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## HOSPITAL AND MEDICAL FACILITIES

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WEDNESDAY, JULY 8, 1964

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

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 4232, New Senate Office Building, Senator Lister Hill, chairman of the subcommittee, presiding.

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

Also present: Senators Clark, a member of the full committee, and Hruska.

Committee staff members present: Stewart E. McClure, chief clerk; John S. Forsythe, general counsel; Robert W. Barclay, professional staff member; and Michael J. Bernstein, minority counsel.

The CHAIRMAN. The subcommittee will kindly come to order.

The Subcommittee on Health is meeting this morning to receive testimony on H.R. 10041 that would extend and expand the Hill-Burton Act.

(H.R. 10041, S. 2531, and S. 894 follow:)

88TH CONGRESS  
2D SESSION

# H. R. 10041

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IN THE SENATE OF THE UNITED STATES

MAY 27 (legislative day, MARCH 30), 1964

Read twice and referred to the Committee on Labor and Public Welfare

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## AN ACT

To improve the public health through revising, consolidating, and improving the hospital and other medical facilities provisions of the Public Health Service Act.

1        *Be it enacted by the Senate and House of Representa-*  
2        *tives of the United States of America in Congress assembled,*  
3        That this Act may be cited as the "Hospital and Medical  
4        Facilities Amendments of 1964".

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

1 "SPECIAL PROJECT GRANTS FOR ASSISTING IN THE AREA-  
2 WIDE PLANNING OF HEALTH AND RELATED FACILITIES

3 "SEC. 318. There are authorized to be appropriated  
4 \$2,500,000 for the fiscal year ending June 30, 1965, and  
5 \$5,000,000 for each of the next four fiscal years to enable  
6 the Surgeon General to make grants to the appropriate  
7 State agency or agencies designated in accordance with  
8 section 604 (a) (1) to cover not to exceed 50 per centum  
9 of the costs of projects for developing (and from time to  
10 time revising) and supervising and assisting in the carrying  
11 out of comprehensive regional, metropolitan area, or other  
12 local area plans for coordination of existing and planned  
13 health facilities, and facilities related thereto, and services  
14 provided by such facilities."

15 SEC. 3. (a) Title VI of the Public Health Service Act  
16 (42 U.S.C., ch. 6A, subch. IV) is amended to read as  
17 follows:

18 "TITLE VI—ASSISTANCE FOR CONSTRUCTION  
19 AND MODERNIZATION OF HOSPITALS AND  
20 OTHER MEDICAL FACILITIES

21 "DECLARATION OF PURPOSE

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

23 "(a) to assist the several States in the carrying out  
24 of their programs for the construction and modernization  
25 of such public or other nonprofit community hospitals

1 and other medical facilities as may be necessary, in con-  
 2 junction with existing facilities, to furnish adequate hos-  
 3 pital, clinic, or similar services to all their people;

4 “(b) to stimulate the development of new or im-  
 5 proved types of physical facilities for medical, diagnostic,  
 6 preventive, treatment, or rehabilitative services; and

7 “(c) to promote research, experiments, and  
 8 demonstrations relating to the effective development and  
 9 utilization of hospital, clinic, or similar services, facilities,  
 10 and resources, and to promote the coordination of such  
 11 research, experiments, and demonstrations and the use-  
 12 ful application of their results.

13 “PART A—GRANTS AND LOANS FOR CONSTRUCTION AND  
 14 MODERNIZATION OF HOSPITALS AND OTHER MEDICAL  
 15 FACILITIES

16 “AUTHORIZATION OF APPROPRIATIONS FOR  
 17 CONSTRUCTION GRANTS

18 “SEC. 601. In order to assist the States in carrying out  
 19 the purposes of section 600, there are authorized to be ap-  
 20 propriated—

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

23 “(1) \$70,000,000 for grants for the construc-  
 24 tion of public or other nonprofit facilities for long-  
 25 term care;

## 4

1           “(2) \$20,000,000 for grants for the construc-  
2           tion of public or other nonprofit diagnostic or treat-  
3           ment centers;

4           “(3) \$10,000,000 for grants for the construc-  
5           tion of public or other nonprofit rehabilitation facili-  
6           ties;

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

15                           “STATE ALLOTMENTS

16          “SEC. 602. (a) (1) Each State shall be entitled for  
17          each fiscal year to an allotment bearing the same ratio to the  
18          sums appropriated for such year pursuant to subparagraphs  
19          (1), (2), and (3), respectively, of section 601 (a), and  
20          to an allotment bearing the same ratio to the new hospital  
21          portion of the sums appropriated for such year pursuant to  
22          section 601 (b), as the product of—

23                   “(A) the population of such State, and

24                   “(B) the square of its allotment percentage,

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

13 “(2) For each fiscal year beginning after June 30,  
14 1965, the Surgeon General shall, in accordance with regu-  
15 lations, make allotments from the remainder of the sums  
16 appropriated pursuant to section 601 (b) (which portion  
17 shall be available for grants for modernization of facilities  
18 referred to in paragraphs (a) and (b) of section 601) on  
19 the basis of the population, the extent of the need for  
20 modernization of the facilities referred to in paragraphs  
21 (a) and (b) of section 601, and the financial need of the  
22 respective States.

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

## 6

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

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

10           “(C) \$100,000 for the Virgin Islands, American  
11           Samoa, or Guam and \$200,000 for any other State in  
12           the case of an allotment for grants for the construction  
13           of public or other nonprofit facilities for long-term care  
14           or for the construction of public or other nonprofit hos-  
15           pitals and public health centers, or for the moderniza-  
16           tion of facilities referred to in paragraph (a) or (b) of  
17           section 601,

18 shall be increased to that amount, the total of the increases  
19 thereby required being derived by proportionately reducing  
20 the allotment from appropriations under such subparagraph  
21 or paragraph to each of the remaining States under subsec-  
22 tion (a) of this section, but with such adjustments as may be  
23 necessary to prevent the allotment of any of such remaining  
24 States from appropriations under such subparagraph or

1 paragraph from being thereby reduced to less than that  
2 amount.

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

10 “(c) For the purposes of this part—

11 “(1) The ‘allotment percentage’ for any State shall be  
12 100 per centum less that percentage which bears the same  
13 ratio to 50 per centum as the per capita income of such State  
14 bears to the per capita income of the United States, except  
15 that (A) the allotment percentage shall in no case be more  
16 than 75 per centum or less than  $33\frac{1}{3}$  per centum, and (B)  
17 the allotment percentage for the Commonwealth of Puerto  
18 Rico, Guam, American Samoa, and the Virgin Islands shall  
19 be 75 per centum.

20 “(2) The allotment percentages shall be determined by  
21 the Surgeon General between July 1 and September 30 of  
22 each even-numbered year, on the basis of the average of the  
23 per capita incomes of each of the States and of the United  
24 States for the three most recent consecutive years for which

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1 satisfactory data are available from the Department of Com-  
2 merce, and the States shall be notified promptly thereof.  
3 Such determination shall be conclusive for each of the two  
4 fiscal years in the period beginning July 1 next succeeding  
5 such determination.

6 “(3) The population of the several States shall be de-  
7 termined on the basis of the latest figures certified by the  
8 Department of Commerce.

9 “(4) The term ‘United States’ means (but only for pur-  
10 poses of paragraphs (1) and (2)) the fifty States and the  
11 District of Columbia.

12 “(d) (1) Any sum allotted to a State, other than the  
13 Virgin Islands, American Samoa, and Guam for a fiscal year  
14 under this section and remaining unobligated at the end of  
15 such year shall remain available to such State, for the purpose  
16 for which made, for the next fiscal year (and for such year  
17 only), in addition to the sums allotted to such State for such  
18 purpose for such next fiscal year.

19 “(2) Any sum allotted to the Virgin Islands, American  
20 Samoa, or Guam for a fiscal year under this section and re-  
21 maining unobligated at the end of such year shall remain  
22 available to it, for the purpose for which made, for the next  
23 two fiscal years (and for such years only), in addition to the

1 sums allotted to it for such purpose for each of such next two  
2 fiscal years.

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

4 “(A) a specified portion of any allotment of such  
5 State under paragraph (1) of subsection (a), other  
6 than an allotment for grants for the construction of  
7 public or other nonprofit rehabilitation facilities, be  
8 added to another allotment of such State under para-  
9 graph (1) or (2) of such subsection, other than an  
10 allotment for grants for the construction of public or  
11 other nonprofit hospitals and public health centers, or

12 “(B) a specified portion of an allotment of such  
13 State under paragraph (2) of subsection (a) be added  
14 to an allotment of such State under paragraph (1) of  
15 such subsection,

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

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

22 “(D) in the case of a request to transfer a portion

## 10

1 of an allotment under paragraph (1) of subsection (a)  
2 for grants for the construction of public or other non-  
3 profit hospitals and public health centers, use of such  
4 portion as requested by such State agency will better  
5 carry out the purposes of this title,

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

10 “(2) In addition to the transfer of portions of allot-  
11 ments under paragraph (1), the Surgeon General, upon the  
12 request of any State that a specified portion of an allotment  
13 of such State under paragraph (2) of subsection (a) be  
14 added to an allotment of such State under paragraph (1) of  
15 such subsection for grants for the construction of public or  
16 other nonprofit hospitals and public health centers and upon  
17 simultaneous certification to him by the State agency in such  
18 State to the effect that the need for new public or other non-  
19 profit hospitals and public health centers is substantially  
20 greater than the need for modernization of facilities referred  
21 to in paragraph (a) or (b) of section 601, shall promptly  
22 (but after application of subsection (b) of this section)  
23 adjust the allotments of such State in accordance with such  
24 request and shall notify the State agency; except that not  
25 more than the following portions of allotments of a State

## 11

1 under paragraph (2) of subsection (a) may be so added  
2 (under this paragraph) to allotments of such State under  
3 paragraph (1) of such subsection:

4 “(A) in the case of an allotment under paragraph  
5 (2) of subsection (a) for the fiscal year ending June  
6 30, 1966, one-half of such allotment;

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

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

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

16 “(3) After adjustment of allotments of any State as  
17 provided in paragraph (1) or (2) of this subsection, the  
18 allotments as so adjusted shall be deemed to be the State’s  
19 allotments under this section.

20 “(f) In accordance with regulations, any State may file  
21 with the Surgeon General a request that a specified portion  
22 of an allotment to it under this part for grants for construction  
23 of any type of facility, or for modernization of facilities, be  
24 added to the corresponding allotment of another State for the  
25 purpose of meeting a portion of the Federal share of the cost

1 of a project for the construction of a facility of that type in  
2 such other State, or for modernization of a facility in such  
3 other State, as the case may be. If it is found by the Surgeon  
4 General (or, in the case of a rehabilitation facility, by the  
5 Surgeon General and the Secretary) that construction or  
6 modernization of the facility with respect to which the re-  
7 quest is made would meet needs of the State making the re-  
8 quest and that use of the specified portion of such State's  
9 allotment, as requested by it, would assist in carrying out  
10 the purposes of this title, such portion of such State's allot-  
11 ment shall be added to the corresponding allotment of the  
12 other State, to be used for the purpose referred to above.

13 "GENERAL REGULATIONS

14 "SEC. 603. The Surgeon General, with the approval of  
15 the Federal Hospital Council and the Secretary of Health,  
16 Education, and Welfare, shall by general regulations pre-  
17 scribe—

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

23 "(1) in the case of projects for the construc-  
24 tion of hospitals, to facilities serving rural com-

## 13

1           munities and areas with relatively small financial  
2           resources;

3           “(2) in the case of projects for the construc-  
4           tion of rehabilitation facilities, to facilities operated  
5           in connection with a university teaching hospital  
6           which will provide an integrated program of medi-  
7           cal, psychological, social, and vocational evaluation  
8           and services under competent supervision;

9           “(3) in the case of projects for modernization  
10          of facilities, to facilities serving densely populated  
11          areas; and

12          “(4) to the extent deemed feasible by the State  
13          agency, to hospital facilities which will include  
14          new or expanded facilities for nurse training;

15          “(b) general standards of construction and equip-  
16          ment for facilities of different classes and in different  
17          types of location, for which assistance is available under  
18          this part;

19          “(c) criteria for determining needs for general  
20          hospital and long-term care beds, and needs for hos-  
21          pitals and other facilities for which aid under this part is  
22          available, and for developing plans for the distribution  
23          of such beds and facilities;

24          “(d) criteria for determining the extent to which

## 14

1 existing facilities, for which aid under this part is avail-  
2 able, are in need of modernization; and

3 “(e) that the State plan shall provide for adequate  
4 hospitals, and other facilities for which aid under this  
5 part is available, for all persons residing in the State, and  
6 adequate hospitals (and such other facilities) to furnish  
7 needed services for persons unable to pay therefor.  
8 Such regulations may also require that before approval  
9 of an application for a project is recommended by a  
10 State agency to the Surgeon General for approval under  
11 this part, assurance shall be received by the State from  
12 the applicant that (1) the facility or portion thereof  
13 to be constructed or modernized will be made available  
14 to all persons residing in the territorial area of the appli-  
15 cant; and (2) there will be made available in the facility  
16 or portion thereof to be constructed or modernized a  
17 reasonable volume of services to persons unable to pay  
18 therefor, but an exception shall be made if such a re-  
19 quirement is not feasible from a financial viewpoint.

20 “STATE PLANS

21 “SEC. 604. (a) Any State desiring to participate in this  
22 part may submit a State plan. Such plan must—

23 “(1) designate a single State agency as the sole  
24 agency for the administration of the plan, or designate

## 15

1 such agency as the sole agency for supervising the ad-  
2 ministration of the plan;

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

7 “(3) provide for the designation of a State advisory  
8 council which shall include representatives of nongov-  
9 ernmental organizations or groups, and of public  
10 agencies, concerned with the operation, construction, or  
11 utilization of hospital or other facilities for diagnosis,  
12 prevention, or treatment of illness or disease, or for pro-  
13 vision of rehabilitation services, and an equal number of  
14 representatives of consumers familiar with the need for  
15 the services provided by such facilities, to consult with  
16 the State agency in carrying out the plan, and provide,  
17 if such council does not include any representatives of  
18 nongovernmental organizations or groups, or State  
19 agencies, concerned with rehabilitation, for consultation  
20 with organizations, groups, and State agencies so  
21 concerned;

22 “(4) set forth, in accordance with criteria estab-  
23 lished in regulations prescribed under section 603 and  
24 on the basis of a statewide inventory of existing facili-

## 16

1 ties, a survey of need, and (except to the extent pro-  
2 vided by or pursuant to such regulations) community,  
3 area, or regional plans—

4 “(A) the number of general hospital beds and  
5 long-term care beds, and the number and types of  
6 hospital facilities and facilities for long-term care,  
7 needed to provide adequate facilities for inpatient  
8 care of people residing in the State, and a plan for  
9 the distribution of such beds and facilities in service  
10 areas throughout the State;

11 “(B) the public health centers needed to pro-  
12 vide adequate public health services for people re-  
13 siding in the State, and a plan for the distribution  
14 of such centers throughout the State;

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

20 “(D) the rehabilitation facilities needed to  
21 assure adequate rehabilitation services for disabled  
22 persons residing in the State, and a plan for dis-  
23 tribution of such facilities throughout the State;  
24 and

25 “(E) effective January 1, 1966, the extent

1 to which existing facilities referred to in section  
2 601 (a) or (b) in the State are in need of  
3 modernization;

4 “(5) set forth a construction and modernization  
5 program conforming to the provisions set forth pursuant  
6 to paragraph (4) and regulations prescribed under sec-  
7 tion 603 and providing for construction or moderniza-  
8 tion of the hospital or long-term care facilities, public  
9 health centers, diagnostic or treatment centers, and re-  
10 habilitation facilities which are needed, as determined  
11 under the provisions so set forth pursuant to paragraph  
12 (4);

13 “(6) set forth, with respect to each of such types  
14 of medical facilities, the relative need, determined in  
15 accordance with regulations prescribed under section  
16 603, for projects for facilities of that type, and provide  
17 for the construction or modernization, insofar as financial  
18 resources available therefor and for maintenance and  
19 operation make possible, in the order of such relative  
20 need;

21 “(7) provide minimum standards (to be fixed in  
22 the discretion of the State) for the maintenance and op-  
23 eration of facilities providing inpatient care which receive  
24 aid under this part and, effective July 1, 1966, provide

1 for enforcement of such standards with respect to proj-  
2 ects approved by the Surgeon General under this part  
3 after June 30, 1964;

4 “(8) provide such methods of administration of the  
5 State plan, including methods relating to the establish-  
6 ment and maintenance of personnel standards on a merit  
7 basis (except that the Surgeon General shall exercise  
8 no authority with respect to the selection, tenure of  
9 office, or compensation of any individual employed in  
10 accordance with such methods), as are found by the  
11 Surgeon General to be necessary for the proper and  
12 efficient operation of the plan;

13 “(9) provide for affording to every applicant for  
14 a construction or modernization project an opportunity  
15 for a hearing before the State agency;

16 “(10) provide that the State agency will make such  
17 reports, in such form and containing such information, as  
18 the Surgeon General may from time to time reasonably  
19 require, and will keep such records and afford such  
20 access thereto as the Surgeon General may find neces-  
21 sary to assure the correctness and verification of such  
22 reports;

23 “(11) provide that the Comptroller General of the

1 United States or his duly authorized representatives shall  
2 have access for the purpose of audit and examination to  
3 the records specified in paragraph (10) ; and

4 “(12) provide that the State agency will from time  
5 to time, but not less often than annually, review its  
6 State plan and submit to the Surgeon General any modi-  
7 fications thereof which it considers necessary.

8 “(b) The Surgeon General shall approve any State plan  
9 and any modification thereof which complies with the provi-  
10 sions of subsection (a). If any such plan or modification  
11 thereof shall have been disapproved by the Surgeon General  
12 for failure to comply with subsection (a), the Federal Hos-  
13 pital Council shall, upon request of the State agency, afford it  
14 an opportunity for hearing. If such Council determines that  
15 the plan or modification complies with the provisions of such  
16 subsection, the Surgeon General shall thereupon approve  
17 such plan or modification.

18 “APPROVAL OF PROJECTS FOR CONSTRUCTION OR  
19 MODERNIZATION

20 “SEC. 605. (a) For each project pursuant to a State  
21 plan approved under this part, there shall be submitted to  
22 the Surgeon General, through the State agency, an applica-  
23 tion by the State or a political subdivision thereof or by a

1 public or other nonprofit agency. If two or more such agen-  
2 cies join in the project, the application may be filed by one  
3 or more of such agencies. Such application shall set forth—

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

5 “(2) plans and specifications therefor, in accord-  
6 ance with regulations prescribed under section 603;

7 “(3) reasonable assurance that title to such site is  
8 or will be vested in one or more of the agencies filing the  
9 application or in a public or other nonprofit agency  
10 which is to operate the facility on completion of the  
11 project;

12 “(4) reasonable assurance that adequate financial  
13 support will be available for the completion of the proj-  
14 ect and for its maintenance and operation when com-  
15 pleted;

16 “(5) reasonable assurance that all laborers and  
17 mechanics employed by contractors or subcontractors in  
18 the performance of construction or modernization on the  
19 project will be paid wages at rates not less than those  
20 prevailing on similar work in the locality as determined  
21 by the Secretary of Labor in accordance with the Davis-  
22 Bacon Act, as amended (40 U.S.C. 276a—276a-5) ;  
23 and the Secretary of Labor shall have with respect to the  
24 labor standards specified in this paragraph the authority  
25 and functions set forth in Reorganization Plan Numbered

1 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-15) and  
2 section 2 of the Act of June 13, 1934, as amended (40  
3 U.S.C. 276c); and

4 “(6) a certification by the State agency of the Fed-  
5 eral share for the project.

6 “(b) The Surgeon General shall approve such applica-  
7 tion if sufficient funds to pay the Federal share of the cost of  
8 such project are available from the appropriate allotment to  
9 the State, and if the Surgeon General finds (1) that the  
10 application contains such reasonable assurance as to title,  
11 financial support, and payment of prevailing rates of wages;  
12 (2) that the plans and specifications are in accord with the  
13 regulations prescribed pursuant to section 603; (3) that the  
14 application is in conformity with the State plan approved  
15 under section 604 and contains an assurance that in the  
16 operation of the project there will be compliance with the  
17 applicable requirements of the regulations prescribed under  
18 section 603 (e), and with State standards for operation and  
19 maintenance; and (4) that the application has been  
20 approved and recommended by the State agency and is en-  
21 titled to priority over other projects within the State in  
22 accordance with the regulations prescribed pursuant to sec-  
23 tion 603 (a). Notwithstanding the preceding sentence, the  
24 Surgeon General may approve such an application for a

1 project for construction or modernization of a rehabilitation  
2 facility only if it is also approved by the Secretary of Health,  
3 Education, and Welfare.

4 “(c) No application shall be disapproved until the  
5 Surgeon General has afforded the State agency an oppor-  
6 tunity for a hearing.

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

10 “(e) Notwithstanding any other provision of this title,  
11 no application for a diagnostic or treatment center shall be  
12 approved under this section unless the applicant is (1) a  
13 State, political subdivision, or public agency, or (2) a  
14 corporation or association which owns and operates a non-  
15 profit hospital (as defined in section 625).

16 “PAYMENTS FOR CONSTRUCTION OR MODERNIZATION

17 “SEC. 606. (a) Upon certification to the Surgeon Gen-  
18 eral by the State agency, based upon inspection by it, that  
19 work has been performed upon a project, or purchases have  
20 been made, in accordance with the approved plans and speci-  
21 fications, and that payment of an installment is due to the  
22 applicant, such installment shall be paid to the State, from  
23 the applicable allotment of such State, except that (1) if  
24 the State is not authorized by law to make payments to the  
25 applicant, or if the State so requests, the payment shall be

1 made directly to the applicant, (2) if the Surgeon General,  
2 after investigation or otherwise, has reason to believe that  
3 any act (or failure to act) has occurred requiring action  
4 pursuant to section 607, payment may, after he has given  
5 the State agency notice of opportunity for hearing pursuant  
6 to such section, be withheld, in whole or in part, pending  
7 corrective action or action based on such hearing, and (3)  
8 the total of payments under this subsection with respect to  
9 such project may not exceed an amount equal to the Federal  
10 share of the cost of construction of such project.

11 “(b) In case an amendment to an approved application  
12 is approved as provided in section 605 or the estimated cost  
13 of a project is revised upward, any additional payment with  
14 respect thereto may be made from the applicable allotment  
15 of the State for the fiscal year in which such amendment or  
16 revision is approved.

17 “(c) (1) At the request of any State, a portion of any  
18 allotment or allotments of such State under this part shall  
19 be available to pay one-half (or such smaller share as the  
20 State may request) of the expenditures found necessary by  
21 the Surgeon General for the proper and efficient administra-  
22 tion during such year of the State plan approved under this  
23 part; except that not more than 2 per centum of the total  
24 of the allotments of such State for a year, or \$50,000, which-  
25 ever is less, shall be available for such purpose for such year.

1 Payments of amounts due under this paragraph may be  
2 made in advance or by way of reimbursement, and in such  
3 installments, as the Surgeon General may determine.

4 “(2) Any amount paid under paragraph (1) to any  
5 State for any fiscal year shall be paid on condition that there  
6 shall be expended from State sources for such year for ad-  
7 ministration of the State plan approved under this part not  
8 less than the total amount expended for such purposes from  
9 such sources during the fiscal year ending June 30, 1964.

10 “WITHHOLDING OF PAYMENTS

11 “SEC. 607. Whenever the Surgeon General, after rea-  
12 sonable notice and opportunity for hearing to the State  
13 agency designated as provided in section 604 (a) (1), finds—

14 “(a) that the State agency is not complying sub-  
15 stantially with the provisions required by section 604  
16 to be included in its State plan; or

17 “(b) that any assurance required to be given in  
18 an application filed under section 605 is not being or  
19 cannot be carried out; or

20 “(c) that there is a substantial failure to carry out  
21 plans and specifications approved by the Surgeon Gen-  
22 eral under section 605; or

23 “(d) that adequate State funds are not being pro-  
24 vided annually for the direct administration of the State  
25 plan,

1 the Surgeon General may forthwith notify the State agency  
2 that—

3 “(e) no further payments will be made to the State  
4 under this part, or

5 “(f) no further payments will be made from the  
6 allotments of such State from appropriations under any  
7 one or more subparagraphs or paragraphs of section  
8 601, or for any project or projects, designated by the  
9 Surgeon General as being affected by the action or in-  
10 action referred to in paragraph (a), (b), (c), or (d)  
11 of this section,

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

22 “JUDICIAL REVIEW

23 “SEC. 608. (a) If the Surgeon General refuses to ap-  
24 prove any application for a project submitted under section

1 605 or section 610, the State agency through which such  
2 application was submitted, or if any State is dissatisfied with  
3 his action under section 607 such State may appeal to the  
4 United States court of appeals for the circuit in which such  
5 State is located, by filing a petition with such court within  
6 sixty days after such action. A copy of the petition shall be  
7 forthwith transmitted by the clerk of the court to the Surgeon  
8 General, or any officer designated by him for that purpose.  
9 The Surgeon General shall thereupon file in the court the  
10 record of the proceedings on which he based his action, as  
11 provided in section 2112 of title 28, United States Code.  
12 Upon the filing of such petition, the court shall have jurisdic-  
13 tion to affirm the action of the Surgeon General or to set it  
14 aside, in whole or in part, temporarily or permanently, but  
15 until the filing of the record, the Surgeon General may  
16 modify or set aside his order.

17 “(b) The findings of the Surgeon General as to the  
18 facts, if supported by substantial evidence, shall be con-  
19 clusive, but the court, for good cause shown, may remand  
20 the case to the Surgeon General to take further evidence,  
21 and the Surgeon General may thereupon make new or  
22 modified findings of fact and may modify his previous action,  
23 and shall file in the court the record of the further proceed-  
24 ings. Such new or modified findings of fact shall likewise  
25 be conclusive if supported by substantial evidence.

1       “(c) The judgment of the court affirming or setting  
2       aside, in whole or in part, any action of the Surgeon General  
3       shall be final, subject to review by the Supreme Court of the  
4       United States upon certiorari or certification as provided in  
5       section 1254 of title 28, United States Code. The com-  
6       mencement of proceedings under this section shall not, unless  
7       so specifically ordered by the court, operate as a stay of the  
8       Surgeon General’s action.

9

## “RECOVERY

10       “SEC. 609. If any facility with respect to which funds  
11       have been paid under section 606 shall, at any time within  
12       twenty years after the completion of construction—

13               “(a) be sold or transferred to any person, agency,  
14       or organization (1) which is not qualified to file an  
15       application under section 605, or (2) which is not  
16       approved as a transferee by the State agency desig-  
17       nated pursuant to section 604, or its successor, or

18               “(b) cease to be a public health center or a public  
19       or other nonprofit hospital, diagnostic or treatment cen-  
20       ter, facility for long-term care, or rehabilitation facility,  
21       unless the Surgeon General determines, in accordance  
22       with regulations, that there is good cause for releasing  
23       the applicant or other owner from this obligation,  
24       the United States shall be entitled to recover from either the  
25       transferor or the transferee (or, in the case of a facility

1 which has ceased to be public or nonprofit, from the owners  
2 thereof) an amount bearing the same ratio to the then  
3 value (as determined by the agreement of the parties or by  
4 action brought in the district court of the United States for  
5 the district in which the facility is situated) of so much of  
6 the facility as constituted an approved project or projects,  
7 as the amount of the Federal participation bore to the cost  
8 of the construction or modernization under such project or  
9 projects. Such right of recovery shall not constitute a lien  
10 upon said facility prior to judgment.

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

13 "SEC. 610. (a) In order further to assist the States in  
14 carrying out the purposes of this title, the Surgeon General  
15 is authorized to make a loan of funds to the applicant for  
16 any project for construction or modernization which meets  
17 all of the conditions specified for a grant under this part.

18 "(b) Except as provided in this section, an application  
19 for a loan with respect to any project under this part shall be  
20 submitted, and shall be approved by the Surgeon General, in  
21 accordance with the same procedures and subject to the same  
22 limitations and conditions as would be applicable to the mak-  
23 ing of a grant under this part for such project. Any such  
24 application may be approved in any fiscal year only if suffi-

1 cient funds are available from the allotment for the type of  
2 project involved. All loans under this section shall be paid  
3 directly to the applicant.

4       “(c) (1) The amount of a loan under this part shall not  
5 exceed an amount equal to the Federal share of the estimated  
6 cost of construction or modernization under the project.  
7 Where a loan and a grant are made under this part with  
8 respect to the same project, the aggregate amount of such  
9 loan and such grant shall not exceed an amount equal to the  
10 Federal share of the estimated cost of construction or mod-  
11 ernization under the project. Each loan shall bear interest  
12 at the rate arrived at by adding one-quarter of 1 per centum  
13 per annum to the rate which the Secretary of the Treasury  
14 determines to be equal to the current average yield on all  
15 outstanding marketable obligations of the United States as  
16 of the last day of the month preceding the date the applica-  
17 tion for the loan is approved and by adjusting the result so  
18 obtained to the nearest one-eighth of 1 per centum. Each  
19 loan made under this part shall mature not more than forty  
20 years after the date on which such loan is made, except that  
21 nothing in this part shall prohibit the payment of all or part  
22 of the loan at any time prior to the maturity date. In addi-  
23 tion to the terms and conditions provided for, each loan under  
24 this part shall be made subject to such terms, conditions, and

1 covenants relating to repayment of principal, payment of  
2 interest, and other matters as may be agreed upon by the  
3 applicant and the Surgeon General.

4 “(2) The Surgeon General may enter into agreements  
5 modifying any of the terms and conditions of a loan made  
6 under this part whenever he determines such action is neces-  
7 sary to protect the financial interest of the United States.

8 “(3) If, at any time before a loan for a project has been  
9 repaid in full, any of the events specified in clause (a) or  
10 clause (b) of section 609 occurs with respect to such project,  
11 the unpaid balance of the loan shall become immediately due  
12 and payable by the applicant, and any transferee of the fa-  
13 cility shall be liable to the United States for such payment.

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

19 “PART B—GENERAL

20 “FEDERAL HOSPITAL COUNCIL AND ADVISORY COMMITTEES

21 “SEC. 621. (a) In administering this title, the Surgeon  
22 General shall consult with a Federal Hospital Council con-  
23 sisting of the Surgeon General, who shall serve as Chairman  
24 ex officio, and twelve members appointed by the Secretary  
25 of Health, Education, and Welfare. Six of the twelve

1 appointed members shall be persons who are outstanding in  
2 fields pertaining to medical facility and health activities, and  
3 three of these six shall be authorities in matters relating to  
4 the operation of hospitals or other medical facilities, one of  
5 them shall be an authority in matters relating to the mentally  
6 retarded, and one of them shall be an authority in matters  
7 relating to mental health, and the other six members shall  
8 be appointed to represent the consumers of services provided  
9 by such facilities and shall be persons familiar with the need  
10 for such services in urban or rural areas.

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

20 “(c) The Council shall meet as frequently as the Sur-  
21 geon General deems necessary, but not less than once each  
22 year. Upon request by three or more members, it shall be  
23 the duty of the Surgeon General to call a meeting of the  
24 Council.

25 “(d) The Council is authorized to appoint such special

1 advisory or technical committees as may be useful in carry-  
2 ing out its functions.

3       “(e) Appointed Council members and members of ad-  
4 visory or technical committees, while serving on business of  
5 the Council, shall be entitled to receive compensation at rates  
6 fixed by the Secretary of Health, Education, and Welfare,  
7 but not exceeding \$75 per day, including travel time, and,  
8 while so serving away from their places of residence, they  
9 may be allowed travel expenses, including per diem in lieu  
10 of subsistence, as authorized by section 5 of the Administra-  
11 tive Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in  
12 the Government service employed intermittently.

13                       “CONFERENCE OF STATE AGENCIES

14       “SEC. 622. Whenever in his opinion the purposes of this  
15 title would be promoted by a conference, the Surgeon Gen-  
16 eral may invite representatives of as many State agencies,  
17 designated in accordance with section 604, to confer as he  
18 deems necessary or proper. A conference of the representa-  
19 tives of all such State agencies shall be called annually by  
20 the Surgeon General. Upon the application of five or more  
21 of such State agencies, it shall be the duty of the Surgeon  
22 General to call a conference of representatives of all State  
23 agencies joining in the request.

## 1 "STATE CONTROL OF OPERATIONS

2 "SEC. 623. Except as otherwise specifically provided,  
3 nothing in this title shall be construed as conferring on any  
4 Federal officer or employee the right to exercise any super-  
5 vision or control over the administration, personnel, main-  
6 tenance, or operation of any facility with respect to which  
7 any funds have been or may be expended under this title.

8 "STUDIES AND DEMONSTRATIONS RELATING TO COORDI-  
9 NATED USE OF HOSPITAL FACILITIES

10 "SEC. 624. (a) The Surgeon General is authorized to  
11 conduct research, experiments, and demonstrations relating  
12 to the effective development and utilization of services, facili-  
13 ties, and resources of hospitals or other medical facilities and,  
14 after consultation with the Federal Hospital Council, to make  
15 grants-in-aid to States, political subdivisions, universities,  
16 hospitals, and other public and nonprofit private institutions  
17 or organizations for projects for the conduct of research,  
18 experiments, or demonstrations relating to the development,  
19 utilization, and coordination of services, facilities, and re-  
20 sources of hospitals or other medical facilities, agencies, or  
21 institutions, and including the construction of units of hos-  
22 pitals or other medical facilities which involve experimental  
23 architectural designs or functional layout, the efficiency or

1 economy of which can be tested and evaluated, or the demon-  
2 stration thereof, and projects for acquisition of experimental or  
3 demonstration equipment for use in connection with hospitals  
4 or other medical facilities. Any award for any such project  
5 made from an appropriation under this section for any fiscal  
6 year may include such amounts as the Surgeon General de-  
7 termines to be necessary for succeeding fiscal years for com-  
8 pletion of the Federal participation in the project as approved  
9 by the Surgeon General. Payments of any such grant may  
10 be made in advance or by way of reimbursement, and in such  
11 installments, as may be determined by the Surgeon General;  
12 and shall be made on such conditions as the Surgeon General  
13 finds necessary to carry out the purposes of this section. A  
14 grant under this section with respect to any project for con-  
15 struction of a facility or for acquisition of equipment (1) may  
16 not exceed \$500,000, and (2) except where the Surgeon  
17 General determines that unusual circumstances make a larger  
18 percentage necessary in order to effectuate the purposes of  
19 this section, may not exceed 50 per centum of so much of  
20 the cost of such facility or such equipment as the Surgeon  
21 General determines is reasonably attributable to experi-  
22 mental or demonstration purposes. The provisions of clause  
23 (5) of the third sentence of subsection (a) of section 605  
24 and any other provisions of such section which the Surgeon  
25 General deems appropriate shall be applicable, along with

1 such other conditions as the Surgeon General may determine,  
2 to grants under this section for projects for construction or for  
3 acquisition of equipment. There is authorized to be appro-  
4 priated not to exceed \$10,000,000 for any fiscal year to  
5 carry out the provisions of this section.

