitals are paid entirely through voluntary or governmental auspices other than public assistance. The extent to which such funds are utilized for patients in the other types of facilities is considerably less: 2 percent in proprietary nursing homes, 12 percent in nonproprietary nursing homes, and 15 percent in domiciliary care homes.

Although the data on average monthly charges are available only for three States

(Connecticut, Minnesota, and Oklahoma), they reveal, as we should anticipate, that services in facilities offering a form of hospital care do cost more. The average (median) monthly charge of \$185 in chronic disease hospitals in the three States reporting these data is roughly $2\frac{1}{2}$ times as high as the median monthly charge of \$72 in the domiciliary care homes. Within this range are the average monthly charge of about \$150 in the proprietary nursing homes and the average monthly charge of \$102 in the nonproprietary nursing homes.

Paralleling previous observations for the various types of homes, the average amount paid by patients financing their own hospital care is larger, though only slightly, than the average amount paid for cases financed entirely by public assistance funds—\$213 per month in contrast to \$201. In this respect, the degree of difference between the amounts of payments from private and from public funds is more akin to the relatively small difference in the nonproprietary nursing homes (page 33) than it is to the substantial difference found in proprietary nursing homes.

Age and Occupancy of Hospitals

About half of the 19 chronic disease hospitals studied had been in their present location for 10 years or more. With a median

Table 24. Sources of funds for care of patients in four types of facilities

Source of funds	Chronic disease hospitals	Proprietary nursing homes	Voluntary and public nursing homes	Domiciliary care homes
Number of patients, 4 States ¹	1,970	10,892	2,397	5,888
	Percent of patients			
Patient (or family).....	24	41	34	44
In whole.....	15	35	25	35
In combination with other sources.....	9	6	8	9
Public assistance.....	32	60	53	40
In whole.....	30	54	45	35
In combination with other sources.....	3	6	8	4
Other agency.....	53	2	14	22
In whole.....	46	2	12	15
In combination with other sources.....	7	1	2	7

¹ Excluding Rhode Island.

NOTE: Figures individually rounded and therefore do not necessarily add precisely to their totals.

period of 10 years of operation, chronic disease hospitals as a group exceed the age of the other facilities, which are predominantly of more recent origin. The average proprietary nursing home in the 5 States had been in existence for 4 years; the average nonproprietary nursing home, 7 years; and the average domiciliary care home, 5 years.

None of the hospitals included in the survey had been in operation less than 2 years. But about one-eighth of the nonproprietary nursing homes and as many as three-tenths of the proprietary nursing homes and domiciliary care homes were established within the 2 years preceding the study.

Rate of Occupancy. The overall rate of occupancy of the various facilities studied does not vary substantially. At the time of

the survey, 86 percent of the beds in the chronic disease hospitals and proprietary nursing homes, were occupied. The other types of homes had a slightly higher percentage of beds occupied, 90 percent in the nonproprietary nursing homes and 88 percent in the domiciliary care homes.

In the individual study States, occupancy of chronic disease hospitals varied from about three-fourths of the beds to nearly full occupancy:

	Average percent occupancy
Rhode Island	77
Oklahoma	83
Connecticut	87
Maryland	91
Minnesota	96

V. Nursing Homes in Perspective

The nursing home is not a homogeneous type of institution. Nursing homes cannot be described entirely fairly with precise statistical statements. Such statements are made in this report to represent average situations or ranges of differences, but their object is not precision as such; it is rather to distill out of the arrays of data a fair general sense of what nursing homes are about. This much of a general sense has served the Commission on Chronic Illness and the Public Health Service in their appointed tasks, and it is hoped that it will serve others as well.

This study was undertaken to help develop a broad understanding of the role of establishments known as nursing homes. It focused on (a) what patients in nursing homes are like, and (b) what type of care they are receiving.

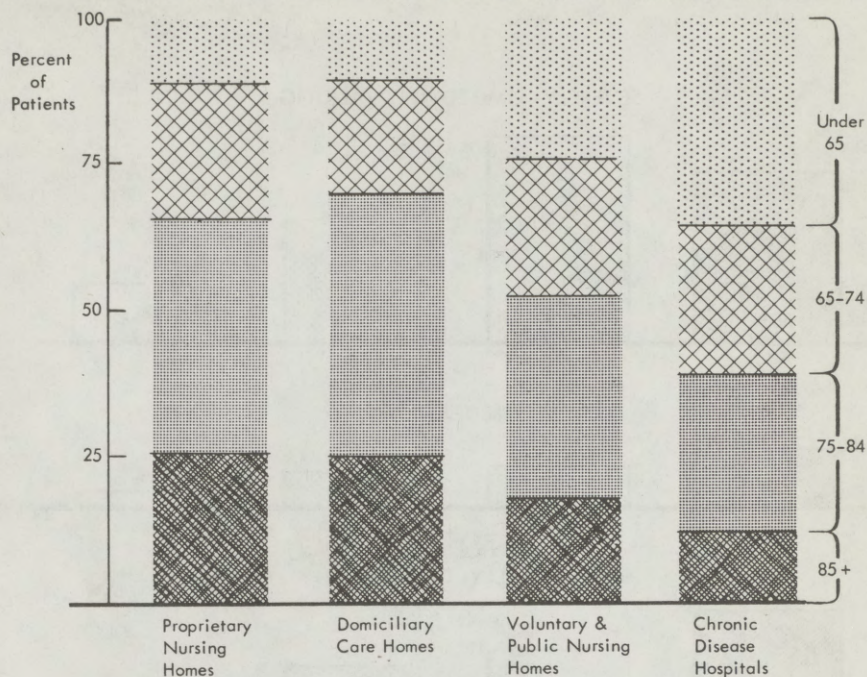
Thirteen States in various parts of the country joined the Commission on Chronic Illness and the Public Health Service in surveying existing nursing homes to gain a better understanding of the function of these homes. Interest was centered on proprietary nursing homes, which have increased so rapidly in numbers in the last two decades. In order to perceive in better perspective the role of this relatively new

and now quite numerous type of facility, the survey to a partial extent also encompassed some similar types of long-term care facilities. These included voluntary and public nursing homes, domiciliary care homes, and chronic disease hospitals.

On the basis of the survey findings, the several types of institutions can be made out to be either quite similar or quite different from each other, depending upon the emphasis one desires to give. There are, in fact, both similarities and differences among the types of institutions; differences sometimes of small degree and sometimes large enough to suggest basic contrasts.

Thus one can say altogether validly that all of these types of facilities—proprietary and nonproprietary nursing homes, domiciliary care homes, and chronic disease hospitals—have an important characteristic in common: they all serve older people predominantly. Nevertheless, significant implications are suggested by the differences contained within this sameness. Figure 12 tells the story by comparing the findings of five States which surveyed all four types of facilities. A large majority of the people in each type of institution are past 65 years of age. But, whereas in proprietary nursing homes, only 1 patient in 10 is less than 65

Figure 12. Age of patients in nursing homes and similar long-term care facilities, 5 States.



years old, in the chronic disease hospitals 1 patient in 3 is below 65 years of age. In chronic disease hospitals, in fact, 1 patient in 10 is less than 45 years old. In the other institutions, a negligible number (between 1 and 3 percent) are that young.

The makeup of the domiciliary care homes and the proprietary nursing homes is virtually identical with respect to age of their residents. Patients in nonproprietary nursing homes are midway between the extremely aged group in domiciliary care homes and proprietary nursing homes on the one hand and the rather younger population in chronic disease hospitals, on the other.

About two-thirds of the patients in proprietary nursing homes are women. Domiciliary care homes show the same predominance of women. The nonproprietary nursing homes, however, average about an equal number of men and women. The

