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MEDICAL CARE FACILITIES CONSTRUCTION AND MODERNIZATION

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

NINETY-FIRST CONGRESS, FIRST SESSION

ON

S. 2182

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO REVISE, EXTEND, AND IMPROVE THE PROGRAM ESTABLISHED BY TITLE VI OF SUCH ACT, AND FOR OTHER PURPOSES

H.R. 11102

TO AMEND THE PROVISIONS OF THE PUBLIC HEALTH SERVICE ACT RELATING TO THE CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES BY PROVIDING SEPARATE AUTHORIZATIONS OF APPROPRIATIONS FOR NEW CONSTRUCTION AND FOR MODERNIZATION OF FACILITIES, AUTHORIZING FEDERAL GUARANTEES OF LOANS FOR SUCH CONSTRUCTION AND MODERNIZATION AND FEDERAL PAYMENT ON PART OF THE INTEREST THEREON, AUTHORIZING GRANTS FOR MODERNIZATION OF EMERGENCY ROOMS OF GENERAL HOSPITALS, AND EXTENDING AND MAKING OTHER IMPROVEMENTS IN THE PROGRAM AUTHORIZED BY THESE PROVISIONS

AND RELATED BILLS

JUNE 12, 17, AND 19, 1969

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

U.S. GOVERNMENT PRINTING OFFICE
31-435 O WASHINGTON : 1969

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MEDICAL CARE FACILITIES CONSTRUCTION AND MODERNIZATION

THURSDAY, JUNE 12, 1969

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

The subcommittee met, pursuant to notice, at 10:12 a.m., in room 4232, New Senate Office Building, Senator Ralph Yarborough (chairman of the subcommittee) presiding.

Present: Senators Yarborough, Kennedy, Eagleton, Hughes, Dominick, Javits, and Saxbe.

Committee staff present: Robert O. Harris, staff director; John S. Forsythe, general counsel; Roy Millenson, minority staff director; and Jay Cutler, minority counsel.

The CHAIRMAN. The Subcommittee on Health of the Senate Labor and Public Welfare Committee will come to order.

Hearings will proceed on S. 2182, H.R. 11102, and related bills.

STATEMENT OF HON. RALPH YARBOROUGH, A U.S. SENATOR FROM THE STATE OF TEXAS

The CHAIRMAN. This is the first major hearing we have held on health legislation of this significance since I have become chairman of the Labor and Public Welfare Committee and chairman of the Health Subcommittee. I have assumed the chairmanship of the Health Subcommittee because I do not think that health care is distributed to the people of this Nation as it should be. We have the best scientific medicine in the world, but the distribution of the benefits of our great scientific discoveries to the mass of the people of this country has not yet taken place.

This Nation, which is the richest in the world and which has the highest level of medical competence in the world, lags behind much of the world in providing health care. We trail 15 other countries—including France, England, and West Germany—in our infant mortality rate; 15 years ago we trailed only seven countries. In terms of males we do, and 11 countries have higher life expectancy rates for females.

Obviously, something is wrong. In a so-called affluent society, we should be able to deliver good health services to everyone; instead, we have crowded hospitals, skyrocketing medical costs, delays in getting into hospitals, and the neglect of millions of Americans who cannot afford even adequate health care. Therefore, we must ask ourselves two questions: (1) what is really wrong, and (2) what can be done

about it? That is one main reason I assumed the chairmanship of this Health Subcommittee.

Part of what is wrong is that the population is growing and the construction of health facilities has not kept pace. The distribution of our knowledge of health care has not been so as to reach many tens of millions of our people. Also, affluent Americans can spend more money on health care. A recent article in U.S. News & World Report states that "Stirred by reports of great advances in hospital-based medicine, people have concluded that only in hospitals can they get the best care. Dr. Roger DeBusk, director of Grace Hospital in Detroit, put it this way: 'When I started in this business, a hospital was a place to go to die. Now it's a health-care center.'"

Hospitals have tried to meet the expectations of the American public by expanding their services to encompass extended care, rehabilitation, psychiatric and social services, home care, prevention, diagnostic, ambulatory and emergency services, and health education. In addition, hospitals have extended themselves into communities in the forms of specialized facilities for the treatment of a particular disease or disability, satellite hospitals, and neighborhood health centers.

It is obvious that hospitals and other health facilities must grow and develop if America is ever to meet a national goal of good health care for all. I do not mean by that that only in hospitals can good health care be procured; we need neighborhood clinics and many other ways to distribute health care out to the people.