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

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

12 “(2) the facility shall cease to be used for the pur-  
13 poses for which it was constructed or for the provision  
14 of hospital or other services for which construction proj-  
15 ects may be approved under this title (unless the Sur-  
16 geon General determines, in accordance with regula-  
17 tions, that there is good cause for releasing the applicant  
18 or other owner from the obligation to do so),

19 the United States shall be entitled to recover from the appli-  
20 cant or other owner of the facility an amount bearing the  
21 same ratio to the then value (as determined by agreement of  
22 the parties or by action brought in the United States district  
23 court for the district in which such facility is situated) of the  
24 facility, as the amount of the Federal participation bore to  
25 the cost of construction of such facility. Such right of re-

1 covery shall not constitute a lien on such facility prior to  
2 judgment.

3 "DEFINITIONS

4 "SEC. 625. For the purposes of this title—

5 "(a) The term 'State' includes the Commonwealth of  
6 Puerto Rico, Guam, American Samoa, the Virgin Islands,  
7 and the District of Columbia.

8 "(b) The term 'Federal share' with respect to any  
9 project means the proportion of the cost of construction of  
10 such project to be paid by the Federal Government, deter-  
11 mined as follows:

12 "(1) With respect to projects for which grants are  
13 made from allotments made from appropriations under  
14 paragraph (b) of section 601, the Federal share shall  
15 be whichever of the following the State elects:

16 "(A) the share determined by the State  
17 agency in accordance with standards, included in  
18 the State plan, which provide equitably for varia-  
19 tions between projects on the basis of objective  
20 criteria related to the economic status of areas and,  
21 if the State so elects, such other factor or factors  
22 as may be appropriate and be permitted by regu-  
23 lations, except that such standards may not provide  
24 for a Federal share of more than  $66\frac{2}{3}$  per centum,  
25 or less than  $33\frac{1}{3}$  per centum, or

1           “(B) the amount (not less than  $33\frac{1}{3}$  per  
2           centum and not more than either  $66\frac{2}{3}$  per centum  
3           or the State’s allotment percentage, whichever is  
4           lower) established by the State agency for all proj-  
5           ects in the State;

6           “(2) With respect to projects for which grants are  
7           made from allotments made from appropriations under  
8           paragraph (a) of section 601, the Federal share shall  
9           be whichever of the following the State elects:

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

14           “(B) the amount (not less than  $33\frac{1}{3}$  per  
15           centum and not more than either  $66\frac{2}{3}$  per centum  
16           or the State’s allotment percentage, whichever is  
17           lower) established by the State agency for all proj-  
18           ects in the State, or

19           “(C) 50 per centum of the cost of construc-  
20           tion of the project.

21           The State agency shall, prior to the approval by it, under  
22           the State plan approved under part A, of the first project  
23           in the State during any fiscal year, give written notification  
24           to the Surgeon General of the Federal share which it has  
25           elected pursuant to paragraph (1), and the Federal share

1 which it has elected pursuant to paragraph (2), of this sub-  
2 section for projects in such State to be approved by the  
3 Surgeon General during such fiscal year, and such Federal  
4 share or shares for projects in such State approved by the  
5 Surgeon General during such fiscal year shall not be changed  
6 after approval of such first project by the State.

7 “(c) The term ‘hospital’ includes general, tuberculosis,  
8 and other types of hospitals, and related facilities, such as  
9 laboratories, out-patient departments, nurses’ home and  
10 training facilities, and central service facilities operated in  
11 connection with hospitals, but does not include any hospital  
12 furnishing primarily domiciliary care.

13 “(d) The term ‘public health center’ means a publicly  
14 owned facility for the provision of public health services,  
15 including related publicly owned facilities such as labora-  
16 tories, clinics, and administrative offices operated in con-  
17 nection with such a facility.

18 “(e) The term ‘nonprofit’ as applied to any facility  
19 means a facility which is owned and operated by one or  
20 more nonprofit corporations or associations no part of the  
21 net earnings of which inures, or may lawfully inure, to the  
22 benefit of any private shareholder or individual.

23 “(f) The term ‘diagnostic or treatment center’ means a  
24 facility for the diagnosis or diagnosis and treatment of  
25 ambulatory patients—

1           “(1) which is operated in connection with a hos-  
2           pital, or

3           “(2) in which patient care is under the professional  
4           supervision of persons licensed to practice medicine or  
5           surgery in the State, or, in the case of dental diagnosis  
6           or treatment, under the professional supervision of per-  
7           sons licensed to practice dentistry in the State.

8           “(g) The term ‘rehabilitation facility’ means a facility  
9           which is operated for the primary purpose of assisting in the  
10          rehabilitation of disabled persons through an integrated pro-  
11          gram of—

12           “(1) medical evaluation and services, and

13           “(2) psychological, social, or vocational evaluation  
14          and services,

15          under competent professional supervision, and in the case of  
16          which—

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

19           “(4) either (A) the facility is operated in connec-  
20          tion with a hospital, or (B) all medical and related  
21          health services are prescribed by, or are under the  
22          general direction of, persons licensed to practice medicine  
23          or surgery in the State.

24           “(h) The term ‘facility for long-term care’ means a  
25          facility providing in-patient care for convalescent or chronic

1 disease patients who require skilled nursing care and  
2 related medical services—

3 “(1) which is a hospital (other than a hospital  
4 primarily for the care and treatment of mentally ill or  
5 tuberculous patients) or is operated in connection with  
6 a hospital, or

7 “(2) in which such nursing care and medical serv-  
8 ices are prescribed by, or are performed under the  
9 general direction of, persons licensed to practice medi-  
10 cine or surgery in the State.

11 “(i) The term ‘construction’ includes construction of  
12 new buildings, expansion, remodeling, and alteration of exist-  
13 ing buildings, and initial equipment of any such buildings  
14 (including medical transportation facilities); including  
15 architects’ fees, but excluding the cost of off-site improve-  
16 ments and, except with respect to public health centers,  
17 the cost of the acquisition of land.

18 “(j) The term ‘cost’ as applied to construction or  
19 modernization means the amount found by the Surgeon Gen-  
20 eral to be necessary for construction and modernization  
21 respectively, under a project, except that such term, as  
22 applied to a project for modernization of a facility for which  
23 a grant or loan is to be made from an allotment under  
24 section 602 (a) (2), does not include any amount found by

1 the Surgeon General to be attributable to expansion of the  
2 bed capacity of such facility.

3 “(k) The term ‘modernization’ includes alteration,  
4 major repair (to the extent permitted by regulations), re-  
5 modeling, replacement, and renovation of existing buildings  
6 (including initial equipment thereof), and replacement of  
7 obsolete, built-in (as determined in accordance with regula-  
8 tions) equipment of existing buildings.

9 “(l) The term ‘title’, when used with reference to a  
10 site for a project, means a fee simple, or such other estate or  
11 interest (including a leasehold on which the rental does not  
12 exceed 4 per centum of the value of the land) as the Sur-  
13 geon General finds sufficient to assure for a period of not  
14 less than fifty years’ undisturbed use and possession for the  
15 purposes of construction and operation of the project.”

16 (b) The amendment made by subsection (a) shall be-  
17 come effective upon the date of enactment of this Act, except  
18 that—

19 (1) all applications approved by the Surgeon Gen-  
20 eral under title VI of the Public Health Service Act  
21 prior to such date, and allotments of sums appropriated  
22 prior to such date, shall be governed by the provisions  
23 of such title VI in effect prior to such date;

24 (2) allotment percentages promulgated by the

1 Surgeon General under such title VI during 1962 shall  
2 continue to be effective for purposes of such title as  
3 amended by this Act for the fiscal year ending June 30,  
4 1965;

5 (3) the terms of members of the Federal Hos-  
6 pital Council who are serving on such Council prior to  
7 such date shall expire on the date they would have ex-  
8 pired had this Act not been enacted;

9 (4) the provisions of the fourth sentence of section  
10 636 (a) of the Public Health Service Act, as in effect  
11 prior to the enactment of this Act, shall apply in lieu  
12 of the fourth sentence of section 624 (a) of the Public  
13 Health Service Act, as amended by this Act, in the case  
14 of any project for construction of a facility or for ac-  
15 quisition of equipment with respect to which a grant  
16 for any part thereof or for planning such construction  
17 or equipment was made prior to the enactment of this  
18 Act;

19 (5) no application with respect to a project for  
20 modernization of any facility in any State may be ap-  
21 proved by the Surgeon General, for purposes of receiv-  
22 ing funds from an allotment under section 602 (a) (2)  
23 of the Public Health Service Act, as amended by this  
24 Act, before July 1, 1965, or before such State has had

- 1 a State plan approved by the Surgeon General as meet-
- 2 ing the requirements of section 604 (a) (4) (E) as well
- 3 as the other requirements of section 604 of such Act
- 4 as so amended.

Passed the House of Representatives May 25, 1964.

Attest:

RALPH R. ROBERTS,

*Clerk.*

↑  
COR B/M DASH

88TH CONGRESS  
2D SESSION

# S. 2531

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## IN THE SENATE OF THE UNITED STATES

FEBRUARY 20 (legislative day, FEBRUARY 10), 1964

Mr. HILL introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

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## A BILL

To improve the public health through revising, consolidating, and improving the hospital and other medical facilities provisions of the Public Health Service Act.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*  
3       That this Act may be cited as the "Hospital and Medical  
4       Facilities Amendments of 1964".

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

1 "SPECIAL PROJECT GRANTS FOR ASSISTING IN THE AREA-  
2 WIDE PLANNING OF HEALTH AND RELATED FACILITIES

3 "SEC. 318. (a) There are authorized to be appropriated  
4 \$5,000,000 for the fiscal year ending June 30, 1965, and  
5 \$10,000,000 for each of the next four fiscal years to enable  
6 the Surgeon General to make grants to public or nonprofit  
7 private agencies and organizations to cover part of the costs  
8 of projects for developing (and from time to time revising)  
9 and supervising and assisting in the carrying out of compre-  
10 hensive regional, metropolitan area, or other local area plans  
11 for coordination of existing and planned health facilities,  
12 and facilities related thereto, and services provided by such  
13 facilities.

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

15 " (1) may be made only for a project for which an  
16 application has been approved by the appropriate State  
17 agency or agencies designated in accordance with section  
18 604 (a) (1) ;

19 " (2) may not exceed  $66\frac{2}{3}$  per centum of the cost  
20 of the project with respect to which it is made, except  
21 that the Surgeon General may, during the first three  
22 years of a project, make a grant to an agency or orga-

## 3

1 nization of a larger percentage of the cost of such project  
2 if he determines that such larger percentage is necessary  
3 to effectuate the purposes of this section; and

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

7 SEC. 3. (a) Title VI of the Public Health Service Act  
8 (42 U.S.C., ch. 6A, subch. IV) is amended to read as  
9 follows:

10 “TITLE VI—ASSISTANCE FOR CONSTRUCTION  
11 AND MODERNIZATION OF HOSPITALS AND  
12 OTHER MEDICAL FACILITIES

13 “DECLARATION OF PURPOSE

14 “SEC. 600. The purpose of this title is—

15 “(a) to assist the several States in the carrying  
16 out of their programs for the construction and modern-  
17 ization of such public or other nonprofit community hos-  
18 pitals and other medical facilities as may be necessary,  
19 in conjunction with existing facilities, to furnish ade-  
20 quate hospital, clinic, or similar services to all their  
21 people;

22 “(b) to further assist in the construction and mod-





## 6

1           “(B) the square of its allotment percentage,  
2 bears to the sum of the corresponding products for all of the  
3 States.

4           “(2) The allotment to any State under paragraph (1)  
5 for any fiscal year which is less than—

6           “(A) \$25,000 for the Virgin Islands, American  
7 Samoa, or Guam and \$50,000 for any other State, in the  
8 case of an allotment from appropriations under subpara-  
9 graph (3) of section 601 (a),

10           “(B) \$50,000 for the Virgin Islands, American  
11 Samoa, or Guam and \$100,000 for any other State in  
12 the case of an allotment from appropriations under sub-  
13 paragraph (2) of section 601 (a), or

14           “(C) \$100,000 for the Virgin Islands, American  
15 Samoa, or Guam and \$200,000 for any other State in  
16 the case of an allotment from appropriations under sub-  
17 paragraph (1) of section 601 (a) or under paragraph  
18 (b) of section 601,

19 shall be increased to that amount, the total of the increases  
20 thereby required being derived by proportionately reducing  
21 the allotment from appropriations under such subparagraph  
22 or paragraph to each of the remaining States under paragraph  
23 (1), but with such adjustments as may be necessary to pre-  
24 vent the allotment of any of such remaining States from ap-

## 7

1 appropriations under such subparagraph or paragraph from  
2 being thereby reduced to less than that amount.

3 “(3) An allotment of the Virgin Islands, American  
4 Samoa, or Guam for any fiscal year may be increased as pro-  
5 vided in paragraph (1) only to the extent it satisfies the  
6 Surgeon General, at such time prior to the beginning of such  
7 year as the Surgeon General may designate, that such in-  
8 crease will be used for payments under and in accordance  
9 with the provisions of this part.

10 “(b) At the request of any State that the sum allotted  
11 to it under subsection (a) from appropriations under section  
12 601 (b) be divided into two parts, one part to be available  
13 for grants for the construction of public or other nonprofit  
14 hospitals and public health centers and the other part to be  
15 available for grants for modernization of facilities referred to  
16 in paragraphs (a) and (b) of section 601, the Surgeon  
17 General shall make such division and the parts resulting  
18 therefrom shall, for purposes of this title, be regarded,  
19 respectively, as the State’s allotment for grants for the con-  
20 struction of public or other nonprofit hospitals and public  
21 health centers and the State’s allotment for grants for  
22 modernization of facilities referred to in paragraphs (a) and  
23 (b) of section 601; except that not more than one-third of  
24 the sum allotted to the State under subsection (a) of this

1 section may be made available under this paragraph for such  
2 allotment for grants for modernization of such facilities. In  
3 the case of any State with respect to which such a request is  
4 not made for a fiscal year, the total sum allotted to it under  
5 subsection (a) shall be regarded as its allotment for such  
6 year for grants for the construction of public or other non-  
7 profit hospitals and public health centers.

8 “(c) For the purposes of this part—

9 “(1) The ‘allotment percentage’ for any State shall  
10 be 100 per centum less that percentage which bears the  
11 same ratio to 50 per centum as the per capita income of  
12 such State bears to the per capita income of the United  
13 States, except that (A) the allotment percentage shall  
14 in no case be more than 75 per centum or less than  $33\frac{1}{3}$   
15 per centum, and (B) the allotment percentage for the  
16 Commonwealth of Puerto Rico, Guam, American Samoa,  
17 and the Virgin Islands shall be 75 per centum.

18 “(2) The allotment percentages shall be deter-  
19 mined by the Surgeon General between July 1 and  
20 September 30 of each even-numbered year, on the basis  
21 of the average of the per capita incomes of each of the  
22 States and of the United States for the three most recent  
23 consecutive years for which satisfactory data are avail-  
24 able from the Department of Commerce, and the States  
25 shall be notified promptly thereof. Such determination

1 shall be conclusive for each of the two fiscal years in the  
2 period beginning July 1 next succeeding such determina-  
3 tion.

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

7 “(4) The term ‘United States’ means (but only  
8 for purposes of paragraphs (1) and (2)) the fifty  
9 States and the District of Columbia.

10 “(d) (1) Any sum allotted to a State, other than the  
11 Virgin Islands, American Samoa, and Guam, for a fiscal  
12 year under this section and remaining unobligated at the  
13 end of such year shall remain available to such State, for the  
14 purpose for which made, for the next fiscal year (and for such  
15 year only), in addition to the sums allotted to such State for  
16 such purpose for such next fiscal year.

17 “(2) Any sum allotted to the Virgin Islands, American  
18 Samoa, or Guam for a fiscal year under this section and re-  
19 maining unobligated at the end of such year shall remain  
20 available to it, for the purpose of which made, for the next  
21 two fiscal years (and for such years only), in addition to  
22 the sums allotted to it for such purpose for each of such next  
23 two fiscal years.

24 “(e) (1) Upon the request of any State that a specified

1 portion of any allotment of such State from appropriations  
2 under subparagraph (1) or (2) of section 601 (a) be added  
3 to another allotment of such State from appropriations under  
4 subparagraph (1), (2), or (3) of such section 601 (a),  
5 or under section 601 (b), and upon simultaneous certifica-  
6 tion to the Surgeon General by the State agency in such  
7 State to the effect that it has afforded a reasonable oppor-  
8 tunity to make applications for the portion so specified and  
9 there have been no approvable applications for such portion,  
10 the Surgeon General shall promptly adjust the allotments of  
11 such State in accordance with such request and shall notify  
12 the State agency, and thereafter the allotments as so adjusted  
13 shall be deemed to be the State's allotments from appropria-  
14 tions under such subparagraphs of section 601 (a) or under  
15 section 601 (b).

16       “(2) Upon the request of any State that a specified  
17 portion of its allotment under subsection (b) for grants for  
18 the construction of public or other nonprofit hospitals and  
19 public health centers be transferred to its allotment under  
20 such subsection for grants for modernization of facilities re-  
21 ferred to in paragraphs (a) and (b) of section 601, and  
22 upon simultaneous certification to the Surgeon General by  
23 the State agency in such State to the effect that it has  
24 afforded a reasonable opportunity to make applications for

1 the portion so specified and there have been no approvable  
2 applications for such portion, the Surgeon General shall  
3 promptly adjust the allotments of such State in accordance  
4 with such request and shall notify the State agency, and  
5 thereafter the allotments as so adjusted shall be deemed to  
6 be the State's allotments under such subsection (b).

7 “(f) In accordance with regulations, any State may file  
8 with the Surgeon General a request that a specified portion  
9 of an allotment to it under this part for grants for construc-  
10 tion of any type of facility, or for modernization of facilities,  
11 be added to the corresponding allotment of another State for  
12 the purpose of meeting a portion of the Federal share of the  
13 cost of a project for the construction of a facility of that type  
14 in such other State, or for modernization of a facility in such  
15 other State, as the case may be. If it is found by the  
16 Surgeon General (or, in the case of a rehabilitation facility,  
17 by the Surgeon General and the Secretary) that construction  
18 or modernization of the facility with respect to which the  
19 request is made would meet needs of the State making the  
20 request and that use of the specified portion of such State's  
21 allotment, as requested by it, would assist in carrying out  
22 the purposes of this title, such portion of such State's allot-  
23 ment shall be added to the corresponding allotment of the  
24 other State, to be used for the purpose referred to above.

## 1 "GENERAL REGULATIONS

2 "SEC. 603. The Surgeon General, with the approval of  
3 the Federal Hospital Council and the Secretary of Health,  
4 Education, and Welfare, shall by general regulations pre-  
5 scribe—

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

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

14 "(2) in the case of projects for the construction  
15 of rehabilitation facilities, to facilities operated in  
16 connection with a university teaching hospital which  
17 will provide an integrated program of medical, psy-  
18 chological, social, and vocational evaluation and  
19 services under competent supervision; and

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

23 "(b) general standards of construction and equip-  
24 ment for facilities, of different classes and in different

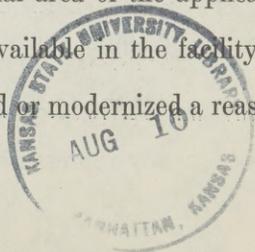
## 13

1 types of location, for which assistance is available under  
2 this part;

3 “(c) criteria for determining needs for general hos-  
4 pital and long-term care beds, and needs for hospitals  
5 and other facilities for which aid under this part is  
6 available, and for developing plans for the distribution  
7 of such beds and facilities.

8 “(d) criteria for determining the extent to which  
9 existing facilities, for which aid under this part is avail-  
10 able, are in need of modernization; and

11 “(e) that the State plan shall provide for adequate  
12 hospitals, and other facilities for which aid under this  
13 part is available, for all persons residing in the State, and  
14 adequate hospitals (and such other facilities) to furnish  
15 needed services for persons unable to pay therefor. Such  
16 regulations may also require that before approval of an  
17 application for a project is recommended by a State  
18 agency to the Surgeon General for approval under this  
19 part, assurance shall be received by the State from the  
20 applicant that (1) the facility or portion thereof to be  
21 constructed or modernized will be made available to all  
22 persons residing in the territorial area of the applicant;  
23 and (2) there will be made available in the facility or  
24 portion thereof to be constructed or modernized a reason-





## 15

1 groups, or State agencies, concerned with rehabilitation,  
2 for consultation with organizations, groups, and State  
3 agencies so concerned;

4 “(4) set forth, in accordance with criteria estab-  
5 lished in regulations prescribed under section 603 and on  
6 the basis of a statewide inventory of existing facilities,  
7 a survey of need, and (except to the extent provided by  
8 or pursuant to such regulations) community, area, or  
9 regional plans,

10 “(A) the number of general hospital beds and  
11 long-term care beds, and the number and types of  
12 hospital facilities and facilities for long-term care,  
13 needed to provide adequate facilities for inpatient  
14 care of people residing in the State, and a plan for  
15 the distribution of such beds and facilities in serv-  
16 ice areas throughout the State;

17 “(B) the public health centers needed to pro-  
18 vide adequate public health services for people  
19 residing in the State, and a plan for the distribution  
20 of such centers throughout the State;

21 “(C) the diagnostic or treatment centers  
22 needed to provide adequate diagnostic or treatment  
23 services to ambulatory patients residing in the State,  
24 and a plan for distribution of such centers through-  
25 out the State;

## 16

1           “(D) the rehabilitation facilities needed to as-  
2           sure adequate rehabilitation services for disabled  
3           persons residing in the State, and a plan for dis-  
4           tribution of such facilities throughout the State;  
5           and

6           “(E) effective January 1, 1965, the extent to  
7           which existing facilities referred to in section 601  
8           (a) or (b) in the State are in need of moderniza-  
9           tion;

10          “(5) set forth a construction and modernization  
11          program conforming to the provisions set forth pursuant  
12          to paragraph (4) and regulations prescribed under sec-  
13          tion 603 and providing for construction or modernization  
14          of the hospital or long-term care facilities, public health  
15          centers, diagnostic or treatment centers, and rehabilita-  
16          tion facilities which are needed, as determined under the  
17          provisions so set forth pursuant to paragraph (4) ;

18          “(6) set forth, with respect to each of such types  
19          of medical facilities, the relative need, determined in  
20          accordance with regulations prescribed under section  
21          603, for projects for facilities of that type, and provide  
22          for the construction or modernization, insofar as financial  
23          resources available therefor and for maintenance and  
24          operation make possible, in the order of such relative  
25          need;

## 17

1           “(7) provide minimum standards (to be fixed in  
2           the discretion of the State) for the maintenance and  
3           operation of facilities providing inpatient care which  
4           receive aid under this part or part B and, effective July  
5           1, 1966, provide for enforcement of such standards with  
6           respect to projects approved by the Surgeon General  
7           under this part after June 30, 1964;

8           “(8) provide such methods of administration of the  
9           State plan, including methods relating to the establish-  
10          ment and maintenance of personnel standards on a merit  
11          basis (except that the Surgeon General shall exercise no  
12          authority with respect to the selection, tenure of office,  
13          or compensation of any individual employed in accord-  
14          ance with such methods), as are found by the Surgeon  
15          General to be necessary for the proper and efficient oper-  
16          ation of the plan;

17          “(9) provide for affording to every applicant for  
18          a construction or modernization project an opportunity  
19          for a hearing before the State agency;

20          “(10) provide that the State agency will make such  
21          reports, in such form and containing such information, as  
22          the Surgeon General may from time to time reasonably  
23          require, and will keep such records and afford such access  
24          thereto as the Surgeon General may find necessary to



## 19

1 one or more of such agencies. Such application shall set  
2 forth—

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

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

6 “(3) reasonable assurance that title to such site is  
7 or will be vested in one or more of the agencies filing  
8 the application or in a public or other nonprofit agency  
9 which is to operate the facility on completion of the  
10 project;

11 “(4) reasonable assurance that adequate financial  
12 support will be available for the completion of the proj-  
13 ect and for its maintenance and operation when com-  
14 pleted;

15 “(5) reasonable assurance that all laborers and  
16 mechanics employed by contractors or subcontractors  
17 in the performance of construction or modernization on  
18 the project will be paid wages at rates not less than  
19 those prevailing on similar work in the locality as deter-  
20 mined by the Secretary of Labor in accordance with the  
21 Davis-Bacon Act, as amended (40 U.S.C. 276a—  
22 276a-5); and the Secretary of Labor shall have with  
23 respect to the labor standards specified in this paragraph  
24 the authority and functions set forth in Reorganization

## 20

1 Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C.  
2 133z-15) and section 2 of the Act of June 13, 1934,  
3 as amended (40 U.S.C. 276c); and

4 “(6) a certification by the State agency of the Fed-  
5 eral share for the project.

6 “(b) The Surgeon General shall approve such applica-  
7 tion if sufficient funds to pay the Federal share of the cost of  
8 such project are available from the appropriate allotment to  
9 the State, and if the Surgeon General finds (1) that the  
10 application contains such reasonable assurance as to title,  
11 financial support, and payment of prevailing rates of wages;  
12 (2) that the plans and specifications are in accord with the  
13 regulations prescribed pursuant to section 603; (3) that the  
14 application is in conformity with the State plan approved  
15 under section 604 and contains an assurance that in the opera-  
16 tion of the project there will be compliance with the appli-  
17 cable requirements of the regulations prescribed under sec-  
18 tion 603 (e), and with State standards for operation and  
19 maintenance; and (4) that the application has been approved  
20 and recommended by the State agency and is entitled to  
21 priority over other projects within the State in accordance  
22 with the regulations prescribed pursuant to section 603 (a).  
23 Notwithstanding the preceding sentence, the Surgeon Gen-  
24 eral may approve such an application for a project for con-  
25 struction or modernization of a rehabilitation facility only if

1 it is also approved by the Secretary of Health, Education,  
2 and Welfare.

3 “(c) No application shall be disapproved until the Sur-  
4 geon General has afforded the State agency an opportunity  
5 for a hearing.

6 “(d) Amendment of any approved application shall be  
7 subject to approval in the same manner as an original appli-  
8 cation.

9 “PAYMENTS FOR CONSTRUCTION OR MODERNIZATION

10 “SEC. 606. (a) Upon certification to the Surgeon Gen-  
11 eral by the State agency, based upon inspection by it, that  
12 work has been performed upon a project, or purchases have  
13 been made, in accordance with the approved plans and  
14 specifications, and that payment of an installment is due  
15 to the applicant, such installment shall be paid to the State,  
16 from the applicable allotment of such State, except that (1)  
17 if the State is not authorized by law to make payments to  
18 the applicant, or if the State so requests, the payment shall  
19 be made directly to the applicant, (2) if the Surgeon Gen-  
20 eral after investigation or otherwise, has reason to believe  
21 that any act (or failure to act) has occurred requiring action  
22 pursuant to section 607, payment may, after he has given  
23 the State agency notice of opportunity for hearing pursuant  
24 to such section, be withheld, in whole or in part, pending  
25 corrective action or action based on such hearing, and (3)

1 the total of payments under this subsection with respect  
2 to such project may not exceed an amount equal to the  
3 Federal share of the cost of construction of such project.

4 “(b) In case an amendment to an approved applica-  
5 tion is approved as provided in section 605 or the estimated  
6 cost of a project is revised upward, any additional payment  
7 with respect thereto may be made from the applicable al-  
8 lotment of the State for the fiscal year in which such amend-  
9 mend or revision is approved.

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

22 “(2) Any amount paid under paragraph (1) to any  
23 State for any fiscal year shall be paid on condition that there  
24 shall be expended from State sources for such year for ad-  
25 ministration of the State plan approved under this part not

1 less than the total amount expended for such purposes from  
2 such sources during the fiscal year ending June 30, 1964.

3 "WITHHOLDING OF PAYMENTS

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

7 "(a) that the State agency is not complying sub-  
8 stantially with the provisions required by section 604  
9 to be included in its State plan; or

10 "(b) that any assurance required to be given in an  
11 application filed under section 605 is not being or cannot  
12 be carried out; or

13 "(c) that there is a substantial failure to carry out  
14 plans and specifications approved by the Surgeon Gen-  
15 eral under section 605; or

16 "(d) that adequate State funds are not being pro-  
17 vided annually for the direct administration of the State  
18 plan,

19 the Surgeon General may forthwith notify the State agency  
20 that—

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

23 "(f) no further payments will be made from the  
24 allotments of such State from appropriations under any  
25 one or more subparagraphs or paragraphs of section

## 24

1       601, or for any project or projects, designated by the  
2       Surgeon General as being affected by the action or in-  
3       action referred to in paragraph (a), (b), (c), or (d)  
4       of this section,

5       as the Surgeon General may determine to be appropriate  
6       under the circumstances; and, except with regard to any  
7       project for which the application has already been approved  
8       and which is not directly affected, further payments may be  
9       withheld, in whole or in part, until there is no longer any  
10      failure to comply (or carry out the assurance or plans and  
11      specifications or provide adequate State funds, as the case  
12      may be) or, if such compliance (or other action) is im-  
13      possible, until the State repays or arranges for the repay-  
14      ment of Federal moneys to which the recipient was not  
15      entitled.

## "JUDICIAL REVIEW

16  
17       "SEC. 608. (a) If the Surgeon General refuses to ap-  
18      prove any application for a project submitted under section  
19      605 or section 610, the State agency through which such ap-  
20      plication was submitted, or if any State is dissatisfied with his  
21      action under section 607 such State, may appeal to the  
22      United States court of appeals for the circuit in which such  
23      State is located, by filing a petition with such court within  
24      sixty days after such action. A copy of the petition shall be

1 forthwith transmitted by the clerk of the court to the Surgeon  
2 General, or any officer designated by him for that purpose.  
3 The Surgeon General shall thereupon file in the court the  
4 record of the proceedings on which he based his action, as  
5 provided in section 2112 of title 28, United States Code.  
6 Upon the filing of such petition, the court shall have juris-  
7 diction to affirm the action of the Surgeon General or to set  
8 it aside, in whole or in part, temporarily or permanently,  
9 but until the filing of the record, the Surgeon General may  
10 modify or set aside his order.

11 “(b) The findings of the Surgeon General as to the facts,  
12 if supported by substantial evidence, shall be conclusive,  
13 but the court, for good cause shown, may remand the case to  
14 the Surgeon General to take further evidence, and the Sur-  
15 geon General may thereupon make new or modified findings  
16 of fact and may modify his previous action, and shall file in  
17 the court the record of the further proceedings. Such new or  
18 modified findings of fact shall likewise be conclusive if sup-  
19 ported by substantial evidence.

20 “(c) The judgment of the court affirming or setting  
21 aside, in whole or in part, any action of the Surgeon General  
22 shall be final, subject to review by the Supreme Court of the  
23 United States upon certiorari or certification as provided in

1 section 1254 of title 28, United States Code. The com-  
2 mencement of proceedings under this section shall not, un-  
3 less so specifically ordered by the court, operate as a stay of  
4 the Surgeon General's action.

5 "RECOVERY

6 "SEC. 609. If any facility with respect to which funds  
7 have been paid under section 606 shall, at any time within  
8 twenty years after the completion of construction—

9 " (a) be sold or transferred to any person, agency,  
10 or organization (1) which is not qualified to file an ap-  
11 plication under section 605, or (2) which is not  
12 approved as a transferee by the State agency designated  
13 pursuant to section 604, or its successor, or

14 " (b) cease to be a public health center or a public  
15 or other nonprofit hospital, diagnostic or treatment  
16 center, facility for long-term care, or rehabilitation  
17 facility, unless the Surgeon General determines, in  
18 accordance with regulations, that there is good cause for  
19 releasing the applicant or other owner from this obli-  
20 gation,

21 the United States shall be entitled to recover from either the  
22 transferor or the transferee (or, in the case of a facility which  
23 has ceased to be public or nonprofit, from the owners there-  
24 of) an amount bearing the same ratio to the then value (as  
25 determined by the agreement of the parties or by action

1 brought in the district court of the United States for the  
2 district in which the facility is situated) of so much of the  
3 facility as constituted an approved project or projects, as the  
4 amount of the Federal participation bore to the cost of the  
5 construction or modernization under such project or projects.  
6 Such right of recovery shall not constitute a lien upon said  
7 facility prior to judgment.

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

10 "SEC. 610. (a) In order further to assist the States in  
11 carrying out the purposes of this title, the Surgeon General is  
12 authorized to make a loan of funds to the applicant for any  
13 project for construction or modernization which meets all of  
14 the conditions specified for a grant under this part.

15 "(b) Except as provided in this section, an application  
16 for a loan with respect to any project under this part shall be  
17 submitted, and shall be approved by the Surgeon General, in  
18 accordance with the same procedures and subject to the same  
19 limitations and conditions as would be applicable to the mak-  
20 ing of a grant under this part for such project. Any such  
21 application may be approved in any fiscal year only if suffi-  
22 cient funds are available from the allotment for the type of  
23 project involved. All loans under this section shall be paid  
24 directly to the applicant.

25 "(c) (1) The amount of a loan under this part shall not

1 exceed an amount equal to the Federal share of the estimated  
2 cost of construction or modernization under this project.  
3 Where a loan and a grant are made under this part with  
4 respect to the same project, the aggregate amount of such  
5 loan and such grant shall not exceed an amount equal to the  
6 Federal share of the estimated cost of construction or modern-  
7 ization under the project. Each loan shall bear interest at  
8 the rate arrived at by adding one-quarter of 1 per centum  
9 per annum to the rate which the Secretary of the Treasury  
10 determines to be equal to the current average yield on all  
11 outstanding marketable obligations of the United States as of  
12 the last day of the month preceding the date the application  
13 for the loan is approved and by adjusting the result so ob-  
14 tained to the nearest one-eighth of 1 per centum. Each loan  
15 made under this part shall mature not more than forty years  
16 after the date on which such loan is made, except that noth-  
17 ing in this part shall prohibit the payment of all or part of  
18 the loan at any time prior to the maturity date. In addition  
19 to the terms and conditions provided for, each loan under  
20 this part shall be made subject to such terms, conditions, and  
21 covenants relating to repayment of principal, payment of  
22 interest, and other matters as may be agreed upon by the  
23 applicant and the Surgeon General.

24       “(2) The Surgeon General may enter into agreements  
25 modifying any of the terms and conditions of a loan made

1 under this part whenever he determines such action is neces-  
2 sary to protect the financial interest of the United States.

3 “(3) If, at any time before a loan for a project has  
4 been repaid in full, any of the events specified in clause (a)  
5 or clause (b) of section 609 occurs with respect to such proj-  
6 ect, the unpaid balance of the loan shall become immedi-  
7 ately due and payable by the applicant, and any transferee of  
8 the facility shall be liable to the United States for such re-  
9 payment.

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

15 “PART B—MORTGAGE INSURANCE FOR CONSTRUCTION  
16 AND MODERNIZATION OF HOSPITALS AND OTHER  
17 MEDICAL FACILITIES

18 “MORTGAGE INSURANCE

19 “SEC. 621. (a) The Surgeon General, on behalf of the  
20 United States, is authorized, upon application made by the  
21 mortgagor and the mortgagee pursuant to this part, to insure  
22 any mortgage (including advances on such mortgage during  
23 construction) against default in the payment of interest on,  
24 and the repayment of the principal of, the obligation secured

1 by the mortgage if the mortgage is for the purpose of financ-  
2 ing the cost of construction or modernization of a private non-  
3 profit hospital or other medical facility referred to in para-  
4 graph (a) or (b) of section 601 or a proprietary nursing  
5 home, and meets the conditions provided in, or prescribed  
6 pursuant to, this part. The Surgeon General, on behalf of  
7 the United States, is also authorized to make commitments,  
8 upon such terms as he may prescribe, for the insuring of such  
9 mortgages prior to the date of their execution or disburse-  
10 ment thereon.