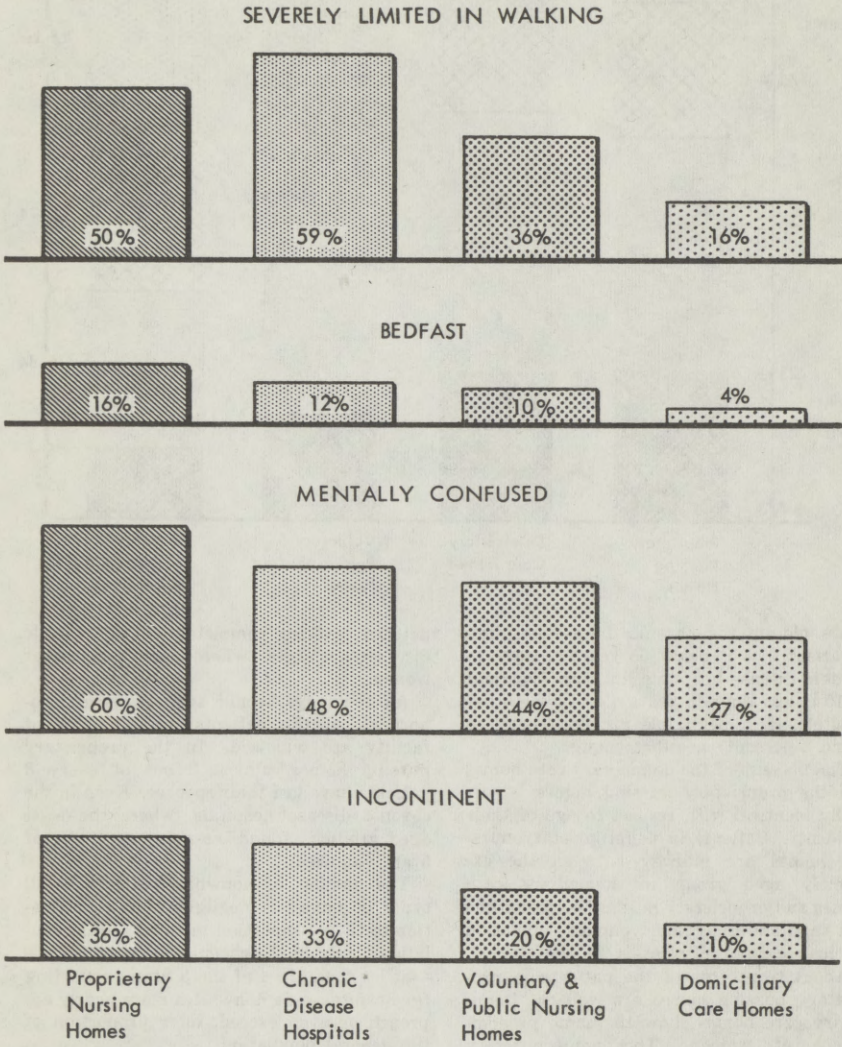
pattern reverses completely in the chronic disease hospitals, where men outnumber women.

As their age would suggest, large proportions of the patients in each type of facility are widowed. In the proprietary nursing homes, almost 2 out of every 3 patients have lost their spouses. Even in the chronic disease hospitals, where the least aged group is found, as many as 2 out of 5 are widowed.

The number of nonwhite patients in all types of homes is negligible, even in relation to their proportion in the general population. Only in the chronic disease hospitals—at least within 4 of the 5 States reporting for hospitals—do nonwhites more nearly approach or even exceed, their proportion of the general population.

Proprietary nursing homes have not only a very aged group of patients, but an ex-

Figure 13. Disability of patients in nursing homes and similar long-term care facilities, 5 States.



tensively disabled one as well. While all 13 study States surveyed proprietary nursing homes, the 5 States which covered the other three types of facilities as well serve to point up similarities and contrasts among the types of patients served, this time with regard to disability (fig. 13).

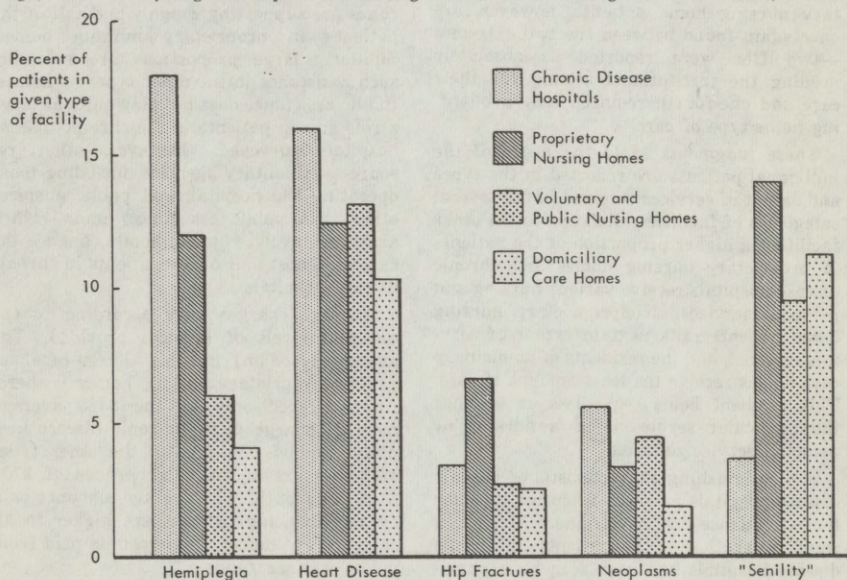
Proprietary nursing homes and chronic disease hospitals serve the groups who are most disabled; voluntary and public nursing homes, those who are, in general, less disabled; and domiciliary care homes, the least disabled group. In all categories, however, if one wishes to emphasize similarity, there is, as figure 13 shows, an imposing extent of disability.

A wide variety of chronic diseases characterize the patients in all the facilities. Cardiovascular conditions are the most common, with heart disease and hemiplegia large elements among these. Found among the patients in each of the types of institutions are such chronic diseases as arthritis, neuromuscular disturbances, diabetes, neoplasms,

and mental disorders; and even fractures take on a chronic character as old age and the severity of hip fractures join to incapacitate so many of the patients with fractures for prolonged periods.

The selected diagnostic information given in figure 14 suggests some distinctions among the several kinds of facilities. The proportion of hemiplegics in each type of institution forms a declining array starting with chronic disease hospitals and followed by proprietary nursing homes. Patients in chronic disease hospitals also show the largest proportions with a primary diagnosis of heart disease and of neoplasms. Persons with hip fractures, however, make up a distinctly larger proportion of proprietary nursing home patients than of any of the other institutional groups. The extent to which intensive medical supervision and active nursing service are demanded by the nature and stage of the patient's condition certainly must play a large part in the choice of type of facility for care of patients with

Figure 14. Primary diagnoses of patients in nursing homes and similar long-term care facilities, 5 States.



conditions within a given diagnostic category as well as among different categories of diseases.

A telling fact about diagnostic reporting is brought out by the "senility" figures, as figure 14 demonstrates. The larger number of patients with a reported primary diagnosis of senility in the various types of homes than in the chronic disease hospitals may of course be partly attributed to the somewhat older age of the patients found in the homes. However, the range of variation also undoubtedly reflects differences among the facilities in access to true medical diagnoses of patients. Proprietary nursing homes seem to a startling extent to lack definitive medical information on their patients.

Substantiating the comparative disability pattern, a relatively high proportion of the patients in proprietary nursing homes and chronic disease hospitals were judged by the persons caring for them actually to require a type of care which could not ordinarily be given in the patient's own home. In domiciliary care homes, as we would expect, about one-half of the patients were adjudged to need mainly boarding care. The nonproprietary nursing home patients, however, are once again found between the two extremes—two-fifths were reported as absolutely needing the institutional setting for their care and one-fourth required only a boarding home type of care.

These judgments as to the needs of the individual patients are reflected in the types and extent of services received in the several categories of facilities. Relative to the other facilities, a higher proportion of the patients in proprietary nursing homes and chronic disease hospitals receive various nursing and personal services. Nonproprietary nursing home patients rank next in extent of services received, and the residents of domiciliary care homes receive the least amount of care. This gradient holds regardless of whether the particular service is of a nursing or personal service nature.

A distinguishing characteristic of chronic disease hospitals emerges when we consider the attendance by physicians. All but a small proportion of the patients in chronic disease hospitals had been seen by a physi-

cian within 30 days preceding the survey. This is far from true in nursing homes, where somewhat more than half of the patients had been seen that recently. A not inconsiderable number of nursing home patients are medically unattended for very long periods of time; approximately 15 percent had not been seen by a physician for 6 months or more.

Although no attempt was made to obtain data on the total length of time spent in the facilities surveyed, information was secured on the length of stay up to the date of the survey. The average patient in a proprietary nursing home had spent about a year in the present home—the shortest length of stay observed among the four types of establishments. Patients in chronic disease hospitals and nonproprietary nursing homes had been in these institutions for somewhat longer periods, and residents of domiciliary care homes had an average stay of more than 2 years.

These long periods of care naturally impose a severe financial drain on many patients and their families. It is, therefore, quite natural to find that public welfare funds are supporting roughly one-half of the patients in proprietary nursing homes. Similarly large proportions are receiving such assistance in the other types of homes. Public assistance does not play quite as large a role among patients in the chronic disease hospitals surveyed. However, other resources—voluntary agencies, including those operating the hospital, and public auspices other than public assistance funds—which are little involved in the homes, finance the care of almost half of the patients in chronic disease hospitals.

Average charges vary according to the different levels of services provided. The average (median) monthly charge of about \$150 in proprietary nursing homes is therefore exceeded only by the \$185 average monthly charge in the chronic disease hospitals studied. Charges in the other types of homes are in the neighborhood of \$70–\$105 per month. The average amounts paid by self-financing patients are higher in all categories of homes than amounts paid from public welfare funds.

Nursing homes without professionally trained nurses are very common. Approximately 60 percent of all proprietary nursing homes have not a single professional nurse on their staffs. In a few States where licensure requirements specify high staffing standards, however, nursing homes commonly have at least a professional supervising nurse.

Interestingly, voluntary and public nursing homes, although their residents are generally less ill and disabled than residents of proprietary nursing homes, maintain a higher standard in this respect. Less than one-fifth of the nonproprietary nursing homes do not employ a professional nurse.

In number of staff, both categories of nursing homes and the chronic disease hos-

pitals as well have an average of about two patients per staff member. Fewer staff, relatively, are found in domiciliary care homes.