Figures from the Department of Health, Education, and Welfare show that the 50 States report urgent needs for the construction of new health facilities at an estimated cost of $6 billion now, and urgent needs for the modernization or replacement of obsolete health care facilities at an estimated cost of $10.5 billion now. That is in addition to the $6 million of new health care facilities.

The present urgent need is for an additional 85,007 acute care hospital beds, 893 public health centers, 164,430 additional long-term care beds, 872 diagnostic and treatment centers, and 388 rehabilitation facilities.

In Texas alone the cost to construct needed health facilities is estimated at $469 million now, and the cost of replacement and modernization of health facilities is estimated at $383 million now. I take my own State because I am more familiar with that to illustrate this great national shortage of expenditures of money in this needed field.

What has actually happened is that Texas has received only about $17 million from the Federal Government for both construction and modernization of health facilities for each of the past 3 years.

It seems to me that part of what can be done is an improved Federal program, adequately funded, for health facilities and modernization; we need more health facilities and we need more up-to-date health facilities so that the patient load will be better distributed between the so-called prestige hospitals and other medical facilities.

Among the bills under consideration today is a bill I introduced, S. 2182, which would provide for vastly expanded Federal help in the form of financial assistance through grants, insured loans, and direct loans for the construction and modernization of health facilities. My bill would authorize $5.4 billion over the next 5 years, over $1 billion each year.

Good health is not a luxury; it is as basic as food, clothing, and shelter; it should be available to every American. To provide the highest possible quality health services at the lowest possible cost should be a national goal. It is my sincere hope that these hearings will constitute an important step in the achievement of that goal.

I place these bills I referred to in the record.

(The bills referred to appear on following page:)

91ST CONGRESS
1ST SESSION

S. 2182

IN THE SENATE OF THE UNITED STATES

MAY 16, 1969

Mr. YARBOROUGH (for himself, Mr. CRANSTON, Mr. EAGLETON, Mr. HUGHES, Mr. KENNEDY, Mr. MONDALE, Mr. NELSON, 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

A BILL

To amend the Public Health Service Act to revise, extend, and improve the program established by title VI of such Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Hospital and Medical Facilities Construction and Modernization Amendments of 1969".

TITLE I—GRANTS FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

PART A—EXTENSION OF GRANT PROGRAM

AUTHORIZATION OF APPROPRIATIONS FOR CONSTRUCTION GRANTS

SEC. 101. (a) Section 601 of the Public Health Service Act (42 U.S.C. 219a) is amended—

(1) by striking out "next five" in paragraph (a) and inserting in lieu thereof "next ten";

(2) (A) by striking out "$70,000,000" in subparagraph (1) of paragraph (a) and inserting in lieu thereof "$100,000,000",

(B) by striking out "$20,000,000" in subparagraph (2) of such paragraph and inserting in lieu thereof "$40,000,000", and

(C) by striking out "$10,000,000" in subparagraph (3) of such paragraph and inserting in lieu thereof "$15,000,000"; and

(3) by striking out in paragraph (b) "and $195,000,000 for the fiscal year ending June 30, 1970." and inserting in lieu thereof "$195,000,000 for the fiscal year ending June 30, 1970, $160,000,000 for the fiscal year ending June 30, 1971, $170,000,000 for the fiscal year ending June 30, 1972, $180,000,000 for the fiscal

year ending June 30, 1973, $190,000,000 for the fiscal year ending June 30, 1974, and $200,000,000 for the fiscal year ending June 30, 1975; and".

(b) The amendments made by subsection (a) shall take effect with respect to appropriations made under such section 601 for fiscal years beginning after June 30, 1970.

AUTHORIZATION OF APPROPRIATIONS FOR MODERNIZATION GRANTS

SEC. 102. (a) Effective with respect to appropriations made under section 601 of the Public Health Service Act for fiscal years beginning after June 30, 1970, such section is further amended—

(1) by striking out in paragraph (b) the following: "and for grants for modernization of such facilities and the facilities referred to in paragraph (a)";

(2) by adding after paragraph (b) the following new paragraph:

"(c) for grants for modernization of the facilities referred to in paragraphs (a) and (b), $75,000,000 for the fiscal year ending June 30, 1971, $95,000,000 for the fiscal year ending June 30, 1972, $105,000,000 for the fiscal year ending June 30, 1973, $115,000,000 for the fiscal year ending June 30, 1974, and $125,000,000 for the fiscal year ending June 30, 1975."; and

(3) by inserting "AND MODERNIZATION" after "CONSTRUCTION" in the section heading.