11 “(b) No mortgage shall be insured under this part  
12 unless—

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

18 “(2) the State agency certifies and the Surgeon  
19 General finds that there is a need for the project as  
20 determined in accordance with the provisions required  
21 to be set forth in the State plan under section 604 (a)  
22 (4) ;

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

1           “(4) the mortgagor is approved by the Surgeon  
2           General as responsible and able to repay the obligation  
3           secured by the mortgage, and the mortgagee is ap-  
4           proved by the Surgeon General as responsible and able  
5           to service the mortgage properly;

6           “(5) the principal obligation secured by the mort-  
7           gage (A) has a maturity satisfactory to the Surgeon  
8           General but not to exceed 40 years, and provides for  
9           complete amortization of such principal obligation by  
10          periodic payments within such terms as the Surgeon  
11          General shall prescribe, and (B) bears interest (exclu-  
12          sive of charges made pursuant to section 623 (a) ) at  
13          a rate not to exceed 5 per centum per annum of the  
14          amount of the principal obligation at any time, or not  
15          to exceed such rate (not in excess of 6 per centum per  
16          annum of such amount) as the Surgeon General finds  
17          necessary to meet the mortgage market;

18          “(6) the mortgage contains an undertaking (in  
19          accordance with regulations in force at the time the  
20          mortgage is approved for insurance) to the effect that,  
21          except as authorized by the Surgeon General and the  
22          mortgagee, the property will be used as a hospital or  
23          other medical facility until the mortgage has been paid  
24          in full or the contract of insurance is otherwise termi-  
25          nated; and

1           “(7) the mortgagor and the mortgagee certify (1)  
2           that they will keep such records relating to the mortgage  
3           transaction and indebtedness, to the construction or mod-  
4           ernization of the facility covered by the mortgage, and  
5           to the use of such facility as a hospital or other medical  
6           facility as are prescribed by the Surgeon General at the  
7           time of such certification, (2) that they will make such  
8           reports as may from time to time be required by the  
9           Surgeon General pertaining to such matters, and (3)  
10          that the Surgeon General or any authorized officer or em-  
11          ployee of the Public Health Service or of any agency or  
12          institution employed or utilized by the Surgeon General  
13          for that purpose, shall have access to and the right to  
14          examine and audit such records.

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

19                 “(A) may not exceed 50 per centum of the value  
20                 of the facility (including other property subject to the  
21                 mortgage) after completion of the project, as deter-  
22                 mined by the Surgeon General, and

23                 “(B) may not, when added to the amount of any  
24                 grant or loan approved for such project under part A  
25                 or of any other Federal grant or loan which the mort-

1       gagor has obtained or is assured of obtaining for such  
2       project under any other law of the United States, ex-  
3       ceed 75 per centum of the value of the facility (includ-  
4       ing other property subject to the mortgage) after com-  
5       pletion of the project, as determined by the Surgeon  
6       General.

7       “(2) In the case of a project for construction or mod-  
8       ernization of a proprietary nursing home, the amount of the  
9       principal obligation secured by the mortgage may not ex-  
10      ceed 90 per centum of the value of the facility (including  
11      other property subject to the mortgage) after completion  
12      of the project, as determined by the Surgeon General.

13      “(d) Any contract of insurance executed by the Sur-  
14      geon General under this part shall be conclusive evidence of  
15      the eligibility of the mortgage for insurance, and the validity  
16      of any contract for insurance so executed shall be incontest-  
17      able in the hands of an approved mortgagee from the date of  
18      the execution of such contract, except for fraud or misrepre-  
19      sentation on the part of such approved mortgagee.

20      “(e) The failure of the mortgagor to make any payment  
21      provided for under the terms of a mortgage insured under  
22      this part shall be considered a default under such mortgage.  
23      If such default continues for a period of thirty days, the mort-  
24      gagee shall be entitled to receive the insurance benefits upon

1 conveyance to the Surgeon General of the title to the prop-  
2 erty with respect to which the mortgage was insured and  
3 assignment of all related claims of the mortgagee: *Provided,*  
4 That the mortgagee may, in the event of such default, assign  
5 to the Surgeon General all rights and interests arising under  
6 the mortgage and all related claims and assets, and in such  
7 event the insurance benefits shall be reduced by 1 per centum  
8 of the unpaid amount of the principal obligation. The insur-  
9 ance benefits shall include the sum of the unpaid principal  
10 amount of the loan and the unpaid interest on the loan to  
11 the date of default; and, in addition, shall include interest on  
12 such sum from the date of default to the date of payment of  
13 such benefits, at the rate determined by the Secretary of the  
14 Treasury for the purpose of section 622 (b) for the fiscal year  
15 during which such benefits are paid.

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

22 “(g) The maximum aggregate amount of insurance  
23 liability (contingent or actual) with respect to mortgages  
24 insured under this part and outstanding at any one time shall  
25 not exceed \$250,000,000, increased by annual increments

1 of \$500,000,000 on July 1, 1965, and on July 1 of each  
2 of the next three years. For the purposes of this subsection,  
3 the insurance liability (contingent or actual) with respect to  
4 any mortgage insured under this part shall be deemed to be  
5 the outstanding principal obligation of the mortgage.

6 "FINANCING; MEDICAL FACILITIES MORTGAGE INSURANCE

7 FUND

8 "SEC. 622. (a) (1) There is hereby established a medi-  
9 cal facilities mortgage insurance fund (hereafter in this sub-  
10 section called the 'fund') which shall be available without  
11 fiscal year limitation to the Surgeon General for carrying out  
12 the provisions of this part. In addition to sums transferred  
13 to the fund pursuant to paragraph (2) of this subsection, all  
14 amounts received by the Surgeon General as premium  
15 charges for insurance and as receipts, earnings, or proceeds  
16 derived from any mortgage or claim or from any other  
17 property acquired by the Surgeon General in connection  
18 with his operations under this part, or from the disposal of  
19 such mortgage, claim, or other property, and any other  
20 moneys, property, or assets derived by the Surgeon General  
21 from his operations in connection with this part, shall be  
22 deposited in the fund. All expenses pursuant to operations  
23 under this part, including sums authorized from year to year  
24 in appropriation Acts to be paid from the fund for adminis-  
25 trative expenses under this part, shall be paid from the

1 fund. Moneys in the fund not needed for current operations  
2 under this part may be invested in obligations of the United  
3 States or obligations guaranteed as to principal and interest  
4 by the United States. If at any time the Surgeon General  
5 determines that the capital surplus and reserves of the fund  
6 exceed the present and any reasonably prospective future  
7 requirements of the fund, such excess may be deposited in  
8 the Treasury as miscellaneous receipts.

9 “(2) There are authorized to be appropriated, for  
10 transfer from time to time, at the direction of the Surgeon  
11 General, to the medical facilities mortgage insurance fund,  
12 \$5,000,000 for the fiscal year ending June 30, 1965, and  
13 such sums as may be necessary for each of the next four  
14 fiscal years. Any sums appropriated under this subsection  
15 shall remain available until expended. No contract for in-  
16 surance shall be entered into under this part after June 30,  
17 1969, except pursuant to a commitment to insure issued on  
18 or before that date.

19 “(b) Interest shall accrue to the Treasury on outstand-  
20 ing capital transferred to the medical facilities mortgage  
21 insurance fund from appropriations authorized by subsection  
22 (a) (1) of this section and shall, for each fiscal year, be  
23 determined on the basis of the average daily amount of such  
24 capital outstanding during such year. The rate of such in-  
25 terest shall be determined annually in advance by the Sec-

1 retary of the Treasury taking into consideration the current  
2 average yields to maturity (on the basis of daily closing  
3 market bid quotations during the month of June of the pre-  
4 ceding fiscal year) on outstanding interest-bearing market-  
5 able public debt obligations of the United States having  
6 maturities comparable to loans secured by mortgages insured  
7 under this part. From time to time and at least at the  
8 close of each fiscal year, the Surgeon General shall pay to  
9 the Treasury, as miscellaneous receipts, all accrued interest.

10       “(c) If at any time the moneys in the medical facilities  
11 mortgage insurance fund are insufficient to make payments in  
12 connection with the default of any loan insured under this  
13 part, the Surgeon General is authorized to issue to the Secre-  
14 tary of the Treasury notes or other obligations in such forms  
15 and denominations, bearing such maturities, and subject to  
16 such terms and conditions as may be prescribed by the Sur-  
17 geon General, with the approval of the Secretary of the  
18 Treasury. Such notes or other obligations shall bear interest  
19 at a rate determined by the Secretary of the Treasury, taking  
20 into consideration the current average market yield on out-  
21 standing marketable obligations of the United States of com-  
22 parable maturities during the month preceding the issuance  
23 of such notes or other obligations. The Secretary of the  
24 Treasury is authorized and directed to purchase any notes  
25 and other obligations to be issued hereunder and for such

1 purpose he is authorized to use as a public debt transaction  
2 the proceeds from the sale of any securities issued under the  
3 Second Liberty Bond Act, as amended, and the purposes for  
4 which securities may be issued under such Act, as amended,  
5 are extended to include any purchases of such notes and obli-  
6 gations. The Secretary of the Treasury may at any time sell  
7 any of the notes or other obligations acquired by him under  
8 this subsection. All redemptions, purchases, and sales by  
9 the Secretary of the Treasury of such notes or other obli-  
10 gations shall be treated as public debt transactions of the  
11 United States. Funds borrowed under this subsection shall  
12 be deposited in the medical facilities mortgage insurance fund  
13 and redemption of such notes and obligations shall be made  
14 by the Surgeon General from such fund.

15 "PROVISIONS APPLICABLE TO INSURANCE

16 "SEC. 623. (a) The Surgeon General shall fix premium  
17 charges for the insurance of mortgages under this part at  
18 rates which in his judgment are adequate to cover expenses  
19 and probable losses, but such charges shall not be more than  
20 one-half of 1 per centum per annum of the amount of the  
21 principal obligation of the mortgage outstanding at any time,  
22 without taking into account delinquent payments or prepay-  
23 ments. Such premium charges shall be payable by the  
24 mortgagëe at such times and in such manner as may be pre-  
25 scribed by the Surgeon General.

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

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

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

18           “(3) include in any contract for insurance such  
19 terms, conditions, and covenants relating to repayment  
20 of principal and payment of interest, relating to his  
21 obligations and rights and to those of mortgagees and  
22 mortgagors in case of default, and relating to other mat-  
23 ters as the Surgeon General determines necessary to  
24 assure that the purposes of this part will be achieved,  
25 and any term, condition, and covenant made pursuant

1 to this clause or any other provision of this part may be  
2 modified by the Surgeon General if he determines such  
3 modification is necessary to protect the financial interest  
4 of the United States;

5 “(4) foreclose on any property or commence any  
6 action to protect or enforce any right conferred upon him  
7 by any law, contract, or other agreement, and accept  
8 assignment of, foreclose on, or bid for and purchase at  
9 any foreclosure or any other sale, any real or personal  
10 property (tangible or intangible in connection with  
11 which he has insured a mortgage pursuant to this part;  
12 and, in the event of any such acquisition (and notwith-  
13 standing any other provisions of law relating to the  
14 acquisition, handling, or disposal of real or personal  
15 property by the United States), complete, administer,  
16 remodel and convert, sell, exchange, or otherwise dis-  
17 pose of, lease, and otherwise deal with, such property in  
18 such manner as he deems appropriate to protect the  
19 financial interest of the United States: *Provided*, That no  
20 action shall be taken in connection with any such acquisi-  
21 tion of real property which would deprive any State or  
22 political subdivision thereof of its civil or criminal juris-  
23 diction in and over such property or impair the civil  
24 rights under the State or local laws of the inhabitants on  
25 such property;



1

## "PART C—GENERAL

2

## "FEDERAL HOSPITAL COUNCIL AND ADVISORY

3

## COMMITTEES

4

"SEC. 641. (a) In administering this title, the Surgeon

5

General shall consult with a Federal Hospital Council con-

6

sisting of the Surgeon General, who shall serve as Chairman

7

ex officio, and twelve members appointed by the Secretary

8

of Health, Education, and Welfare. Six of the twelve ap-

9

pointed members shall be persons who are outstanding in

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fields pertaining to medical facility and health activities,

11

and three of these six shall be authorities in matters relating

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to the operation of hospitals or other medical facilities, one

13

of them shall be an authority in matters relating to the

14

mentally retarded, and one of them shall be an authority

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in matters relating to mental health, and the other six mem-

16

bers shall be appointed to represent the consumers of serv-

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ices provided by such facilities and shall be persons familiar

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with the need for such services in urban or rural areas.

19

"(b) Each appointed member shall hold office for a

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term of four years, except that any member appointed to fill

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a vacancy occurring prior to the expiration of the term for

22

which his predecessor was appointed shall be appointed for

23

the remainder of such term. An appointed member shall not

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be eligible to serve continuously for more than two terms

25

(whether beginning before or after enactment of this sec-

1 tion) but shall be eligible for reappointment if he has not  
2 served immediately preceding his reappointment.

3 “(c) The Council shall meet as frequently as the Sur-  
4 geon General deems necessary, but not less than once each  
5 year. Upon request by three or more members, it shall be  
6 the duty of the Surgeon General to call a meeting of the  
7 Council.

8 “(d) The Council is authorized to appoint such special  
9 advisory or technical committees as may be useful in carrying  
10 out its functions.

11 “(e) Appointed Council members and members of ad-  
12 visory or technical committees, while serving on business of  
13 the Council, shall be entitled to receive compensation at rates  
14 fixed by the Secretary of Health, Education, and Welfare,  
15 but not exceeding \$75 per day, including travel time, and,  
16 while so serving away from their places of residence, they  
17 may be allowed travel expenses, including per diem in lieu  
18 of subsistence, as authorized by section 5 of the Administra-  
19 tive Expenses Act of 1946 (5 U.S.C. 73b-2) for persons  
20 in the Government service employed intermittently.

21 “CONFERENCE OF STATE AGENCIES

22 “SEC. 642. Whenever in his opinion the purposes of this  
23 title would be promoted by a conference, the Surgeon Gen-  
24 eral may invite representatives of as many State agencies,  
25 designated in accordance with section 604, to confer as he

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1 deems necessary or proper. A conference of the representa-  
2 tives of all such State agencies shall be called annually by  
3 the Surgeon General. Upon the application of five or more  
4 of such State agencies, it shall be the duty of the Surgeon  
5 General to call a conference of representatives of all State  
6 agencies joining in the request.

## 7 "STATE CONTROL OF OPERATIONS

8 "SEC. 643. Except as otherwise specifically provided,  
9 nothing in this title shall be construed as conferring on any  
10 Federal officer or employee the right to exercise any super-  
11 vision or control over the administration, personnel, main-  
12 tenance, or operation of any facility with respect to which  
13 any funds have been or may be expended under this title.

14 "STUDIES AND DEMONSTRATIONS RELATING TO COORDI-  
15 NATED USE OF HOSPITAL FACILITIES

16 "SEC. 644. (a) The Surgeon General is authorized to  
17 conduct research, experiments, and demonstrations relating  
18 to the effective development and utilization of services, facili-  
19 ties, and resources of hospitals or other medical facilities and,  
20 after consultation with the Federal Hospital Council, to make  
21 grants-in-aid to States, political subdivisions, universities,  
22 hospitals, and other public and nonprofit private institutions  
23 or organizations for projects for the conduct of research, ex-  
24 periments, or demonstrations relating to the development,  
25 utilization, and coordination of services, facilities, and re-

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1 sources of hospitals or other medical facilities, agencies, or in-  
2 stitutions, and including the construction of units of hospitals  
3 or other medical facilities which involve experimental archi-  
4 tectural designs or functional layout, the efficiency or econ-  
5 omy of which can be tested and evaluated, or the demonstra-  
6 tion thereof, and projects for acquisition of experimental or  
7 demonstration equipment for use in connection with hospitals  
8 or other medical facilities. Any award for any such project  
9 made from an appropriation under this section for any fiscal  
10 year may include such amounts as the Surgeon General de-  
11 termines to be necessary for succeeding fiscal years for com-  
12 pletion of the Federal participation in the project as approved  
13 by the Surgeon General. Payments of any such grant may  
14 be made in advance or by way of reimbursement, and in such  
15 installments, as may be determined by the Surgeon General;  
16 and shall be made on such conditions as the Surgeon General  
17 finds necessary to carry out the purposes of this section. A  
18 grant under this section with respect to any project for  
19 construction of a facility or for acquisition of equipment (1)  
20 may not exceed \$500,000 and (2) except where the Surgeon  
21 General determines that unusual circumstances make a larger  
22 percentage necessary in order to effectuate the purposes of  
23 this section, may not exceed 50 per centum of so much of  
24 the cost of such facility or such equipment as the Surgeon  
25 General determines is reasonably attributable to experimental

1 or demonstration purposes. The provisions of clause (5) of  
2 the third sentence of subsection (a) of section 605 and any  
3 other provisions of such section which the Surgeon General  
4 deems appropriate shall be applicable, along with such other  
5 conditions as the Surgeon General may determine, to grants  
6 under this section for projects for construction or for acqui-  
7 tion of equipment. There is authorized to be appropriated not  
8 to exceed \$10,000,000 for any fiscal year to carry out the  
9 provisions of this section.

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

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

16 “(2) the facility shall cease to be used for the pur-  
17 poses for which it was constructed or for the provision  
18 of hospital or other services for which construction proj-  
19 ects may be approved under this title (unless the Sur-  
20 geon General determines, in accordance with regulations,  
21 that there is good cause for releasing the applicant or  
22 other owner from the obligation to do so),

23 the United States shall be entitled to recover from the appli-  
24 cant or other owner of the facility an amount bearing the  
25 same ratio to the then value (as determined by agreement

1 of the parties or by action brought in the United States dis-  
2 trict court for the district in which such facility is situated)  
3 of the facility, as the amount of the Federal participation  
4 bore to the cost of construction of such facility. Such right  
5 of recovery shall not constitute a lien on such facility prior  
6 to judgment.

7 "DEFINITIONS

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

9 "(a) The term 'State' includes the Commonwealth of  
10 Puerto Rico, Guam, American Samoa, the Virgin Islands,  
11 and the District of Columbia.

12 "(b) The term 'Federal share' with respect to any  
13 project means the proportion of the cost of construction of  
14 such project to be paid by the Federal Government, deter-  
15 mined as follows:

16 "(1) With respect to projects for which grants  
17 are made from allotments made from appropriations un-  
18 der paragraph (b) of section 601, the Federal share  
19 shall be whichever of the following the State elects:

20 "(A) the share determined by the State  
21 agency in accordance with standards, included in  
22 the State plan, which provide equitably for varia-  
23 tions between projects on the basis of objective  
24 criteria related to the economic status of areas and,  
25 if the State so elects, such other factor or factors

1 as may be appropriate and be permitted by regula-  
2 tions, except that such standards may not provide  
3 for a Federal share of more than  $66\frac{2}{3}$  per centum,  
4 or less than  $33\frac{1}{3}$  per centum, or

5 “(B) the amount (not less than  $33\frac{1}{3}$  per  
6 centum and not more than either  $66\frac{2}{3}$  per centum  
7 or the State’s allotment percentage, whichever is  
8 lower) established by the State agency for all proj-  
9 ects in the State;

10 “(2) With respect to projects for which grants are  
11 made from allotments made from appropriations under  
12 paragraph (a) of section 601, the Federal share shall be  
13 whichever of the following the State elects:

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

18 “(B) the amount (not less than  $33\frac{1}{3}$  per cen-  
19 tum and not more than either  $66\frac{2}{3}$  per centum or  
20 the State’s allotment percentage, whichever is  
21 lower) established by the State agency for all  
22 projects in the State, or

23 “(C) 50 per centum of the cost of construction  
24 of the project.

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

12 “(c) The term ‘hospital’ includes general, tuberculosis,  
13 and other types of hospitals, and related facilities, such as  
14 laboratories, outpatient departments, nurses’ home and train-  
15 ing facilities, and central service facilities operated in con-  
16 nection with hospitals, but does not include any hospital  
17 furnishing primarily domiciliary care.

18 “(d) The term ‘public health center’ means a publicly  
19 owned facility for the provision of public health services, in-  
20 cluding related publicly owned facilities such as laboratories,  
21 clinics, and administrative offices operated in connection with  
22 such a facility.

23 “(e) The term ‘nonprofit’ as applied to any facility  
24 means a facility which is owned and operated by one or

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1 more nonprofit corporations or associations no part of the  
2 net earnings of which inures, or may lawfully inure, to the  
3 benefit of any private shareholder or individual.

4 “(f) The term ‘proprietary nursing home’ means a  
5 facility which is not nonprofit and which is for the accommo-  
6 dation of convalescents or other persons who are not acutely  
7 ill and not in need of hospital care but who require skilled  
8 nursing care and related medical services, and in which  
9 such nursing care and medical services are prescribed by, or  
10 are performed under the general direction of, persons licensed  
11 to provide such care or services in accordance with the laws  
12 of the State where the facility is located.

13 “(g) The term ‘diagnostic or treatment center’ means  
14 a facility for the diagnosis or diagnosis and treatment of  
15 ambulatory patients—

16 “(1) which is operated in connection with a hos-  
17 pital, or

18 “(2) in which patient care is under the professional  
19 supervision of persons licensed to practice medicine or  
20 surgery in the State, or, in the case of dental diagnosis  
21 or treatment, under the professional supervision of per-  
22 sons licensed to practice dentistry in the State.

23 “(h) The term ‘rehabilitation facility’ means a facility  
24 which is operated for the primary purpose of assisting in the

1 rehabilitation of disabled persons through an integrated pro-  
2 gram of—

3 “(1) medical evaluation and services, and

4 “(2) psychological, social, or vocational evaluation  
5 and services,

6 under competent professional supervision, and in the case of  
7 which—

8 “(3) the major portion of the required evaluation  
9 and services is furnished within the facility, and

10 “(4) either (A) the facility is operated in connec-  
11 tion with a hospital, or (B) all medical and related  
12 health services are prescribed by, or are under the gen-  
13 eral direction of, persons licensed to practice medicine or  
14 surgery in the State.

15 “(i) The term ‘facility for long-term care’ means a  
16 facility providing inpatient care for convalescent or chronic  
17 disease patients who require skilled nursing care and related  
18 medical services—

19 “(1) which is a hospital (other than a hospital  
20 primarily for the care and treatment of mentally ill or  
21 tuberculous patients) or is operated in connection with  
22 a hospital, or

23 “(2) in which such nursing care and medical serv-  
24 ices are prescribed by, or are performed under the gen-

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1 eral direction of, persons licensed to practice medicine or  
2 surgery in the State.

3 “(j) The term ‘construction’ includes construction of new  
4 buildings, expansion, remodeling, and alteration of existing  
5 buildings, and initial equipment of any such buildings (in-  
6 cluding medical transportation facilities); including archi-  
7 tects’ fees, but excluding the cost of off-site improvements and,  
8 except with respect to public health centers, the cost of the  
9 acquisition of land.

10 “(k) The term ‘cost’ as applied to construction or mod-  
11 ernization means the amount found by the Surgeon General  
12 to be necessary for construction and modernization, respec-  
13 tively, under a project, except that such term, as applied to  
14 a project for modernization of a facility for which a grant or  
15 loan is to be made from an allotment under section 602 (b)  
16 for grants for modernization of facilities referred to in para-  
17 graph (a) or (b) of section 601, does not include any  
18 amount found by the Surgeon General to be attributable to  
19 expansion of the bed capacity of such facility.

20 “(l) The term ‘modernization’ includes alteration, major  
21 repair (to the extent permitted by regulations), remodeling,  
22 replacement, and renovation of existing buildings (including  
23 initial equipment thereof) and replacement of obsolete, built-  
24 in (as determined in accordance with regulations) equip-  
25 ment of existing buildings.

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

8       “(n) The term ‘mortgage’ means a first mortgage (1)  
9 on real estate, in fee simple, or (2) on such other estate or  
10 interest (including a leasehold on which the rental does not  
11 exceed 4 per centum of the value of the land) as the Surgeon  
12 General finds sufficient to secure the mortgage debt and  
13 to assure, for a period of not less than fifty years from the  
14 date the mortgage is executed, undisturbed use and posses-  
15 sion for the purposes of construction and operation of the  
16 project. The term ‘first mortgage’ means such classes of  
17 first liens as are commonly given to secure advances (in-  
18 cluding but not limited to advances during construction) on,  
19 or the unpaid purchase price of, real estate, under the laws  
20 of the State in which the real estate is located, together  
21 with the credit instrument or instruments, if any, secured  
22 thereby, and any mortgage may be in the form of one or  
23 more trust mortgages or mortgage indentures or deeds of  
24 trust, securing notes, bonds, or other credit instruments,  
25 and, by the same instrument or by a separate instrument,

1 may create a security interest in initial equipment, whether  
2 or not attached to the realty.

3 “(o) The term ‘mortgagee’ includes the original lender  
4 under a mortgage, and his or its successors and assigns, and  
5 includes the holders of credit instruments issued under a trust  
6 mortgage or deed of trust pursuant to which such holders  
7 act by and through a trustee named therein.

8 “(p) The term ‘mortgagor’ includes the original bor-  
9 rower under a mortgage and its successors and assigns.”

10 (b) The amendment made by subsection (a) shall be-  
11 come effective upon the date of enactment of this Act, except  
12 that—

13 (1) all applications approved by the Surgeon Gen-  
14 eral under title VI of the Public Health Service Act  
15 prior to such date, and allotments of sums appropriated  
16 prior to such date, shall be governed by the provisions  
17 of such title VI in effect prior to such date;

18 (2) allotment percentages promulgated by the  
19 Surgeon General under such title VI during 1962 shall  
20 continue to be effective for purposes of such title as  
21 amended by this Act for the fiscal year ending June 30,  
22 1965;

23 (3) the terms of members of the Federal Hospital  
24 Council who are serving on such Council prior to such

1 date shall expire on the date they would have expired  
2 had this Act not been enacted;

3 (4) no application with respect to a project for  
4 modernization of any facility in any State may be ap-  
5 proved by the Surgeon General, for purposes of receiv-  
6 ing funds from an allotment, under section 602 (b) of  
7 the Public Health Service Act, as amended by this Act,  
8 for grants for modernization of facilities referred to in  
9 paragraphs (a) and (b) of section 601 of such Act (as  
10 so amended) before January 1, 1965, or before such  
11 State has had a State plan approved by the Surgeon  
12 General as meeting the requirements of section 604 (a)  
13 (4) (E) as well as the other requirements of section  
14 604 of such Act as so amended.

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

21 (d) (1) The sixth sentence of paragraph "Seventh"  
22 of section 5136 of the Revised Statutes, as amended (12  
23 U.S.C. 24), is amended by inserting after the words "Federal  
24 home loan banks," the following: "or obligations which are

1 insured by the Surgeon General of the Public Health Service  
2 under title VI of the Public Health Service Act”.

3 (2) The third sentence of the first paragraph of section  
4 24 of the Federal Reserve Act, as amended (12 U.S.C.  
5 371), is amended by inserting after the words “or title V of  
6 the Housing Act of 1949, as amended,” the following: “or  
7 which are insured by the Surgeon General of the Public  
8 Health Service pursuant to title VI of the Public Health  
9 Service Act.”.

10 (c) (1) Section 35(4) of chapter III of the Act en-  
11 titled “An Act to regulate the business of life insurance in  
12 the District of Columbia”, approved June 19, 1934 (48 Stat.  
13 1125), as amended (D.C. Code, 1961 edition, sec. 35-535),  
14 is further amended by inserting after the words “the National  
15 Housing Act, as amended,” the following: “or insured under  
16 the provisions of title VI of the Public Health Service Act.”.

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

1       “(4) Bonds or notes secured by mortgages or deeds of  
2 trust insured by the Federal Housing Administrator, or in-  
3 sured under the provisions of title VI of the Public Health  
4 Service Act, or in debentures issued by the Federal Housing  
5 Administrator: *Provided*, That the restrictions in subpara-  
6 graph (3) of this section in regard to the ratio of the loan  
7 to the value of the property shall not apply to such insured  
8 mortgages or deeds of trust.”

9       (f) Subsection (a) of section 304 of the Trust Inden-  
10 ture Act of 1939 (15 U.S.C. 77ddd) is amended by strik-  
11 ing out the word “or” at the end of subparagraph (8);  
12 by striking out the period at the end of subparagraph (9)  
13 and inserting in lieu thereof a semicolon and the word “or”;  
14 and by adding after subparagraph (9) a new subparagraph  
15 as follows:

16       “(10) any security issued under a mortgage or  
17 trust deed indenture as to which a contract of insurance  
18 under title VI of the Public Health Service Act is in  
19 effect; and any such security shall be deemed to be  
20 exempt from the provisions of the Securities Act of  
21 1933 to the same extent as though such security were  
22 specifically enumerated in section 3 (a) (2), as amended,

1 of the Securities Act of 1933 (15 U.S.C. 77c(a)  
2 (2)).”  
3 (g) Section 263 of chapter X of the Bankruptcy Act  
4 (11 U.S.C. 663) is amended by adding at the end thereof  
5 the following: “Nothing contained in this chapter shall be  
6 deemed to affect or apply to the creditors of any corporation  
7 under a mortgage insured pursuant to title VI of the Public  
8 Health Service Act.”

88TH CONGRESS  
1ST SESSION

# S. 894

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## IN THE SENATE OF THE UNITED STATES

FEBRUARY 21, 1963

Mr. CLARK (for himself, Mr. ENGLE, Mr. HART, Mr. LONG of Missouri, Mr. PELL, Mr. RANDOLPH, and Mr. WILLIAMS of New Jersey) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

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## A BILL

To provide for Federal assistance on a combination grant and loan basis in order to improve patient care in public and other nonprofit hospitals and nursing homes through the modernization or replacement of those institutions which are structurally or functionally obsolete 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 this Act may be cited as the "Hospital Modernization  
4 Act".

5 FINDINGS

6 SEC. 2. (a) The grants for hospital construction author-  
7 ized by title VI of the Public Health Service Act have

1 resulted, through the assistance and stimulation given to the  
2 States and localities, in the construction of many greatly  
3 needed hospitals throughout the Nation. In accordance with  
4 the purpose of that title, federally aided hospital construc-  
5 tion has in the main been construction of new beds in areas  
6 suffering from a total lack or an acute shortage of hospital  
7 facilities. The geographic distribution of hospital beds is now  
8 far better than it was when the Hospital Survey and Con-  
9 struction Act was enacted. Because of the rapid growth  
10 and changing distribution patterns of the population, how-  
11 ever, there continues to be widespread need for construction  
12 of new hospital beds. In recent years, moreover, a further  
13 important need has developed in the growing obsolescence  
14 of many of the hospitals that were already in existence when  
15 the program of new construction was originally projected.  
16 Continued progress toward the declared congressional ob-  
17 jective, the provision of adequate hospital facilities for the  
18 people of the Nation, now requires not only continuing and  
19 rapid addition to the number of hospital beds, but also the  
20 modernization, or where necessary the replacement, of many  
21 existing structures, in order (1) to improve patient care by  
22 increasing the adequacy of services, safety, and efficiency;  
23 (2) to keep the Nation's hospital plant functional in relation  
24 to evolving medical practice; and (3) to adapt the facilities  
25 to new hospital and related medical uses.

## 3

1           (b) There is throughout the country a grave shortage  
2 of nursing homes of high quality, a shortage which becomes  
3 ever more serious with the growth in the number of aged  
4 persons. Through grants for the construction of public and  
5 other nonprofit nursing homes, Congress has taken steps to  
6 increase the number of nursing home beds. But many of the  
7 older institutions are in serious need of modernization or re-  
8 placement.

9           (c) The public and nonprofit institutions which are in  
10 need of modernization or replacement are generally unable  
11 to raise locally the substantial sums required otherwise than  
12 by borrowing, and though able to give adequate assurance of  
13 repayment, many are unwilling to borrow the necessary  
14 funds at commercial interest rates because of the substantial  
15 additional cost which would be imposed on their patients.

16           (d) With respect to new construction of public and  
17 other nonprofit health facilities, it is the policy of the Con-  
18 gress to provide the needed assistance in the form of capital  
19 grants. With respect to modernization or replacement of  
20 obsolete facilities, on the other hand, the established sources  
21 of income of the institutions make practicable and desirable a  
22 Federal program of grant and loan payments. Under such  
23 a program any payment may consist of a grant amounting to  
24 not more than half the cost of such modernization or replace-  
25 ment project, and/or a loan without a grant or to supplement

1 a grant as long as the Federal share does not exceed 80 per  
2 centum of the cost of the project. The establishment of such  
3 a combination grant and loan program, as a corollary to the  
4 program of grants for new construction, is now essential to  
5 the orderly and balanced development of the Nation's health  
6 facilities.

7 AMENDMENT ADDING TITLE VII TO THE PUBLIC HEALTH  
8 SERVICE ACT

9 SEC. 3. The Public Health Service Act (42 U.S.C.  
10 ch. 6A) is hereby amended by adding, immediately after  
11 title VII thereof, the following new title:

12 "TITLE VIII—GRANTS AND LOANS FOR MODERN-  
13 IZATION OR REPLACEMENT OF HOSPITALS  
14 AND NURSING HOMES

15 "DECLARATION OF PURPOSE

16 "SEC. 801. The purpose of this title is to assist, through  
17 payments which consist of grants and/or loans in the mod-  
18 ernization or replacement of public and other nonprofit  
19 hospitals and nursing homes which are necessary to the  
20 provision of adequate hospital and nursing home services  
21 to the people, but which are structurally or functionally  
22 obsolete.

23 "DEFINITIONS

24 "SEC. 802. As used in this title—

25 "(a) The term 'hospital' includes general, mental,

1 chronic disease, and other types of hospitals, and related  
2 facilities, such as laboratories, outpatient departments,  
3 nurses' homes and training facilities, and central service  
4 facilities operated in connection with hospitals, but does not  
5 include any hospital furnishing primarily domiciliary care;

6 “(b) The term ‘nursing home’ means a facility for the  
7 accommodation of convalescents or other persons who are  
8 not acutely ill and not in need of hospital care, but who re-  
9 quire skilled nursing care and related medical services—

10 “(1) which is operated in connection with a hos-  
11 pital; or

12 “(2) in which such nursing care and medical serv-  
13 ices are prescribed by, or are performed under the gen-  
14 eral direction of, persons licensed to practice medicine  
15 or surgery in the State;

16 “(c) The term ‘public’ means owned and operated by a  
17 political subdivision of a State or by an instrumentality of  
18 such a political subdivision, or by a State university or medi-  
19 cal school, or by a State (in the case of general hospitals  
20 only);

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

25 “(e) The term ‘modernization’ means major repair (to

1 the extent permitted in regulations), renovation, or remodel-  
2 ing of an existing structure, and includes equipment incident  
3 thereto, but does not include any expansion of the structure  
4 which increases bed capacity by more than 5 per centum;

5 “(f) The term ‘replacement’ means construction (as  
6 defined in section 631 (h)) of a facility designed primarily  
7 as determined pursuant to regulations prescribed under sec-  
8 tion 806 (4), to serve the same needs as a facility or facili-  
9 ties which have been or will be closed, and does not include  
10 any construction to provide bed capacity of more than 105  
11 per centum of the capacity of such closed facility or facilities;

12 “(g) The term ‘State’ includes Puerto Rico, Guam, the  
13 Virgin Islands, and the District of Columbia;

14 “(h) The term ‘State agency’ means the agency desig-  
15 nated in accordance with section 623 (a) (1);

16 “(i) The terms ‘cost of construction’ and ‘title’ shall  
17 have the meanings, respectively, prescribed in section 631  
18 (i) and (j); and

19 “(j) The term ‘Federal Hospital Council’ means the  
20 Council appointed under section 633 (b).