There seems, on the whole, to be strong demand for the available accommodations in all types of long-term care facilities. Between 80 and 90 percent of the beds in each type of facility were occupied at the time of the survey.

That proprietary nursing homes are still a relatively fresh new phenomenon is demonstrated by the recent origin of many of the existing homes. One-fourth of them have been established only in the last 2 years. Nonproprietary nursing homes, on the whole, date back longer, as do the chronic disease hospitals.

VI. Conclusions

Nursing homes, in overall perspective, fill a very particular set of needs. As they exist today, these homes respond as much to social needs as to medical needs. The impelling problem is that of accommodating and caring for people who require personal and nursing attention not forthcoming in their own homes or in the homes of relatives. Sometimes this entails a type of care which can be given properly only by trained personnel operating in a special facility such as the nursing home. Sometimes the care required is of a sort which might have been arranged at home but is not the arrangement of choice by the family or the individual. Personality difficulties at home may be the factor inducing choice of being cared for in a nursing home in preference to being cared for at home; or space may not be available at home to accommodate the person needing care or supervision; or considerations of undesired effects on young children in the home may lead the family to avoid providing for the dependent individual in the home setting. But whatever the underlying reason—and there are many environmental and social pressures in our society today to add to the sheer medical needs of the patient—the outcome has been the evolution of the

specialized institution known as the nursing home.

As it has evolved, the nursing home is today primarily a home for aged people. This growing segment of the population very frequently bears the brunt of combined physical and social dislocations. The nursing home becomes for aging individuals either a haven or a symbol of rejection by their familiar world and consequently bears a heavy responsibility. It needs to provide a long-term or even permanent home substitute for the individual at one of his most stress-laden periods. And it needs to do this concurrently with providing medically indicated nursing care of a proper quality to the ill individual. In many homes, the two roles make for ambiguity of function; in many others, the twin responsibilities are blended.

The role of the nursing home in relation to the role of other types of institutions providing long-term care is also subject to either blending or ambiguity. The study reflects the uncertainty which pervades the field of long-term care facilities concerning their respective roles in the care of the chronically ill. While distinctions are observed among the several types of institutions surveyed, the study has pointed up the ambiguities of function in two ways.

To begin with, extreme difficulties encountered in attempting to achieve a uniform classification of facilities according to type brought sharply to the fore the variations which exist in the concept of a nursing home. Furthermore, the individual establishments within any one category of facilities exhibit a wide range of variation. Establishments at the extremes of these variations obviously overlap between categories. This is merely another way of saying that facilities in this field exist not so much as units of clearly recognized types (for example, nursing home, chronic disease hospital) but rather as highly individual institutions which actually array themselves on a continuum. To draw a discriminating line between individual institutions on this continuum is, in close perspective, an arbitrary act. In broad perspective, however, it is a necessary device for distinguishing classes of facilities for purposes of applying standards.

Certainly, there is great need for developing some standardization of the meaning of the designation "nursing home." This would simultaneously require some more rigorous defining of what constitutes a chronic disease hospital. Inevitably, in the process, clarification of terms for the surrounding types of institutions will emerge. With clarification of functions will perhaps more easily come coordination of the services of the various types of facilities in the best interests of the patients.

Even worse than ambiguity of function

is isolation from necessary supplementing services and facilities. Isolation, sometimes geographical but certainly figurative, of the nursing home from the medical resources of a community is perhaps the most prominent issue in appraising nursing homes today. Many problems converge on this issue. It is not only lack of appreciation by nursing home administrators which erects a wall between close active medical care and supervision of the patients and the nursing and personal care received by them in the home. Appreciation of the needs of these kinds of patients and the impulse to act on such appreciation is also notoriously lacking on the part of hospitals and medical and paramedical practitioners. To many of these, the picture of the nursing home patient—aged, disabled, with multiple illnesses and chronic disabilities—is neither appealing nor promising. Some, however, have sensed a need and a potential for positive preventive and remedial care with rehabilitative aspects.

The sometimes extreme variations in levels of nursing home care which have been noted among the States are by no means to be taken as discouraging signs. On the contrary, they indicate that areas are at different stages of development of this type of facility. They indicate further that, with time, recognition of need, and positive action, States and communities do gradually achieve improved levels of standards in nursing homes.

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Appendix A

Representativeness of Sample States and Consolidation of Data

The study of patients in nursing homes was designed as a State-by-State rather than as a national study. Interested, voluntary participation by States was desired, as is explained in the description of the method and scope of the study. While a planned national sample of nursing homes was not designed, it was anticipated that, if participation were sufficiently large and sufficiently representative, the results might be projected to indicate the national situation in nursing homes.

As the survey proceeded, with the 13 participating States exercising the option to expand the survey coverage beyond proprietary nursing homes, three other broad categories of facilities became involved: nonproprietary (voluntary and public) nursing homes, domiciliary care homes, and chronic disease hospitals. The States which surveyed each type of home and the proportion of the national population represented by each of these groups of States are listed in the table on page 3. All 13 States surveyed the proprietary nursing homes; 11 States included nonproprietary nursing homes; 11 States surveyed domiciliary care homes; and 5 States extended the survey to chronic disease hospitals.

On other than proprietary nursing homes, the coverage was deemed either too indeterminate or too small to carry any serious promise of national representativeness. Ap-

pendix A examines the representativeness of the 13 States with respect to proprietary nursing homes and reviews the process by which the procedural scheme for consolidating the findings of the individual States was determined.

The proprietary nursing home beds in the 13 participating States were found to represent 30 percent of the proprietary nursing home beds in the Nation. These States were judged to be fairly representative of the totality within the degree of precision sufficient for the purposes of this study. Exploration of alternatives determined that direct combination of the reported data on the respondent homes and patients in the 13 States was the preferred method of consolidation of data.

Representativeness of States in Sample

If the survey results are to be taken as nationally applicable, the sample of proprietary nursing homes in the 13 States must be regarded as representative of all proprietary nursing homes in the country. With a sampling scheme of self-selection of States, the question of bias in the sample is crucial.

To test for bias, a variety of population, economic, and health resources data for the States were examined, on the supposition that these factors might conceivably be related to the distribution and character of proprietary nursing homes.

Table 1 shows what proportion of the national total is constituted by the 13 States with regard to the general population and its various sectors, income, and health personnel and facilities. Save for nonwhite persons, the proportion is quite consistently

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about 25 percent on general population items. On health resources and income features, however, the 13 States account for somewhat more of the national total, with many items running about 30 percent.

Table 2 shows the representativeness of the survey States from a related perspective, comparing averages for various pertinent economic and health characteristics for the group of 13 States with averages for the total United States. In all instances, the averages for the 13 States are higher than the national averages.

Two conclusions were drawn from these data:

1. The 13 States could be taken in aggregate to represent 30 percent of the Nation's proprietary nursing home facilities.
2. The 13 States represent a sample somewhat biased toward better economic and

health resources, and therefore an adjustment should be attempted in the derivation of consolidated data from the 13 individual States.

Consolidation of Data

The too-obvious method for combining the data from the 13 States would have been a mere pooling of the raw data. Two impulses initially moved against this straightforward method of consolidation: the element of bias noted above, for which adjustment seemed indicated, and the variability among the States in the survey information, which it was thought could be accounted for and properly balanced through some underlying characteristics of the individual States. If these characteristics could be determined, then a weighting scheme could be effected

Table 1. Proportion of national totals represented by 13 survey States

Population data ¹	13 States as percent of United States	Income, medical personnel, hospital and nursing home beds	13 States as percent of United States
Total population.....	25.9	Income ²	27.9
Age:		Medical personnel: ³	
65 and over.....	26.2	Physicians and surgeons.....	27.4
20 and under.....	24.5	Nurses:	
Race:		Professional.....	29.4
White.....	26.0	Practical.....	28.5
Nonwhite.....	18.2	Professional and practical.....	29.2
Sex:		Hospital beds: ⁴	
Male.....	25.2	All types.....	30.1
Female.....	25.1	General.....	25.7
Marital status:		Mental.....	35.6
Single.....	24.6	Tuberculosis.....	27.5
Married.....	25.4	Chronic disease.....	31.7
Widowed or divorced.....	26.3	Nursing home beds: ⁵	
Residence:		In skilled nursing homes.....	29.1
Urban.....	26.2	In personal care homes with skilled nursing.....	34.6
Rural.....	23.3	In skilled nursing homes and personal care homes with skilled nursing.....	30.8
Resident at present address 1 year or more.....	25.6	In proprietary—	
Labor force.....	25.5	Skilled nursing homes.....	32.1
Inmates of institutions.....	31.6	Personal care homes with skilled nursing.....	30.9
Persons in homes for aged and dependent.....	31.0	Skilled nursing homes and personal care homes with skilled nursing.....	32.0
Persons in proprietary homes for aged and dependent.....	30.9		

¹ From U. S. Bureau of the Census. Total population for 1954 from Current Population Reports, Series P-25, No. 108, January 3, 1955. Other data from Census of Population, 1950.

² 1954 data, from Survey of Current Business, September 1955.