(b) Effective with respect to allotments from appropriations made under such section 601 for fiscal years beginning after June 30, 1970, section 602 (a) of such Act (42 U.S.C. 291b) is amended—

(1) by striking out "the new hospital portion of" the first time it appears in paragraph (1),

(2) by striking out the last sentence of paragraph (1), and

(3) by amending paragraph (2) to read as follows:

"(2) For each fiscal year beginning after June 30, 1970, the Secretary shall, in accordance with regulations, make allotments among the States for grants for modernization of the facilities referred to in section 601. Such allotments shall be made from the sums appropriated under paragraph (c) of section 601, and shall be made among the States on the basis of the population, the financial need, and the extent of the need for modernization of such facilities, of the respective States."

(c) Effective with respect to allotments from appropriations made under such section 601 for fiscal years beginning after June 30, 1970, paragraph (2) of section 602 (c) of such Act is amended by striking out "; except that" and all that follows in such paragraph and inserting in lieu thereof a period.

PART B—OPERATION OF GRANT PROGRAM

PRIORITY OF PROJECTS

SEC. 110. Effective with respect to applications approved under title VI of the Public Health Service Act after June 30, 1970, section 603 (a) of such Act (42 U.S.C. 291c) is amended—

(1) by striking out "rural communities and areas with relatively small financial resources" in clause (1), and inserting in lieu thereof "areas with relatively small financial resources and, at the option of the State, rural communities",

(2) by striking out "and" at the end of clause (2), and

(3) by adding after clause (3) the following new clauses:

"(4) in the case of projects for construction or modernization of general hospitals, to any general hospital with respect to which there is reasonable assurance that services of a long-term care facility will be available, either through a facility of the applicant for the project or a facility with which the applicant is affiliated (to the extent and in the manner determined in accordance with regulations), to patients of such hospital who no longer need care in such hospital but require the services of a long-term care facility;

"(5) in the case of projects for construction or modernization of outpatient facilities, to any outpatient facility that will be located in, and provide services for residents of, an area determined by the Secretary to be a metropolitan area with low per capita income;

"(6) to projects for facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization, particularly projects for facilities which will serve a defined population; and

"(7) in the case of projects for construction or modernization of facilities, to facilities which provide training in health professions;".

AREAWIDE HEALTH PLANNING AGENCIES

SEC. 111. Effective with respect to applications approved under title VI of the Public Health Service Act after June 30, 1970, clause (4) of the first sentence of section 605(b) of such Act (42 U.S.C. 291e) is amended (1) by inserting after "the application has been approved and recommended by the State agency" the following: ", opportunity has been provided, prior to such approval and recommendation, for consideration of the project by the public or nonprofit private agency or organization (if any) which has developed the comprehensive regional, metropolitan area, or other local area plan or plans re-

ferred to in section 314(b) covering the area in which such project is to be located,"; and (2) by inserting "the application is for a project which" immediately before "is entitled".

PORTION OF ALLOTMENT AVAILABLE FOR STATE PLAN ADMINISTRATION

SEC. 112. Effective with respect to expenditures under a State plan approved under title VI of the Public Health Service Act which are made for administration of such plan during any fiscal year beginning after June 30, 1970—

(1) the first sentence of subsection (c) (1) of section 606 of such Act (42 U.S.C. 291f) is amended (A) by striking out "2 per centum" and inserting in lieu thereof "4 per centum" and (B) by striking out "$50,000" and inserting in lieu thereof "$100,000"; and

(2) paragraph (2) of subsection (c) of such section 606 is amended by striking out "June 30, 1964" and inserting in lieu thereof "June 30, 1970".

FEDERAL SHARE

SEC. 113. Effective with respect to applications approved under title VI of the Public Health Service Act after June 30, 1969, paragraph (b) of the section of such Act redesignated (by section 201 of this Act) as section 655 is amended by

adding at the end thereof the following new sentence: "Notwithstanding the provisions of subparagraphs (1) and (2) of this paragraph, the Federal share shall, at the option of the State agency, be equal to the per centum provided under such subparagraphs plus an incentive per centum (which shall not exceed 20 per centum) specified by the State agency in the case of projects that offer potential for reducing health care costs through shared services among health care facilities, interfacility cooperation, or dispersed ambulatory care centers."

DEFINITION OF HOSPITALS

SEC. 114. (a) Effective with respect to applications approved under title VI of the Public Health Service Act after June 30, 1970, paragraph (c) of the section of such Act redesignated (by section 201 of this Act) as section 655 is amended—

(1) by inserting after "nurses' home facilities," the following: "extended care facilities, facilities related to programs for home health services, self-care units,"; and

(2) by inserting a comma immediately before "operated" and inserting immediately before "but does not include" the following: "and also includes education or training facilities for health professions personnel operated as an integral part of a hospital,".