21 “AUTHORIZATION OF PAYMENTS

22 “SEC. 803. The Surgeon General is authorized to make  
23 grant and/or loan payments for the modernization or replace-  
24 ment of public and other nonprofit hospitals or nursing homes

1 which he finds are necessary for the provision of adequate  
2 hospital or nursing home services to the people of the respec-  
3 tive States, but which are structurally or functionally obso-  
4 lete (as determined in accordance with the regulations). As  
5 requested in the application and as determined by the Sur-  
6 geon General to be necessary to carry out the purpose of this  
7 Act, any such payment may include or consist exclusively  
8 of a grant from funds appropriated pursuant to section 804 in  
9 an amount not to exceed 50 per centum of the cost of con-  
10 struction for such modernization or replacement, and may  
11 include or consist exclusively of a loan from funds obtained  
12 under section 805, amounting to part of such cost or part of  
13 the remaining portion of such cost, but in no event shall a  
14 payment consisting exclusively of a loan, or including a grant  
15 and a loan, exceed in amount 80 per centum of such cost.

16 "AUTHORIZATION OF GRANT FUNDS

17 "SEC. 804. There is authorized to be appropriated for  
18 making grants under the provisions of this title the sum of  
19 \$100,000,000 for the fiscal year beginning July 1, 1964,  
20 and the same sum for each of the three fiscal years there-  
21 after.

22 "AUTHORIZATION OF LOAN FUNDS

23 "SEC. 805. (a) In order to obtain funds for loans under  
24 this title, the Surgeon General may, on or after July 1, 1964,  
25 from time to time issue notes and obligations for purchase by

1 the Secretary of the Treasury. The maximum aggregate  
2 principal amount of such notes and obligations outstanding  
3 at any one time shall not exceed the sum of \$100,000,000.

4       “(b) Notes or other obligations issued by the Surgeon  
5 General under this section shall be in such forms and  
6 denominations, have such maturities, and be subject to such  
7 terms and conditions as may be prescribed by the Surgeon  
8 General, with the approval of the Secretary of the Treasury,  
9 and shall bear interest at a rate determined by the Secretary  
10 of the Treasury which shall be not less than the average  
11 annual interest rate on all interest-bearing obligations of  
12 the United States then forming a part of the public debt as  
13 computed at the end of the fiscal year next preceding the  
14 issuance by the Surgeon General and adjusted to the nearest  
15 one-eighth of 1 per centum. The Secretary of the Treasury  
16 is authorized and directed to purchase any notes and other  
17 obligations of the Surgeon General issued under this section  
18 and for such purpose is authorized to use as a public-debt  
19 transaction the proceeds from the sale of any securities  
20 issued under the Second Liberty Bond Act as amended, and  
21 the purposes for which securities may be issued under such  
22 Act, as amended, are extended to include any purchases of  
23 such notes and other obligations. The Secretary of the  
24 Treasury may at any time sell any of the notes or other

1 obligations acquired by him under this section. All redemp-  
2 tions, purchases, and sales by the Secretary of the Treasury  
3 of such notes or other obligations shall be treated as public-  
4 debt transactions of the United States.

5 “(c) There are hereby authorized to be appropriated  
6 to the Surgeon General such sums as may be necessary,  
7 together with loan principal and interest payments made  
8 under this title, for payments on notes or other obligations  
9 issued by the Surgeon General under this section. Such  
10 principal and interest payments, if not necessary for such  
11 payments on notes or other obligations, shall be available  
12 for loans under this title.

13 “GENERAL REGULATIONS

14 “SEC. 806. The Surgeon General, after consultation  
15 with the Federal Hospital Council and with the approval  
16 of the Secretary, shall by regulation prescribe—

17 “(1) the method of allotting among the States  
18 grant and loan funds made available under this title for  
19 each fiscal year, on the basis of the population of the re-  
20 spective States, as determined on the basis of the latest  
21 figures certified by the Department of Commerce, and  
22 other factors which the Surgeon General finds pertinent  
23 in such manner as to reflect so far as possible the relative

1 need of the States for such funds for modernization and  
2 replacement of public and other nonprofit hospitals and  
3 nursing homes;

4 “(2) subject to the provisions of this title, the terms  
5 and conditions applicable to any funds loaned here-  
6 under;

7 “(3) the general manner in which the State agency  
8 shall determine the priority of projects based on the  
9 relative degree of obsolescence of the various hospitals  
10 and nursing homes within the State which are in need  
11 of modernization or replacement, and the relative parts  
12 which such hospitals and nursing homes play in the pro-  
13 vision of services to the people of the State and such  
14 other factors as the Surgeon General may by regulation  
15 prescribe;

16 “(4) criteria for determining whether a facility  
17 proposed to be constructed is designed primarily to serve  
18 the same needs as a facility or facilities which have been  
19 or will be closed, taking into account the population to  
20 be served and the general character of the services  
21 to be provided;

22 “(5) supplementation for application to replace-  
23 ment projects, and revision for application to moderni-  
24 zation projects, of the regulations relating to standards  
25 for construction and equipment issued under section 622

1 (e), and of the regulations supplementary thereto issued  
2 under section 653 (a) with respect to nursing homes;  
3 and

4 “(6) supplementation and modification, for applica-  
5 tion to projects under this title, of (A) the regulations  
6 relating to nondiscrimination and to services to persons  
7 unable to pay therefor issued under section 622 (f), with  
8 the modification that the exemption relating to separate  
9 facilities stated in clause (1) of such section shall not  
10 apply to projects under this title, (B) the regulations  
11 relating to methods of administration issued under sec-  
12 tion 622 (g), and (C) the regulations supplementary  
13 thereto issued under section 653 (a) with respect to  
14 nursing homes.

15 “STATE PLANS

16 “SEC. 807. (a) Any State desiring to take advantage of  
17 this title may submit, as a revision of or supplement to its  
18 hospital construction plan approved under section 623 (or  
19 such plan as extended to the construction of nursing homes  
20 under section 653), a plan for the modernization and re-  
21 placement of hospitals, or of hospitals and nursing homes,  
22 which meet the conditions stated in section 801. Such plan  
23 must—

24 “(1) meet the requirements of section 623 (a)  
25 other than paragraphs (4), (5), and (10) thereof (re-

1       lating to the State hospital construction program,  
2       priorities of construction, and periodic review and modi-  
3       fication of the construction program) ; and if the plan  
4       includes nursing homes, meet the requirements of section  
5       653 (a) (2) (relating to the conformity of the State  
6       nursing home construction program with regulations of  
7       the Surgeon General) ;

8               “(2) set forth a program of modernization and re-  
9       placement of hospitals, or of hospitals and nursing  
10      homes, which (A) is based on a statewide survey of  
11      need and takes into consideration any areawide program  
12      developed in an area within (or partly within) the State  
13      and approved by the State agency, and (B) meets the  
14      requirements as to lack of discrimination on account of  
15      race, creed, or color, and for furnishing needed hospital  
16      services to persons unable to pay therefor, prescribed by  
17      regulations issued under section 622 (f) as supplemented  
18      and modified for the purposes of this title as provided in  
19      section 806 (6) above ;

20              “(3) set forth, with respect to hospitals or with  
21      respect to hospitals and nursing homes, the relative need  
22      determined in accordance with regulations issued under  
23      section 806 (3) , for the several projects included in such  
24      program, and provide for carrying them out, insofar as

1 the financial resources available therefor make possible,  
2 in the order of such relative need; and

3 “(4) provide that the State agency will from time  
4 to time, and in any event whenever an areawide pro-  
5 gram referred to in clause (2) has been developed and  
6 approved by the State agency, review its program and  
7 submit to the Surgeon General any modifications thereof  
8 which it considers necessary.

9 “(b) The Surgeon General shall approve any State plan  
10 and any modification thereof which complies with the pro-  
11 visions of subsection (a).

12 “ALLOTMENTS TO STATES OF GRANT AND LOAN FUNDS

13 “SEC. 808. Each State shall be entitled for each fiscal  
14 year for which funds are authorized under this title to an  
15 allotment, determined in accordance with regulations issued  
16 under section 806 (1), from the amounts made available for  
17 that fiscal year pursuant to section 804 and section 805.  
18 The Surgeon General shall notify each State agency, as  
19 promptly as possible after funds for a fiscal year are made  
20 available under each such section, of the amount of the  
21 State's allotment of the funds provided pursuant to such  
22 section, but no payment shall be made out of the allotment  
23 of a State until a State plan under section 807 (a) has been

1 submitted by such State and approved by the Surgeon Gen-  
2 eral. Sums allotted to a State under this title for a fiscal  
3 year and remaining unobligated at the end of such year  
4 shall remain available to such State for the same purposes  
5 for the next fiscal year (and for such year only), in addition  
6 to the sums allotted for such State for such next fiscal year.

7 "APPLICATIONS FOR AND APPROVAL OF PAYMENTS

8 "SEC. 809. (a) An application for a payment under  
9 this title shall be submitted, by a public or other nonprofit  
10 agency, to the Surgeon General through the State agency.  
11 If two or more public or other nonprofit agencies join in the  
12 project, the application may be filed by one or more of  
13 such agencies.

14 "(b) The application shall set forth (1) a description  
15 of the project, including a description of the site of the proj-  
16 ect; (2) plans and specifications for the project which are in  
17 accord with regulations as revised and supplemented under  
18 section 806 (5); (3) reasonable assurance that title to the  
19 site of the project, and to any structure thereon, is or will  
20 be vested in one or more of the agencies filing the applica-  
21 tion, or in a public or other nonprofit agency which is to  
22 operate the hospital or nursing home; (4) the amount, if  
23 any, requested as a loan under the provisions of this title;  
24 (5) reasonable assurance that any financial support needed,  
25 in addition to that furnished under the provisions of this

## 15

1 title, will be available for carrying out the project, and  
2 that adequate financial support will be available for mainte-  
3 nance and operation when completed, and for payment of  
4 interest and repayment of principal of any funds loaned, in  
5 accordance with the terms of the loan; (6) reasonable  
6 assurance that the operation will be in compliance with  
7 applicable State standards for operation and maintenance,  
8 and with regulations as supplemented and modified under  
9 section 806 (6) relating to nondiscrimination and to services  
10 to persons unable to pay; (7) the estimated cost of the  
11 project; (8) assurance that no grant has been made for the  
12 same project under title VI, and that no application for such  
13 grant is pending; (9) if the project is one for replacement,  
14 satisfactory evidence, in accordance with regulations issued  
15 under section 806 (4), that the facility to be constructed is  
16 designed primarily to serve the same needs as a facility or  
17 facilities which have been or will be closed; and (10)  
18 adequate assurance that all laborers and mechanics employed  
19 by contractors or subcontractors in the performance of work  
20 on construction assisted by such payment will be paid wages  
21 at rates not less than those prevailing on similar construction  
22 in the locality as determined by the Secretary of Labor in  
23 accordance with the Davis-Bacon Act, as amended (40  
24 U.S.C. 276a—276a-5), and will receive compensation at a  
25 rate not less than one and one-half times the basic rate of

1 pay for all hours worked in any workweek in excess of  
2 eight hours in any workday or forty hours in the workweek,  
3 as the case may be. The Secretary of Labor shall have, with  
4 respect to the labor standards specified in paragraph (10)  
5 of this subsection, the authority and functions set forth in  
6 Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176;  
7 64 Stat. 1267), and section 2 of the Act of June 13, 1934,  
8 as amended (40 U.S.C. 276c).

9 “(c) Each such application shall be accompanied by  
10 (1) a recommendation by the State agency of approval of  
11 the project, based on findings that the project meets the  
12 requirements of subsection (b) and that the estimated cost  
13 of construction is reasonable; and (2) a certification by the  
14 State agency that the application is in accordance with the  
15 State plan approved under section 807 (b), that funds for  
16 the project are available from the State’s allotments under  
17 this title, and that the project is entitled to priority over  
18 other projects within the State in accordance with regulations  
19 issued under section 806 (3).

20 “(d) The Surgeon General shall approve such applica-  
21 tion if sufficient funds to pay the Federal share of the cost  
22 of the project are available from the allotment to the State,  
23 and if the Surgeon General (A) finds that the application  
24 contains reasonable assurance as to title, financial support,  
25 and payment of prevailing rates of wages; (B) finds that the

1 application is in conformity with the State plan approved  
2 under section 807 of this title and contains an assurance that  
3 in the operation of the hospital or nursing home there will  
4 be compliance with the applicable requirements of the State  
5 plan and of the regulations prescribed under section 806 (6)  
6 of this title; and (C) concurs in the findings and certification  
7 by the State agency under subsection (c). No application  
8 shall be disapproved because of disagreement with the find-  
9 ings or certification of the State agency until the Surgeon  
10 General has afforded the State agency an opportunity for  
11 a hearing.

12 “(e) Amendment of any approved application shall be  
13 subject to approval in the same manner as an original appli-  
14 cation.

#### 15 “PAYMENTS

16 “SEC. 810. (a) Whenever an application has been ap-  
17 proved under section 809 (d), the Surgeon General is au-  
18 thorized to make a payment to the applicant in accordance  
19 with the provisions of this title. Any loan or portion of such  
20 payment which is a loan shall (1) bear interest at a rate  
21 not less than the rate arrived at by adding one-quarter of 1  
22 per centum per annum to the rate which the Secretary of the  
23 Treasury determines to be equal to the average annual inter-  
24 est rate on all interest-bearing obligations of the United  
25 States then forming a part of the public debt as computed at

1 the end of the fiscal year next preceding the date the applica-  
2 tion for the loan is approved and by adjusting the result so  
3 obtained to the nearest one-eighth of 1 per centum, and (2)  
4 subject to the provisions of regulations issued under section  
5 806 (2), shall be secured in such manner (if any) and repaid  
6 in such installments and within such period, not exceeding  
7 forty years, as the Surgeon General may determine. Subject  
8 to the provisions of this subsection and of such regulations,  
9 the amount or terms of a loan may be modified upon approval  
10 of an amendment of an application.

11 “(b) A grant or portion of a payment which is a grant  
12 under this title shall be made to the applicant in installments,  
13 each of which shall be paid upon certification by the State  
14 agency, based upon inspection by it, that work has been per-  
15 formed upon the project, or purchases have been made, in  
16 accordance with the approved plans and specifications, and  
17 that an installment is due. A loan or portion of a payment  
18 which is a loan under this title shall be made to the applicant  
19 in such installments or in lump sum and in advance or other-  
20 wise as the Surgeon General may prescribe by regulations.  
21 If the Surgeon General, after investigation or otherwise, has  
22 ground to believe that a default has occurred requiring action  
23 pursuant to section 811 (a) he may, upon giving notice of  
24 hearing pursuant to such subsection, withhold further ad-  
25 vances pending action based on such hearing.

1       “(c) If, at any time before any loan or loan portion of  
2 a payment for a project has been repaid in full, any of the  
3 events specified in clause (A) or clause (B) of section 625  
4 (e) shall occur with respect to such project, the unpaid  
5 balance of the loan shall become immediately due and pay-  
6 able by the applicant, and any transferee of the facility shall  
7 be liable to the United States for such repayment to the same  
8 extent as the borrower. The provisions of section 625 (e),  
9 relating to recovery of expenditures under certain conditions,  
10 shall apply in the case of any grant payment made under this  
11 title.

12                                   “WITHHOLDING OF FUNDS

13       “SEC. 811. (a) Whenever the Surgeon General, after  
14 reasonable notice and opportunity for hearing to the State  
15 agency designated in accordance with section 623 (a) (1),  
16 finds (1) that the State agency is not complying substan-  
17 tially with the provisions required by section 807 (a) to be  
18 contained in its plan, or (2) that any funds have been di-  
19 verted from the purposes for which they were advanced, or  
20 (3) that any assurance given in an application filed under  
21 section 809 is not being or cannot be carried out, or (4)  
22 that there is a substantial failure to carry out plans and  
23 specifications approved by the Surgeon General under sec-  
24 tion 809, or (5) that adequate State funds are not being  
25 provided annually for the direct administration of the State

1 plan, the Surgeon General may withhold further advances  
2 from all projects in the State, or from any project or proj-  
3 ects affected by the default as he may determine to be ap-  
4 propriate under the circumstances, until the default has  
5 been corrected; and if it is not corrected he shall reduce, by  
6 the proper amount, the Federal share of the cost of the proj-  
7 ect affected by the withholding.

8 “(b) The provisions of section 632 (b), relating to ju-  
9 dicial review of action by the Surgeon General under section  
10 632 (a), shall be applicable to action by him under sub-  
11 section (a) of this section.

12 “ADMINISTRATION; GENERAL PROVISIONS

13 “SEC. 812. (a) In administering this title the Surgeon  
14 General shall consult with the Federal Hospital Council.  
15 He is authorized to make such administrative regulations and  
16 perform such other functions as he finds necessary to carry  
17 out the provisions of this title. Any such regulations shall  
18 be subject to the approval of the Secretary.

19 “(b) In the performance of, and with respect to, the  
20 functions, powers, and duties vested in him by this title, the  
21 Surgeon General notwithstanding the provisions of any other  
22 law, shall maintain an integral set of accounts which shall  
23 be audited annually by the General Accounting Office in  
24 accordance with the principles and procedures applicable  
25 to commercial transactions as provided by the Government

1 Corporation Control Act, as amended, and no other audit  
2 shall be required: *Provided*, That such financial transactions  
3 of the Surgeon General as the making of loans and vouchers  
4 approved by the Surgeon General in connection with such  
5 financial transactions shall be final and conclusive upon all  
6 officers of the Government.

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

11 “(1) sue and be sued;

12 “(2) foreclose on any property or commence any  
13 action to protect or enforce any right conferred upon  
14 him by any law, contract, or other agreement, and bid  
15 for and purchase at any foreclosure or any other sale  
16 any property in connection with which he has made a  
17 payment pursuant to this title, and in the event of any  
18 such acquisition, the Surgeon General may, notwith-  
19 standing any other provision of law relating to the  
20 acquisition, handling, or disposal of real property by the  
21 United States, complete, administer, remodel and con-  
22 vert, dispose of, lease and otherwise deal with, such  
23 property: *Provided*, That any such acquisition of real  
24 property shall not deprive any State or political sub-  
25 division thereof of its civil or criminal jurisdiction in and

1 over such property or impair the civil rights under the  
2 State or local laws of the inhabitants on such property;

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

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

10 “(5) obtain insurance against loss in connection  
11 with property and other assets held;

12 “(6) subject to the specific limitations in this title,  
13 consent to the modification, with respect to the time  
14 of payment of any installment of principal or interest,  
15 security, or any other term of any loan under this title,  
16 of any contract or agreement to which he is a party or  
17 which has been transferred to him pursuant to this  
18 title; and

19 “(7) include in any contract or instrument made  
20 pursuant to this title such other covenants, conditions,  
21 or provisions as he may deem necessary to assure that  
22 the purposes of this title will be achieved.

23 “(d) Section 3709 of the Revised Statutes shall not  
24 apply to any contract for services or supplies on account of

1 any property acquired pursuant to this title if the amount  
2 of such contract does not exceed \$1,000.

3 “(e) In administering this title, the Surgeon General,  
4 with the approval of the Secretary, is authorized to utilize  
5 the services and facilities of any executive department or  
6 agency in accordance with an agreement with the head  
7 thereof. Payment for such services and facilities shall be  
8 made in advance or by way of reimbursement, as may be  
9 agreed upon between the Secretary and the head of the  
10 department or agency furnishing them.

11 “(f) Except as otherwise specifically provided, nothing  
12 in this title shall be construed as conferring on any Federal  
13 officer or employee the right to exercise any supervision or  
14 control over the administration, personnel, maintenance, or  
15 operation of any hospital or nursing home with respect to  
16 which any funds have been or may be expended under this  
17 title.

18 “ASSISTANCE IN AREA PLANNING

19 “SEC. 813. (a) In order to carry out more effectively  
20 his duties under the Public Health Service Act, the Surgeon  
21 General may make grants-in-aid on such terms and conditions  
22 and in such installments, and in advance or otherwise as he  
23 may determine, to States, political subdivisions, universities,  
24 hospitals, and other public and private nonprofit institutions

1 or organizations, to assist in developing and publicizing com-  
2 prehensive regional, metropolitan, or local area plans for  
3 coordination of hospitals, nursing homes, and other health  
4 facilities, provided that such grants may be made only for  
5 the development of plans specifically certified to be needed  
6 by a State agency or agencies.

7 “(b) There is authorized to be appropriated for the  
8 purpose of this section the sum of \$5,000,000 for the fiscal  
9 year beginning July 1, 1963, and the same sum for each  
10 of the three fiscal years thereafter.”

11 TECHNICAL AMENDMENTS

12 SEC. 4. (a) Section 1 of the Public Health Service Act  
13 is amended to read:

14 “SEC. 1. Titles I to VIII, inclusive, of this Act may be  
15 cited as the ‘Public Health Service Act.’”

16 (b) Section 625 (a) of such Act (42 U.S.C. 291h (a) )  
17 is amended by inserting at the end thereof: “No application  
18 shall be approved for the same project for which a payment  
19 has been made under title VIII, or for which an application  
20 for such a payment is pending.”

21 (c) Section 632 (b) (3) of such Act (42 U.S.C.  
22 291j(b) (3) ) is amended by striking out “sections 239 and  
23 240 of the Judicial Code, as amended” and inserting in lieu  
24 thereof: “section 1254 of title 28, United States Code”.

25 (d) The Act of July 1, 1944 (58 Stat. 682), as

1 amended, is further amended by renumbering title VIII (as  
 2 in effect prior to the enactment of this Act) as title IX, and  
 3 by renumbering sections 801 through 814 (as in effect prior  
 4 to the enactment of this Act), and references thereto, as  
 5 sections 901 through 914.

STATEMENT OF HON. JOSEPH S. CLARK, U.S. SENATOR FROM THE  
 STATE OF PENNSYLVANIA

Senator Clark. Thank you, Mr. Chairman. I apologize to the  
 General for displacing him.  
 Surgeon General Tarry. It is perfectly all right, Senator.  
 Senator Clark. I have another committee meeting going on up  
 stairs at which I must be present, and I shall be quite brief, Mr.  
 Chairman. I appreciate your courtesy.  
 The Chairman. You just go ahead, Senator. We are glad to have  
 you here, sir.  
 Senator Clark. Thank you, sir.  
 I have a prepared statement which I would like, with your per-  
 mission, to have printed in full in the record.  
 The Chairman. We will print that in full in the record, just as if  
 you had read it.

The CHAIRMAN. H.R. 10041 would extend the hospital and medical facilities construction program for 5 years and authorize appropriations for the construction of hospitals and public health centers and the modernization of health facilities ranging from \$150 million for fiscal year 1965 through \$180 million annually for the last 2 years of the program. Of these amounts, \$20 million is specifically earmarked for modernization in fiscal year 1966, \$35 million in 1967, \$50 million in 1968, and \$55 million in 1969. Additional funds can be made available for modernization since provision is made for the transfer of funds from new hospital construction into modernization if such transfer would better carry out the purposes of the title.

Furthermore, H.R. 10041 authorizes the States to transfer sums from the modernization category to the category for the new construction of hospitals, in amounts which, when added to other funds appropriated for new construction, will not exceed in the aggregate \$150 million for new construction in any fiscal year.

H.R. 10041 consolidates nursing home and chronic disease categories and increases the combined authorization by \$30 million (to \$70 million) in fiscal 1965. The existing authorizations for \$20 million annually for the diagnostic and treatment centers and \$10 million for rehabilitation facilities are continued for 5 years with no change in amounts.

H.R. 10041 adds grants for areawide health facility planning in metropolitan and other areas (\$2.5 million in fiscal 1965 and \$5 million in each of the next 4 years, with 50-50 Federal-State matching).

Finally, H.R. 10041 permits States to use 2 percent of their allotments (not to exceed \$50,000 a year) for State administration of the construction program, on a 50-50 matching basis.

We are happy to have with us this morning the Surgeon General of the U.S. Public Health Service, General Luther Terry.

General Terry, would you come up, please, sir.

General, we are very glad to have you and your assistants here with us and you may proceed in your own way.

First, however, we find that Senator Clark has a short statement that he would like to make.

Senator Clark, you can sit right here.

#### STATEMENT OF HON. JOSEPH S. CLARK, U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator CLARK. Thank you, Mr. Chairman. I apologize to the General for displacing him.

Surgeon General TERRY. It is perfectly all right, Senator.

Senator CLARK. I have another committee meeting going on upstairs at which I must be present, and I shall be quite brief, Mr. Chairman. I appreciate your courtesy.

The CHAIRMAN. You just go ahead, Senator. We are glad to have you here, sir.

Senator CLARK. Thank you, sir.

I have a prepared statement which I would like, with your permission, to have printed in full in the record.

The CHAIRMAN. We will print that in full in the record, just as if you had read it.

Senator CLARK. Thank you, sir.

My purpose in appearing before the subcommittee this morning is to urge serious consideration of S. 894, introduced in the Senate on February 21, 1963, on behalf of Senators Engle, Hart, Long of Missouri, Pell, Randolph, Williams of New Jersey, and myself.

This bill would provide a very substantial fund in the form of both grants and loans for hospital modernization. As I am sure the Chair will appreciate, the problem of adequate hospital care and a sufficient number of hospital beds in some of the older areas of the country in terms of health facilities is very great. There is a great need to modernize the existing facilities and to build new hospitals under the Hill-Burton Act.

This is not to say that we in Pennsylvania are not grateful for the fine work which the Chairman initiated when the Hill-Burton Act was first passed, and which continues right down to today. We have taken advantage in Pennsylvania of the Hill-Burton Act to a very substantial extent. But particularly in areas such as Philadelphia, Scranton, Wilkes-Barre, and Pittsburgh we need modernization.

As I pointed out in my prepared statement, we are very unhappy in Pennsylvania, not only with the current status of modernization, but with—if I may be so bold as to say so—the approach of the chairman to the modernization problem and with the inadequacies of the administration bill. We would hope that the subcommittee, as I say, would give careful attention to the somewhat more expansive provisions for modernization which are contained in S. 894.

I should also indicate that we were very unhappy indeed with the bill passed by the House. One of the things which disturbs us is that with the present gerrymandered condition of State legislatures all over the country, which cannot and will not be remedied under recent Supreme Court decisions for some time to come, the overpowering power of rural legislatures makes it very difficult indeed to get for urban areas and even suburban areas the modernization funds which are essential to upgrade and modernize the fine old but obsolescent hospitals in our great metropolitan areas.

I would urge the subcommittee to bring out in its report the major provisions for loans and grants contained in S. 894. I am realistic enough to appreciate that this plea is unlikely to be granted in full. But I hope it will be granted at least in part.

I would further urge that there should be a guaranteed minimum for the amount of hospital modernization which grant money would provide, so that the States cannot cut down on this guaranteed minimum nor build a lot of new fancy hospitals in rural areas when the real need for beds and hospital services is in the great metropolitan areas.

I would also hope that the committee would assure a substantial amount of funds for modernization in fiscal year 1965. The need would require, as I said in my prepared statement, somewhere in the neighborhood of \$3 to \$4 billion countrywide, and the situation has been getting worse every year. It is much later than we think. The program is long overdue, and I would hope that the modernization aspects of the bill, which we hope will clear the Congress this year, would be made effective immediately and not put off.

The basic statistics, Mr. Chairman, I will not take the time to reiterate here. They are contained in my prepared statement and in S. 894.

I thank the chairman for the courtesy of hearing me here this morning, and hope that the cause of the older urban communities in this country, which need so desperately adequate funds for hospital modernization, will receive a sympathetic hearing, as I have no doubt they will.

The CHAIRMAN. Thank you, Senator. We were very happy to have you here this morning, and thank you for your statement. You may be assured we will consider this full statement very carefully. It will be inserted in the record at this point.

(The prepared statement of Senator Clark follows:)

PREPARED STATEMENT OF SENATOR CLARK

Mr. Chairman, thanks to the foresight of you and the members of this subcommittee, the Hill-Burton program which you fathered has resulted in the construction of many greatly needed hospitals over the last 18 years. And those hospitals have been built in those areas where hospital shortages were most acute. As a result of this most successful program, it is estimated that we now have 83 percent of the general hospital beds we need, in comparison with only 59 percent of the need in 1948.

But while the number of new hospital beds have been steadily increasing, thanks to the Hill-Burton program, obsolescence in many of our older hospital facilities has become chronic. While new beds are being added, our older facilities are going rapidly downhill.

I regret to say that this has occurred largely in our urban areas where most of the great hospital centers are 35 to 65 years old, or even older, as in my own home city of Philadelphia. There are, of course, a good many rural areas where this has been a problem, too.

But as a result of our failure to keep pace with obsolescence, the need to modernize our hospitals now bears a staggering price tag and an impelling urgency. A survey by the Public Health Service, in 1960, estimated the modernization needs at \$3.6 billion. In the 4 years since then, there is every reason to believe that the situation has further deteriorated.

With this growing problem in mind, I, last year, introduced legislation on behalf of Senators Engle, Hart, Long (of Missouri), Pell, Randolph, and Williams (of New Jersey), which is a corollary to the Hill-Burton program and provides for a Federal grant-and-loan program that would help the hospitals, nonprofit nursing homes, and other public and nonprofit institutions of the country modernize in order to keep their plants functional in relation to evolving medical practices and improve patient care by increasing the adequacy of services, safety, and efficiency.

Under my bill, a qualifying institution may receive a Federal grant of up to 50 percent of the cost of a modernization or replacement project and/or a loan at going interest rates on Federal interest-bearing obligations so long as the total Federal contribution does not total more than 80 percent of the cost of the project.

The bill allows a total of \$400 million in grants and a ceiling of \$100 million in loans over the 4 years of the bill's life.

Frankly, Mr. Chairman, I view my bill quite modest in the face of the problem which confronts us.

As you know, the administration proposed a somewhat smaller program as a part of the amendments to the Hill-Burton Act. The administration proposal would, over a 5-year period, provide \$340 million in grants for modernization. This figure I view as minimal. However, the House Interstate and Foreign Commerce Committee has reduced this program drastically in H.R. 10041, which this committee is considering today. The total appropriations earmarked for modernization are but \$160 million for 5 years. There are no modernization appropriations authorized at all during the first year of the program. And in addition, nearly half of the funds earmarked for modernization can, at State option, be diverted into new construction. As a result, the amounts that the bill in its present form guarantees for use in bringing our medical facilities

up to date are as follows: Fiscal 1965, nothing; 1966, \$10 million; 1967, \$20 million; 1968-69, \$30 million. These are but token amounts and, I believe, most ill advised in relation to the demonstrated need. The Department of Health, Education, and Welfare said, in its letter supporting the original administration proposal: "\* \* \* the new modernization program represents the highest priority item included in this draft bill." The response of the Congress to the health needs of great masses of our people must be more than token on this score.

It is true that the bill as written is, in theory, flexible, in that funds allocated for construction can, at the option of the States, be diverted to modernization. We cannot, however, have any assurance that significant funds will be so diverted. It should be remembered that the old law permitted the use of construction funds for modernization; despite this, we have built up this \$3 to \$4 billion backlog in modernization needs. We must have guarantees written into the bill.

Mr. Chairman, I still very strongly feel that a program of the magnitude of my earlier bill would be advisable. Lacking this, I would make the following proposals as alternatives:

(1) The bill should be amended to prohibit the transfer of any modernization funds to construction.

(2) The authorization earmarked for modernization should be increased by a large factor. I would urge the adoption of the proposals put forth by the Johnson administration, which would provide the following amounts earmarked for modernization:

Fiscal year ending June—	Million
1965.....	\$50
1966.....	60
1967.....	70
1968.....	80
1969.....	80

(3) The entire modernization allocation should be based on a formula which is primarily based on the need for modernization. If per capita income is considered a determinant, it is precisely those areas with large urban concentrations and outmoded hospitals that will obtain the least money. Per capita income should, therefore, be completely removed as a determinant for modernization allocation.

(4) It is imperative that the Nation begin to cope with this problem right away. No matter what money figures are adopted, I would strongly urge that the modernization program begin in fiscal 1965 rather than be kept in mothballs for another year.

(5) It is unfortunate that the bill as presently constituted does not include provisions for a loan fund. The necessity to obtain loans at high commercial rates has been one of the major deterrents to hospital modernization. I would propose the creation of a revolving loan fund which, for fiscal 1965, would make available \$50 million for modernization, and which would increase for each of the 5 years of the program by an additional \$50 million per year, to a maximum of \$250 million. Interest would be computed in the same fashion as specified in the loan option of the bill under consideration.

Mr. Chairman, I believe that we must squarely meet this problem now. If, during the next 5 years, we have only a token program, we will face then a problem of monumental proportions. We must act now to counter this very serious threat to the health and safety of our Nation, and to the progress of clinical medicine itself.

The CHAIRMAN. All right, General, you may proceed now, sir, in your own way.

Surgeon General TERRY. Mr. Chairman, although I have been asked by the Secretary to represent the Department here, Secretary Celebrezze has prepared a brief statement on these hearings, and I have presented it to your clerk, Mr. Chairman. With your permission, I would like to request that this be included in the record.

The CHAIRMAN. We will have that statement included in the record at this point in full.

(The prepared statement of Secretary Celebrezze follows:)

PREPARED STATEMENT OF HON. ANTHONY J. CELEBREZZE, SECRETARY OF HEALTH,  
EDUCATION, AND WELFARE

Mr. Chairman and members of the subcommittee, I am pleased to have this opportunity of presenting our views regarding H.R. 10041 and S. 2531, the Hospital and Medical Facilities Amendments of 1964. S. 2531 was introduced by the distinguished chairman of this committee, Senator Hill, who was one of the co-sponsors of the original 1946 legislation which marked a great awakening of the Nation's concern with the need for improved health facilities. For more than a quarter of a century Senator Hill has achieved a most enviable record in Congress for his vision and leadership in advancing sound legislation to safeguard the health of our people.

The amendments he has introduced would expand the Hill-Burton program of Federal aid for the construction of health facilities and authorize the operation of a revised program for an additional 5 years. While differing methodologies are proposed, it is significant that S. 2531, H.R. 10041 recently passed by the House, and the draft bill submitted by the administration to the Congress include the same general objectives.