³ 1950 data, from Public Health Service, Health Manpower Source Book, sec. 5.

⁴ From State hospital plans for 1953, submitted to Public Health Service under the hospital and medical facilities survey and construction program.

⁵ From Public Health Service, 1954 national inventory of nursing homes and related facilities (9).

to produce more refined estimates than would be derived by simple pooling.

Three factors, or indices, were hypothesized in an attempt to account for the differential results among the States. These were: proportion of population aged 65 years and over, number of professional and practical nurses per 100,000 population, and per capita income.

Table 2. Averages for 13 States compared with United States averages for relevant items of information

Item	13-State average	United States average
Median age (years).....	30.8	30.2
White population (percent of total).....	92.4	89.5
Urban population (percent of total).....	66.7	64.0
Per capita income.....	\$1,906	\$1,770
Physicians per 1,000 population.....	1.4	1.3
Nurses per 1,000 population:		
Professional.....	3.1	2.7
Practical.....	1.0	.9
Professional and practical.....	4.2	3.6
Hospital beds (total) per 1,000 population.....	8.8	7.6
Nursing home beds per 1,000 population:		
Skilled nursing.....	1.3	1.1
Personal care with skilled nursing.....	.7	.5
Skilled nursing and personal care with skilled nursing.....	1.9	1.6
Proprietary nursing home beds per 1,000 population:		
Skilled nursing.....	1.0	.8
Personal care with skilled nursing.....	.2	.1
Skilled nursing and personal care with skilled nursing.....	1.1	.9

To test each of these three indices, a sample of 18 items was selected from the patient study. The choice was based upon the basic importance of the item, its variation among the 13 States, or the connection which it was intuitively felt the item might have with any of the three indices. Treating each State as a unit, correlations were run between each proposed index and each of the 18 patient-study items (table 3).

The factors of nurses per 100,000 population and per capita income yielded a number of statistically significant correlations. Multiple correlations employing both of

these factors did not materially increase the correlation coefficients. Per capita income was chosen as the basic factor to be further pursued in attempting to project the survey results to a national scale. The object now was to apply per capita income as a factor in combining data from the 13 States.

The following procedure was applied: 50 jurisdictions (the District of Columbia, New York City, upstate New York, and the remaining 47 States) were ranked by per capita income. Nine categories of per capita income were designated (table 4). For each category the study State or States (shown in boldface letters) were taken to represent all States in that category. Since there were no study States in the two lowest income categories, Georgia had to be taken to represent all three lowest income categories. The relative weights to be carried by the respective categories in deriving weighted data for the country as a whole were then determined on the basis of the distribution of beds in proprietary skilled nursing homes. This distribution was obtained from the inventory of nursing homes and related national facilities.

For example, Connecticut, Delaware, and Nevada, constituting the highest per capita income category, account for 3.7 percent of the Nation's proprietary skilled nursing home beds. Since Connecticut was the only study State in this group, it was assigned a weight of .037.

In classes represented by more than one study State, the several study States shared the weight for the category, according to the relative number of patients in the study States involved. For example, in the fourth income category there were three study States—Indiana, Rhode Island, and Wyoming—which when combined were to carry a weight of .121. Of the total of 5,346 patients in the three States, Indiana accounted for 4,277, or 80.0 percent of the patients. Hence Indiana received a weight of $.121 \times .800$ or .097. Rhode Island, with 911 patients, or 17.0 percent of the patients in the three States, received a weight of $.121 \times .170$ or .020. Wyoming, with 158 patients, or 3.0 percent of the patients in the three States,

Table 3. Correlations between proposed indices and selected patient-study items

Item	Percent of population 65 years and over	Number of professional and practical nurses per 100,000 population	Per capita income
Percentage of bedfast patients.....	-.10	-.29	-.12
Percentage of patients who never walk.....	.30	.22	.30
Percentage of patients mentally always clear.....	-.19	-.34	-.58*
Percentage of patients who are continent.....	-.11	-.43	-.55
Percentage of patients with cardiovascular primary diagnosis.....	.38	.70**	-.76**
Median length of stay (months).....	.76**	.67*	.34
Percentage of patients on public assistance.....	.08	-.22	-.12
Median monthly charge.....	.50	.76**	.75**
Median monthly charge for private-pay patients.....	.36	.67*	.87**
Median monthly charge for public assistance patients.....	.69*	.74**	.72**
Percentage of patients who receive hypodermic injections.....	.38	.56*	.63*
Percentage of patients not seen by a physician in 6 months or more.....	-.64*	-.71**	-.64*
Median size of homes (beds).....	.07	.27	.47
Percentage occupancy of homes.....	.30	.57*	.38
Percentage of registered nurses or licensed practical nurses on staff.....	.33	.60*	.49
Ratio of patients to nurses (all types).....	-.59	-.62	-.52
Percentage of homes with a registered nurse or a licensed practical nurse as highest skill-level of staff.....	.31	.60	.56
Percentage of establishments less than 1 year old.....	-.55	-.58	-.40

* Statistically significant at 5-percent level.

** Statistically significant at 1-percent level.

Table 4. Distribution of beds in proprietary skilled nursing homes in the United States, by State, according to per capita income

Per capita income category and jurisdiction ¹	Per capita income	Percent of total beds in proprietary skilled nursing homes	Per capita income category and jurisdiction ¹	Per capita income	Percent of total beds in proprietary skilled nursing homes
United States.....		100.0	Iowa.....	1,667	3.62
\$2,300-\$2,499		3.7	Minnesota	1,644	2.29
Nevada.....	\$2,414	.05	Nebraska.....	1,635	0
Delaware.....	2,372	0	Florida.....	1,610	.39
Connecticut	2,361	3.68	New Hampshire.....	1,605	1.00
\$2,100-\$2,299		22.5	Arizona.....	1,582	.11
New York City.....	2,293	3.82	Texas.....	1,574	1.99
District of Columbia.....	2,220	.04	\$1,300-\$1,499		7.1
New Jersey.....	2,219	2.44	Maine.....	1,492	1.82
California	2,162	7.83	Utah.....	1,483	.01
Illinois.....	2,155	8.41	Virginia.....	1,480	1.88
\$1,900-\$2,099		39.2	Oklahoma	1,466	1.38
New York (upstate).....	2,062	9.89	Idaho.....	1,433	0
Michigan.....	2,017	6.00	Vermont.....	1,408	.62
Ohio.....	1,953	7.07	New Mexico.....	1,387	.28
Washington.....	1,949	5.68	South Dakota.....	1,332	.01
Maryland	1,940	2.35	Louisiana.....	1,302	1.07
Massachusetts.....	1,922	8.20	\$1,100-\$1,299		2.5
\$1,700-\$1,899		12.1	Georgia.....	1,237	.96
Indiana.....	1,834	2.50	West Virginia.....	1,232	.93
Rhode Island.....	1,823	.52	Kentucky.....	1,216	
Pennsylvania.....	1,785	2.22	Tennessee.....	1,212	.46
Wyoming.....	1,779	.08	North Carolina.....	1,190	.03
Oregon.....	1,757	2.62	North Dakota.....	1,186	.07
Missouri.....	1,747	1.76	\$900-\$1,099		2.1
Montana.....	1,729	.20	Alabama.....	1,091	1.02
Wisconsin.....	1,706	2.16	South Carolina.....	1,063	.37
\$1,500-\$1,699		10.8	Arkansas.....	979	.75
Kansas.....	1,680	.09	\$700-\$899		0
Colorado	1,686	1.31	Mississippi.....	873	0

¹ Figures for New York State and New York City given separately.

NOTE: 13 study States shown in boldface letters.

² Percentage for combined income categories \$700-\$1,299 is 4.6 percent.

received a weight of $.121 \times .030$ or $.004$.

The resulting weights for the 13 States appear in the first column of table 5. To test the relative effect of this scheme, another weighting method was employed, using as a basis the total number of patients (respondent and nonrespondent) in the State as accounted for by the survey (col. 2). In addition, a weighting scheme using only respondent patients in the State was employed (col. 3). The latter is, of course, the equivalent of simple pooling of the data for the 13 States.

Each of these three schemes was applied to each of the 18 items selected from the patient study (table 6). The resulting national estimates show comparatively little variation among the three schemes applied and are well within the degree of precision warranted for the purposes of this study. Consequently, the simplest and most expedient of the three schemes—straightforward pooling of the reported data from the 13 States—was selected.

Table 5. Weights assigned the 13 survey States for obtaining consolidated results

Study State	Weights employing scheme of—		
	Per capita income and beds in proprietary skilled nursing homes	Total patients within study States	Respondent patients within study States ¹
Total.....	1.000	1.000	1.000
California.....	.225	.173	.176
Colorado.....	.043	.053	.052
Connecticut.....	.037	.097	.028
Georgia.....	.046	.025	.024
Indiana.....	.097	.109	.111
Maryland.....	.058	.052	.049
Minnesota.....	.065	.082	.077
New Mexico.....	.006	.006	.007
New York (upstate).....	.334	.296	.301
Oklahoma.....	.049	.058	.059
Rhode Island.....	.020	.023	.024
Vermont.....	.016	.019	.020
Wyoming.....	.004	.004	.004

¹In California and New York (upstate), where the survey covered a planned sample, the actual number of respondent patients was multiplied by 4 and 8, respectively, to give logically comparable figures.