(b) Effective July 1, 1970, section 604(a)(3) of such Act is amended—

(1) by inserting "(A)" after "shall include", and

(2) by inserting after "rehabilitation services, and" the following: "representatives particularly concerned with education or training of health professions personnel, and (B)".

CHANGE IN NAME AND CLARIFICATION OF FUNCTIONS OF DIAGNOSTIC OR TREATMENT CENTER

SEC. 115. (a) Sections 601(a)(2) and 602(b)(1)(B) of the Public Health Service Act (42 U.S.C. 291a, 291b) are each amended by striking out "diagnostic or treatment centers" and inserting in lieu thereof "outpatient facilities".

(b) Section 604(a)(4)(C) of such Act (42 U.S.C. 291d) is amended by striking out "diagnostic or treatment centers" and inserting in lieu thereof "outpatient facilities" and by striking out "such centers" and inserting in lieu thereof "such facilities".

(c) Section 604(a)(5) of such Act (42 U.S.C. 291d) is amended by striking out "diagnostic or treatment centers" and inserting in lieu thereof "outpatient facilities".

(d) Section 609(b) of such Act (42 U.S.C. 291i) is

is amended by striking out "diagnostic or treatment center" and inserting in lieu thereof "outpatient facility".

(e) Section 605(e) of such Act (42 U.S.C. 291e) is amended to read as follows: "In the case of public or other nonprofit outpatient facilities which are not a part of a general hospital, reasonable assurance that the services of a general hospital will be made available."

(f) Paragraph (f) of the section of the Public Health Service Act redesignated (by section 201 of this Act) as section 655 (42 U.S.C. 291o) is amended—

(1) by striking out "diagnostic or treatment center" and inserting in lieu thereof "outpatient facility",

(2) by inserting after "means a facility" the following: "(located in or apart from a hospital)", and

(3) by inserting after "ambulatory patients" the following: "(including ambulatory inpatients)".

(g) The amendment made by paragraphs (2) and (3) of subsection (f) of this section shall apply with respect to applications approved under title VI of such Act after June 30, 1970.

DEFINITION OF FACILITY FOR LONG-TERM CARE

SEC. 116. Effective with respect to applications approved under title VI of the Public Health Service Act after June 30, 1970, paragraph (h) of the section of such Act redesignated (by section 201 of this Act) as section 655 (42 U.S.C.

291o) is amended by inserting after "means a facility" the following: " (including an extended care facility) ".

INCLUSION OF COST OF ACQUISITION OF LAND

SEC. 117. Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1970, so much of paragraph (i) of the section of such Act redesignated (by section 201 of this Act) as section 655 (42 U.S.C. 291o) as follows the semicolon is amended to read: "including architect's fees and the cost of the acquisition of land, but excluding the cost of off-site improvements."

GRANTS FOR EQUIPMENT

SEC. 118. Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1970, paragraph (i) of the section of such Act redesignated (by section 201 of this Act) as section 655 (42 U.S.C. 291o) is further amended by inserting before the semicolon "and, in any case in which it will help to provide a service not previously provided in the community, equipment of any buildings".

TITLE TO SITE

SEC. 119. Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1970, paragraph (1) of the section of such Act redesignated (by section 201 of this Act) as section 655 (42 U.S.C. 291o) is further amended by striking out "for

a period of not less than fifty years" and inserting in lieu thereof the following: ", for not less than the period specified in section 609 (or, in the case of a loan guaranteed under part B or a loan made under part C which is for a longer period, for not less than that longer period),".

INCLUSION OF THE TRUST TERRITORY OF THE PACIFIC ISLANDS

SEC. 120. (a) (1) Subparagraphs (A), (B), and (C) of paragraph (1) of subsection (b) of section 602 of the Public Health Service Act (42 U.S.C. 291b) are each amended by inserting "the Trust Territory of the Pacific Islands," after "American Samoa,".

(2) Paragraph (2) of such subsection is amended by inserting "the Trust Territory of the Pacific Islands," after "American Samoa,".

(b) Paragraph (1) of subsection (c) of such section is amended by inserting "the Trust Territory of the Pacific Islands," after "American Samoa,".

(c) Paragraphs (1) and (2) of subsection (d) of such section are each amended by inserting "the Trust Territory of the Pacific Islands," after "American Samoa,".

(d) The section of such Act redesignated (by section 201 of this Act) as section 655 (a) (42 U.S.C. 291o) is

amended by inserting "the Trust Territory of the Pacific Islands," after "American Samoa,".

(e) The amendments made by this section shall apply with respect to allotments (and grants therefrom) under part A of title VI of the Public Health Service Act for fiscal years ending after June 30, 1970, and with respect to loan guarantees under part B and loans under part C of such title made after June 30, 1970.