The Hill-Burton program is one of the most widely known and well-accepted programs of the Department of Health, Education, and Welfare. Enactment of the Hill-Burton legislation in August 1946 marked the beginning of a national policy recognizing the responsibility of the Federal Government to assist in the construction of needed hospital and other health facilities throughout the land. This program has helped to improve the health of our citizens in a very practical way—by assisting communities to plan and build needed hospitals and other health facilities. It has accomplished this by relying primarily on the States for direct administration and supervision of the program and on community initiative for the design and construction of the facilities. The Federal Government's role is one of setting the broad requirements and relying on the States for the initial selection of projects. The results of this combination of a worthwhile program and local initiative can be measured by the modern and efficient hospitals which have been built throughout the country, particularly in smaller towns and rural areas.

The Surgeon General of the Public Health Service will present the recommendations of this Department regarding the various provisions of H.R. 10041. While we sincerely believe that our proposals would better accomplish the objectives of this legislation, we endorse the general provisions of H.R. 10041.

If we may be of further assistance to the committee in connection with its deliberations regarding this legislation, please feel free to call upon us.

The CHAIRMAN. You may go right ahead now, General.

STATEMENT OF DR. LUTHER L. TERRY, SURGEON GENERAL, U.S.  
PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION,  
AND WELFARE; ACCOMPANIED BY DR. HARALD M. GRANING,  
CHIEF, DIVISION OF HOSPITAL AND MEDICAL FACILITIES;  
AND WILLIAM B. BURLEIGH, SPECIAL ASSISTANT OF THE DIVISION  
OF HOSPITAL AND MEDICAL FACILITIES

Surgeon General TERRY. Thank you, sir. Mr. Chairman, I am accompanied this morning by Dr. Harald Graning, who is the chief of our division of hospital facilities construction and Mr. Bill Burleigh, who is well known to the subcommittee, and who has worked for more than 15 years in this program area.

I have prepared a statement, Mr. Chairman, which I would like to present, read to the subcommittee, if I may.

The CHAIRMAN. All right, sir. Go right ahead. Take your time, sir.

Surgeon General TERRY. Mr. Chairman and members of the subcommittee: It is always a pleasure to appear before this subcommittee, and particularly so, when the Hill-Burton legislation is being discussed. This program not only bears the name of the distinguished chairman of this subcommittee, but in addition, is well accepted, both by the Congress and by the general public.

H.R. 10041, as recently enacted by the House, S. 2531, and the legislative proposals made by the administration all have the same general objectives. While differing methodologies are proposed, each proposal "zeros in" on the two prime objectives of extending the program for 5 years and adjusting some of its provisions to meet current-day needs.

Examination of a few of its accomplishments will emphasize the major impact which the Hill-Burton program has had on health facilities in this country. Since the beginning of the program 7,263 projects have been approved as of April 30, 1964. These projects cost \$6.64 billion, involving Federal grants of \$2.11 billion. These funds have been transformed into 307,443 general, mental, tuberculosis, and chronic disease hospital and nursing home beds. In addition, Hill-Burton funds have helped construct 2,046 rehabilitation facilities, public health centers, diagnostic and treatment centers, and State health laboratories.

In 1948, for example, this country had only 59 percent of the general hospital beds it needed. Today, 83 percent of current need has been met. But State agencies report that 133,000 additional new beds must be provided to meet the Nation's requirements.

Systematic planning of hospitals and other medical facilities has been undertaken in this country on a continuing basis as a result of the Hill-Burton program. It has (1) stimulated improved hospital design and construction, (2) raised State licensing standards for maintenance and operation and for construction and equipment, and (3) encouraged efficient and economical care through coordinated planning for hospitals and other health facilities. Further, by encouraging more even distribution of health facilities throughout the country, the program has helped attract vitally needed physicians and other health specialists to rural areas.

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

New concepts of treatment and care require new kinds of facilities to provide services to the aging and the chronically ill. Changes in our society have occurred which should be reflected in changing program emphasis and direction in the Hill-Burton program. Since the basic authorization was due to expire June 30, 1964, and has been only temporarily extended under the terms of a recently enacted continuing resolution, we are confronted with the need to adjust its provisions and provide for its continuation for an additional period of years. This bill proposes to extend the program to June 30, 1969.

During the 1st session of the 88th Congress, we saw the enactment of legislation to develop the facilities so badly needed for the mentally

retarded and the mentally ill. Enactment of the proposed amendments now before this committee will help close other significant gaps in our planning and health facility needs. I should like now to review briefly each of the major amendments contained in the bill and explain why I think they will extend and expand the Hill-Burton program to meet the changing health needs of the Nation.

With regard to planning: Because of the number and variety of health facilities, services, and organizations in most communities today, which are concerned with the health of their citizens, no single facility can be considered to stand alone. It is part of an interrelated and interdependent web of facilities and services. The program decisions of one organization frequently influence the program needs and decisions of several others. Organizations and consumer groups either react and accommodate themselves as best they can to the decisions of other organizations, or they can come together and agree on some common approach to their problems. Areawide health facility planning by local and State agencies is a mechanism for achieving this goal, and is the best insurance that large sums of capital funds—for Federal, State, and local levels—are spent wisely. Approximately \$1.5 billion is spent annually for construction of health facilities.

A limited amount of aid has been provided to some communities in the last 3 years to demonstrate the role and feasibility of areawide health facility planning agencies. The response from communities and from those in the hospital field, we feel, justifies going forward on a more formal basis. In other words, the areawide planning agency is no longer a hopeful experiment but an accomplished fact that has demonstrated its value in almost 30 major metropolitan areas.

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

Under the terms of S. 2531 and the administration's proposal, \$5 million would be authorized during fiscal year 1965 and \$10 million for each of the next 4 fiscal years. Public and nonprofit agencies and organizations would be eligible for grants paying up to two-thirds of the cost of an approved project. However, the Surgeon General may, if he feels it is necessary to stimulate the local planning agency, make a grant of a larger percentage of the cost during the first 3 years of the project.

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

Not only should each health facility be related to the whole network of health facilities and services in the community and metropolitan area, but it should also be planned in relation to the neighborhood, community, and urban area in which it is located. Therefore, the Surgeon General will take steps to assure that health facilities and services are developed in close coordination with plans and planning for the general development of communities and metropolitan areas. In addition, we recognize the need for coordinated efforts by Federal agencies, and plan to take all appropriate steps to assure coordination with other Federal programs which are related to ours.

H.R. 10041, as passed by the House, would authorize the appropriation of only \$2.5 million for fiscal year 1965 and only \$5 million for each of the next 4 years, and would also reduce the Federal share of approved expenditures to 50 percent. We believe the planning provisions of S. 2531, which are identical to those included in the administration's proposal, are more desirable than those included in H.R. 10041.

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

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

S. 2531 would authorize each State, beginning with fiscal year 1965, to set aside funds for the modernization of hospitals and other health facilities in an amount not to exceed one-third of its allotment for hospitals and public health centers. Over the 5-year period, \$280 million could be made available for modernization work if each State set aside the full one-third of its allotment.

In this respect S. 2531 differs markedly from the provisions of H.R. 10041 and the administration's proposal. The latter two legislative proposals would vest authority in the Congress for deciding the extent to which funds will be used for modernization work, whereas S. 2531 would vest such authority in each State. Also, H.R. 10041 and the administration's proposal provide authority for allocation of funds for modernization work on the basis of population, financial need, and need for modernization work, whereas S. 2531 requires that funds be allotted on the basis of population and per capita income only.

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

Projects for modernization are eligible under the present Hill-Burton program. However, the allotment formula and the priority principles contained in the existing law have favored rural areas on the basis of their relatively greater need for additional beds. While

urban areas tend to show a relatively high level of available beds, the beds are often in increasingly obsolete and undesirable facilities. Because of the legislative formula, priorities for Hill-Burton funds in these areas are often very low. We believe it preferable, therefore, that a category of modernization funds be specifically established along the lines of the administration's proposal, and that the annual appropriation authorizations be sufficient to make a significant impact on the backlog of modernization needs.

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

The future will present even more serious deficiencies unless action is taken. In 1960 the population aged 65 and older numbered nearly 17 million. By 1980 the elderly group will probably exceed 24 million. Special effort is needed, therefore, not only to correct present deficiencies but also to prevent the gap between existing and needed facilities from widening as the numbers of aged increase. Additional long-term-care facilities will tend to ease the pressures for hospital beds for some areas by permitting chronic-disease patients to be cared for in nursing homes rather than in expensive hospital beds.

This bill, as well as H.R. 10041 and the administration's proposal, would combine the two existing categories in the Hill-Burton legislation for chronic-disease hospitals and nursing homes into a new category entitled "Long-Term-Care Facilities." The present annual appropriation ceiling of \$20 million for each of the categories would also be combined and increased to \$70 million annually.

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

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

The CHAIRMAN. Let me ask you a question there, General.

Surgeon General TERRY. Yes, sir.

The CHAIRMAN. You speak of these 30,000 long-term care beds. Are they largely proprietary nursing homes?

Surgeon General TERRY. They are, generally speaking, proprietary. Not entirely, but largely.

The CHAIRMAN. I see. All right, sir. Thank you.

Surgeon General TERRY. Mortgage insurance for hospital and medical facility construction: In spite of the grant programs authorized by the Congress through the years, the demands for Hill-Burton grant funds will inevitably exceed the amounts available for needed construction. Many worthwhile projects, therefore, will fail to be built unless the necessary funds can be found elsewhere. Also, in some areas nonprofit organizations have been unable to raise sufficient local matching funds when Hill-Burton grants were available.

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

We anticipate, for example, that as large hospitals in urban areas undertake essential modernization, they will find it necessary in many instances to finance a significant portion of their expenditures from private lending sources. Experience in the Hill-Burton program, however, has shown that relatively few health facilities have been able to obtain long-term loans for construction purposes. The average term of such loans has been 14 years for general hospitals and 12.4 years for nursing homes.

S. 2531 and the administration's proposal would alleviate this situation by authorizing as of July 1, 1964, the creation of a mortgage loan insurance program for the construction or modernization of private nonprofit hospitals, nursing homes, and other medical facilities.

To improve coordination of Federal health programs, it is also desirable to place within a single health-oriented agency responsibility for Federal financial assistance programs for the construction of health facilities. S. 2531 and the administration's proposal would therefore authorize the Surgeon General to guarantee private loans made in connection with the construction of proprietary nursing homes, and would in effect transfer the present mortgage insurance program for proprietary nursing homes from the Federal Housing Administration, to the Department of Health, Education, and Welfare.

Mr. Chairman, this concludes my opening statement. As I mentioned before, I have Dr. Graning and Mr. Burleigh here with me to assist in answering any questions, and we shall all be happy to respond to the committee's desires.

The CHAIRMAN. May I say to you it is a fine statement, General. It is very much appreciated.

General, let me ask you this question. What is the actual amount of funds that could be used under the House bill 10041 for modernization, including the funds authorized by transfer?

Surgeon General TERRY. Mr. Chairman, under the House-passed bill, there would be no funds for modernization during the fiscal year 1965. Over the succeeding 4 years there would be: in 1966, \$20 million; in 1967, \$35 million; in 1968, \$50 million; and in 1969, \$55 million, for a total during the entire 5-year program, which would actually be active only in the last 4 years, of \$160 million.

The CHAIRMAN. Would that include any possible transfers, too, of funds?

Surgeon General TERRY. No, sir. This is the basic authorization.

The CHAIRMAN. Well, I am speaking, though, of what is the maximum amount of funds that could be used under the bill, H.R. 10041, for modernization, including the funds authorized by transfer.

Surgeon General TERRY. The bill also provides for the transfer from other areas of appropriation into the modernization category, provided it is in the best interests of carrying out the purposes of the program in that State.

The CHAIRMAN. Could one of you give us a figure now of the possible total amount that could be used for modernization, using the funds authorized directly for modernization and funds that could be or might be transferred for modernization?

Surgeon General TERRY. As I understand the House bill, Mr. Chairman, there is no limitation on the amount of funds from the new hospital and public health center category that could be transferred into modernization if modernization was deemed to be of that priority need within that State.

The CHAIRMAN. Then, what would that total be, Dr. Graning?

Dr. GRANING. It would be the extent of the State's allotments for new hospitals and modernization.

The CHAIRMAN. It would be what?

Dr. GRANING. The extent of the State's appropriation.

Surgeon General TERRY. The State's allotment.

The CHAIRMAN. Then, would the State's allotment mean that it could be the whole State allotment for new hospital construction, in addition to funds earmarked for modernization?

Dr. GRANING. Yes.

The CHAIRMAN. That could go into modernization under the circumstances. Is that right?

Surgeon General TERRY. That is right, sir. This is my understanding, sir, that there is no limitation of the funds from the category for new hospital construction that could be transferred into modernization if the State certifies that such action would better carry out the purposes of the title.

The CHAIRMAN. I see.

Surgeon General TERRY. So that the figures that I gave you earlier, the total of \$160 million over the period of the program, would be earmarked primarily for modernization and would go for that purpose; but in addition, the House-passed bill would provide for the transfer of new hospital funds into this modernization category if deemed desirable and necessary by the State Hill-Burton agency.

The CHAIRMAN. The determination would be made by the State agency?

Surgeon General TERRY. Yes, sir.

The CHAIRMAN. I have here a table, I may say, compiled by the Legislative Reference Service of the Library of Congress, giving the number of hospital service areas which have a need for general hospital beds. I will put the statement in the record at the conclusion of your testimony, General Terry.

Senator YARBOROUGH, do you have any questions?

Senator YARBOROUGH. Dr. Terry, in your report the statement appears that "Under the terms of S. 2531 and the administration's proposal, \$5 million would be authorized during fiscal year 1965 and \$10 million for each of the next 4 fiscal years. Public and nonprofit agencies and organizations would be eligible for grants paying up to two-thirds of the cost of an approved project."

Does this mean that the Federal Government could grant up to two-thirds of the cost of this modernization or building of hospitals?

Surgeon General TERRY. No, sir. This has to do with areawide planning, sir. You will note that it comes under the general heading of planning.

Senator YARBOROUGH. Then, on a specific project, the Federal Government could grant up to two-thirds. What is the maximum amount that could be granted under the bill for the construction of hospitals or modernization?

Surgeon General TERRY. It differs in the various States. But generally speaking, it extends from one-third to two-thirds Federal participation for construction.

Senator YARBOROUGH. Then in building a hospital, the Federal Government could grant up to two-thirds of the cost?

Surgeon General TERRY. In certain States that is correct.

Senator YARBOROUGH. The next sentence says, "However, the Surgeon General may, if he feels it is necessary to stimulate the local planning agency, make a grant of a larger percentage of the cost during the first 3 years of the project."

Is that for the planning only, or for construction of buildings?

Surgeon General TERRY. This is on planning only, sir; and has nothing to do with the formula for the allocation of construction funds.

Senator YARBOROUGH. So the maximum amount that the Government could grant in the building of a hospital or the modernization of one would be two-thirds of the cost of the individual hospital.

Surgeon General TERRY. That is correct, sir. And those are the provisions which obtain at the present time.

Senator YARBOROUGH. Thank you, sir.

The CHAIRMAN. Are there any other questions?

Senator PELL. I have two questions. One is, I hope that a greater emphasis to the urban areas. But in that connection, the modernization of facilities, I was wondering if you had a chance to look over the bill sponsored by Senator Clark and of which I am a cosponsor,

S. 894, which goes in the same direction. If so, what is your opinion of the relative merits of the two bills?

Surgeon General TERRY. Senator Pell, I have reviewed the bill previously, but unfortunately I have not been over it in the last day or two, so I am not acquainted with the details.

Senator PELL. It goes a bit further.

Surgeon General TERRY. However, in general, I think we could say this: That we agree with the emphasis indicated in this bill toward special funds earmarked or allocated for modernization.

Senator PELL. In the urban areas.

Surgeon General TERRY. In the States.

I think one of the points that has not been generally appreciated—and actually, we are just beginning to get some evidence in this direction, is that there are many of the hospitals and other facilities in the smaller towns and more rural areas which are also in bad need of modernization at the present time. Admittedly, the bulk of the need is in our urban areas. But at the same time, I think it should be appreciated by the committee that there is very definite need for modernization funds in the smaller towns and more rural areas.

Actually, Senator, it involves in some instances some of the facilities that were constructed in the very early years of the current Hill-Burton program.

Senator PELL. One other question is, I note on page 23 of the bill H.R. 10041 there is a reference to the fact that not more than 2 percent of the total of the allotments of the State for a year or \$50,000, whichever is less, should be available for administration. Is that not a rather generous amount, the 2 percent?

Surgeon General TERRY. No, sir. As a matter of fact, I think it is a very minimal amount, in order to give the real assistance that we need.

In looking over our program over those years, it is difficult in some respects to criticize a program that has been so highly successful as this one has. At the same time, however, we feel that there have been a few things which have not allowed the program to produce as well as it should have. One is the lack of emphasis on funds for modernization. Another is the amount of attention given to funds for staff to be made available at the State level to really have some good statewide planning. Then, thirdly, the lack of areawide planning in regions or areas.

Now, this specific provision is directed toward trying to help the States correct this in terms of giving them some support to better staffing at the State level.

I would call your attention to the fact that it is a maximum of 2 percent of the allotments or \$50,000 per year in any State, whichever is less, and also it could not exceed the amount that the State has put into that program for the preceding years. In other words, I think this is well couched in terms of the fact that it will prevent the substi-

tution of Federal funds for local funds, local and State funds. At the same time, however, I think it would be a real stimulus to the States to get better staffing so that they could really carry out their responsibilities in a better fashion.

Senator PELL. Thank you.

The CHAIRMAN. Do you have any further questions, sir?

Senator YARBOROUGH. Dr. Terry, I think the data that you have included in your statement is very timely.

I would at this time like to compliment the able chairman of this full committee and chairman of the Health Subcommittee, the distinguished senior Senator from Alabama, for his authorship and sponsorship of this Hill-Burton program. Your statement reveals that since the beginning of this program there have been approved, up to April 30 of this year, 7,243 projects, with 307,443 hospital and nursing home beds; and that in addition to these projects, those funds have helped construct 2,046 rehabilitation facilities, public health centers, diagnostic and treatment centers, and State health laboratories.

When we consider that just 3,000 counties and parishes are involved in the 50 States and the number of these projects approved, 7,243, as well as 2,046 other projects, some 9,000. We see that this averages about 3 of these facilities or hospitals per county in the United States. I think this is a great tribute to the leadership of the chairman of this subcommittee and the full committee and a great testimonial to what this Government under his leadership, at the legislative level, and the Public Health Service through its implementation and executive work have done to bring about better health care for the American people. I believe I would be remiss if I did not comment on these figures now and express my appreciation to the chairman of this committee for his leadership in this field, and for his vision back when this was considered, when first adopted, to be a rather radical proposal. It has meant a great benefit for the American people through the Hill-Burton program.

The CHAIRMAN. I want to thank the distinguished Senator from Texas for his very kind and generous words. May I say that the compliments have been due to teamwork of the members of this subcommittee and the members of the House committee, as well as the U.S. Public Health Service and the Department of Health, Education, and Welfare, all working as a team together.

I certainly appreciate the Senator's very kind and generous remarks.

Surgeon General TERRY. Mr. Chairman, if I may, I would like again to express my great appreciation to you and to the members of this subcommittee for the leadership that you have given us in this program, which I think is one of the programs of which the Public Health Service is most proud.

In addition, Senator Yarborough, as to the point that you made with regard to numbers of projects and the numbers of beds that have

been constructed under this program, I think it is very significant to point out again that those projects cost \$6.64 billion, of which the Federal participation was only \$2.11 billion; in other words, only around 30 percent. I think it shows very clearly, as we have seen in many of our grant programs, what the Federal dollar can do to assist, to stimulate, and assist the States and communities in developing their health facilities and their health programs when it is properly used. And I think it has been exceedingly well used in this program.

Senator YARBOROUGH. I think it is well that you have pointed that out, Doctor. The same incentive is provided for through many other Federal programs, as in the field of education and other things. It is surprising how much the States will do, as in this instance, putting up about twice as much money as the Federal Government.

Surgeon General TERRY. That is right.

Senator YARBOROUGH. Sometimes we find that under the accelerated public works program and in the area redevelopment program, that the States themselves could not quite raise the total amount and the contribution of the Federal Government in the form of a grant or a loan of 20, 25, 30, 35, or 50 percent is often the added margin that enables a county, or city, or other community to get the improvement that means so much improvement in the kind of living the people have in that area of the country.

The CHAIRMAN. Senator Pell, do you have any questions?

Senator PELL. No questions except to endorse the comments of my colleague from Texas about your leadership, Senator.

The CHAIRMAN. Thank you, sir. Thank you.

Do you have anything you would like to add, General?

Surgeon General TERRY. I think that is all, Mr. Chairman.

The CHAIRMAN. Dr. Graning, is there anything you would like to add?

Dr. GRANING. No, thank you, Mr. Chairman.

The CHAIRMAN. Mr. Burleigh?

Mr. BURLEIGH. No, sir. I am very happy, sir.

The CHAIRMAN. Gentlemen, we want to thank you. As I said, Doctor and General, you have made a very fine statement, and we certainly appreciate that very, very much.

Surgeon General TERRY. It is always a pleasure to appear before this committee, Mr. Chairman.

The CHAIRMAN. Thank you. If you are not in too big a hurry or have too much compulsion to get somewhere else, we would like to have you stay, at least one of you, and hear the rest of the testimony of the witnesses.

Surgeon General TERRY. Yes, sir.

The CHAIRMAN. At this point there will appear in the record the table to which I referred earlier that was prepared by the Legislative Service of the Library of Congress.

(The table referred to follows:)

*Number of hospital service areas which have met 100 percent of need for general hospital beds<sup>1</sup>*

	Number of hospital service areas within State	Number of hospital service areas within State that have met 100 percent (or more) of their general hospital bed need	Percent of hospital service areas that have met 100 percent of general hospital bed need
Alabama.....	65	12	18.5
Alaska.....	21	12	<sup>2</sup> 57.1
Arizona.....	17	4	23.5
Arkansas.....	39	10	25.6
California.....	160	49	30.6
Colorado.....	24	11	45.8
Connecticut.....	11	2	18.2
Delaware.....	5	1	20.0
District of Columbia.....	( <sup>3</sup> )	( <sup>3</sup> )	100.0
Florida.....	57	16	28.1
Georgia.....	42	2	4.8
Hawaii.....	7	6	85.7
Idaho.....	28	15	53.6
Illinois.....	92	57	62.0
Indiana.....	75	29	38.7
Iowa.....	79	27	34.2
Kansas.....	46	34	73.9
Kentucky.....	75	28	37.3
Louisiana.....	73	33	<sup>4</sup> 45.2
Maine.....	23	8	34.8
Maryland.....	15	0	0
Massachusetts.....	68	10	14.7
Michigan.....	75	20	26.7
Minnesota.....	73	63	86.3
Mississippi.....	66	22	33.3
Missouri.....	45	29	64.4
Montana.....	23	18	78.3
Nebraska.....	37	19	51.4
Nevada.....	12	4	33.3
New Hampshire.....	20	3	<sup>2</sup> 15.0
New Jersey.....	27	12	44.4
New Mexico.....	28	11	39.3
New York.....	58	16	27.6
North Carolina.....	102	23	22.5
North Dakota.....	45	35	77.8
Ohio.....	80	19	23.8
Oklahoma.....	78	41	52.6
Oregon.....	27	13	48.1
Pennsylvania.....	74	18	24.3
Rhode Island.....	3	1	33.3
South Carolina.....	46	3	6.5
South Dakota.....	43	13	30.2
Tennessee.....	61	7	11.5
Texas.....	134	63	47.0
Utah.....	21	13	61.9
Vermont.....	12	7	58.3
Virginia.....	45	13	28.9
Washington.....	31	<sup>5</sup> 17	54.8
West Virginia.....	40	26	65.0
Wisconsin.....	92	65	70.7
Wyoming.....	22	18	81.8
U.S. total.....	2,443	979	40.1

<sup>1</sup> All figures are from the fiscal year 1964 revisions of the State hospital and medical facilities construction plans, unless otherwise noted.<sup>2</sup> Fiscal year 1963 figures.<sup>3</sup> Overall general hospital bed need filled by 132 percent.<sup>4</sup> These figures are for general private hospitals. Louisiana has also designated 8 general charity hospitals of which 5 have met 100 percent of bed need.<sup>5</sup> This figure is an estimate for the year 1968.

The CHAIRMAN. Now I see our colleague, Senator Hruska, has come in.

Senator, we are happy to have you here with us and would be very glad to have you proceed, sir.

**STATEMENT OF HON. ROMAN L. HRUSKA, A U.S. SENATOR FROM THE STATE OF NEBRASKA; ACCOMPANIED BY REX STURM, LEGISLATIVE ASSISTANT**

Senator HRUSKA. Thank you very much, Mr. Chairman. For some time now, my staff has been working with members of the subcommittee staff on an amendment about which I would like to speak a little bit this morning. It has to do with the various categories and the flexibility of transfer from one to another of these categories under certain circumstances.

First I would like to say, Mr. Chairman, that the Hill-Burton program has been very well received in Nebraska as well as in the entire Nation. For this reason the Department of Health in Nebraska is very eager to have this program continued.

The extension of this program has very wisely foreseen the diversified needs of future medical facilities and promoted construction in needed areas by providing categorical controls. This is a good step to insure responsible use of the funds provided under the program. I am also pleased to see that in both the House bill and the Senate bill certain flexible features are included to allow the States to tailor their construction program to the most urgently needed categories.

In anticipation of the extension of this program and in reviewing their future needs, the Department of Health of Nebraska, as well as a number of other States, have found that they need another kind of flexibility. Assuming that either the House-passed bill or the pending Senate bill has sufficient flexibility for transferring allotments between categories, there is still a need for allowing States to decide when they should use their funds in each of these categories.

As an example, in a State receiving a relatively small allotment under this program, when assisting a large construction project, adequate funds may not be available to keep the project moving at its most efficient and expeditious pace. Under either of the bills, the House-passed bill or the pending Senate bill, a State may merely hold its allotment in one category over until the next year and use the 2-year total for a large project, but this would not solve the problem.

The need in one category may be very great in 1 year and much less pressing in another category during that year, and yet adequate funds for the urgent need would not be available for, say, 2 years.

The result would be to give financial assistance while dragging our feet on the actual construction of the project. In the meantime, other funds would be pushing ahead projects in which the need had not fully matured.

The purpose of the amendment which I have proposed would be to extend a degree of time flexibility to the States, allowing them to construct their most needed facilities first during the life of this act.

Basically, this amendment would allow States to use as much as necessary of the total allotment in any urgently needed category for the overall 5-year life of the act in any one of 2 years of

the life of the act simply by deferring the use of funds from other less needed categories. These less urgent needs could then be provided for in subsequent years. The net effect at the end of the 5 years would be unchanged since the average spent in each category would be the same as allowed under the pending provisions. In the meantime the needed facilities would have been in use years earlier.

This amendment provides for supervision of these transfers by the Surgeon General to carry through the control features. As a formula which avoids the necessity for some projects to be delayed, awaiting adequate assistance, it will prevent waste not only in terms of money but also from the standpoint of those needing the required facilities.

It is felt that this amendment will help to more closely achieve the purposes of the Hill-Burton program by meeting the needs of the individual States while retaining the control and assistance of the Surgeon General, who is responsible to the Congress for the administration of these funds.

There are several States that have indicated their support of this amendment, primarily States where the allocation is rather limited, Mr. Chairman. In fact, in some of the letters from States, it is suggested that this amendment apply only to States having \$2.5 million or less, where this problem is particularly acute. I do not know what the committee's thinking on that might be.

I would like to give one example of where this would really apply. One of the problems of Federal grants-in-aid to specific categories is that in order for a State to participate, they must build the specific type of facility, whether or not it is a first priority in that State.

For example, a State's principal problem may be to obtain mental retardation facilities, but when the Hill-Burton Act provides only a limited amount for such facilities, and a much larger sum for, say, general hospitals, the primary need of that State is not met in timely fashion. In other words, they would have to spread over several years the construction of the much-needed mental retardation facilities, and at the same time be building general hospital facilities which are not nearly as urgent at this particular time.

Now, we have no pride of authorship in the amendment. I would be just as anxious as any other Member of the Senate to see that there were proper safeguards there to achieve the ultimate spread of those funds among the categories. But it is simply that flexibility within that 5-year period that we would ask for this amendment.

The CHAIRMAN. Senator, of course, you recall the mental retardation and mental health act, that makes special provision for the construction of facilities for the mentally retarded?

Senator HRUSKA. Yes, I understand. It is a preferred category.

The CHAIRMAN. Yes.

Senator HRUSKA. But that example could be extended to any one of the other categories, Mr. Chairman, and I would certainly ask the committee to take it under consideration to see if there would not be some merit in it from the standpoint of those small States where each of those pigeonholes is so small that they have to pass up the necessities of the moment and stretch them out. In many of these it really causes the shoe to pinch severely.

This could be overcome by the good judgment and discretion of the Surgeon General and the department of health in each respective State.

The CHAIRMAN. Are there any more questions? Senator Yarborough?

Senator YARBOROUGH. No questions.

The CHAIRMAN. Do you have any more questions, Senator Pell?

Senator PELL. No, Mr. Chairman.

The CHAIRMAN. Well, Senator, I certainly want to thank you very much for your statement. We assure you that we will consider it carefully, sir.

Senator HRUSKA. I believe the subcommittee staff has the amendment and the other supporting papers. But if there is anything further you need, we would be happy to supply it.

The CHAIRMAN. Do you want the amendment printed in the record, Senator?

Senator HRUSKA. Yes, sir.

The CHAIRMAN. Fine. We will be very happy to put it in the record.

(The document referred to follows:)

AMENDMENT INTENDED TO BE PROPOSED BY MR. HRUSKA TO H.R. 10041

An act to improve the public health through revising, consolidating, and improving the hospital and other medical facilities provisions of the Public Health Service Act, viz: On page 12, between lines 12 and 13, insert the following:

“(g) (1) In addition to the amounts, if any, which a State is authorized under subsection (e) to have transferred from one allotment of such State under subparagraph (1) or (2) of subsection (a) to another such allotment, any State shall, upon request to the Surgeon General, be entitled to have such amounts as it may specify transferred from one such allotment to another such allotment, if such request is accompanied by a certification of the State agency of such State that a transfer of the amounts made in accordance with such request will more effectively serve the needs of the people of such State than if such transfer were not made.

“(2) Transfers under paragraph (1) to any allotment of a State under subparagraph (1) or (2) of subsection (a) shall be made only to the extent that the aggregate, for the period beginning with the fiscal year ending June 30, 1965, and ending June 30, 1969, of the amounts of such allotment plus all amounts transferred thereto under paragraph (1) and subsection (e) does not exceed the aggregate, for such period, of the amounts which would, without regard to the provisions of paragraph (1) and of subsection (e), have been available for such allotment for such period. The Surgeon General, in applying the provisions of the preceding sentence to any allotment of a State, shall assume that, with respect to any future fiscal year within such a period, there will be appropriated the maximum amount authorized in this part for such year for purposes of making allotments of the type of such allotment and that there will be no change in the population of such State or in the allotment percentage of such State.

The CHAIRMAN. Thank you again for your statement, sir.

Now, Mr. Williamson of the American Hospital Association.

You have been with us many times in the past, Mr. Williamson. We are happy to have you here, and we welcome you back, sir.

Mr. WILLIAMSON. Thank you, sir.

STATEMENT OF KENNETH WILLIAMSON, ASSOCIATE DIRECTOR,  
AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C.

Mr. WILLIAMSON. On behalf of the American Hospital Association, I would first wish to express our appreciation for the opportunity to discuss with you the operation and accomplishments of the Hospital Survey and Construction Act and our views with respect to the Hos-

pital and Medical Facilities Amendments of 1964. The amendments are incorporated in S. 2531 and H.R. 10041. However, inasmuch as the House of Representatives has passed H.R. 10041, my remarks will be directed primarily in that bill.

I would also like to take this opportunity to express a great personal pleasure in being able to appear not only before the subcommittee but before the chairman of this committee, who we in the hospital field consider has made such an enormous personal contribution to meeting the health and hospital needs of the American people. I must say that as we work day to day at the level of the problems of hospital care in this country, we are constantly reminded of the sad situation we would be in today if it were not for the Hill-Burton Act and its enormous accomplishments.

The CHAIRMAN. May I say, Mr. Williamson, that this program has had the wholehearted and most effective and helpful support of the American Hospital Association and yourself, too, sir, as the representative of the American Hospital Association.

Mr. WILLIAMSON. Thank you.

The CHAIRMAN. You certainly have been with us here all the time, working and helping us, and we are indeed grateful.

Mr. WILLIAMSON. Senator, with your permission, I would like to have my prepared statement appear in the record.

The CHAIRMAN. Your full statement will appear in the record, sir, at this point.

Mr. WILLIAMSON. It spells out the accomplishments of the act and the role of our association in assisting in the development of the Hill-Burton program.

We have outlined what we believe to be at this stage the major unmet facility problem facing the Nation, that of the modernization of our older hospital facilities, and I discuss a study which we made jointly with the Public Health Service some years ago, and the later study which the Public Health Service made.

Further on, we indicate the total cost of needed modernization in the Nation of about \$3.6 billion. As we add to that the increasing cost of constructing hospital beds in the country since the study was made, we reach a figure of at least \$4 billion which we believe to be conservative.

Also we have listed figures indicating the results of detailed studies made in particular areas of the country, which give a further amplification of the fact that we think that \$4 billion figure is, looking at the Nation, perhaps a conservative figure indeed.

We also point out that we are in general agreement with the provisions of H.R. 10041, but we have some specific amendments to suggest, which I would like to spend some time on.

The first of these is in relation to section 318, which deals with title II of the U.S. Public Health Service Act. We say:

We have for several years recorded our support of the Federal Government providing "seed money" to develop areawide planning and to assist in demonstrations which would provide experience and guidance that is needed. Through the research and demonstration funds provided under the Hospital Survey and Construction Act, a good start has been made. However, we have not felt that Government support should be provided for the continued operation of such

endeavors beyond the initial stages of development. These areawide planning agencies are intended to be voluntary community organizations, and we believe their support should come from local sources on a continuing basis.

H.R. 10041 as originally introduced provided \$5 million for the first fiscal year and \$10 million each for the next 4 fiscal years. We believe that this amount of money is warranted and would permit the widespread development of regional planning agencies throughout the country which is urgently needed. We suggest, therefore, that these amounts be restored. We believe the provision now in the bill for a maximum grant of 50 percent for a single project is desirable.

The proposal in the bill which suggests continued financing of area-wide planning agencies for the full period of 5 years may well carry such support beyond the point of initiation and demonstration and in essence becomes continued Federal financing for their operation. We would suggest, therefore, that the proposal be amended to limit such support to a 3-year period for any given project.

Section 601 dealing with Title VI: Authorization of Appropriations: I would like to say we fully support the expanded funds proposed here for construction of long-term care facilities and the combining of the previous separate categories of chronic disease and nursing homes. The unmet need for such facilities amply supports the proposal for a substantial increase in the funds to be made available.