Table 6. Consolidated survey results under alternative schemes

Item	Consolidated results by scheme employing—		
	Per capita income and beds in proprietary skilled nursing homes	Total patients within study States	Respondent patients within study States
Percentage of bedfast patients.....	21	20	20
Percentage of patients who never walk.....	32	31	31
Percentage of patients mentally always clear.....	44	44	43
Percentage of patients who are continent.....	65	65	65
Percentage of patients with cardiovascular primary diagnosis.....	40	40	40
Median length of stay (months).....	13	13	12
Percentage of patients on public assistance.....	49	52	51
Median monthly charge.....	\$154	\$152	\$154
Median monthly charge for private-pay patients.....	\$176	\$176	\$175
Median monthly charge for public assistance patients.....	\$122	\$125	\$128
Percentage of patients who receive hypodermic injections.....	17	18	18
Percentage of patients not seen by a physician in 6 months or more.....	12	12	12
Median size of homes (beds).....	15	15	15
Percentage occupancy of homes.....	83	83	83
Percentage of registered nurses or licensed practical nurses on staff.....	27	27	27
Ratio of patients to nurses (all types).....	3.1	3.1	3.1
Percentage of homes with a registered nurse or a licensed practical nurse as highest skill-level of staff.....	66	66	66
Percentage of establishments less than 1 year old.....	14	14	15

Sampling Error

No attempt was made to determine sampling errors. Since no random element was involved in selection of the sample, calculation of sampling errors seemed unwarranted on theoretical grounds.

Furthermore, even if an assumption of randomness had been made, calculation of

sampling errors on data for patients would have required information on variability among individual homes within States. Tabulation of such information would have involved extensive time and expense.

It was felt, too, that the significance of sampling errors was likely to be minor com-

pared with the extent of response errors which are inevitably involved in this type of survey. To measure one without the other might imply a false degree of precision.

Hence, on both theoretical and practical grounds, calculation of sampling errors was not attempted.

Appendix B

Table 1. Estimated number of nursing homes and related facilities in the United States, by type of ownership, 1954

Type of facility	Homes					Beds				
	Total	Type of ownership				Total	Type of ownership			
		Proprietary	Nonproprietary				Proprietary	Nonproprietary		
			Total	Voluntary	Public			Total	Voluntary	Public
Total.....	25,000	20,700	4,300	2,600	1,700	450,000	232,000	217,900	120,100	97,800
Skilled nursing homes.....	7,000	6,400	600	400	200	180,000	127,300	52,700	24,800	27,900
Personal care homes with skilled nursing.....	2,000	1,300	700	500	200	80,000	19,600	60,400	37,100	23,300
Personal care homes without skilled nursing.....	7,000	5,600	1,400	900	500	110,000	51,400	58,600	30,300	28,300
Sheltered homes.....	9,000	7,400	1,600	800	800	80,000	33,700	46,200	27,900	18,300

SOURCE: Ownership and size of nursing homes (10).

Table 2. Age, race, sex, and marital status of patients in proprietary nursing homes, by State

Age, race, sex, and marital status	California	Colorado	Connecticut	Georgia	Indiana	Maryland	Minnesota	New Mexico	New York (upstate)	Oklahoma	Rhode Island	Vermont	Wyoming
Number of patients.....	6,784	2,016	3,763	918	4,264	1,874	2,964	254	11,609	2,291	908	754	158
Percentage distribution													
Total.....	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Age:													
Under 45.....	1.8	1.7	1.0	2.2	.9	1.1	1.2	3.5	1.1	1.4	.9	3.1	2.2
45-64.....	8.8	10.3	7.7	9.6	5.3	11.1	6.5	10.6	6.7	7.1	7.7	8.4	7.0
65-74.....	18.7	18.9	24.0	24.5	18.2	22.4	20.4	22.8	20.5	21.0	24.0	18.0	26.3
75-84.....	40.6	42.0	40.1	40.8	44.7	38.5	40.7	38.2	44.4	44.1	40.2	39.1	36.1
85 and over.....	27.9	24.7	25.0	18.4	28.6	22.4	28.1	19.3	26.0	24.9	27.2	27.0	26.6
Unknown.....	1.2	2.4	2.3	4.5	2.3	4.5	3.1	5.5	1.2	1.4	0	3.6	7.0
Median age (years).....	80	79	79	78	80	78	80	78	80	79	79	80	79
Race:													
White.....	91.7	96.7	97.6	95.0	97.2	93.7	98.2	100.0	97.1	96.0	99.3	97.9	93.0
Nonwhite.....	1.0	.9	1.9	5.0	2.7	6.3	1.5	0	1.5	3.4	.6	.1	1.9
Unknown.....	7.3	2.4	.5	0	.1	0	.3	0	1.4	.6	.1	2.0	5.1
Sex:													
Male.....	28.1	35.8	34.5	29.5	34.3	27.2	41.0	43.3	30.1	42.0	25.6	27.5	49.4
Female.....	70.7	63.9	64.4	70.3	65.6	72.8	58.9	56.7	69.9	57.8	74.4	72.0	50.0
Unknown.....	1.2	.3	1.1	.2	.1	0	.1	0	0	.2	0	.5	.6
Marital status:													
Widowed.....	63.9	66.1	56.9	68.1	70.2	60.7	60.2	65.0	67.3	75.0	62.7	59.2	65.2
Single.....	18.2	18.1	24.3	17.3	15.5	21.1	22.1	12.2	17.8	12.7	26.9	21.8	17.1
Married.....	12.7	9.3	10.3	8.2	8.6	12.9	10.1	13.0	10.4	8.6	7.6	11.5	11.4
Separated or divorced.....	2.2	3.4	3.3	1.5	3.0	2.9	2.9	4.7	2.5	2.8	2.1	4.4	4.4
Unknown.....	8.0	5.1	5.1	4.9	2.7	2.3	4.8	5.1	2.0	.9	.8	3.2	1.9

Table 3. Physical and mental condition of patients in proprietary nursing homes, by State

Condition of patient	California	Colorado	Connecticut	Georgia	Indiana	Maryland	Minnesota	New Mexico	New York (upstate)	Oklahoma	Rhode Island	Vermont	Wyoming
Number of patients.....	6,784	2,016	3,763	918	4,264	1,874	2,964	254	11,609	2,291	908	754	158
Percentage distribution													
Total.....	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Walking status:													
Alone or with cane or crutch.....	29.6	52.8	45.2	45.9	45.7	48.8	54.6	51.6	50.0	49.1	45.3	45.5	58.2
With walker, wheelchair, etc.....	9.5	10.0	5.6	8.8	7.2	4.1	8.1	8.3	8.8	7.7	3.2	4.4	10.1
Only with attendant's help.....	12.5	11.3	18.1	14.5	13.0	20.2	12.9	18.5	14.2	9.1	18.2	18.2	12.7
Does not walk or get about.....	45.8	25.2	28.3	29.7	33.9	24.9	23.6	21.7	26.9	34.1	33.4	27.9	17.1
Unknown.....	2.5	.7	1.8	1.1	.2	2.1	.8	0	.1	0	0	3.1	1.9
Bed status:													
Out of bed except to sleep or rest.....	31.1	54.3	50.9	45.5	45.5	60.8	45.5	39.8	53.6	38.5	47.7	52.0	62.7
In bed part of time.....	16.5	18.3	24.7	21.1	13.7	2.6	23.2	20.9	22.0	13.4	20.5	17.5	11.4
In bed most of time.....	17.0	7.7	12.2	12.7	15.2	24.2	17.3	16.9	9.7	18.8	12.8	13.1	8.9
In bed all of time.....	35.4	19.5	12.1	30.0	28.6	11.9	13.8	22.4	14.4	29.2	18.7	17.0	16.5
Unknown.....	0	.2	.2	.5	.0	.1	.1	0	.2	.1	0	.4	.6
Mental condition:													
Always clear.....	39.6	45.8	33.0	46.8	40.8	39.3	42.7	47.6	49.8	43.2	44.3	47.5	52.5
Confused part of time.....	37.4	24.9	40.4	35.7	29.7	40.4	38.1	31.5	31.7	27.7	31.4	30.4	25.9
Confused most of time.....	22.8	28.5	26.1	16.7	29.2	19.7	19.0	20.9	18.0	29.1	24.3	20.8	20.9
Unknown.....	.3	.8	.4	.8	.2	.5	.2	0	.4	.1	0	1.3	.6
Continence:													
Continent.....	54.8	71.3	57.3	71.5	65.2	67.6	64.9	63.4	69.1	68.4	66.9	64.5	71.5
Incontinent, feces only.....	.8	1.0	1.7	2.1	1.9	1.5	2.6	1.6	1.0	1.9	1.8	2.1	3.2
Incontinent, urine only.....	5.5	3.1	10.2	3.4	5.2	5.7	7.8	10.6	9.8	6.3	6.5	7.4	5.7
Incontinent, both urine and feces.....	38.5	24.2	30.3	21.6	27.7	24.4	23.6	24.4	19.6	23.1	24.9	24.4	18.4
Unknown.....	.4	.4	.6	1.5	.1	.7	1.1	0	.5	.2	0	1.6	1.3