PART C—RESEARCH AND DEMONSTRATIONS; AND MISCELLANEOUS

RESEARCH AND DEMONSTRATIONS RELATING TO HEALTH FACILITIES AND SERVICES

SEC. 130. Section 304 (d) of the Public Health Service Act (42 U.S.C. 242b) is amended by inserting after "June 30, 1970" the following: ", $80,000,000 for the fiscal year ending June 30, 1971, $85,000,000 for the fiscal year ending June 30, 1972, $90,000,000 for the fiscal year ending June 30, 1973, $95,000,000 for the fiscal year ending June 30, 1974, and $100,000,000 for the fiscal year ending June 30, 1975".

WAIVING OF RIGHT OF RECOVERY

SEC. 131. Section (3) (b) of the Hospital and Medical Facilities Amendments of 1964 (Public Law 88-443) is

amended by striking out the period at the end of paragraph (5) and inserting in lieu thereof a semicolon, and by adding after such paragraph the following new paragraph:

"(6) the provisions of clause (b) of section 609 of the Public Health Service Act, as amended by this Act, shall apply with respect to any project whether it was approved, and whether the event specified in such clause occurred, before, on, or after the date of enactment of this Act, except that it shall not apply in the case of any project with respect to which recovery under title VI of such Act has been made prior to the enactment of this paragraph."

TITLE II—LOAN GUARANTEES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

LOAN GUARANTEES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

SEC. 201. Title VI of the Public Health Service Act is amended by redesignating part B as part E; by redesignating sections 621 through 625 (42 U.S.C. 291k–291o), and all references thereto, as sections 651 through 655, respectively; and by inserting after section 610 (42 U.S.C. 291j) the following new part:

"PART B—LOAN GUARANTEES FOR MODERNIZATION AND CONSTRUCTION OF HOSPITALS AND OTHER MEDICAL FACILITIES

"AUTHORIZATION OF LOAN GUARANTEES

"SEC. 621. (a) In order to assist nonprofit private agencies to carry out needed projects for the modernization or construction of private nonprofit hospitals, facilities for long-term care, outpatient facilities, and rehabilitation facilities, the Secretary, during the period July 1, 1970, through June 30, 1975, may guarantee in accordance with this part to non-Federal lenders making loans to such agencies for such projects, payment when due of the principal of and interest on loans approved under this part.

"(b) No loan guarantee under this part with respect to any modernization or construction project may apply to so much of the principal amount thereof as, when added to the amount of any grant or loan under part A with respect to such project, exceeds 90 per centum of the cost of such project.

"(c) The Secretary, with the consent of the Secretary of Housing and Urban Development, shall obtain from the Department of Housing and Urban Development such assist-

ance with respect to the administration of this part as will promote efficiency and economy thereof.

"LOAN GUARANTEE ALLOTMENTS

"SEC. 622. (a) For each fiscal year, the Secretary shall determine (1) the total amount of principal of loans which may be guaranteed under this part in such fiscal year, and (2) the portion of such total amount which shall be available for allotments with respect to loans for modernization of facilities referred to in section 621 and the portion thereof which shall be available for allotments with respect to loans for construction of such facilities. Each such portion shall then be allotted among the States, in accordance with regulations, on the basis of each State's relative population, financial need, and need for modernization and for construction, respectively, of facilities referred to in section 621.

"(b) Any amount allotted under subsection (a) to a State, other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands, for a fiscal year ending before July 1, 1975, and remaining unobligated at the end of such year shall remain available to such State, for the purpose for which made, for the next fiscal year (and for such year only), and any such amount shall be in addition to the amounts allotted to such State for such purpose for such next fiscal year; except that, with the consent of the State, any such amount remaining unobligated

at the end of the first six months of such next fiscal year may be reallotted (on such basis as the Secretary deems equitable and consistent with the purposes of this title) to other States which have need therefor. Any amount so reallotted to a State shall be available for the purposes for which made until the close of such next fiscal year and shall be in addition to the amount allotted and available to such State for the same period. Any amount allotted under subsection (a) to the Virgin Islands, American Samoa, Guam, or the Trust Territory of the Pacific Islands for a fiscal year ending before July 1, 1975, and remaining unobligated at the end of such year shall remain available to it, for the purposes for which made, for the next two fiscal years (and for such years only), and any such amount shall be in addition to the amounts allotted to it for such purpose for each of such next two fiscal years; except that, with the consent of the Virgin Islands, American Samoa, Guam, or the Trust Territory of the Pacific Islands, as the case may be, any such amount remaining unobligated at the end of the first of such next two fiscal years may be reallotted (on such basis as the Secretary deems equitable and consistent with the purposes of this title) to any other of such four States which have need therefor. Any amount reallotted to a State under the preceding sentence shall be available for the purposes

for which made until the close of the second of such next fiscal years and shall be in addition to the amounts allotted and available to such State for the same period.