The bill proposes to continue grants for the construction of rehabilitation facilities under this section. We support the need for Federal assistance to provide such facilities. We were pleased that the Congress amended the Hospital Survey and Construction Act in 1961 to assure that encouragement would be provided for the development of such facilities on a much broader basis. We recognize the special need of "comprehensive" facilities which involve services other than purely medical services. However, we feel that encouragement should be given for the widest possible development of rehabilitation facilities, even though they are not comprehensive in character. Therefore, we oppose the provision set forth under section 603(a)(2) of the bill, which would establish a priority for rehabilitation facilities developed in university centers. We feel this provision will result in there being less facilities than are clearly needed throughout the country—less in number, that is. We would prefer that the States be permitted to allocate funds for more and a wider range of facilities than they would with the priorities provided in this bill.

The Hospital Survey and Construction Act has since its enactment in 1946 made a substantial contribution to the development of needed health facilities in the Nation. At the time the program was started, it was essential that first priority and particular attention be given to areas of the country which were without hospital facilities, and therefore where the public was not likely to have available to them the benefits of modern medical advances. The picture today is different. Though a considerable need still exists for additional beds and other health facilities, the urgent need of rural areas has been met in substantial part in most sections of the country.

I might point out here that when the act started the country was plotted out into regions, and I think there were about 230 population areas in the country, and 25 percent of these had no hospitals at all.

This was the critical problem. We believe it is significant that now 21 percent of those areas have hospital facilities. There remain only 4 percent of these areas throughout the Nation that do not have hospital facilities.

We believe we are now at the point where the great unmet hospital facility needs of our large urban population centers must be cared for. We consider the surmounting and major problem of health facility needs in the Nation today to be that of the older hospitals with outmoded, inefficient, and often unsafe physical plants. This problem, though it exists in large part in metropolitan centers and in the older cities of the country, exists also to an appreciable extent in older smaller facilities in small cities and towns.

A growing awareness of the problem occasioned the association to make a nationwide questionnaire study. This revealed a dollar need for modernization of over \$1 billion, and the later study in somewhat greater detail made by the U.S. Public Health Service indicated a figure of \$3.6 billion needed for modernization.

Since that time, several areas have undertaken regional or metropolitan studies. In the city of New York a team of architects and engineers visited and studied the needs of 83 hospitals. The study determined that the modernization of these hospitals would require an expenditure of well over \$250 million. This study in New York serves to validate the opinion of many authorities that the nationwide figures may have understated the size of the problem. In New York, it was found that an expenditure of \$120 million is needed merely to replace non-fire-resistant hospital structures.

The large urban teaching hospitals are the key to the whole health structure of this Nation. These hospitals provide the essential education for physicians, nurses, dietitians, medical record librarians, physical therapists, and the other people who make up the health team. We are spending vast amounts of money for medical research in the country. Much of this research must be carried out in these large, older teaching hospitals. A good deal of the medical research being done, if it is to be made available and to be beneficial to the people, must be translated into actual procedures for patient care. It is in these larger and older hospitals where this essential task is and must be performed. We believe that the American public, which in large part depends upon the older and outmoded hospitals of the Nation, are often treated unfairly and are, in fact, being discriminated against in terms of the Nation's expenditure for hospital improvement. The largest percentage of the Nation's population receives care in the hospitals of our metropolitan centers. Also, large numbers of the rural population must turn to these metropolitan hospital complexes for care of the more serious types of illnesses. When we speak of large metropolitan centers, we are not talking of metropolitan areas versus rural areas. We are talking about a coordinated effort, really.

But it is our belief that the problem of modernization has reached such proportions and is of such severity that we must meet it with action. We are therefore extremely pleased that this bill at least recognizes the problem and the need for the Federal Government's participation in working toward a solution.

Any appreciable impact on the problem will require the expenditure of large amounts of money and large amounts of Federal assistance.

H.R. 10041 provides \$160 million over a 4-year period for modernization as directly allocated. Of this amount, however, \$60 million may be used for new construction instead of modernization at the discretion of the States. S. 2531 provides a larger sum for modernization. I believe it is about \$280 million. Neither bill reflects the magnitude of the need.

We recommend that the bill be amended so that for the fiscal year ending June 30, 1965, \$50 million be provided for renovation for the fiscal year ending June 30, 1966, at least \$70 million; and for each of the following 3 years, \$100 million, making a total of \$420 million earmarked in grants over a 5-year period. We believe, in fact, that this amount is minimal and will only produce an adequate beginning. We feel it is unnecessary to lose the first year as H.R. 10041 provides. We are pleased that the Senate bill does not lose this year; it starts right at the beginning. Many projects could move ahead rapidly if funds were made available.

We recommend further that \$100 million be provided annually in each of the 5 years covered by the bill for the construction of new hospitals and other medical facilities. These amounts are recommended in addition to the amounts provided for under the section for long-term care facilities, diagnostic, and treatment centers, and rehabilitation facilities.

The bill provides that States may transfer renovation and modernization funds into the new construction category. We believe this to be an unwise provision and recommend that funds provided for modernization purposes be earmarked entirely for this purpose.

It is recognized that the extent of the problem varies in different sections of the country. Individual projects for modernization often will require large expenditures and in numerous cases run into several millions of dollars. Under the Hospital Survey and Construction Act, by administrative decision, limited amounts of money have been provided to a single project. This was necessary to make the funds assist as many projects as possible. Generally, of course, these were smaller projects than the ones we are talking about for modernization. A different philosophy for the allocation of funds is essential if boards of trustees of individual hospitals are likely to assume the financial obligations of large-scale modernization projects. A different grant formula will be required from that used in the Hospital Survey and Construction Act, wherein grants run from 33 $\frac{1}{3}$  to 66 $\frac{2}{3}$  percent, depending upon the financial position of the State. The great bulk of modernization projects will be in those States that fall in the lowest percentage grant areas.

We believe, therefore, the minimum grant for any project should be at least 50 percent in order to accomplish any substantial amount of modernization.

Next we comment on the financing of borrowed money. Even with 50-percent grants, project sponsors will have to obtain large amounts of additional funds thereby creating a heavy burden of debt. This indebtedness will be borne largely by paying patients and will cause an appreciable increase in the price of hospital care. The size of this indebtedness is a matter of serious concern to boards of trustees and would, we believe, discourage many of them from going ahead with needed projects if they are subject to the interest rates of the commercial money market.

We have attached a table indicating the effect of various interest rates on patient-day costs. I would just mention the area of large hospitals, say an 800-bed hospital, which will be the area of many of these modernization projects, that the money market rate which many hospitals would have to turn to, of 6½ percent, would cost \$2.81 per patient per day, over a 30-year repayment period, which points out, as we say, an appreciable increase in the price of hospital care.

As a matter of basic principle, it is felt that the needs of modernization must be approached so as to cause the least possible increase in the cost of hospital care. We recommend, therefore, that the bill be amended to provide for a program of direct Federal loans. Such a program of loans is proposed in S. 894, introduced by Senator Joseph Clark of this committee. It is our belief that the Federal Government could provide a great incentive for modernization of hospital facilities if it were willing in fact to underwrite in part the cost of the money to be provided by bringing the interest rate down to around 2 percent. However, if such a subsidized rate of interest is not feasible, we urge at least a system of direct Federal loans at the interest rate available to the Federal Government for numerous other programs, as the Clark bill proposes. We agree with Senator Clark that project sponsors should be enabled to receive a 50-percent grant from the Federal Government and to borrow additional needed funds from the Federal Government through direct, low-interest loans up to a maximum of 80 percent of the total project cost.

A separate method of allocating money among the States for modernization is highly essential. We believe the single factor essential to take account of the varying need for nationwide modernization is the total amount of modernization needed in a given State in relationship to the total modernization needs for the Nation as a whole. Neither population nor the financial needs of the respective States are appropriate factors to be considered in the allocation of the funds for modernization.

Section 603 deals with the general regulations.

We believe that the rural priority is no longer needed. We recommend, therefore, that the provision granting priority to rural areas be stricken from the bill and the language be amended to permit the States to give special consideration to "areas of greatest need."

This section of the bill also provides that special consideration be given to rehabilitation facilities. I have already discussed that, and we would provide that the priority in respect to rehabilitation facilities in university centers be eliminated.

The bill also authorizes the Surgeon General to develop criteria for determining the need for hospital beds and facilities in a given area, thus removing the previous statutory provision establishing ceilings. The ceilings have not been helpful, being too high in some areas and too low in others. We feel the language in the bill is a decided improvement, and it will encourage more intelligent planning.

Section 604 deals with State plans. The bill provides for the establishment of State advisory councils and names the types of individuals to be selected to serve on such councils.

We would recommend that the language be amended so as to provide for the inclusion of an individual who is authoritative in the field of mental health. The recently passed mental health-mental retardation

program will be administered in some States by the same State agency which administers the hospital survey and construction program. In all States there is a need to coordinate planning activities between mental facilities and others. It is noted that the bill requires the appointment of a mental health authority to the Federal Hospital Council, and we suggest a similar requirement for State advisory councils.

They were the best we knew at the time, but in some areas they were too high and in some areas they were too low. We feel that the language in the bill is a decided improvement.

Section 621 deals with the Federal Hospital Council and advisory committees. We are more than a little concerned by the language of this particular section. The section provides that the Surgeon General in administering this title shall consult with a Federal Hospital Council. We have always strongly advocated such a provision. However, as we read the amended language in the bill, it did not require the appointment of any hospital authority to the Advisory Council. The Council is expanded from 8 members to 12 members and this would permit the addition of authorities relating to the mentally retarded and relating to mental health to the Council which we fully supported.

We believe the provisions set forth in the Hospital Survey and Construction Act in the past should be continued in this bill. This provides for the appointment of four members who are "outstanding in fields pertaining to hospital and health activities, three of whom shall be authorities in matters relating to the operation of hospitals." The wording as it appears in the bill S. 10041 is vague, and the term "medical facility" has been substituted for the term "hospital." Further, the bill provides that authorities in the operation of hospitals need not be appointed, and that persons who are authoritative in matters relating to "other medical facilities" can be appointed. We believe it would be most unwise to have a Council appointed which is to advise on the development of hospital facilities throughout the Nation without assuring adequate representation of persons who are authoritative in the administration and operation of hospitals. We, therefore, urge that this section of the bill be amended accordingly.

Senator PELL. Is not the reason for your suggestion that the term "medical facility" be substituted for the term "hospital" so that we can include nursing homes?

Mr. WILLIAMSON. Well, the definition of "hospital" included nursing homes under the old bill. I am not sure what the reason was, Senator.

Section 625, dealing with definitions:

The term "hospital" as defined in this subsection differs from the definition of hospital in section 631 (e) of the existing law. The new definition does not include mental hospitals. We believe the language should be amended so that the term "hospital" clearly includes mental hospitals as it does in the existing law. This provision has been extremely valuable in encouraging the development of new acute psychiatric facilities in general hospitals. In view of the great need for such facilities, we feel it would be a serious mistake to omit "mental hospital" from the definition of "hospital" in this section of the bill.

In conclusion, Mr. Chairman, we have greatly appreciated the opportunity of appearing before this committee and presenting the views of the American Hospital Association. We sincerely hope that our comments and recommendations will prove helpful in the final development of legislation. We wish to commend the committee for the

enormous contribution that it has made in the past to advance the health and welfare of the American people. We recognize the important role of this committee in the provision of health facilities for the Nation. We feel that your consideration of the need for modernization of our older health facilities is a major step forward. The American Hospital Association stands ready as we have in the past to be of all possible assistance to this committee.

(The patient-day costs chart follows:)

*Varying interest rates reflected in hospital patient-day costs*

Three different size hospitals were selected as examples. The figures are based upon present-day costs to replace the facilities. A maximum loan of 80 percent was used in each example with a 30-year repayment period. National averages of occupancy were used in each example as well as average patient-day costs nationwide. The cost of repayment of principal is not included in the figures.

Hospital size	Average cost of care per patient per day, 1962	Interest costs per patient per day			
		3½ percent	4½ percent	5½ percent	6½ percent
100 .....	\$35.51	\$1.49	\$1.99	\$2.51	\$3.06
200 .....	38.74	1.41	1.88	2.38	2.90
400 .....	38.71	1.36	1.82	2.30	2.80
800 .....	39.31	1.37	1.82	2.31	2.81

Mr. WILLIAMSON. Thank you, Mr. Chairman.

The CHAIRMAN. Are there any questions? Senator Pell?

Senator PELL. Just one question. In connection with your comment on section 603, the suggestion that the emphasis should be on the urban areas a bit more, do you have specific language you are proposing or not?

Mr. WILLIAMSON. Oh, yes. We have language to put in there, to strike "rural priorities" and insert "areas of greatest need," so the State can decide where the greatest need lies, so that if it is in an urban area, that is where the need is to be met, and if it is a nonurban area, they are free to meet the need in that area.

Senator PELL. What would you strike in the bill? I am just looking at the bill now.

Mr. WILLIAMSON. Well, the bill at present specifies a priority for rural areas and we would strike the priorities, Senator.

Senator PELL. All right, thank you.

The CHAIRMAN. Are there any other questions, Senator?

Senator PELL. No, thank you.

The CHAIRMAN. Well, Mr. Williamson, we want to thank you, sir, for your statement and express to you again our appreciation for the help and support that you have given us through the years, and which we have received from the American Hospital Association.

Mr. WILLIAMSON. Thank you, Senator.

The CHAIRMAN. We are always happy to have you here with us. As I say, we deeply appreciate all you have done in the past.

Mr. WILLIAMSON. Thank you, Senator.

The CHAIRMAN. Your prepared statement will be printed in the record in full at this point.

(The prepared statement of Mr. Williamson follows:)

PREPARED STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

My name is Kenneth Williamson. I am associate director of the American Hospital Association and director of its Washington service bureau.

On behalf of the association, I first wish to express our appreciation for the opportunity to discuss with you the operation and accomplishments of the Hospital Survey and Construction Act and our views with respect to the Hospital and Medical Facilities Amendments of 1964. The amendments are incorporated in S. 2531 and H.R. 10041. However, inasmuch as the House of Representatives has passed H.R. 10041, my remarks will be directed primarily to that bill.

The American Hospital Association, which has supported this program since its inception in 1946, is a voluntary, nonprofit membership organization including within its membership the great majority of all types of hospitals, among which are 90 percent of the Nation's general hospital beds, which in 1962 admitted more than 26.5 million patients and treated over 99 million in their outpatient facilities. Our primary interest—and the reason for the organization of the association—is to promote the public welfare through the development of better hospital care for all the people.

During the years of the depression and the years of the Second World War, which followed, there had been very little hospital construction in the Nation. Many communities throughout the country were without hospitals and other health facilities, and consequently, without doctors. To millions of Americans, there was very little sense in talking about the miracles of modern medicine, because, lacking hospitals, they were deprived of the benefits of this new day in medicine. Basic studies sponsored by this association, beginning in 1944, through the Commission on Hospital Care, documented the problem and supplied the framework on which the Hospital Survey and Construction Act was built. Throughout the 18 years since its enactment, we have followed the program closely. We have maintained continuous and close communication with the hospital field regarding the operation of the program. We have worked with the State agencies responsible for the operation of the program. We have worked closely with the Surgeon General and his staff. Officers of the association have been members of the advisory council to the program. We have sponsored conferences throughout the country for the discussion of the program and its operation. We have consistently supported appropriations before the House and Senate Appropriations Committees. In more recent years, we have worked closely with the Surgeon General in regional planning studies. Throughout the years, as there have been hearings before congressional committees, we have appeared and presented our views with respect to the program and our recommendations for its continued improvement. We have been gratified that the Congress has in most instances accepted our recommendations.

Under the Hospital Survey and Construction Act, hospitals have been built in several hundred communities where hospital care had not previously been available. Doctors followed the building of the hospitals and thus were brought into these communities.

In a total of 7,061 projects, which were approved as of June 31, 1963, 271,478 hospital beds have been built or are under construction; 28,864 nursing home beds, 974 public health centers, 588 diagnostic and treatment facilities and 280 rehabilitation facilities have been completed or are under construction.

Despite the encouraging progress, however, much still remains to be done. There appears to be a continued race between obsolescence of existing facilities, increased need for care and population expansion. It is our belief that the Federal Government through this act is doing much more than provide dollars for construction. The Government through the program has become a major force in shaping the kind of health services we are to have in this country. It is thus influencing the cost of care, the quality of care, and the quantity of care to be made available.

Since the time the Congress first enacted the Hospital Survey and Construction Act, there have been many changes in patterns of care and needs. For years relatively few hospitals provided emergency services. This has now become a nearly universal practice. However, a definite change has taken place. The public is now coming to hospitals in tremendous numbers as ambulatory patients seeking a wide range of medical care and not just emergency care. This past year, 99 million such ambulatory patients received care in general hospitals. A broad spectrum of diagnostic and treatment facilities is needed. One particular example is in respect to the treatment of mentally ill patients.

The change that has taken place in medicine and in hospitals is seen most forcefully in the fact that 18 years ago 65 to 75 percent of the total area constructed in hospitals went into patient bed areas. The balance of the space went to meet all other service needs. Today perhaps 20 percent of the total area constructed goes to patient beds and the balance for diagnostic and treatment facilities and service areas needed to serve the patients.

You are well aware of the fact that the cost of care has increased greatly. This cost involved medical progress and change, facility and equipment costs, but most of all, personnel costs. This latter is perhaps 75 percent of the total. Personnel needs have gone from 1.5 per patient 18 years ago to 2.8 on the average today. Though great improvement has been made in the salaries of hospital personnel, there is still considerable need for further improvement to make these salaries comparable to the education, qualification and responsibility of the individuals involved. This is going to take a lot more money.

The original cost of the hospital is its least cost. The year by year cost of operation is the really big factor. Empty and unused beds are wasteful and increase the cost of care to patients who are occupying beds. This is a serious problem for smaller hospitals since many of them run an occupancy rate of well below what is considered to be an economic level. Ever greater care must be taken that we do not construct unneeded hospital facilities and that we avoid wasteful duplication of both facilities and services. Better planning and greater cooperation and control are an absolute necessity.

Great pressure is being exerted both from within and without the health field for higher standards of care. Higher standards and improved quality generally mean higher costs. Higher quality of health care will require more and better larger hospitals and a greater concentration of very costly diagnostic facilities together with the most efficient use of highly skilled personnel who are in short supply. It also means higher standards of care in small facilities and stricter adherence to limiting the care undertaken in such facilities to relative levels of ability. As the diagnosis and treatment of patients becomes ever more intricate and specialized, it behooves us to concentrate facilities and services and strengthen the ability of such centers to perform.

The voluntary health system of the country is unique. It has enormous potential for the future. To move ahead in some area of need we must have the help of Government. We most earnestly urge that the Federal Government now plan to assist the country to move ahead in this area of serious neglect; that of modernization of existing hospital plants. To do this may require a reappraisal of Government expenditures for totally new facilities, but we do hope also with a resulting decision to provide substantial new financing. We have some specific recommendations in this regard.

In 1958, when we appeared before committees of the Congress, the cost of construction of hospitals averaged somewhat in excess of \$17,000 per bed. The general average cost today is over \$21,000 per bed. Thus, the delay in meeting needs becomes ever more costly.

I wish to quote the following statement which the American Hospital Association made to the Congress in 1958:

While the Hospital Survey and Construction Act has accomplished a great deal to improve the Nation's hospital plant, it has done this primarily in terms of new construction and has left largely untouched a serious and rapid-growing need for renovation and modernization of our older hospital facilities. The channeling of these funds so largely into new construction rather than renovation, together with the emphasis which the act places on rural areas, has produced in many cases a pattern of modern and efficient small hospitals in regions surrounding metropolitan areas, while the metropolitan areas themselves are served by institutions many of which are far from being either modern or efficient. The plight of these urban hospitals and the growing deficiency of their physical plant are important to the total health picture, not only because of the large population served by these hospitals, but because as centers of both medical research and professional training they exert influences which are felt throughout the Nation.

The picture has not improved; it has simply become worse.

In 1956 the association conducted a survey, in collaboration with the U.S. Public Health Service, of the modernization needs of hospitals. This study indicated at that time a total need of well over \$1 billion. Of the 2,634 hospitals covered by this survey, 435, or 1 in 6, were more than 50 years of age. There are obsolete facilities in every section of the country. In 1960 the Public Health Service, in a further effort to determine the magnitude of the problem of

modernization, undertook a nationwide study in cooperation with the State hospital construction agencies and metropolitan planning bodies. Direct reports were obtained from 25 metropolitan areas each having more than 2,500 general hospital beds; and sample reports were received from 32 smaller metropolitan areas. This study indicated a total cost of needed modernization of \$3.6 billion. Since the study was made in 1960, it is felt that, due to increased cost of construction, a total of \$4 billion would now be a conservative estimate.

More recent detailed studies have been made in several areas:

New York City-----	\$250,000,000
Toledo, Ohio-----	20,000,000
Kansas City-----	45,000,000
Philadelphia-----	100,000,000
Rochester, N.Y.-----	35,000,000
Pittsburgh, Pa.-----	80,000,000
Charleston, W. Va.-----	12,000,000
Columbus, Ohio, and surrounding area-----	41,000,000
Greater Chicago area-----	180,000,000

The modernization bed-need figures indicated by the State of California in their statewide study provided for modernization in the Los Angeles area of \$164 million and the San Francisco Bay area of \$134.4 million.

The American Hospital Association believes that the Hospital Survey and Construction Act is still urgently needed and should be continued for the provision of new facilities; and that various changes should be made in the act to improve its operation and that it should be restructured so that a major new addition in the form of a program for modernization of facilities is added to the act. We are in general agreement with the intent of H.R. 10041. However, I will devote a major part of my comments to the area of modernization which is, we feel, the most important new subject set forth in the bill.

SECTION 318: TITLE III OF THE U.S. PUBLIC HEALTH SERVICE ACT—SPECIAL PROJECT GRANTS FOR ASSISTING IN THE AREAWIDE PLANNING OF HEALTH AND RELATED FACILITIES

We strongly support the need for areawide planning of health facilities. The continued cost involved in the operation of health facilities demands that there be advance planning and control to avoid any unnecessary duplication of facilities and service within a give community. Recently, our association joined the U.S. Public Health Service in an extensive study of this subject and in the development of a basic document setting forth the principles which should guide area planning agencies. This document called "Procedures for Areawide Health Facilities Planning," has been widely distributed and is considered as a fundamental guide. I have a copy of this text which I will be glad to leave with you, Mr. Chairman.

At the time the Hospital Survey and Construction Act was initiated, we all had a vision that the program would gradually work toward coordinated planning and operation of health facilities. We have not as yet moved very far in this direction. It seems to us quite clear that we must now begin to take such steps. We believe that areawide planning is the best mechanism to bring this about.

We have, for several years, recorded our support of the Federal Government providing "seed money" to develop areawide planning and to assist in demonstrations which would provide experience and guidance that is needed. Through the research and demonstration funds provided under the Hospital Survey and Construction Act, a good start has been made. However, we have not felt that Government support should be provided for the continued operation of such endeavors beyond the initial stages of development. These areawide planning agencies are intended to be voluntary community organizations, and we believe their support should come from local sources.

H.R. 10041, as originally introduced, provided \$5 million for the first fiscal year and \$10 million each for the next 4 fiscal years. We believe that this amount of money is warranted and would permit the widespread development of regional planning agencies throughout the country which is urgently needed. We suggest, therefore, that these amounts be restored. We believe the provision now in the bill for a maximum grant of 50 percent for a single project is desirable.

The proposal in the bill, which suggests continued financing of areawide planning agencies for the full period of 5 years, may well carry such support beyond the point of initiation and demonstration and, in essence, becomes continued Federal financing for their operation. We would suggest, therefore, that the proposal be amended to limit such support to a 3-year period for any given project.

SECTION 601, TITLE VI—AUTHORIZATION OF APPROPRIATIONS

We fully support the expanded funds proposed for construction of long-term care facilities and the combining of the previous separate categories of chronic disease and nursing homes. The unmet need for such facilities amply supports the proposal for a substantial increase in the funds to be made available.

The bill proposes to continue grants for the construction of rehabilitation facilities. We support the need for Federal assistance to provide such facilities. We were pleased that the Congress amended the Hospital Survey and Construction Act in 1961 to assure that encouragement would be provided for the development of such facilities on a much broader basis. We recognize the special need of "comprehensive" facilities which involve services other than purely medical services. However, we feel that encouragement should be given for the widest possible development of rehabilitation facilities even though they are not comprehensive in character. Therefore, we oppose the provision set forth under section 603(a)(2) which would establish a priority for rehabilitation facilities developed in university centers. We feel this provision will result in there being less facilities than are clearly needed throughout the country. We would prefer that the States be permitted to allocate funds for more and a wider range of facilities than they would with the priorities provided in this bill.

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The Hospital Survey and Construction Act has, since its enactment in 1946, made a substantial contribution to the development of needed health facilities in the Nation. At the time the program was started, it was essential that first priority and particular attention be given to areas of the country which were without hospital facilities, and therefore, where the public was not likely to have available to them the benefits of modern medical advances. The picture today is different. Though a considerable need still exists for additional beds and other health facilities, the urgent need of rural areas has been met in substantial part in most sections of the country. We believe we are now at the point where the great unmet hospital facility needs of our large urban population centers must be cared for. We consider the surmounting and major problem of health facility needs in the Nation today to be that of the older hospitals with outmoded, inefficient, and often unsafe physical plants. This problem, though it exists in large part in metropolitan centers and in the older cities of the country, exists also to an appreciable extent in older smaller facilities in small cities and towns.

A growing awareness of the problem occasioned the association to make a nationwide questionnaire study. This revealed a dollar need for modernization of over \$1 billion, and the later study in somewhat greater detail made by the U.S. Public Health Service indicated a figure of \$3.6 billion needed for modernization.

Since that time, several areas have undertaken regional or metropolitan studies. In the city of New York a team of architects and engineers visited and studied the needs of 83 hospitals. The study determined that the modernization of these hospitals would require an expenditure of well over \$250 million. This study in New York serves to validate the opinion of many authorities that the nationwide figures may have understated the size of the problem. In New York it was found that an expenditure of \$120 million is needed merely to replace non-fire-resistant hospital structures.

The large urban teaching hospitals are the key to the whole health structure of this Nation. These hospitals provide the essential education for physicians, nurses, dietitians, medical-record librarians, physical therapists, and the other people who make up the health team. We are spending vast amounts of money for medical research in the country. Much of this research must be carried out in these large, older, teaching hospitals. A good deal of the medical research being done, if it is to be made available and to be beneficial to the people, must be translated into actual procedures for patient care. It is in these larger

and older hospitals where this essential task is performed. We believe that the American public, which in large part depends upon the older and outmoded hospitals of the Nation, are often treated unfairly and are, in fact, being discriminated against in terms of the Nation's expenditure for hospital improvement. The largest percentage of the Nation's population receives care in the hospitals of our metropolitan centers. Also, large numbers of the rural population turn to these metropolitan hospital complexes for care of the more serious types of illnesses.

It is our belief that the problem of modernization has reached such proportions and is of such severity that we must meet it with action. We are, therefore, extremely pleased that this bill at least recognizes the problem and the need for the Federal Government's participation in working toward a solution.

Any appreciable impact on the problem will require the expenditure of large amounts of money and large amounts of Federal assistance. H.R. 10041 provides \$160 million over a 4-year period for modernization. Of this amount, however, \$60 million may be used for new construction instead of modernization at the discretion of the States. S. 2531 provides a larger sum for modernization. Neither bill reflects the magnitude of the need.

We recommend that the bill be amended so that for the fiscal year ending June 30, 1965, \$50 million be provided for renovation; for the fiscal year ending June 30, 1966, at least \$70 million; for each of the following 3 years, \$100 million, making a total of \$420 million in grants over a 5-year period. We believe, in fact, that this amount is minimal and will only produce an adequate beginning. We feel it is unnecessary to lose the first year as H.R. 10041 provides. Many projects could move ahead rapidly if funds were made available.

We recommend that \$100 million be provided annually in each of the 5 years covered by the bill for the construction of new hospitals and other medical facilities. These amounts are recommended in addition to the amounts provided for under the section for long-term care facilities, diagnostic and treatment centers, and rehabilitation facilities.

The bill provides that States may transfer renovation and modernization funds into the new construction category. We believe this to be an unwise provision and recommend that funds provided for modernization purposes be earmarked entirely for this purpose.

It is recognized that the extent of the problem varies in different sections of the country. Individual projects for modernization often will require large expenditures and in numerous cases run into several millions of dollars. Under the Hospital Survey and Construction Act, by administrative decision, limited amounts of money have been provided to a single project. This was necessary to make the funds assist as many projects as possible. Generally, of course, these were smaller projects than the ones we are talking about for modernization. A different philosophy for the allocation of funds is essential if boards of trustees of individual hospitals are likely to assume the financial obligations of large-scale modernization projects. A different grant formula will be required from that used in the Hospital Survey and Construction Act, wherein grants run from 33 $\frac{1}{3}$  percent to 66 $\frac{2}{3}$  percent depending upon the financial position of the State. The great bulk of modernization projects will be in those States that fall in the lowest percentage grants.

We believe, therefore, the minimum grant for any project should be at least 50 percent in order to accomplish any substantial amount of modernization.

#### FINANCING OF BORROWED MONEY

Even with 50 percent grants, project sponsors will have to obtain large amounts of additional funds thereby creating a heavy burden of debt. This indebtedness will be borne largely by paying patients and will cause an appreciable increase in the price of hospital care. The size of this indebtedness is a matter of serious concern to boards of trustees and would, we believe, discourage many of them from going ahead with needed projects if they are subject to the interest rates of the commercial money market. The attached table indicates the effect of various interest rates on patient-day costs.

As a matter of basic principle, it is felt that the needs of modernization must be approached so as to cause the least possible increase in the cost of hospital care. We recommend, therefore, that the bill be amended to provide for a program of direct Federal loans. Such a program of loans is proposed in S. 894 introduced by Senator Joseph Clark of this committee. It is our belief that the Federal Government could provide a great incentive for modernization of hospital facilities if it were willing to underwrite in part the cost of the money to

be provided by bringing the interest rate down to around 2 percent. However, if such a subsidized rate of interest is not feasible, we urge at least a system of direct Federal loans at the interest rate available to the Federal Government for numerous other programs as the Clark bill proposes. We agree with Senator Clark that project sponsors should be enabled to receive a 50-percent grant from the Federal Government and to borrow additional needed funds from the Federal Government through direct, low-interest loans up to a maximum of 80 percent of the total project cost.

A separate method of allocating money among the States for modernization is highly essential. We believe the single factor essential to take account of the varying need for nationwide modernization is the total amount of modernization needed in a given State in relationship to the total modernization needs for the Nation as a whole. Neither population nor the financial needs of the respective States are appropriate factors to be used in the allocation of the funds.

#### SECTION 603—GENERAL REGULATIONS

This section provides for special consideration to facilities serving rural communities. At the time the program was started it was essential that rural areas receive preferred treatment and first priority in the allocation of funds. As a consequence, the most acute rural needs have been met. The rapid growth of population in urban areas has resulted in unmet needs for new urban facilities.

We believe that the rural priority is no longer needed. We recommend, therefore, that the provision granting priority to rural areas be stricken from the bill and the language be amended to permit the States to give special consideration to "areas of greatest need."

This section of the bill also provides that special consideration be given to rehabilitation facilities in university teaching hospitals. We have previously questioned the wisdom of this provision not because we are in any way opposed to comprehensive rehabilitation centers in universities but rather that we believe the States should be free to provide the additional, though less than comprehensive, programs needed in many areas.

The bill also authorizes the Surgeon General to develop criteria for determining the need for hospital beds and facilities in a given area, thus removing the previous statutory provision establishing ceilings. The ceilings have not been helpful, being too high in some areas and too low in others. We feel the language in the bill is a decided improvement, and it will encourage more intelligent planning.

#### SECTION 604—STATE PLANS

The bill provides for the establishment of State advisory councils and names the types of individuals to be selected to serve on such councils.

We would recommend that the language be amended so as to provide for the inclusion of an individual who is authoritative in the field of mental health. The recently passed mental health-mental retardation program will be administered in some States by the same State agency which administers the hospital survey and construction program. In all States there is a need to coordinate planning activities between mental facilities and others. It is noted that the bill requires the appointment of a mental health authority to the Federal hospital council, and we suggest a similar requirement for State advisory councils.

#### SECTION 621—FEDERAL HOSPITAL COUNCIL AND ADVISORY COMMITTEES

This section provides that the Surgeon General in administering this title shall consult with a Federal Hospital Council. However, as we read the amended language in the bill, it did not require the appointment of any hospital authority to the advisory council. The council is expanded from 8 members to 12 members and this would permit the addition of authorities relating to the mentally retarded and relating to mental health to the council which we fully supported.

We believe the provisions set forth in the Hospital Survey and Construction Act should be continued in this bill. This provides for the appointment of four members who are "outstanding in fields pertaining to hospital and health activities, three of whom shall be authorities in matters relating to the operation of hospitals." The wording as it appears in the bill is vague and the term "medical facility" has been substituted for the term "hospital." Further, the bill provides that authorities in the operation of hospitals need not be appointed and that persons who are authoritative in matters relating to "other medical facilities" can be appointed. We believe it would be most unwise to have a

council appointed which is to advise on the development of hospital facilities without assuring adequate representation of persons who are authoritative in the administration and operation of hospitals. We, therefore, urge that this section of the bill be amended accordingly.

#### SECTION 625—DEFINITIONS

The term "hospital" as defined in this subsection differs from the definition of hospital in section 631(e) of the existing law. The new definition does not include mental hospitals. We believe the language should be amended so that the term "hospital" clearly includes mental hospitals as in the existing law. This provision has been extremely valuable in encouraging the development of a new acute psychiatric facilities in general hospitals. In view of the great need for such facilities, we feel it would be a serious mistake to omit "mental hospital" from the definition of "hospital."

In conclusion, we have greatly appreciated the opportunity of appearing before this subcommittee and presenting the views of the American Hospital Association. We sincerely hope that our comments and recommendations will prove helpful in the final development of legislation. We wish to commend the committee for the enormous contribution that it has made in the past to advance the health and welfare of the American people. We recognize the important role of the committee in the provision of health facilities for the Nation. We feel that your consideration of the need for modernization of our older health facilities is a major step forward. The American Hospital Association stands ready to be of all possible assistance to this subcommittee.

The CHAIRMAN. Now, General Terry and Dr. Graning.

#### STATEMENT OF DR. LUTHER L. TERRY, SURGEON GENERAL; ACCOMPANIED BY DR. HARALD M. GRANING—Resumed

The CHAIRMAN. General, do you have any comments you would like to make on the amendment proposed by Senator Hruska?

Surgeon General TERRY. Yes, sir, Mr. Chairman.

Since the Senator presented his proposal, I have had an opportunity to look it over and to discuss it with some of the members of my staff. As I understand it, this amendment would authorize the transfer of funds from one allotment to any other allotment, upon the State agency certifying that the transfer would more effectively serve the needs of the people of that State. The amendment would also establish limitations on such transfers by stating that the amount of the transfers into any one allotment over the 5-year life of the program, plus the amounts of that allotment originally, could not exceed the amounts which would otherwise have been available.

In other words, presumably the bill provided so much funds over a period of 5 years in a part C category and, if transfers were made in or out of that, at the end of the 5-year period the total amount in part C could not exceed that basic authorization in the bill.

Very frankly, Mr. Chairman, we feel that the allotment transfer provisions which are already included in H.R. 10041 are quite liberal.