Table 4. Primary diagnoses reported for patients in proprietary nursing homes, by State

Diagnostic group	California	Colorado	Connecticut	Georgia	Indiana	Maryland	Minnesota	New Mexico	New York (upstate)	Oklahoma	Rhode Island	Vermont	Wyoming
Number of patients.....	6,784	2,016	3,763	918	4,264	1,874	2,964	254	11,609	2,291	908	754	158
Percentage distribution of patients													
Total.....	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Cardiovascular diseases.....	44.5	26.2	32.4	34.6	30.6	37.5	33.1	30.3	45.8	28.5	39.2	35.3	31.6
Heart disease.....	8.8	6.6	17.4	6.6	6.5	9.9	10.4	9.4	15.8	8.1	15.3	9.4	8.2
Hemiplegia (mainly from stroke).....	25.4	8.0	7.0	12.2	17.4	14.0	13.2	13.0	13.6	15.2	13.3	13.3	15.8
Other circulatory diseases.....	10.3	11.6	28.0	15.8	6.7	13.6	9.5	7.9	16.4	5.1	10.6	12.6	7.6
Senility.....	16.5	29.7	8.5	20.5	27.2	18.4	18.2	20.1	13.6	12.6	17.8	17.8	33.5
Fractures.....	10.7	6.9	7.9	11.0	8.9	7.9	9.0	9.4	8.3	7.9	10.1	6.2	5.7
Hip.....	7.5	5.1	6.0	7.2	6.8	6.2	7.3	7.1	5.7	6.6	7.4	5.2	3.8
Other.....	3.2	1.9	1.9	3.8	2.1	1.7	1.7	2.4	2.6	1.3	2.8	1.1	1.9
Arthritis and rheumatism.....	5.5	8.9	6.7	5.6	6.8	6.0	7.8	5.9	6.1	7.9	6.8	5.6	7.0
Paralyses (excluding hemiplegia) and degenerative diseases of central nervous system.....	5.9	5.9	5.1	6.3	4.8	5.9	4.5	3.9	3.9	5.8	2.5	5.8	1.9
Paralysis agitans.....	2.6	2.4	2.4	1.6	.7	2.0	2.3	1.2	2.3	2.7	1.2	2.3	0
Multiple sclerosis.....	1.5	.7	.9	.1	.6	.6	1.0	.4	1.1	.3	.8	1.2	0
Other.....	1.8	2.7	1.8	4.6	3.6	3.3	1.2	2.4	.4	2.7	.6	2.4	1.9
Mental disorders.....	2.0	4.9	4.3	3.1	7.9	4.5	1.8	2.0	1.9	9.3	2.3	2.7	3.8
Psychoses.....	1.4	3.4	2.8	0	1.6	2.9	.4	.8	1.0	5.6	.6	.5	2.5
Psychoneuroses and other behavior disorders.....	.6	1.5	1.5	3.1	6.3	1.6	1.4	1.2	.9	3.8	1.8	2.1	1.3
Diabetes.....	3.1	2.2	4.0	1.5	1.6	2.8	4.0	1.2	4.4	2.7	4.7	3.1	2.5
Neoplasms.....	2.1	1.6	4.0	2.1	3.6	2.5	3.2	2.8	4.3	2.7	4.2	3.2	.6
Genitourinary diseases.....	1.6	1.7	1.0	2.5	1.4	.6	1.9	3.9	1.5	2.8	.9	.5	0
Gastrointestinal diseases.....	.9	1.3	.9	1.7	.9	.6	1.8	2.0	1.0	1.4	1.1	.9	0
Total blindness.....	.9	2.8	1.5	2.5	1.1	1.7	1.8	3.1	1.0	3.3	2.3	1.1	4.4
All other diagnoses.....	5.0	8.0	3.4	5.8	3.0	5.5	8.2	11.8	5.1	4.5	5.6	11.8	5.7
No diagnosis.....	.6	2.8	.1	.4	2.3	3.3	3.2	1.2	2.0	8.9	.4	5.6	3.2
Unknown.....	.5	.2	.2	2.4	0	2.9	1.6	2.4	1.2	1.7	1.9	1.2	0

Table 5. Diagnoses reported for patients in proprietary nursing homes in 13 States, by sex and age

Diagnostic group	Sex ¹		Age ¹				
	Male	Female	Under 55	55-64	65-74	75-84	85 and over
Number of patients.....	12,468	25,943	1,321	2,123	7,955	16,300	10,106
	Percent of patients ²						
Cardiovascular diseases.....	66.8	64.9	35.8	78.9	74.6	69.4	53.4
Heart disease.....	19.4	16.2	5.5	13.5	15.8	19.9	16.3
Hemiplegia (mainly from stroke).....	16.2	16.4	13.2	30.1	22.5	15.8	9.9
Other circulatory diseases.....	31.2	32.3	17.1	35.4	36.3	33.7	27.2
Senility.....	22.8	26.9	1.8	7.7	14.7	23.4	41.2
Fractures.....	6.8	13.5	8.6	4.5	9.2	11.6	14.6
Hip.....	4.4	9.7	2.2	1.9	6.2	8.4	10.8
Other.....	2.3	3.8	6.4	2.6	3.0	3.2	3.8
Arthritis and rheumatism.....	7.2	10.6	6.3	8.0	11.1	9.7	8.7
Paralyses (excluding hemiplegia) and degenerative diseases of central nervous system.....	7.3	5.0	28.0	12.7	8.0	4.3	2.1
Paralysis agitans.....	3.1	2.2	3.8	4.6	4.5	2.3	.8
Multiple sclerosis.....	1.3	.9	13.9	2.3	.6	.3	.3
Other.....	2.9	2.0	10.3	4.9	3.0	1.7	1.0
Mental disorders.....	5.4	5.5	12.5	7.3	6.4	5.1	4.0
Psychoses.....	2.0	2.4	1.1	2.0	2.7	2.1	2.3
Psychoneuroses and other behavior disorders.....	3.4	3.2	11.4	5.4	3.7	3.0	1.8
Diabetes.....	4.4	5.8	3.9	8.8	7.8	5.5	2.6
Neoplasms.....	4.2	4.6	7.0	5.1	4.4	4.1	4.7
Genitourinary diseases.....	6.4	2.6	3.3	2.8	3.5	3.9	4.2
Gastrointestinal diseases.....	4.1	2.5	2.0	2.2	2.7	3.5	2.7
Total blindness.....	4.1	3.4	3.3	3.1	2.6	2.7	5.4
All other diagnoses.....	16.9	12.7	19.3	16.7	15.0	14.7	11.0
No diagnosis.....	2.6	2.0	.6	1.6	1.5	2.4	2.7
Unknown.....	.9	1.0	2.0	1.1	1.2	.8	.8

¹ Sex unknown, 146; age unknown, 752.² Both primary and additional diagnoses are included.

Table 6. Length of stay of patients in proprietary nursing homes, by State

Length of stay to date	California	Colorado	Connecticut	Georgia	Indiana	Maryland	Minnesota	New Mexico	New York (upstate)	Oklahoma	Rhode Island	Vermont	Wyoming
Number of patients.....	6,784	2,016	3,763	918	4,264	1,874	2,964	254	11,609	2,291	908	754	158
	Percentage distribution												
Total.....	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Less than 6 months.....	38.4	32.1	31.6	34.1	32.7	31.8	31.5	49.6	25.3	38.7	31.9	30.5	41.1
6 months to 1 year.....	19.3	17.7	17.1	17.9	18.5	17.0	16.3	18.5	16.5	20.7	17.1	15.6	21.5
1 to 2 years.....	17.7	19.9	19.6	21.8	21.7	20.7	20.8	16.5	19.0	18.5	19.5	20.8	12.7
2 to 3 years.....	10.4	11.6	12.0	11.0	11.8	13.7	11.4	7.1	14.5	8.8	11.8	10.5	8.9
3 to 5 years.....	8.3	9.6	12.5	9.7	9.5	12.5	6.3	14.3	8.3	12.0	13.5	8.2	8.2
5 years and over.....	5.6	7.9	6.7	3.4	5.4	5.2	6.5	.8	9.9	4.8	7.6	8.4	6.3
Unknown.....	.3	1.1	.5	2.2	.4	3.1	.9	1.2	.5	.2	.1	.7	1.3