"(c) Any amount allotted or reallotted to a State under this section for a fiscal year shall not, until the expiration of the period during which it is available for obligation, be considered as available for allotment for the next fiscal year.

"(d) (1) Transfers between the allotments of a State under this section shall be made as follows: If any State agency (designated under section 604(a)) applies to the Secretary to have all or part of its construction loan allotment transferred to its modernization loan allotment or to have all or part of its modernization loan allotment transferred to its construction loan allotment, the Secretary shall adjust the allotments of such State in accordance with such application if such application is accompanied by a certification by such State agency that the need (determined in accordance with objective criteria established by regulation of the Secretary) for projects to be assisted by loans guaranteed under the allotment to which a transfer is requested is greater than the need for the projects to be assisted by loans guaranteed under the allotment from which a transfer is requested.

"APPLICATIONS AND CONDITIONS

"SEC. 623. (a) For each project for which a loan guarantee is sought under this part, there shall be submitted to the Secretary, through the State agency designated in accordance with section 604, an application by a nonprofit private agency. If two or more such agencies join in the project, the application may be filed by one or more such agencies. Such application shall (1) set forth all of the descriptions, plans, specifications, assurances, and information which are required by the third sentence of section 605(a) (other than clause (6) thereof) with respect to applications submitted under that section, (2) contain such other information as the Secretary may require to carry out the purposes of this part, and (3) include a certification by the State agency of the total cost of the project and the amount of the loan for which a guarantee is sought under this part.

"(b) The Secretary may approve such application only if—

"(1) there remains sufficient balance in the allotment determined for such State pursuant to section 622 to cover the amount of the loan for which a guarantee is sought in such application,

"(2) he makes each of the findings which are required by clauses (1) through (4) of section 605(b)

for the approval of applications for projects thereunder (except that, in the case of the finding required under such clause (4) of entitlement of a project to a priority established under section 603 (a), such finding shall be made without regard to the provisions of clauses (1) and (3) of such section),

"(3) he finds that there is compliance with section 605 (e),

"(4) he obtains assurances that the applicant will keep such records, and afford such access thereto, and make such reports, in such form and containing such information, as the Secretary may reasonably require, and

"(5) he also determines that the terms, conditions, maturity, security (if any), and schedule and amounts of repayments with respect to the loan are sufficient to protect the financial interest of the United States and are otherwise reasonable and in accord with regulations, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States.

"(c) No application under this section shall be dis-

approved until the Secretary has afforded the State agency an opportunity for a hearing.

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

"(e) (1) The United States shall be entitled to recover from the applicant the amount of any payments made pursuant to any guarantee under this part, unless the Secretary for good cause waives its right of recovery, and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

"(2) Guarantees under this part shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this part will be achieved, and, to the extent permitted by subsection (f), any of such terms and conditions may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

"(f) Any guarantee made by the Secretary pursuant to this part shall be incontestable in the hands of an applicant on whose behalf such guarantee is made, and as to any person who makes or contracts to make a loan to such

applicant in reliance thereon, except for fraud or misrepresentation on the part of such applicant or such other person.

"PAYMENT OF INTEREST ON GUARANTEED LOANS

"SEC. 624. The Secretary shall pay to each holder of a loan guaranteed under this part, for and on behalf of the hospital or other medical facility for which such loan was made, an amount equal to one-half of so much of the interest on the portion of the loan so guaranteed as does not exceed the amount of the interest payable on such portion at a rate of 6 per centum per annum, plus one-third of the remainder (if any) of interest payable on such portion.

"LIMITATION ON AMOUNT OF LOANS GUARANTEED

"SEC. 625. The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this part may not exceed the lesser of—

"(1) such limitations as may be specified in appropriations Acts, or

"(2) in the case of loans covered by allotments for the fiscal year ending June 30, 1971, $400,000,000; for the fiscal year ending June 30, 1972, $800,000,000; for the fiscal year ending June 30, 1973, $1,200,000,-

000; $1,600,000,000 for the fiscal year ending June 30, 1974; and $2,000,000,000 for the fiscal year ending June 30, 1975.