The CHAIRMAN. General, I think we might have a clearer picture, when you are speaking of categories, if we explained that. You have the general hospital category.

Surgeon General TERRY. Yes, sir.

The CHAIRMAN. Then we have the diagnostic and treatment center category, and then we have the rehabilitation center categories.

Surgeon General TERRY. That is right.

The CHAIRMAN. Then, we have the chronic diseases category and the nursing home category.

Surgeon General TERRY. Yes, sir.

The CHAIRMAN. Those are the five categories that we are now speaking of; is that not right?

Surgeon General TERRY. Yes, sir.

And, in effect, this provision would allow the funds to be transferred from one allotment or one category into the other.

As I said a moment ago, Mr. Chairman, we feel that the provisions in H.R. 10041 are quite liberal with regard to flexibility and the permission for the States to use transfers to meet the individual problems of that State.

At least upon looking preliminarily at the proposal, one can see that difficulties, serious difficulties, might be encountered in a State program during the fourth and fifth years if they had unwisely transferred too much funds in one category during the first 2 or 3 years of the program.

Frankly, I think that the Congress and the congressional committees have always felt that there was a stimulatory and a guiding effect in having funds placed in categories in this bill, and I think that this could do a great deal to nullify completely the categorical designation of funds.

Therefore, I would much prefer to see a provision such as is included in H.R. 10041.

The CHAIRMAN. Well, General, of course, if there are no approved applications, then funds can be transferred; is that not true?

Surgeon General TERRY. This is true under H.R. 10041 for most categories; yes, sir.

The CHAIRMAN. Under the House-passed bill.

Surgeon General TERRY. Yes, sir.

The CHAIRMAN. For instance, if you had no approved applications for your nursing-home funds, those funds could be transferred to the modernization category, or to the rehabilitation category, or some other category; is that right?

Surgeon General TERRY. Yes, sir.

The CHAIRMAN. Do you have any questions, Senator Pell?

Senator PELL. In connection with Mr. Williamson's suggestion, General Terry, would you with regard to section 603—to give the help to the areas of greatest need, as opposed to those where the emphasis is perhaps more in the rural areas—would you think that that was a good amendment or not?

Surgeon General TERRY. I do not see any necessity for a change there, Senator. Frankly, I did not have an opportunity to discuss this with the staff in detail, but my initial reaction would be that I would not see a need for such change.

Senator PELL. I was wondering what your reaction was. My own view was favorable toward it, but I was interested in your views.

Surgeon General TERRY. Yes, Senator.

The CHAIRMAN. Of course, that only applies within a State. If you have a State that does not have very much rural population, that would not apply.

Surgeon General TERRY. It not only applies within the State, but within the needs of the State. I think the critical point here is that the program has always been predicated upon the needs within the

State. It is true that the program has given preferential treatment to certain States of a lower per capita income, and that sort of thing. But at the same time, I think that within the State there has been sufficient flexibility to meet the State's needs, so I would see no necessity for a change.

The CHAIRMAN. The authority for the allocation of funds among projects within the State has been in the State agency; is that not true?

Surgeon General TERRY. Yes, sir.

The CHAIRMAN. Dr. Graning, would you like to make some comments here?

Dr. GRANING. Senator, I would like to make the comment that this language should be viewed within the context of the other items that are included; all this really says is that special consideration shall be given to facilities serving rural communities and areas of relatively small financial resources. But it also goes on to enumerate the need for modernization facilities; the need for rehabilitation facilities; the need for helping those hospitals that give attention to nurse training. It is one of the items that is enumerated in the act.

Senator WILLIAMS. Mr. Chairman?

The CHAIRMAN. Yes, Senator Williams.

Senator WILLIAMS. I wonder what the actual amount of applications under the hospital construction program is right now?

Dr. GRANING. Sir, perhaps we can best answer this by saying that in the history of the program there have been more applications than there has been money available.

Senator WILLIAMS. I just wanted to get the proportions of the applications to the money available and the money proposed here.

Next year it is \$150 million for hospital construction. How does this compare with the demand as shown in the applications?

Dr. GRANING. Each State has taken its allotments and has considered on a priority basis the applications available, and the extent to which the funds have been oversubscribed has varied on a State-by-State basis, to be sure. But, by and large—

Senator WILLIAMS. Then you do not get the full figure on applications; you only get it after it is sieved through the State agency; is that right?

Dr. GRANING. We know that each State develops a project construction schedule that has many applications on it that cannot be funded at the present time. The funds are already committed for 1965 and 1966 as far as the States are concerned, and they say, "If we get the anticipated money, you can get assistance in such-and-such a year."

Surgeon General TERRY. In other words, Senator Williams, we do not regularly get that. Under certain circumstances we do get information of this sort from the State agencies. An example would be in 1960, when, in working with the State agencies, we received their estimate of what they needed for modernization of the facilities in the States, and the total there, for instance, was \$3.6 billion, which gives you some indication of the needs there.

We also have another criterion, I think. For instance, when we say that on the basis of the State's purported needs and accomplishments to date, we feel that 83 percent of the general hospital beds

needed today have been constructed. Now, that still leaves a big margin of 17 percent of needed beds in the States for general hospital beds. It still leaves some needs in other categories, particularly in the nursing home area, and it also does not provide for the needs of next year or 5 years from now, because of the expansion of our population.

So, in essence, these things are changing every day, every week, every month.

The CHAIRMAN. Excuse me 1 minute.

General, may I say that each year you supply our Appropriations Committee, the Subcommittee on Health, Education, and Welfare, a table showing just what applications there are.

Dr. GRANING. Sir, as of the present time, for instance, the States are reporting 133,000 additional general beds as being needed, 133,000 general beds, some 532,000 long-term care beds, and they are saying that their estimate of the modernization costs to modernize hospitals is in the neighborhood of \$3.6 billion.

The CHAIRMAN. I suggest that you supply us with the same table that you supplied to our Subcommittee on Health, Education, and Welfare for our hearings on the appropriations bill for 1965.

Surgeon General TERRY. We would be very happy to do that, Senator.

The CHAIRMAN. The same table that you have supplied to the Appropriations Subcommittee; if you will supply that for us, I think that might be helpful to Senator Williams.

(The table referred to will be found on p. 178.)

Senator WILLIAMS. Yes.

The CHAIRMAN. Are there any other questions? Senator Pell?

Senator PELL. I have no other questions.

The CHAIRMAN. Is there anything you would like to add, General Terry?

Surgeon General TERRY. I have nothing further, sir.

The CHAIRMAN. Let me ask you a question.

Our friend, Mr. Williamson, raised a question about your Hospital Council. Do you have any comment you would like to raise about that?

Surgeon General TERRY. I do not think that we have encountered any difficulty in that respect in the past with regard to the language. I do not have any strong feelings about it. I think you can appreciate the fact that we are going to get hospital administrators and people experienced in this field on our Council. Whether the term will change it or not, I do not think would make a great deal of difference to us.

The CHAIRMAN. Of course, they are well represented on the Council today, are they not, and have been from the very beginning?

Surgeon General TERRY. That is right.

The CHAIRMAN. Do you have any other questions, gentlemen?

Senator PELL. I have no questions.

The CHAIRMAN. Senator Williams?

Senator WILLIAMS. No, Senator.

The CHAIRMAN. Is there anything you would like to add, General?

Surgeon General TERRY. I have nothing further.

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

Dr. GRANING. No; thank you, sir.

The CHAIRMAN. We want to thank you gentlemen very, very much. At this point in the record we will include the statement of Senator Williams and various statements and letters that the subcommittee has received.

(The statements and letters referred to follow :)

PREPARED STATEMENT OF SENATOR HARRISON A. WILLIAMS, JR.

Mr. Chairman, I support H.R. 10041, the "Hospital and Medical Facilities Amendments of 1964."

It has been 18 years since the Hospital Survey and Construction Act, better known as the Hill-Burton Act, was enacted. Thanks to the leadership and foresight of Senator Hill, a revolution in health care has been accomplished in this Nation.

After the great depression and the Second World War, there were vast areas of our country where hospital and medical care were simply not available. Now, primarily because of the Hill-Burton Act, there are very few such areas left. Hospitals have been built in several hundred communities, and doctors have gone to serve in these hospitals. Millions of people have had a chance to participate in the benefits of modern medical science, who might, if it were not for the Hill-Burton legislation, simply have gone without either medical or hospital care.

I hope that the increases in funds authorized for this program will be approved by the committee and by the Senate.

At the same time that we have been progressing in making hospital facilities available to more people throughout the country, we have been falling behind in another important respect—that of maintaining the quality of care available to patients in our large urban and metropolitan areas.

In these areas, modernization and replacement, rather than new bed construction, is becoming an increasingly desperate need. While the pending legislation recognizes this need, I doubt whether the funds provided will be sufficient to meet it.

A nationwide survey by the Public Health Service in 1960 indicated that modernization and replacement needs would cost \$3.6 billion. Of course both needs and costs have increased since then.

As a cosponsor of Senator Clark's Hospital Modernization Act, I am anxious that Congress act as soon as possible to begin the task of bringing our older, larger hospitals up to standard. Increasingly, modern medicine is being faced with a paradox. As scientific advances make improved medical care possible, both the public and the medical profession insist on a higher standard of patient care. Yet, many of our hospitals are so crowded and their facilities so outmoded that they cannot meet this standard. They cannot give their patients the care that they know how to give, the care they know is needed, because their buildings are overcrowded, obsolete, and often even unsafe. And these hospitals are the ones which serve urban areas, where the vast majority of Americans live, and where the greatest population growth is even now taking place.

The large urban hospitals bear the added burden of providing education for physicians, nurses, technicians, and all the specialists and researchers needed to sustain our progress in medical science. Most of the vast amounts of money we are spending for medical research is spent in these teaching hospitals. Of course the benefit from these teaching and research efforts is felt throughout the country—not just in the urban and metropolitan areas.

Mr. Chairman, I respectfully urge the adoption of H.R. 10041, and I hope that in the future, even more assistance can be given to modernization and replacement of facilities in our larger, older hospitals.

AMERICAN FEDERATION OF LABOR AND CONGRESS OF  
INDUSTRIAL ORGANIZATIONS,  
Washington, D.C., July 7, 1964.

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

DEAR MR. CHAIRMAN: We appreciate this opportunity to support again the Hill-Burton program. We think changes in the act along the lines of H.R. 10041 will significantly improve health services to the American people.

We respectfully request that our letter and the attached statement be included in the record of your hearings on H.R. 10041.

Sincerely yours,

ANDREW J. BIEMILLER,  
Director, Department of Legislation.  
NELSON H. CRUIKSHANK,  
Director, Department of Social Security.

PREPARED STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AFL-CIO, AND NELSON H. CRUIKSHANK, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL-CIO

The longstanding and vigorous support of the AFL-CIO for the Federal hospital and medical facilities construction program is well known to this subcommittee. Both the AFL and the CIO urged the enactment of the Hill-Burton program in 1946. Our two organizations, and, since merger, the AFL-CIO, have appeared before committees of both the Senate and the House on numerous occasions to urge the broadening and further extension of the program when such revisions seemed to be necessary. We regularly appear before the Appropriations Committees to support the adequate financing of the program. Persons closely connected with the labor movement have served as members of the Federal Hospital Council, to advise on the administration of the program.

As representatives of the consumers of hospital services we recognize the enormous contribution of the Hill-Burton program to the improved health of all Americans. There are many ways that we in this country have fallen behind other Western nations in our provisions for the organization and financing of medical care. In hospital and medical facilities construction we are unquestionably ahead of most other nations. This fact is due almost entirely to the existence and successful operation of the Hill-Burton program. The distinguished chairman of the Committee on Labor and Public Welfare deserves the Nation's gratitude for his significant part in this accomplishment.

We believe that the time has come for some modifications in the Hill-Burton program to enable it to continue to serve the Nation's health with full effectiveness. We believe that changes in the act, along the lines of the bill, H.R. 10041, which was enacted by the House, will be of great value and significance in improving the health services available to the American people. Enactment of these changes will keep the Hill-Burton program responsive to new needs and new opportunities.

#### MODERNIZATION

The Committee on Labor and Public Welfare is as aware as we are that the greatest impact of the Hill-Burton program so far has been in rural areas and small communities. These, of course, are the areas that had the greatest deficiencies in hospitals and other facilities at the time that the Federal Government began to make Hill-Burton funds available. As a result of the great success of the Hill-Burton program this picture has radically changed. The great deficiencies in medical care facilities today are no longer almost exclusively in sparsely populated areas. They tend instead to be concentrated in the cores of our big cities. And the deficiencies we find today are not limited to an absence of hospitals and a lack of hospital beds. Today's deficiencies are more likely to be the result of inadequate, obsolete, inefficient, and sometimes hazardous physi-

cal plants. This means that the criteria by which money was allocated under initial Hill-Burton legislation can no longer be relied on, operating by itself, to insure that the Federal funds will go where they are most needed. New criteria must be established, not to substitute for, but to supplement the existing methods of allocation.

We, therefore, endorse wholeheartedly the earmarking of funds to be used for the renovation, replacement and modernization of existing facilities. These funds would be allocated in a different way from the funds that will continue to be used for the construction of new facilities. Although we are inclined to believe that essential modernization and renovation requires a greater allocation of funds than is proposed in the House-passed bill, we favor the enactment of this bill as an important step in the direction of providing adequate hospital services for all the people of the Nation.

#### PLANNING GRANTS

In early 1963, the executive council of the AFL-CIO developed a broad policy statement on community hospitals. Included in this statement was a section endorsing the principle of regional planning. The council stated that:

"No hospital should be built, enlarged or relocated except in accord with a systematic plan of estimated present and future needs for hospitals and allied agencies; a plan prepared by a representative nonprofit agency, enlisting the services of impartial experts should be understood to include not only physical facilities, but also services. Every proposal for expansion, brought forward by individual hospitals or others, should be evaluated according to the needs defined in the plan—needs not only for beds for acutely ill patients, but also for facilities for long-term patients for nursing homes, for home care, for ambulatory facilities, for rehabilitation facilities, for facilities for research and education of professional and technical personnel.

"Our communities, their surrounding areas and their needs have become so large and complex, and the costs of medical facilities have become so high, that we cannot afford the inefficiencies and the costs of unbridled individual autonomy. Persons and institutions have an obligation to discipline their autonomy in terms of the obligations to their communities."

The provisions in section 318 of H.R. 10041 providing special project grants for assisting in the areawide planning of health and related facilities will make possible the kind of rational planning that is required, and we strongly support the enactment.

#### LONG-TERM CARE FACILITIES

The increase in the authorization for the construction of public or other nonprofit facilities for long-term care contained in H.R. 10041 is crucial. There is hardly a family in the country that has not had the experience of trying to find a decent nursing home or chronic disease facility for an aged relative or friend, and been shocked and dismayed at the miserable inadequacy of the vast majority of facilities currently available. The proposed increase in the authorization for financing long-term care facilities would do much to remedy the shameful inadequacies of the facilities available for the care of the chronically ill today.

In conclusion, Mr. Chairman, we congratulate you and this committee on the leadership you have exercised in the past to bring to the people of this country the splendid hospital and medical facilities we now have, and trust that you will continue this tradition into the future. We urge that this committee and the Senate act promptly and favorably on H.R. 10041 in order that the Federal Government will remain in the position of providing the assistance to the States and local communities that is required if we are to reach our goal of making the best of modern medical care available to all Americans.

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#### PREPARED STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association is pleased to support extension of authority for the Hill-Burton hospital construction program. Our association has been a longtime supporter of this program which has for many years made a signal contribution to the bettered health of our Nation. The sagacious fore-

sight of the originators of this program and the wisdom of the Congress in beneficial amendments which have been added during the succeeding years since first enactment have, in the opinion of the APHA, produced a feature of our total health armamentarium of which the Congress can be justifiably proud. Our support of this program emanates from a firsthand knowledge of the contributions which it has made. The broad-gaged support provided through the Hill-Burton enactment, coordinated through a joint Federal, State, and local endeavor, has resulted in general hospitals, tuberculosis hospitals, mental hospitals, and public health centers, public health laboratories, and rehabilitation facilities. The addition of assistance for the provision of facilities to care for persons suffering from chronic disease and the recently added assistance to provide nursing homes has materially increased our medical capabilities to preserve life.

A recitation of the statistics of the accomplishments of the Hill-Burton program to date is truly awesome. These facts will have been made available to the committee and to the Congress by the Public Health Service. A real appreciation for this betterment of life in these United States is reserved, however, for those who have been relieved of pain or disability where previously there was no hospital or where a hospital in close proximity meant the difference between life and death, or by the person who could go to a tuberculosis hospital with a chance to be restored to a fruitful life rather than remain at home to spread his disease to members of his family, or that individual who no longer must see a loved one admitted to a mental institution hopelessly overcrowded with a prognosis for little if any improvement, or the aged individual with limited financial means who can now receive appropriate care in a good nursing home and not be forced into an institution which profits on misery. These millions of persons are those who truly appreciate the contributions of the Hill-Burton program. But these accomplishments must not blind us to unmet needs.

Through the years, the APHA has recommended amendments to the Hill-Burton authority, and we take pride in the knowledge that most of these suggestions have been accepted by the Congress. Still further advances have been made in the legislation proposed by the chairman of this committee, Senator Hill, in S. 2531 and in H.R. 10041. We wish, however, to address ourselves to the present consideration of the extension of the existing authority together with amendments that would make the program even more effective and respectfully request the consideration of this committee to these suggestions. We are in agreement with the deletion of the separate-but-equal clause, the requirement that aid for nonprofit nursing home construction be restricted to those with hospital affiliation, and the assistance directed to remodeling of hospitals in urban areas as contained in both S. 2531 and H.R. 10041. In addition, the APHA believes that the eligibility requirement whereby an applicant must own or operate a hospital in order to receive aid in the construction of a diagnostic or treatment center is neither practical nor realistic in certain areas of the United States, particularly in some rather sparsely populated rural areas. We believe that this requirement should be eliminated from the authority. Second, we support low-interest loans for the construction of public nursing homes and for the modernization of public and nonprofit hospitals. The needs of this Nation for nursing home beds and for the restoration, rehabilitation, or the replacement of large hospitals in metropolitan areas are of gargantuan proportion and are, we believe, beyond the capabilities of the Hill-Burton grant procedure. We believe that the low-interest loan approach would be a significant and beneficial addition in these two instances. Other principles espoused by the APHA are presently incorporated in the legislation under consideration by this committee, and we are pleased to support the principles contained in S. 2531 and H.R. 10041.

A basic tenet of the APHA as it relates to cooperative State-Federal programs is that all legitimate latitude should be allowed to States and to communities within States to decide the precise kind of facilities and services which will best suit the needs of that State and community as well as the method whereby they are to be provided. Such reasonable latitude has been a part of this program throughout its existence, and the entire Nation has benefited as a result thereof. We have studied carefully the language contained in H.R. 10041 as passed by the House of Representatives, particularly as it pertains to the allotment of funds for the construction of new hospitals and the modernization of

existing hospitals and other medical facilities. In the opinion of the APHA, the language contained in section 602 of H.R. 10041 does provide the desired latitude to States to transfer portions of allotment between categories so as to provide the flexibility needed by each individual State to be responsive to the hospital and other medical needs of that State in a precise fashion. It is our opinion that the language contained in section 602(e) provides flexibility similar to that contained in S. 2531. Because of the necessity to act promptly upon the extension of this authority, which except for the continuing resolution approved by the Congress, would have expired on June 30, 1964, we urge the Senate to act with all possible speed to approve H.R. 10041 as passed by the House.

We respectfully bring these considerations to your attention and wish to express our appreciation for this opportunity to make known to this committee the views of the American Public Health Association.

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PREPARED STATEMENT OF THE AMERICAN OSTEOPATHIC ASSOCIATION, BY CARL E. MORRISON, D.O., CHAIRMAN, COUNCIL ON FEDERAL HEALTH PROGRAMS

The American Osteopathic Association appreciates this opportunity for comment in support of the House-passed bill, H.R. 10041, Hospital and Medical Facilities Amendments of 1964, which would revise and extend the Hill-Burton program for an additional 5 years to June 30, 1969.

The American Osteopathic Association is a nonprofit, tax-exempt, federation of divisional societies of osteopathic physicians and surgeons, the first objective of which, as set forth in its constitution is "to promote the public health."

Our support of a national hospital program of Federal assistance for building new hospitals and providing additional beds in existing hospitals, in accordance with State plans, to increase the availability of hospital care particularly in rural areas, dates back to 1940, S. 3230, 76th Congress, and has continued throughout the years.

On May 30, 1940, a national hospital bill, S. 3230, passed the Senate. It included provision for a National Advisory Hospital Council to consist of eight members to be selected from leading medical, osteopathic, or scientific authorities who are outstanding in matters pertaining to hospitals and other public services.

When the Hill-Burton bill was finally adopted in 1946, the areas for appointment to an eight-member Federal Hospital Council were couched in general terms. The act of October 31, 1963, Public Law 88-164, increased the membership of the Federal Hospital Council to 12 members and in so doing reverted to particularity of some of the fields to be represented. Inasmuch as H.R. 10041 retains the increase to 12 members and the Senate voted for appointment of an authority in the field of osteopathic medicine and hospitals on a similar Hospital Advisory Council in 1940 as above stated, we feel that such an appointment should be given priority. Arizona, Maine, Michigan, Missouri, New York, and Oregon have osteopathic representation on State Hill-Burton advisory councils.

Section 2 of H.R. 10041, authorizes \$22.5 million over a 5-year period for matching grants to State Hill-Burton agencies for developing, supervising, and assisting in the carrying out of comprehensive regional, metropolitan areas, or other local area plans for coordination of existing and planned health facilities. A report of the Joint Committee of the American Hospital Association and the Public Health Service (PHS publication No. 855) on "Areawide Planning for Hospitals and Related Health Facilities" points out that planning agencies may find it advisable to:

"Refuse to recommend projects for Federal or State assistance and discourage actively the use of capital funds from any source for construction which is not consonant with the plan."

Legally authorized in all the States and licensed to perform major operative surgery in 39 States and the District of Columbia, the osteopathic profession is manifestly interested and should have a voice in the resolution of such planning problems as duplication of facilities, maldistribution, underutilization, understaffing, and shortage of trained personnel.

The following statistics for the year 1962, the latest available, were prepared by the American Osteopathic Hospital Association, an affiliate of the American Osteopathic Association:

Number of osteopathic hospitals.....	330
Number beds.....	14, 115
Number newborn bassinets.....	2, 390
Number admissions.....	531, 263
Number live births.....	81, 260
Average daily census.....	10, 190
Average daily census (newborn).....	890
Total expenses.....	\$126, 440, 594
Cost per patient day.....	\$34. 75

All hospitals included in the above statistics are professionally directed by osteopathic physicians and surgeons. Ninety-five percent of the beds are in hospitals accredited by the Bureau of Hospitals of the American Osteopathic Association. Accreditation standards relating to professional staff include, among others, the following provisions:

"The hospital must be able to show evidence of maintaining a qualified and well organized professional staff.

a. There must be a minimum of three organized professional departments as follows:

- (1) Osteopathic medicine; (2) obstetrics and gynecology; and (3) surgery.
- b. Radiology and pathology services must be provided.

The staff must be composed of licensed osteopathic physicians who are members in good standing of their national and divisional associations, and local associations where such exist.

Courtesy staff privileges may be accorded other licensed physicians and dentists who are members in good standing of the American Medical Association, American Institute of Homeopathy, American Dental Association and their respective component societies, each in his proper category."

(Excerpted from "Requirements for the Training of Interns and/or Residents" as approved by the American Osteopathic Association.)

Since the inception of the Hill-Burton program, 65 osteopathic projects have been approved involving a total construction cost of \$51,387,242, including the Federal share of \$17,514,198. These projects provided 3,096 beds, of which 1,379 or 44.5 percent were in new hospitals. Categories represented include 51 general hospitals, 7 diagnostic and treatment centers, 4 nursing homes, 2 chronic disease facilities, and 1 rehabilitation facility. A chronological chart showing osteopathic participation through December 1963 is appended.

We are pleased that the bill includes a new program of grants for modernization of hospitals and other medical facilities. In our statement advocating extension of the Hill-Burton program in 1958, we requested that the program be expanded in this respect. We stated:

"Ninety of the hospitals containing 40 percent of the beds are located in cities of over 100,000 population. A substantial number of these need to replace obsolete beds, but they are prevented from Hill-Burton participation for the purpose due to the operation of a priority system that has become unrealistic in this respect."

We hope that the provisions authorizing a new program of mortgage insurance for construction and modernization of hospitals and other medical facilities which were deleted from the original print of H.R. 10041 will be restored. Under that program, the insured loan could not exceed 50 percent of the value of the facility after completion of the project, and could not, when added to the amount of any Federal grant for the project, exceed 75 percent of the value of the facility after completion. The insured loan could not exceed 40 years and must be completely amortized by periodic payments. The interest rate could not exceed 6 percent. The program would apply to nonprofit hospitals and medical facilities and to proprietary nursing homes. Insofar as it applies to nonprofit facilities, we urge that the loans be made directly by the Federal Government and that the interest rate be equated with the going Federal rate for numerous other programs.

## Hill-Burton osteopathic projects by year approved through December 1963

Year	State	Name of facility	Category	Beds provided	Cost	Federal share
1948	Missouri	Kirksville College of Osteopathy & Surgery.	General	100	\$1,055,989	\$351,996
1951	South Dakota	Community Hospital	do	19	244,598	119,893
1952	Michigan	Riverside Hospital	do	36	727,347	261,569
1952	Ohio	Bay View	do	30	371,696	120,357
1952	do	Green Cross Hospital	do	50	800,000	200,796
1952	Pennsylvania	Lancaster Osteopathic	do	34	830,271	303,759
1952	Rhode Island	Osteopathic General	do	24	300,836	75,000
1953	Oklahoma	Oklahoma Osteopathic	do	38	820,101	327,500
1954	Michigan	Mount Clemens	do	100	1,342,134	500,461
1955	California	Sierra Hospital	do	58	1,232,669	254,510
1955	Michigan	Muskegon Osteopathic	do	41	619,211	239,716
1955	Texas	Fort Worth Osteopathic	do	80	1,187,164	535,500
1956	California	COPS, Los Angeles	Rehabilitation facility.		276,283	72,000
1956	Maine	The Osteopathic Hospital	General	51	654,845	300,000
1956	Missouri	Kansas City College of Osteopathy & Surgery.	D. & T.C. <sup>1</sup>		342,444	170,988
1957	Michigan	Lansing General	General	86	1,233,920	368,400
1957	New Mexico	Osteopathic Hospital	do	25	393,490	173,910
1957	Oklahoma	Oklahoma Osteopathic	do	74	887,955	386,892
1957	do	do	D. & T.C.		150,124	74,859
1957	do	do	Chronic disease facility.	34	222,076	106,632
1957	Oregon	Portland Osteopathic	General	45	902,239	222,842
1957	Texas	San Antonio Osteopathic	do	24	498,371	220,137
1958	California	Harbor City Osteopathic	do	50	1,023,638	297,441
1958	Maine	Tri-County Osteopathic	D. & T.C.		153,008	76,350
1958	Michigan	Grand Rapids Osteopathic Hospital.	General	66	912,572	317,000
1958	do	Saginaw Osteopathic	do	62	881,390	272,825
1958	do	Detroit Osteopathic-ASF <sup>2</sup>	do		720,228	233,000
1958	New Mexico	Osteopathic Hospital	Nursing home	16	112,678	56,339
1958	Ohio	Northeastern Ohio General	General	25	570,112	186,528
1958	Pennsylvania	Shenango Valley Osteopathic	do	50	1,025,393	323,285
1958	South Dakota	Community Memorial	do	11	88,156	44,078
1959	Michigan	Flint Osteopathic	do	228	3,236,054	415,000
1959	do	do	D. & T.C.		167,608	83,804
1959	do	Garden City Osteopathic	General	104	1,956,635	600,000
1959	New Mexico	Memorial Osteopathic Hospital.	D. & T.C.		60,450	30,225
1959	do	do	General	25	230,659	115,330
1959	Texas	Groom Memorial	do	18	251,158	125,000
1959	do	Ft. Worth Osteopathic	do	45	347,084	166,500
1960	Maine	Waterville Osteopathic	do	46	716,509	357,300
1960	do	James A. Taylor Osteopathic	Nursing Home	36	362,658	176,000
1960	Michigan	Traverse City Osteopathic	General	49	991,012	335,000
1960	Pennsylvania	York Osteopathic Hospital	do	102	2,202,663	731,647
1960	Rhode Island	Osteopathic General	do	42	575,670	153,080
1960	do	do	D. & T.C.		58,456	28,839
1961	Maine	The Osteopathic Hospital	General	30	342,438	156,782
1961	Michigan	Riverside Osteopathic	do	82	1,617,800	542,500
1961	do	Garden City Osteopathic	do	50	454,093	158,000
1961	Missouri	Tri-State Hospital	do	41	678,230	335,730
1961	Ohio	East Liverpool Hospital	do	20	400,241	124,121
1961	Oklahoma	Hillcrest Osteopathic	do	78	693,119	346,560
1961	Texas	Corpus Christi Osteopathic	do	40	751,672	352,700
1962	Michigan	Mount Clemens General	do	96	1,879,053	633,000
1962	Missouri	Still Osteopathic Hospital	Nursing Home	59	817,218	330,516
1962	New Mexico	Osteopathic Hospital	General	26	333,400	161,485
1962	Texas	San Antonio Osteopathic	do	28	137,600	68,800
1962	do	East Town Osteopathic Hospital.	do	65	944,000	450,000
1962	Vermont	Osteopathic Hospital	do	30	662,620	217,540
1963	Maine	do	Chronic Disease.	24	200,000	100,000
1963	do	do	D. & T.C.		69,469	34,735
1963	Michigan	Bosford General Hospital	General	202	4,233,700	1,376,795
1963	Missouri	Normandy Osteopathic	Nursing Home	50	816,913	316,000
1963	Ohio	Green Cross Hospital	General	96	1,615,000	350,000
1963	Oklahoma	Oklahoma Osteopathic	do	96	2,300,000	800,000
1963	Oregon	Portland Osteopathic	do	40	448,122	61,946
1963	Pennsylvania	Clarion Osteopathic Commission.	do	19	255,000	85,000
				3,096	51,387,242	17,514,198

<sup>1</sup> Diagnostic and treatment center.<sup>2</sup> Adjunct service facility.

[From the Washington Post, July 7, 1964]

AREA HOSPITAL NEEDS IN NEXT 15 YEARS PUT AT 4,400 MORE BEDS—PLANNING COUNCIL REPORT SEES COST OF \$140 MILLION

The Washington area will need about 4,400 more general hospital beds in the next 15 years, at an estimated cost of some \$140 million.

Such new beds, however, should not be located willy-nilly, but should match population trends and areas of concern, according to a report by the Health Facilities Planning Council for Metropolitan Washington, D.C.

The council is a nonprofit community organization set up in 1962 with the encouragement of the Metropolitan Council of Governments.

The recommendations are contained in a guidelines pamphlet entitled "General Hospitals in Metropolitan Washington: A Guide for Planning and Development," published by the council.

Other recommendations included:

New hospitals should be built and existing hospital facilities should be expanded only upon the basis of demonstrated need.

It is desirable that new hospitals which may be needed in future years be relocations or branches of existing hospitals.

No new professionally specialized hospitals should be established in the area unless they are developed as units attached to a general hospital (existing or to be built).

Upon development of a comprehensive areawide plan, future hospital development in the area should conform to its flexible provisions.

In this regard, a spokesman for the council said such a plan is under development now, filling in the details to match the general guidelines and planning principles enunciated in the council's latest report.

Kathryn H. Stone, Arlington County representative to the Virginia House of Delegates, is chairman of the 15-member council. Other members are drawn from representative areas of Virginia, Maryland, and the District of Columbia.

The council's financial support so far has come chiefly from a 4-year Public Health Service grant for the purpose of setting up self-sustaining, area-wide planning organizations in burgeoning major metropolitan areas.

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THE ASSOCIATION OF  
STATE AND TERRITORIAL HEALTH OFFICERS,  
*Indianapolis, Ind., May 6, 1964.*

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

DEAR SENATOR HILL: As president of the Association of State and Territorial Health Officers and the State health commissioner of Indiana, I would like to bring to your attention some of our feelings with regard to the Hospital and Medical Facilities Act. I would also be pleased to have my views be made a part of the record of the hearing of the Senate Committee on Labor and Public Welfare when it conducts such hearing on this legislation.

We all recognize and do not hesitate to state a preference for S. 2531 for several reasons. Not the least one of these reasons is the fact that S. 2531 allows to the State agency the greatest flexibility for the use of the State allotment in answering the needs of the State as to facilities which are required to satisfy these needs. We also feel that the funds available under S. 2531 would be utilized under an allotment system which is thoroughly familiar to the States.

It is to be hoped that the earliest possible action can be secured by the Congress since the authority for the present act expires on June 30, 1964, and we must face the problem of continuing the hospital construction program without interruption. Advance planning that is necessary to the orderly development of hospital and related facilities and their eventual successful achievement should not be interrupted. Such interruption could only result in damage to the overall program for the provision of these very necessary facilities in the State.

We have studied the provisions of H.R. 10041 as it has been reported and find that the provisions of this bill are such that they would be acceptable to my State in continuing the Hill-Burton program. For some time now, e.g., reference H.R. 10041, we have been hoping for inclusion of authority for the State health officer

to use a portion of the funds for better administration of the program. Also in the same bill is another very desirable feature which provides for the channeling of project grants for planning through the State agency.

Finally, I am not qualified to make any specific recommendation, but if in your opinion the legislation could be enacted more expeditiously and the continuation of the program be therefore guaranteed by the enactment of H.R. 10041, I am sure that the State health officers would support your decision in this matter.

Sincerely,

A. C. OFFUTT, M.D., *President.*

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COMMONWEALTH OF VIRGINIA,  
DEPARTMENT OF HEALTH,  
*Richmond, May 13, 1964.*

Hon. LISTER HILL,  
*Chairman, Senate Committee on Labor and Public Welfare, Congress of the United States, Washington, D.C.*

DEAR SENATOR HILL: The Virginia State Health Department favors your proposed S. 2531 and urges prompt action so that the Hill-Burton program may continue without any delay or interruption.

To give you some idea of what the program has meant to Virginia, I am enclosing a copy of our April 1964 Health Bulletin.

With best personal wishes, I am,

Sincerely,

MACK I. SHANHOLTZ,  
*State Health Commissioner.*

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STATE DEPARTMENT OF HEALTH,  
STATE OF OKLAHOMA,  
*Oklahoma City, Okla., May 12, 1964.*

Re S. 2531, 88th Congress, 2d Session.

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

DEAR SENATOR HILL: The Oklahoma State agency for the Hill-Burton program has just completed a review of your proposed amendments to the Hill-Burton Act, as provided for in S. 2531. We have also received the companion House bill 10041, as found in Report No. 1340, House of Representatives.

Please be advised that the Oklahoma State agency concurs with the recommendations of the executive committee and chairmen of standing committees of the Association of State and Territorial Health Officers, as follows:

1. Endorses S. 2531 providing for needed flexibility in meeting individual State problems;
2. Recommends prompt action on present grant authorization which expires June 30, 1964, to prevent any lapse in continuity of the program; and
3. If, in your opinion, considering the press of legislative matters and time limitations, it would be more expedient and feasible to insure continuation of the Hill-Burton program by the enactment of H.R. 10041, the State agency would gladly support you and the ASTHO in this matter.