Table 7. Services received by patients in proprietary nursing homes, by State

Services received	California	Colorado	Connecticut	Georgia	Indiana	Maryland	Minnesota	New Mexico	New York (upstate)	Oklahoma	Rhode Island	Vermont	Wyoming
Number of patients.....	6,784	2,016	3,763	918	4,264	1,874	2,964	254	11,609	2,291	908	754	158
	Percent of patients												
Help in feeding.....	33.5	13.9	28.4	27.8	21.9	29.6	23.0	22.8	19.4	23.0	25.8	23.7	15.8
Help in dressing.....	49.7	26.4	60.4	60.7	32.6	53.4	31.7	50.8	41.4	59.5	50.1	44.8	41.8
Care of hair.....	77.4	12.3	71.8	54.6	68.8	64.6	67.3	60.2	51.8	71.5	66.1	59.3	48.7
Shaving.....	21.4	5.5	27.3	23.7	25.4	19.3	27.6	25.2	17.2	31.2	15.2	16.8	18.4
Help with tub bath or shower.....	34.6	49.0	42.3	33.4	31.7	42.8	51.3	40.2	47.5	46.4	37.7	23.5	39.9
Full bed bath.....	67.7	41.8	59.4	49.5	38.3	57.3	43.4	40.9	52.0	44.4	60.4	62.7	36.1
Rub and massage.....	78.2	42.5	66.3	47.9	65.6	70.2	57.2	60.2	61.1	63.8	48.7	58.9	40.5
Bedpan.....	53.1	26.9	43.3	35.8	38.1	38.3	31.6	25.6	35.0	35.1	40.7	38.5	21.5
Enema.....	51.6	15.1	35.3	27.7	23.2	19.4	22.1	22.4	14.2	25.6	31.9	26.8	14.6
Hypodermic injection.....	24.0	8.8	25.6	10.0	13.7	10.9	13.3	12.6	17.9	15.0	18.4	13.3	4.4
Dressings.....	8.8	3.4	12.2	3.6	5.4	3.8	8.6	8.3	5.2	4.8	10.1	8.0	8.2
Medication.....	71.4	48.5	86.5	51.2	63.6	54.8	67.6	65.4	65.7	54.5	79.5	65.6	38.0
Pulse, temp., or respiration taken.....	61.1	19.7	64.1	37.0	43.4	55.3	64.2	55.1	35.9	36.5	38.4	35.5	23.4
Special diet.....	30.2	28.0	24.1	10.6	14.6	19.6	19.6	25.2	21.6	15.4	30.2	28.6	21.5
None of these.....	1.4	1.9	.5	6.8	3.6	2.5	2.4	8.7	4.3	6.5	.1	7.6	10.8

Table 8. Personnel¹ in proprietary nursing homes, by type of staff and by State

Type of staff	California	Colorado	Connecticut	Georgia	Indiana	Maryland	Minnesota	New Mexico	New York (upstate)	Oklahoma	Rhode Island	Vermont	Wyoming
Number of personnel.....	3,772.0	744.0	1,841.0	388.0	1,794.5	868.5	1,203.5	94.0	5,564.5	930.5	499.0	378.5	57.0
Total.....	Percentage distribution												
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Registered professional nurses.....	11.7	2.6	22.8	5.3	3.4	7.5	7.5	2.7	9.4	1.1	11.9	12.5	.9
Licensed practical nurses.....	19.7	(*)	20.9	28.5	8.5	10.7	6.9	6.9	24.0	8.9	28.1	14.6	(*)
Other nursing staff.....	41.5	66.0	23.8	30.4	65.5	41.1	46.2	46.8	40.7	55.2	31.6	33.9	32.6
All others.....	27.1	31.5	30.5	37.8	32.5	40.8	39.4	43.6	25.9	34.7	28.5	39.0	46.5

¹ Full-time equivalent, representing the full-time plus half the number of part-time personnel.

(*) No provision for licensure of practical nurses.

Table 9. Age of proprietary nursing homes, by State

Age of home (present ownership in present location)	California	Colorado	Connecticut	Georgia	Indiana	Minnesota	New Mexico	New York (upstate)	Oklahoma	Rhode Island	Vermont	Wyoming ¹
Number of homes.....	464	136	180	51	339	187	32	752	248	78	95	28
	Cumulative percent											
Less than:												
6 months.....	15.5	8.1	3.4	3.9	7.1	6.4	(22)	2.8	16.9	1.3	7.4	(14)
1 year.....	18.9	17.7	7.3	11.7	13.6	15.5	(31)	7.9	34.2	7.7	14.8	(32)
2 years.....	32.7	30.2	12.8	23.4	20.3	24.0	(59)	14.9	51.1	15.4	24.3	(46)
3 years.....	48.2	42.0	23.9	29.3	41.4	30.4	(66)	21.9	61.2	24.4	28.5	(57)
5 years.....	73.5	58.2	50.6	50.9	60.9	59.3	(84)	48.8	75.7	48.8	43.2	(71)
10 years.....	90.4	74.4	76.7	78.4	86.6	88.7	(91)	75.4	92.6	89.5	71.6	(75)

¹ Percentages are shown for rough inspection purposes only—computed on too small a base to be reliable.

Table 10. Types of patients in voluntary and public nursing homes, by State

Characteristics of patients and level of care needed	California	Colorado	Connecticut	Georgia	Maryland	Minnesota	New Mexico	Oklahoma	Rhode Island ¹	Vermont ¹	Wyoming ¹
Number of patients.....	774	268	235	66	413	1,545	193	204	14	28	33
	Percent of patients										
Age:											
Under 45.....	3.9	2.6	1.7	9.1	3.1	2.6	7.3	3.9	(7)	(18)	(3)
65 and over.....	87.7	86.2	89.4	75.7	80.6	76.9	75.2	34.9	(86)	(88)	(78)
Median age (years).....	81	79	80	75	76	77	77	68	76	78	77
Sex: Female.....	77.5	54.1	74.9	42.4	75.3	37.4	31.6	15.2	(71)	(71)	(67)
Race: Nonwhite.....	0.	0	1.3	1.5	0	.5	1.6	1.5	(7)	(0)	(0)
Marital status:											
Widowed.....	66.7	60.1	60.9	48.5	49.2	39.8	48.7	29.9	(79)	(43)	(61)
Married.....	4.7	11.9	14.9	10.6	10.7	8.8	8.2	8.8	(7)	(14)	(6)
Medical condition:											
Severely limited in ability to walk.....	42.6	33.2	54.9	39.4	45.0	33.5	37.3	12.3	(64)	(81)	(55)
Completely bedfast.....	21.7	11.9	7.2	27.3	5.8	12.6	3.6	4.9	(29)	(14)	(15)
Mentally confused.....	40.3	43.3	63.4	92.4	31.0	43.6	37.8	48.5	(60)	(29)	(39)
Incontinent.....	24.0	17.2	42.6	22.7	19.4	18.1	27.5	13.2	(36)	(26)	(27)
Level of care needed:											
Could not ordinarily be given in patient's own home.....	55.0	40.3	85.1	81.8	—	36.6	57.0	15.7	(71)	(26)	(64)
Might be given in patient's own home.....	19.4	43.3	14.0	16.7	—	39.7	25.9	12.3	(14)	(46)	(30)
Mainly boarding care.....	24.8	16.0	.4	0	—	23.7	17.1	71.6	(14)	(18)	(6)
Unknown.....	.8	.4	.4	1.5	—	0	0	.5	(0)	(0)	(0)

¹ Percentages are shown for rough inspection purposes only—computed on too small a base to be reliable.

NOTE: A dash (—) indicates that data are not available.

Table 11. Types of residents in domiciliary care homes, by State

Characteristics of residents and level of care needed	California	Connecticut	Georgia	Indiana	Maryland	Minnesota	New Mexico	Oklahoma	Rhode Island	Vermont	Wyoming
Number of residents.....	13,440	351	975	5,629	1,187	3,706	129	644	248	395	260
	Percent of residents										
Age:											
Under 45.....	0.3	2.0	2.8	2.6	1.0	0.2	7.0	3.9	1.2	2.8	1.5
45 and over.....	99.3	73.2	70.3	78.0	84.5	95.0	69.8	77.4	92.4	85.0	80.0
Median age (years).....	80	75	75	76	77	81	75	77	79	78	78
Sex: Female.....	70.2	44.4	62.5	48.5	62.8	66.2	46.5	48.3	62.9	63.5	37.3
Race: Nonwhite.....	.4	2.6	26.7	2.9	9.9	.2	3.1	3.7	.4	.3	.8
Marital status:											
Widowed.....	64.4	45.9	54.6	45.3	45.0	61.7	48.8	65.2	58.5	52.4	49.2
Married.....	6.1	10.0	6.1	5.2	4.9	9.3	4.7	6.7	6.5	5.1	11.9
Medical condition:											
Severely limited in ability to walk.....	8.2	42.7	39.6	17.3	9.0	14.2	24.0	22.4	19.4	16.7	13.8
Completely bedfast.....	.8	5.4	11.5	5.9	3.3	3.0	7.0	9.0	6.9	3.3	1.9
Mentally confused.....	23.6	55.8	59.3	38.0	32.1	44.2	27.6	42.3	26.8	23.8	23.8
Incontinent.....	6.6	27.1	24.4	9.6	3.5	10.0	16.3	11.5	20.6	8.4	8.1
Level of care needed:											
Could not ordinarily be given in patient's own home.....	4.5	72.1	41.9	20.1	—	20.8	15.5	15.8	17.7	20.0	8.5
Might be given in patient's own home.....	29.2	20.2	41.1	29.1	—	27.4	38.0	28.7	33.3	24.0	20.2
Mainly boarding care.....	66.3	7.7	16.2	50.8	—	51.6	46.5	54.7	49.2	55.2	62.3
Unknown.....	0	0	7	0	—	2	0	0	0	.5	0

NOTE: A dash (—) indicates that data are not available.