"LOAN GUARANTEE FUND

"SEC. 626. There is hereby established in the Treasury a loan guarantee fund (hereinafter in this section referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation to enable him to discharge his responsibilities under any guarantee issued by him under this part and for payment of interest on the loans so guaranteed. There are authorized to be appropriated to the fund from time to time such amounts as may be necessary to provide capital for the fund."

TITLE III—LOANS FOR CONSTRUCTION AND MODERNIZATION OF PUBLIC HOSPITALS AND OTHER PUBLIC MEDICAL FACILITIES

LOANS FOR CONSTRUCTION AND MODERNIZATION OF PUBLIC HOSPITALS AND OTHER PUBLIC MEDICAL FACILITIES

SEC. 301. Title VI of the Public Health Service Act is further amended by adding after part B (added by section 201 of this Act) the following new part:

"PART C—LOANS FOR CONSTRUCTION AND MODERNIZATION OF PUBLIC HOSPITALS AND OTHER PUBLIC MEDICAL FACILITIES

"AUTHORIZATION OF LOANS

"SEC. 631. (a) In order to assist public agencies to carry out needed projects for the construction or modernization of facilities referred to in paragraphs (a) and (b) of section 601, the Secretary is authorized to loan funds, in accordance with this part, to such agencies for the purpose of carrying out such projects.

"(b) No loan under this part to carry out any project may, when added to the amount of any grant or loan under part A with respect to such project, exceed 90 per centum of the cost of such project.

"ALLOCATION AMONG THE STATES

"SEC. 632. (a) The Secretary shall allot among the States the amounts available for each fiscal year for the making of loans under this part. The allotments under this part shall be made among the States on the basis of the population, the financial need, and the extent of the need for construction and modernization of the facilities referred to in paragraphs (a) and (b) of section 601, of the respective States.

"(b) Any sum allotted to a State for a fiscal year and remaining unobligated at the end of such year shall remain

available to such State, for the purpose for which made, for the next fiscal year (and for such year only), and any such sum shall be in addition to the sums allotted to such State for such purpose for such next fiscal year. Any sum so allotted to a State for a fiscal year shall not (even though remaining unobligated at the close thereof) be considered as available for allotment among the States for the next fiscal year.

"APPLICATIONS

"SEC. 633. (a) For each project for which a loan is sought under this part, there shall be submitted to the Secretary, through the State agency designated in accordance with section 604, an application by the State or a political subdivision thereof or by any other public agency. If two or more such agencies join in the project, the application may be filed by one or more such agencies. Such application shall (1) set forth all of the descriptions, plans, specifications, assurances, and information which are required by clauses (1) through (5) of section 605(a) with respect to applications submitted under that section, (2) contain such other information as the Secretary may require to carry out the purposes of this part, and (3) include a certification by the State agency of the total cost of the project and the amount of the loan sought under this part.

"(b) The Secretary may approve such application only if—

"(1) there remains sufficient balance in the allotment determined for such State pursuant to section 632 to make the loan applied for,

"(2) he makes each of the findings which are required by clauses (1) through (4) of section 605(b) for the approval of applications for projects thereunder (except that, in the case of the finding required under such clause (4) of entitlement of a project to a priority established under section 603(a), such findings shall be made without regard to clauses (1) and (3) of such section),

"(3) he obtains assurances that the applicant will keep such records, and afford such access thereto, and make such reports, in such form and containing such information, as the Secretary may reasonably require, and

"(4) he also determines that the terms, conditions, maturity, security (if any), and schedule and amounts of repayments are reasonable and in accord with regulations.

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

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

"RECOVERY

"SEC. 634. If any of the events specified in clause (a) or clause (b) of section 609 occurs with respect to any facility for which a loan has been made under this part, before the termination of the period during which a loan made by the Secretary under this part is outstanding, the balance of any loan made by the Secretary under this part shall become immediately due and payable, unless the Secretary for good cause determines to waive the provisions of this section.

"GENERAL PROVISIONS FOR LOAN PROGRAM

"SEC. 635. Loans made under this part shall—

"(1) be repayable in equal periodic installments over a period of not to exceed twenty-five years,

"(2) bear interest at the rate of 3 per centum per annum, and

"(3) be secured by such evidence of financial obligation as the Secretary shall determine to be necessary or desirable to protect the interests of the United States against failure on the part of the borrower to repay the principal and interest on such loan in accordance with the terms thereof.

"REVOLVING LOAN FUND

"SEC. 636. (a) There is hereby created within the Treasury a separate fund (hereafter in this section referred to as the 'fund') for loans for the construction and modernization of the facilities referred to in paragraphs (a) and (b) of section 601. The fund shall be available to the Secretary without fiscal year limitation as a revolving fund for the purposes of this part. The total of any loans made from the fund in any fiscal year shall not exceed such limitations as may be specified in appropriation Acts. A business-type budget for the fund shall be prepared, transmitted to the Congress, considered, and enacted in the manner prescribed by sections 102, 103, and 104 of the Government Corporation Control Act (31 U.S.C. 847–849) for wholly owned Government corporations.