The original legislation and its subsequent amendments, has had far-reaching beneficial effects upon the health and welfare of our entire citizenry for many years and undoubtedly will be felt for many years to come. Those of us who are close to the program shall always feel deeply indebted to you for your legislative abilities, devotion, and tireless efforts not only to maintain but to improve upon a highly respected and deserving program.

Your continuing interest and sponsorship of revised legislation will be greatly appreciated.

Very truly yours,

KIRK T. MOSLEY, M.D.,  
*Commissioner of Health.*

STATE OF GEORGIA,  
DEPARTMENT OF PUBLIC HEALTH,  
Atlanta, Ga., May 12, 1964.

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

DEAR SENATOR: I wanted to write you personally in support of the position of the Association of State and Territorial Health Officers relative to Hill-Burton legislation which is now before your committee.

I support, with great appreciation, your proposal (S. 2531) providing, as it does, the needed flexibility for State programs.

I am concerned, as I know you are, with the timing of this legislation inasmuch as we in the States need to have the assurance of continuation of the authorization well below the expiration date of the present law in order to avoid slowdown in programs and in order to provide for orderly continuation of the development of medical facilities.

If in your opinion, however, in view of the pressure of business on the Congress, you believe it would be more expedient for the Senate to enact H.R. 10041 you would have our enthusiastic support for this alternative inasmuch as the provisions of 10041 are also acceptable in light of this State's needs.

I would appreciate your permitting this letter to be made a part of the record of the hearing.

With continued appreciation for all you have done, and with best personal regards, I am,

Sincerely yours,

JOHN H. VENABLE, M.D., *Director.*

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THE STATE OF WASHINGTON,  
DEPARTMENT OF HEALTH,  
Olympia, May 6, 1964.

HON. LISTER HILL,  
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: As the hospital and medical facilities construction authority for the State of Washington, I would like to express the concern of many people in our State about the fact that authorization for Hill-Burton funds is due to expire June 30, 1964, and that no appropriation has as yet been requested for this most important program.

Letters from several of our Representatives in Congress, and a letter from Senator Warren Magnuson, indicate to me that action in this regard is awaiting passage of either H.R. 10041 or S. 2531.

Senator Magnuson informs me that the House Committee on Interstate and Foreign Commerce has reported out favorably H.R. 10041, and that quick action is expected on this bill in the House.

No one recognizes more than you, I am sure, the very acute problems which would arise should there be a break in the continuity of the Hill-Burton program. I will therefore not attempt to enumerate these.

We are, of course, aware of the bill which you have introduced; namely, S. 2531. I hope you will not think we are getting too "jittery" if I suggest to you that, while we are favorably disposed to your bill, H.R. 10041 is quite acceptable to us, and that in the interest of retaining continuity of the program you consider expediting passage of H.R. 10041 when it reaches the Senate.

I sincerely hope that you will give this your most careful thought. If possible, would you please make this letter a part of the record favoring H.R. 10041.

Sincerely,

BERNARD BUCOVE, M.D.,  
*State Director of Health.*

**STATEMENT OF HON. E. L. BARTLETT, A U.S. SENATOR FROM THE STATE OF ALASKA**

Mr. BARTLETT. Mr. Chairman, S. 2531, a bill to revise and extend the Hill-Burton Act, has my firm backing. It is a measure of the greatest importance to the Nation and to the State of Alaska.

During its 16 years, the Hill-Burton program has made possible a network of efficient, modern hospitals and health services throughout the country, particularly in rural areas and smaller towns. The program has had a marked effect in improving the design, operation, and maintenance of health facilities in every State. Urgently needed physicians and other specialists have been drawn to outlying areas. And as State planning has developed, the Nation has taken the first steps toward coordinating hospital and clinic systems to provide more effective and economical care. Thanks in large part to Hill-Burton funds, the United States has achieved a preeminence in medical science. Since 1900 life expectancy has been increased by more than 20 years. Many communicable diseases have been practically eliminated; medical science has developed or is working on the means for overcoming many others. Infant mortality rates have been sharply reduced. We lead the world in drugs, surgery, and equipment to prevent and treat illness.

Yet we do have national health problems that demand national action. Presently more than two-thirds of our people live in urban areas which continue to grow. Here the citizen is placed amid serious threats to health: the greater psychological stress, dangers of industrial employment, shortages of land for homes and recreation, and the contamination of foods, water, and air. Improved health has itself brought new problems. As the population rises, especially because of lengthened lifespan, ever more strain is put on the limited supply of facilities and trained personnel.

Senator Hill has given to these problems the same study and vision that inspired the original Hill-Burton Act and all its renewals. I think the request for somewhat over \$1.36 billion to finance the construction and modernization of hospitals and other medical services is a request fully in order. Senate bill 2531 is in my judgment admirably fitted to meet the problems which I have outlined.

This bill makes available funds to assist public and nonprofit agencies in planning for health and related facilities. This planning will insure against the waste of money on the construction and equipping of plants that are not needed, are poorly located, or would result in further imbalances among the kinds of services provided.

Grants for modernization would be a new feature of Hill-Burton legislation, but the need is clear when we learn that almost half of the hospitals in the Nation require some form of upgrading. There are 75,000 beds in general hospitals that have structural or fire hazards. These are dangerous to patients and staff alike. Modern and efficient general hospitals are vital to us all for they conduct much research and are largely responsible for teaching, by example and training, the care of the sick.

Proposed spending on facilities for long-term patients, \$350 million over 5 years, will go far to remedy a real need. We are short an estimated 500,000 beds in nursing homes and chronic disease hospitals.

Regrettably, the version of this bill approved by the House, H.R. 10041, did not contain provisions to make Federal insurance of mortgages available for private nonprofit hospitals, proprietary nursing homes, or other health facilities. I think such provisions, which have presidential endorsement, would be an intelligent way to help meet the fundraising difficulties of many communities. These communities are not always able to obtain a high priority rating from their State authorities and are thus unable to obtain the benefits of Hill-Burton assistance. As a result, many desirable projects across the country have had to be abandoned. The nonprofit agency, anxious to build its hospital or clinic, often is hard pressed to match Government grants while loans from private lenders often call for repayment in a short period. With a Federal guarantee of loans more construction and modernization of health services could be undertaken.

All these facets of S. 2531 would be of especial significance in Alaska, as the Hill-Burton programs have been since their inception. Within Alaska we face the financing pains common to the whole Nation, pains the more severe because of high materials and labor costs, inadequate roads and transportation, and a harsh climate over a large part of the State. An earthquake disaster, to be sure, does not ease such pains.

Alaska is, then, most grateful for the \$5 million received under the Hill-Burton Act since 1948. At this time State and local funds make up 61 percent of hospital construction efforts and 50 percent of expenses of other health facilities built under Hill-Burton. Our yearly allotment from the Government is \$200,000 for hospital construction and \$350,000 for long-term patient care, diagnostic and treatment centers, and rehabilitation centers. The improvements of the Hill-Burton program embodied in S. 2531 would mean \$200,000 in new money for the modernization of existing plants.

These new matching funds would be most helpful but helpful, too, would be the Federal mortgage insurance plan which does not require outright aid. Our towns are spread far apart and so must be medical services. This unavoidable duplication is costly and especially a frustration to smaller communities. The Seward General Hospital survived the ravages of the earthquake but it still needs an extension to house long-term and isolation patients. Local resources for matching Federal money for the extension, as a result of the devastation of the Good Friday tremors, are almost nonexistent. Even at Fairbanks, St. Joseph's hospital has halted plans to rebuild. Hospital officials write that "the amount received from Hill-Burton and State matching funds would require too high a borrowing load for this project. We could not expect the citizens of Fairbanks to make up the deficit by a fund drive." Insurance of loans with maturities up to 40 years would mean such areas would find it easier to secure a loan and bear a debt. It might even mean loans on more favorable terms, although the confidence which insurance gives to lenders would itself be of much benefit.

I am hopeful that your committee, in its consideration of this most important legislation expanding the Hill-Burton program, will give careful thought to including a provision allowing Federal mortgage insurance. Needless to say, this, as well as the Hill-Burton program itself, has my very strongest support.

The late President Kennedy, in asking for the enactment of this measure, reminded us of Emerson's saying that "health is the first wealth." President Johnson has since stated that the "American people are not satisfied with better-than-average health. As a nation, they want, they need, and they can afford the best of health." I concur with these remarks and I urge the early approval by the committee of S. 2531.

AMERICAN MEDICAL ASSOCIATION,  
Chicago, Ill., July 9, 1964.

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

DEAR SENATOR HILL: I should like to take this opportunity on behalf of the American Medical Association to respectfully submit, for your consideration, our views on H.R. 10041, Hospital and Medical Facilities Amendments of 1964, which is now under consideration by your committee. This is a subject in which the medical profession has a deep and continuing interest. The association hopes that you will find its comments helpful to your subcommittee's discussions and deliberations.

We believe that the Hill-Burton hospital construction program has generally been administered effectively and in the interest of the public. We further believe that the objectives of the original legislation have, for the most part, been achieved and that emphasis should now be toward modernization and expansion of existing facilities in metropolitan areas. It is our opinion that continuation of the Hill-Burton program for a period of time is warranted.

Our support of this type of legislation is long standing. The American Medical Association has on numerous occasions gone on record as approving the principle of hospital construction by the use of grants-in-aid. In 1940, the AMA house of delegates supported President Roosevelt's plan for the construction of hospitals with Federal funds and in 1945 endorsed the AMA board of trustees' support of the original Hill-Burton bill. At its 113th annual convention in San Francisco late last month, the AMA house of delegates once again reaffirmed its policy endorsing matching Federal grants for the construction and renovation of medical schools, hospitals and related facilities, and mental health centers.

The house of delegates also recommended that the advantages and desirability of multiple-source financing be kept clearly in mind and that the Hill-Burton program continue to be operated on a voluntary basis, with local control.

On March 12, 1964, representatives of the American Medical Association appeared before the Committee on Interstate and Foreign Commerce of the House of Representatives to offer its general support of H.R. 10041 and to suggest some important amendments which it believed would improve and strengthen the Hill-Burton program. Several of the association's recommendations were adopted by the committee.

There are, however, certain features of H.R. 10041 which we believe should be amended so as to better serve the purposes of the Hill-Burton program. It is to these provisions of the bill that we would like to invite the consideration of your subcommittee.

The bill would provide that the funds appropriated for the construction and modernization of new hospitals and public health centers be used entirely for new construction during fiscal 1965. In the succeeding 4 years, the major portion of the appropriated funds would be designated for such construction. According to the State Hill-Burton agencies, as of January 1, 1963, there were 338,170 unacceptable hospital beds which represented approximately 19 percent of existing beds. Between 1957 and 1963, while the number of inpatient beds increased from 1,505,695 to 1,786,461, the number of unacceptable beds increased from 285,149 to 338,170. We believe that the purposes of the program would best be served if the enactment of H.R. 10041 encouraged, from the outset, the use of funds for modernization. Accordingly, we suggest that section 602 under "State allotments" be amended to permit, for modernization purposes, an immediate and greater use of the allotted funds.

Section 621 of part B would increase the membership of the Federal Hospital Council from 8 to 13 members. In the 18 years since the enactment of the Hill-Burton law, only 2 physicians representing medicine have served on the

Council, and such representation has not been granted recently. We believe that the bill should be amended so as to specifically provide for at least two physicians on this Council. Since the American Medical Association represents over 200,000 physicians, it seems appropriate that the representatives from medicine be selected from a panel submitted by the association. We believe that the objectives encompassed in H.R. 10041 can be best accomplished with the support and counsel of representatives of organized medicine on the Federal Hospital Council.

With respect to "diagnostic and treatment centers," we urge that they be deleted as facilities eligible to participate in the Hill-Burton program. There is little evidence of demand for these facilities since their inclusion in 1954. Moreover, the definition of the term "diagnostic or treatment center" in section 625, subsection (f) is vague. If these facilities are intended to be a part of a hospital, or hospital complex, we believe that other provisions of H.R. 10041 would permit such facilities to be financed without the necessity of maintaining a separate and distinct category.

In concluding our testimony before the House Interstate and Foreign Commerce Committee last March, the AMA representatives urged that section 623 be amended so as to clearly express the intent of Congress with respect to the acceptance of funds under the proposed law. We stated at that time, "We are confident that it has always been the intention of Congress that the non-governmental character of a hospital would not be affected by its participation in the Hill-Burton program."

It is the opinion of the AMA's general counsel that the recent *Simkins v. Moses H. Cone Memorial Hospital* (323 R. 2d 959) decision is limited to civil rights problems. The American Medical Association, however, is still deeply concerned about the possibility that the *Cone* decision might be further extended to include matters other than civil rights. We therefore urge a reaffirmation of congressional intent that the participation of a private hospital in the Hill-Burton program does not in any way change the private character of the hospital in any respect other than outlawing discrimination based on race, creed, or color. We believe that the subcommittee should add language to the bill which, while in accord with the *Cone* decision, would effectively guarantee that this doctrine would not be extended to matters other than civil rights.

Thank you for permitting me this opportunity of presenting the views of the Nation's physicians on this important legislative proposal. I respectfully request that this statement be considered by your subcommittee and made a part of the record of your hearings on H.R. 10041.

Sincerely,

F. J. L. BLASINGAME, M.D.



	16	11	5	571			1	1	2	60	24,789	8,267	22,296	7,432	2,503	35
Connecticut.....																8
1965.....	13	8	5	416			1	1	2	60	22,849	7,617	20,346	6,782	2,503	885
1966.....	3	3		155			1				1,950	650	1,950	650		
Delaware.....																
1965.....	5	3	2	55	110		1	1		75	5,140	2,138	2,597	866	2,543	1,272
1966.....	5	3	2	55	110		1	1		75	5,140	2,138	2,597	866	2,543	1,272
District of Columbia.....																
1965.....	4		4					3	1		22,800	1,350			22,800	1,350
1966.....	4		4					3	1		22,800	1,350			22,800	1,350
Florida.....																
1965.....	75	49	26	3,420	638		7	9	4	845	73,049	34,624	59,774	27,985	13,275	6,639
1966.....	75	49	26	3,420	638		7	9	4	845	73,049	34,624	59,774	27,985	13,275	6,639
Georgia.....																
1965.....	65	44	21	2,339	75		11	1	3	812	76,703	34,159	54,974	21,986	21,729	12,173
1966.....	36	28	8	1,373	75		11	1	3	92	50,498	23,016	35,890	14,153	15,108	8,863
Hawaii.....																
1965.....	29	16	13	966			4	2	1	720	26,205	11,143	19,584	7,833	6,621	3,310
1966.....	22	17	5	267	174		4	2	1	50	26,516	12,723	23,516	11,283	3,000	1,440
Idaho.....																
1965.....	12	9	3	100	114		3	1	1	50	5,692	2,728	3,662	1,768	2,000	960
1966.....	10	8	2	167	60		1	1	1	50	20,824	9,995	19,824	9,515	1,000	480
Illinois.....																
1965.....	52	36	16	3,333	860					114	4,515	2,132	3,150	1,445	1,375	687
1966.....	52	36	16	3,333	860					114	4,515	2,132	3,150	1,445	1,375	687
Indiana.....																
1965.....	25	18	7	3,297												
1966.....	21	14	7	2,898												
Iowa.....																
1965.....	46	34	12	1,973	100			1	2		72,080	24,200	63,050	20,990	9,030	3,210
1966.....	28	20	8	1,147	100			1	1		37,605	12,575	31,775	10,565	5,730	2,010
Kansas.....																
1965.....	18	14	4	826	80				1		34,575	11,625	31,275	10,425	3,300	1,200
1966.....	28	19	9	907					2	575	61,638	30,809	53,138	26,559	8,500	4,250
	4	2	2	100						190	5,646	2,063	4,146	2,063	1,500	750
	24	17	7	807					2	385	55,992	27,996	48,992	24,496	7,000	3,500







Texas.....	114	81	33	4,740	1,482	30	7	3	142	4	3,133	140,984	63,697	116,673	51,542	24,311	12,185
1965.....	73	50	23	3,686	822	30	5	3	98	4	1,588	102,451	39,780	87,426	32,268	15,025	7,512
1966.....	41	31	10	1,104	660	80	2	44	44	---	1,545	38,533	23,917	29,247	9,286	4,643	---
Utah.....	28	24	4	1,263	---	80	4	---	---	---	150	37,150	16,524	35,700	15,799	1,450	725
1965.....	16	12	4	235	---	80	2	---	---	---	150	11,400	4,912	9,950	4,187	1,450	725
1966.....	12	12	---	1,028	---	---	2	---	---	---	---	25,750	11,612	25,750	11,612	---	---
Vermont.....	8	4	4	290	---	---	---	2	15	---	25	7,516	2,862	6,075	2,141	1,441	721
1965.....	8	4	4	290	---	---	---	2	15	---	25	7,516	1,630	6,075	1,154	1,441	476
1966.....	---	---	---	---	---	---	---	---	---	---	---	1,232	1,232	987	---	---	245
Virginia.....	19	12	7	1,287	---	---	---	---	225	---	290	33,921	20,518	28,661	17,658	5,280	2,860
1965.....	12	6	6	652	---	---	---	---	225	---	140	18,621	11,453	14,161	9,033	4,460	2,420
1966.....	7	6	1	635	---	---	---	---	---	---	150	15,300	9,065	14,500	8,625	800	440
Washington.....	33	28	5	1,662	---	---	10	2	---	1	100	53,737	21,494	51,565	20,625	2,172	869
1965.....	25	21	4	1,412	---	---	6	2	---	1	50	42,517	14,806	40,695	14,077	1,822	729
1966.....	8	7	1	250	---	---	4	---	---	---	50	11,220	6,688	10,870	6,548	350	140
West Virginia.....	32	29	3	955	45	70	7	1	---	---	175	32,370	16,175	28,970	14,475	3,400	1,700
1965.....	19	16	3	590	45	60	3	1	---	---	175	22,890	11,436	19,490	9,736	3,400	1,700
1966.....	13	13	---	365	---	10	4	---	---	---	---	9,480	4,739	9,480	4,739	---	---
Wisconsin.....	86	42	44	3,162	162	---	1	6	450	6	1,480	125,343	50,105	95,460	38,152	29,883	11,953
1965.....	51	23	28	1,318	112	---	1	2	300	5	1,028	55,931	22,342	37,964	15,154	17,967	7,188
1966.....	35	19	16	1,844	50	---	---	4	150	1	452	69,412	27,763	57,496	22,998	11,916	4,765
Wyoming.....	15	6	9	229	---	---	---	1	---	---	263	6,345	2,530	3,625	1,120	2,820	1,410
1965.....	15	6	9	229	---	---	---	1	---	---	263	6,345	1,410	3,625	510	2,820	900
1966.....	---	---	---	---	---	---	---	---	---	---	---	---	1,120	610	---	---	510
Guam.....	1	1	---	---	---	---	1	---	---	---	---	36	24	36	24	---	---
1965.....	1	1	---	---	---	---	1	---	---	---	---	36	24	36	24	---	---
1966.....	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Puerto Rico.....	47	38	9	1,932	---	---	---	7	---	---	150	50,508	43,943	45,783	40,288	4,725	3,655
1965.....	17	13	4	1,156	---	---	---	2	---	---	150	29,501	25,096	26,026	23,243	3,475	1,853
1966.....	30	25	5	776	---	---	---	5	---	---	---	21,007	18,847	19,757	17,045	1,250	1,802
Virgin Islands:	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
1965.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
1966.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)

2 Source: State agency reports to the Public Health Service.

1 Not available.

## PREPARED STATEMENT OF SENATOR HRUSKA

Mr. Chairman, the Hill-Burton program has been very well received in Nebraska as well as the entire Nation. For this reason the Department of Health in Nebraska is very eager to have this program continued.

The extension of this program has very wisely foreseen the diversified needs of future medical facilities and promoted construction in needed areas by providing categorical controls. This is a good step to insure responsible use of the funds provided under the program. I am also pleased to see that in both the House bill and the Senate bill certain flexible features are included to allow the States to tailor their construction program to the most urgently needed categories.

In anticipation of the extension of this program and in reviewing their future needs, the Department of Health of Nebraska as well as a number of other States have found that they need another kind of flexibility. Assuming that either the House-passed bill or the pending Senate bill has sufficient flexibility for transferring allotments between categories there is still a need for allowing States to decide when they should use their funds in each of these categories.

As an example, in a State receiving a relatively small allotment under this program, when assisting a large construction project adequate funds may not be available to keep the project moving at its most efficient and expeditious pace. Under either the House-passed bill or the pending Senate bill a State may merely hold its allotment in one category over until the next year and use the 2-year total for a large project, but this would not solve the problem. The need in one category may be very great in 1 year and much less pressing in another category during that year and yet adequate funds for the urgent need would not be available for 2 years.

The result would be to give financial assistance while dragging our feet on the actual construction of the project. In the meantime, other funds would be pushing ahead projects in which the need has not fully matured.

The purpose of the amendment which I have proposed would be to extend a degree of time flexibility to the States, allowing them to construct their most needed facilities first during the life of this act.

Basically, this amendment would allow States to use as much as necessary of the total allotment in an urgently needed category for the overall 5-year life of the act in any one of 2 years of this life of the act simply by deferring the use of funds from other less needed categories. These less urgent needs could then be provided for in subsequent years. The net effect at the end of 5 years would be unchanged since the average spent in each category would be the same as allowed under the pending provisions. In the meantime the needed facilities would have been in use years earlier.

This amendment provides for supervision of these transferred by the Surgeon General to carry through the control features. As a formula which avoids the necessity for some projects to be delayed awaiting adequate assistance it will prevent waste not only in terms of money but also from the standpoint of those needing the required facilities.

It is felt that this amendment will help to more closely achieve the purposes of the Hill-Burton program by meeting the needs of the individual States while retaining the control and assistance of the Surgeon General who is responsible to the Congress for the administration of these funds.

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STATE OF ALASKA  
OFFICE OF THE GOVERNOR,  
*Juneau, May 16, 1964.*

HON. FRANK B. MORRISON,  
*Governor of Nebraska,  
Lincoln, Nebr.*

DEAR GOVERNOR MORRISON: Thank you for your letter of May 7 concerning the suggestion of Dr. Rogers in regard to merging of Hill-Burton funds.

As suggested by you, the proposal was brought to the attention of the Alaska Department of Health and Welfare which felt that it contained such merit that letters have been sent to the Alaska congressional delegation urging support for its adoption.

Sincerely,

WILLIAM A. EGAN, *Governor.*

STATE OF COLORADO,  
EXECUTIVE CHAMBERS,  
Denver, May 29, 1964.

Hon. FRANK B. MORRISON,  
Governor of Nebraska,  
State Capitol, Lincoln, Nebr.

DEAR GOVERNOR: Your suggestion contained in your letter of May 7 made to your Senators and Representatives in Congress concerning the allocation among the several States of funds appropriated by Congress under the Hill-Burton Act for hospital-type construction is in general conformity with my thinking concerning the earmarking of Federal grants-in-aid and is a good case in point.

Your suggestion that the Hill-Burton Act be amended to provide that "any State having a total allocation of less than \$2½ million a year from all categories may request a merger of these funds and, upon showing a need by the State, the Surgeon General of the Public Health Service shall approve such request," is the minimum that should be requested. I would go a step further and suggest that the first \$2½ million of the Hill-Burton Act moneys to any State be permitted to be merged at the option of the State concerned.

One of the problems of Federal grants-in-aid to specific categories is that in order for a State to participate they must build the specific type of facility whether or not that is their first priority. Some flexibility should be allowed the States to meet health facility construction which is most urgent in their priorities, if Federal grants-in-aid are to be more in accord with what States believe should be done. For example, a State's principal problem may be to obtain mental retardation facilities, but when the Hill-Burton Act provides only a limited amount for such facilities and a much larger sum for say general hospitals, the primary need of the State is not met.

The tendency of the Federal Government to earmark grants-in-aid for specific problems to the exclusion of their problems is a most serious criticism that States have of such grants. It is a shifting of decisionmaking from the State capitols to Washington as to what is the most urgent priority need in our States. This is one type of control that accompanies Federal grants-in-aid and which, if it continues, will result in the shifting of decisionmaking in other categories. I believe that our public health director and our State legislature are in a better position to make decisions as to health priority needs in the State of Colorado than is someone far removed from our States.

Copies of this letter are being sent to our Senators and Representatives so they, too, may be informed of our general thinking in this regard.

Sincerely,

JOHN A. LOVE.

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THE STATE OF NEVADA,  
EXECUTIVE CHAMBER,  
Carson City, May 21, 1964.

Hon. FRANK B. MORRISON,  
Governor of the State of Nebraska,  
State Capitol, Lincoln, Nebr.

DEAR FRANK: Thank you for your May 7th letter suggesting that I check with my hospital survey and construction authority relative to proposed amendments to the Hill-Burton program.

Dr. Daniel J. Hurley, acting State health officer, has recently heard from your Dr. E. A. Rogers and has written to Nevada's Senators and Representative supporting Dr. Rogers' request.

I, too, will advise our Senators and Representative of the wishes of my health division regarding the proposed legislation.

Kindest regards,

Grant,  
GRANT SAWYER, Governor.

STATE OF HAWAII,  
EXECUTIVE CHAMBERS,  
Honolulu, June 8, 1964.

Hon. FRANK B. MORRISON,  
Governor of Nebraska,  
Lincoln, Nebr.

DEAR GOVERNOR MORRISON: Thank you very much for your letter and proposals relative to the revised public health law title VI (Hill-Burton). We will be in touch with our Congressmen urging the passage of this revised legislation.

We agree that certain changes would be desirable to permit a State that is receiving minimum or close to minimum allotments under this legislation, the latitude of arranging these allotments to provide the most suitable resources to the people of the State. With this view in mind, we are urging for greater flexibility on the transfer of funds from the categorical allotment.

Sincerely,

WILLIAM R. RICHARDSON,  
Acting Governor of Hawaii.

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DEPARTMENT OF HEALTH,  
STATE OF HAWAII,  
Honolulu, May 22, 1964.

E. A. ROGERS, M.D., M.P.H.,  
Director of Health, Department of Health,  
Lincoln, Nebr.

DEAR DR. ROGERS: Thank you very much for your letter and proposals relative to the revised public health law title VI (Hill-Burton). We will be in touch with our Congressmen urging the passage of this revised legislation.

We agree that certain changes would be desirable to permit a State that is receiving minimum or close to minimum allotments under this legislation, the latitude of arranging these allotments to provide the most suitable resources to the people of the State. With this view in mind, we are urging for greater flexibility on the transfer of funds from the categorical allotment.

Sincerely yours,

LEO BERNSTEIN, M.D.,  
Director of Health.

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STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS,  
DEPARTMENT OF HEALTH,  
Providence, May 22, 1964.

E. A. ROGERS, M.D., M.P.H.,  
Director, Nebraska Department of Health,  
Lincoln, Nebr.

DEAR DR. ROGERS: I am pleased to attach herewith a copy of a letter which I have written to our Senators and Congressmen from Rhode Island.

As stated in our letter we are in agreement with your views and we hope that our Representatives will give them serious consideration.

Sincerely yours,

JOSEPH E. CANNON, M.D., M.P.H.

MAY 21, 1964.

Hon. CLAIBORNE PELL,  
New Senate Office Building,  
Washington, D.C.

DEAR SENATOR PELL: In considering the amendment and extension of the Hill-Burton Act, I am in agreement with the views of the State of Nebraska that the following amendment be inserted in the section providing for allotting the appropriation among the several States and territories:

"Provided, That any State having an annual allotment of less than \$2½ million may request the Surgeon General to merge all categorical funds

into one allotment. Upon a showing by the State of a construction schedule where highest priority projects would utilize all available funds to meet the needs of such State for construction of such facilities, the Surgeon General shall approve such request."

I hope that you will give serious consideration to this view.

Sincerely yours,

JOSEPH E. CANNON, M.D., M.P.H.

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STATE OF MONTANA,  
STATE BOARD OF HEALTH,  
Helena, Mont., May 6, 1964.

HON. ARNOLD H. OLSEN,  
Congress of the United States,  
House of Representatives,  
Washington, D.C.

DEAR CONGRESSMAN OLSEN: The Nebraska State Board of Health proposes an amendment to the Hill-Burton bills now being studied in Congress. This proposal would be advantageous to Montana.

It is as follows (to be inserted in the section providing for allotting the appropriation among the several States and territories):

"Provided, That any State having an annual allotment of less than \$2½ million may request the Surgeon General to merge all categorical funds into one allotment. Upon a showing by the State of a construction schedule where highest priority projects would utilize all available funds to meet the needs of such State for construction of such facilities, the Surgeon General shall approve such request."

Montana would have less need for hospital modernization than States with large metropolitan areas. We could use our allocation to better advantage for new construction.

Senator Roman L. Hruska, Nebraska, is studying this proposal. If you feel that this amendment would be worthwhile, it is suggested that Senator Hruska have your viewpoint.

Sincerely yours,

JOHN S. ANDERSON, M.D.,  
Executive Officer.

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STATE OF ALASKA,  
DEPARTMENT OF HEALTH AND WELFARE,  
Juneau, May 8, 1964.

HON. RALPH J. RIVERS,  
House of Representatives, House Office Building,  
Washington, D.C.

DEAR MR. RIVERS: In the consideration by the Congress of the United States as to the amendments and extension of the Hill-Burton Act, it is our earnest opinion in the department of health and welfare that the best interest of the State would be served if the categorical allocations to Alaska, a minimum allotment State, could be merged into one category. Because of the minimum allotments to Alaska and the high construction costs, we could better plan our hospital replacements if we could combine general hospital, diagnostic and treatment center, long-term care facilities, etc., into grants for one project.

The State of Nebraska has presented a proposal which reads as follows:

"Provided, That any State having an annual allotment of less than \$2½ million (Alaska's allotment has been \$550,000 under minimum allotment provisions) may request the Surgeon General to merge all categorical funds into one allotment. Upon a showing by the State of a construction schedule where highest priority projects would utilize all available funds to meet the needs of such State for construction of such facilities, the Surgeon General shall approve such a request."

We would be in agreement with the above provisions and so recommend unless you have knowledge of any adverse effect.

Sincerely yours,

HENRY A. HARMON, Deputy Commissioner.

MAY 12, 1964.

Hon. HOWARD CANNON,  
U.S. Senator, Senate Office Building,  
Washington, D.C.

DEAR SENATOR CANNON: You may recall that over the past many years Nevada has advocated and strived to attain changes in Hill-Burton legislation that would allow minimum allotment States more freedom with the use of their Federal allocations by allowing transfers between all categories whether they fall under part C or part G of the act. The limited funds received by minimum allotment States oftentimes makes it extremely difficult to do a project in a way that is the most beneficial to both sponsor and public. For example, in Nevada (we receive but \$200,000 per year to assist with general, mental, and tuberculosis hospital construction) in a hospital project that costs \$1,500,000, the Federal share will range from \$500,000 to \$1 million and require our entire annual hospital allotment for 2½ to 5 years. The problems created by "splitting" a project over several years make full participation impractical, if not impossible, and as a consequence, results in a project receiving something less than the total allowable Federal share. On the other hand, freedom to transfer between all Hill-Burton categories would enable us to develop projects in a more nearly equitable manner.

E. A. Rogers, M.D., State health officer of Nebraska, has sent me a copy of a proposed amendment to the Hill-Burton Act that Nebraska is asking be inserted in that section providing for allotting the appropriations among the several States and territories. The proposal is as follows: "Provided That any State having an annual allotment of less than \$2½ million may request the Surgeon General to merge all categorical funds into one allotment. Upon a showing by the State of a construction schedule where highest priority projects would utilize all available funds to meet the needs of such State for construction of such facilities, the Surgeon General shall approve such request."

Dr. Rogers also advises that Senator Roman L. Hruska is studying this proposal at their request and should you feel you can support this provision, may I ask that you express your views to Senator Hruska.

You will find it noteworthy that even though Nebraska is not a minimum allotment State that she, too, is experiencing problems in not being allowed the freedom of using her Hill-Burton funds to the best possible advantage.

Sincerely,

DANIEL J. HURLEY,  
State Health Officer.

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GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES,  
VIRGIN ISLANDS DEPARTMENT OF HEALTH,  
St. Thomas, V.I., May 28, 1964.

E. A. ROGERS, M.D., M.P.H.  
Director of Health, State of Nebraska,  
Department of Health Section of Hospitals and Medical Facilities,  
Lincoln, Nebr.

DEAR DR. ROGERS: The proposed amendment to the Hill-Burton Act which you submitted in your letter is indeed, in my opinion, an extremely desirable one, and I would recommend that it be endorsed fully.

Unfortunately we have no congressional delegation, but I am requesting that the Governor of the Virgin Islands, through the Department of the Interior, endorse this proposal which will obviously help the smaller States and territories.

Very sincerely yours,

MELVIN H. EVANS, M.D.,  
Commissioner of Health.

STATE OF DELAWARE,  
EXECUTIVE DEPARTMENT,  
*Dover, Del., May 25, 1964.*

HON. FRANK B. MORRISON,  
*Governor of the State of Nebraska,  
Lincoln, Nebr.*

DEAR GOVERNOR MORRISON: Thank you for your letter of May 7 regarding proposed bills now pending before Congress to amend the Hill-Burton Act.

I have been advised by the Delaware State Board of Health that their representative met with 12 health officers from other States in Chicago recently to discuss among other things, this matter. The current urgency is that legislation be passed promptly to assure that there will not be a temporary halt in the Hill-Burton program within the States. Dr. Floyd I. Hudson, Delaware's representative to the meeting in Chicago, states that they were assured that the Harris bill, H.R. 10041, would promptly pass the House as soon as it has been approved by the committee.

The amendments which you mention in your letter were also discussed at this meeting and the feeling was that they would be helpful to many of the smaller States but would be opposed by the larger ones. In view of the fact that an amendment would delay the renewal of the Hill-Burton authority, the conclusion was reached that it would not be wise to attempt such an amendment this year.

Cordially yours,

ELBERT N. CARVEL,  
*Governor of Delaware.*

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STATE OF MAINE,  
DEPARTMENT OF HEALTH AND WELFARE,  
*Augusta, Maine, May 28, 1964.*

E. A. ROGERS, M.D., M.P.H.,  
*Director, Department of Health,  
Lincoln, Nebr.*

DEAR DR. ROGERS: In reply to your recent letter regarding your suggestion for change in the proposed revision of the Hill-Burton Act, I should not be favorable to the suggested change. I believe it would defeat the purposes of the act, which are to emphasize the various categories of medical facilities need.

However, I believe in maximum flexibility in the transfer of the State's allotments among the various categories of need, if there are insufficient satisfactory applications to encumber individual category funds in a fiscal year.

Sincerely yours,

DEAN FISHER, M.D., *Commissioner.*

The CHAIRMAN. If there is anyone who would like to file any statement on this matter, we would be very happy to have him file it with Mr. Barclay. We would only ask that you submit your statement by Friday of this week.

The subcommittee will now stand in recess.

(Whereupon, at 11:40 a.m., the subcommittee adjourned, subject to the call of the Chair.)