Table 12. Care of patients in voluntary and public nursing homes, by State

Selected information on care	California	Colorado	Connecticut	Georgia	Maryland	Minnesota	New Mexico	Oklahoma	Rhode Island	Vermont	Wyoming
Number of patients.....	774	268	235	66	413	1,545	193	204	14	28	33
	Percent of patients										
Services received:											
Help in feeding.....	21.7	16.8	35.7	12.1	24.0	15.8	19.7	8.8	(21)	(36)	(36)
Help in dressing.....	30.2	33.6	63.8	10.6	44.3	26.2	44.6	17.2	(64)	(46)	(36)
Care of hair.....	46.5	32.1	71.5	12.1	69.0	39.1	25.9	16.7	(71)	(61)	(61)
Shaving.....	15.5	22.8	16.2	3.0	12.1	30.7	49.2	7.8	(14)	(11)	(27)
Help with tub bath or shower.....	58.9	47.8	55.3	0	45.3	36.8	79.8	9.8	(0)	(7)	(45)
Full bed bath.....	28.7	33.2	40.4	10.6	54.7	29.8	9.8	10.3	(100)	(64)	(45)
Rub and massage.....	58.9	32.8	63.4	3.0	45.0	24.7	24.9	14.7	(96)	(79)	(70)
Bedpan.....	31.0	28.0	73.6	10.6	42.9	16.4	19.7	10.3	(64)	(54)	(36)
Enema.....	38.0	28.0	68.1	3.0	5.3	8.9	13.5	11.3	(64)	(39)	(30)
Hypodermic injection.....	14.0	17.9	26.0	0	18.4	11.6	7.3	9.3	(50)	(21)	(36)
Dressings.....	3.1	6.0	7.2	0	6.3	6.2	13.5	10.3	(21)	(4)	(12)
Medication.....	76.0	50.0	90.2	69.7	74.3	54.2	90.7	84.3	(86)	(68)	(79)
Pulse, temperature, or respiration taken.....	36.4	20.5	93.6	1.5	32.2	34.2	97.9	88.2	(86)	(57)	(61)
Special diet.....	16.3	13.1	15.7	6.1	24.0	13.5	11.9	18.1	(14)	(21)	(23)
None of these.....	11.6	5.6	1.3	21.2	2.7	15.3	0	6.4	(0)	(0)	(0)
Attendance by physicians:											
Last seen within 30 days of survey.....	76.7	41.4	94.0	7.6	87.7	41.6	81.9	83.3	(86)	(46)	(58)
Last seen 1-3 months ago.....	14.0	10.8	3.8	7.6	3.1	21.2	8.8	4.4	(0)	(7)	(12)
Not seen in 6 months or more.....	6.3	34.7	1.3	66.7	5.5	23.6	2.6	7.9	(14)	(18)	(24)

Percentages are shown for rough inspection purposes only—computed on too small a base to be reliable.

Table 13. Care of residents in domiciliary care homes, by State

Selected information on care	California	Connecticut	Georgia	Indiana	Maryland	Minnesota	New Mexico	Oklahoma	Rhode Island	Vermont	Wyoming
Number of residents.....	13,440	351	975	5,629	1,187	3,706	129	644	248	395	260
	Percent of residents										
Services received:											
Help in feeding.....	3.5	32.2	29.5	7.2	4.6	9.0	15.5	9.3	4.4	6.1	3.8
Help in dressing.....	13.5	57.5	54.2	16.2	7.2	19.0	34.1	25.8	29.0	13.9	10.0
Care of hair.....	24.8	68.1	50.8	23.9	22.4	24.9	34.1	47.7	33.1	19.7	11.2
Shaving.....	6.4	39.3	25.9	17.4	5.7	9.7	18.6	25.2	12.5	6.1	13.5
Help with tub bath or shower.....	36.7	78.1	51.9	28.2	22.2	31.2	42.6	33.9	62.5	18.0	26.9
Full bed bath.....	5.1	45.6	31.3	11.0	8.3	11.2	8.5	16.1	23.4	12.2	4.6
Rub and massage.....	8.9	42.5	29.6	9.8	7.5	12.5	23.3	19.9	12.5	10.9	8.1
Bedpan.....	2.5	34.5	26.7	8.4	4.5	9.1	6.2	11.6	11.7	4.8	3.5
Enema.....	2.0	24.2	40.4	2.6	3	7.9	4.7	9.3	4.8	1.8	1.9
Hypodermic injection.....	3.4	26.8	38.2	6.4	4.0	6.8	3.9	7.5	3.2	4.1	4.6
Dressings.....	1.6	22.5	8.1	2.0	1.5	2.8	8	1.1	4.0	1.0	1.2
Medication.....	10.6	82.9	77.6	44.0	21.2	34.2	31.0	36.5	47.6	25.1	11.6
Pulse, temperature, or respiration taken.....	3.3	67.5	53.9	11.9	35.3	15.9	3.9	14.0	1.6	4.6	11.2
Special diet.....	10.3	16.0	15.4	4.0	3.1	9.3	14.7	9.6	18.5	6.3	5.4
None of these.....	39.9	.9	11.2	35.4	35.9	42.7	28.7	30.1	.4	53.4	54.2
Attendance by physicians:											
Last seen within 30 days of survey.....	37.9	94.0	59.8	37.4	30.5	22.0	26.4	52.3	36.3	22.9	30.4
Last seen 1-3 months ago.....	15.3	3.4	9.4	11.5	8.8	13.7	11.6	12.1	25.4	19.5	9.6
Not seen in 6 months or more.....	30.8	0	26.1	41.1	48.4	45.4	38.1	21.1	24.1	33.7	37.7

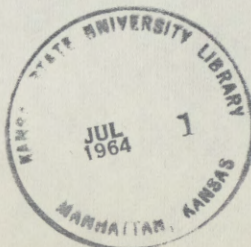


Table 14. Types of patients in chronic disease hospitals, by State

Characteristics of patients and level of care needed	Con-necticut	Mary-land	Min-nesota	Okla-homa	Rhode Island
Number of patients...	502	828	507	133	781
	Percent of patients				
Age:					
Under 45.....	12.7	7.6	2.4	0	11.0
65 and over.....	39.0	60.6	80.3	94.0	70.7
Median age (years)...	68	70	79	80	78
Sex: Female.....	14.9	44.7	45.4	57.9	47.0
Race: Nonwhite.....	6.0	30.6	1.6	0	2.0
Marital status:					
Widowed.....	20.5	38.9	48.5	69.2	35.3
Married.....	35.9	16.5	15.4	14.3	13.2
Medical condition:					
Severely limited in ability to walk.....	55.6	61.5	74.0	63.2	47.9
Completely bedfast.....	8.4	8.6	13.2	27.8	13.1
Mentally confused.....	30.3	51.2	56.6	80.5	44.6
Incontinent.....	24.5	30.9	42.6	43.6	33.9
Level of care needed:					
Could not ordinarily be given in patient's own home.....	45.2	—	64.9	81.2	83.4
Might be given in patient's own home.....	45.6	—	32.3	17.3	12.9
Mainly boarding care.....	8.4	—	2.6	1.5	2.8
Unknown.....	.8	—	.2	0	.9

NOTE: A dash (—) indicates that data are not available.

Table 15. Care of patients in chronic disease hospitals, by State

Selected information on care	Con-necticut	Mary-land	Min-nesota	Okla-homa	Rhode Island
Number of patients...	502	828	507	133	781
	Percent of patients				
Services received:					
Help in feeding.....	14.3	26.9	32.0	28.6	17.4
Help in dressing.....	34.7	53.1	53.5	85.7	44.2
Care of hair.....	27.9	63.6	78.7	94.7	74.4
Shaving.....	29.3	28.4	45.4	41.4	48.0
Help with tub bath or shower.....	32.9	82.2	57.6	51.1	82.5
Full bed bath.....	30.3	29.7	43.0	54.9	17.0
Rub and massage.....	33.9	64.4	46.7	60.9	12.2
Bedpan.....	29.5	50.0	43.0	54.1	20.1
Enema.....	19.1	20.9	45.4	75.9	16.9
Hypodermic injection.....	27.5	24.3	29.2	40.6	14.2
Dressings.....	20.5	12.0	10.7	6.0	6.3
Medication.....	77.9	73.8	85.2	93.2	59.3
Pulse, temperature, or respiration taken.....	48.2	59.8	71.4	90.2	53.3
Special diet.....	45.8	36.8	26.4	57.1	14.7
None of these.....	1.6	.1	.4	0	.9
Attendance by physicians:					
Last seen within 30 days of survey.....	100.0	100.0	58.8	44.4	99.0
Last seen 1-3 months ago.....	0	0	18.1	24.8	0
Not seen in 6 months or more.....	0	0	10.7	9.1	.9