"(b) (1) The Secretary, when authorized by an appropriation Act, may transfer to the fund available appropriations provided under section 637 to provide capital for the fund. Amounts received by the Secretary as interest payments or repayments of principal on loans, and any other moneys, property, or assets derived by him from his operations in connection with this part, including any moneys derived directly or indirectly from the sale of assets, or beneficial interests or participations in assets, of the fund,

shall be deposited in the fund, in such amounts as may be authorized from time to time in appropriation Acts.

"(2) All loans, expenses, and payments pursuant to operations of the Secretary under this part shall be paid from the fund, including (but not limited to) expenses and payments of the Secretary in connection with sale, under section 302(c) of the Federal National Mortgage Association Charter Act, of participations in obligations acquired under this part. From time to time, and at least at the close of each fiscal year, the Secretary shall pay from the fund into the Treasury as miscellaneous receipts interest on the cumulative amount of appropriations paid out for loans under this part or available as capital to the fund, less the average undisbursed cash balance in the fund during the year. The rate of such interest shall be determined by the Secretary of the Treasury, taking into consideration the average market yield during the month preceding each fiscal year on outstanding Treasury obligations of maturity comparable to the average maturity of loans made from the fund. Interest payments may be deferred with the approval of the Secretary of the Treasury, but any interest payments so deferred shall themselves bear interest. If at any time the Secretary determines that moneys in the fund exceed the present and any reasonably prospective future requirements

of the fund, such excess may be transferred to the general fund of the Treasury.

"APPROPRIATION AUTHORIZATION

"SEC. 637. There are authorized to be appropriated to the Secretary over a period of five fiscal years, beginning with the fiscal year ending June 30, 1971, such sums as may be necessary for transfers to the revolving fund established under section 636, but not to exceed in the aggregate $750,000,000. Of the sums authorized to be appropriated under this section not more than $150,000,000 is authorized to be appropriated for the fiscal year ending June 30, 1971.

"DURATION OF LOAN PROGRAM

"SEC. 638. No loans shall be made under this part after June 30, 1975."

AMENDMENT TO FEDERAL NATIONAL MORTGAGE ASSOCIATION CHARTER ACT

SEC. 302. Section 302 (c) (2) (B) of the Federal National Mortgage Association Charter Act is amended to read as follows:

"(B) The Department of Health, Education, and Welfare, but only with respect to loans (i) made by the Commissioner of Education for construction of academic facilities, and loans to help finance student loan programs, and (ii) made under part B of title VI of the Public

Health Service Act for the modernization of hospitals and other health facilities."

TITLE IV—GRANTS FOR MODERNIZATION OF EMERGENCY ROOMS OF GENERAL HOSPITALS

SEC. 401. Title VI of the Public Health Service Act is further amended by adding after part C (added by section 301 of this Act) the following new part:

"PART D—MODERNIZATION OF EMERGENCY ROOMS

"AUTHORIZATION

"SEC. 641. In order to assist in the provision of adequate emergency room service in various communities of the Nation for treatment of accident victims and handling of other medical emergencies through special project grants for the modernization of emergency rooms of general hospitals, there are authorized to be appropriated $10,000,000 each for the fiscal year ending June 30, 1971, and the next four fiscal years.

"ELIGIBILITY FOR GRANTS

"SEC. 642. Funds appropriated pursuant to section 641 shall be available for grants by the Secretary for not to exceed 50 per centum of the cost of modernization of emergency rooms of public or other nonprofit general hospitals. Such grants shall be made by the Secretary only after consultation with the State agency designated in accordance with section 604(a)(1) of the Public Health Service Act. In order to

be eligible for a grant under this part, the project, and the applicant therefor, must meet such criteria as may be prescribed by regulations. Such regulations shall be so designed as to provide aid only with respect to projects for which adequate assistance is not readily available from other Federal, State, local, or other sources, and to assist in providing modern, efficient, and effective emergency room service needed to care for victims of highway, industrial, agricultural, or other accidents and to handle other medical emergencies, and to assist in providing such service in geographical areas which have special need therefor.

"PAYMENTS

"SEC. 643. Grants under this part shall be paid in advance or by way of reimbursement, in such installments and on such conditions, as in the judgment of the Secretary will best carry out the purposes of this part."

91ST CONGRESS
1ST SESSION

H. R. 11102

IN THE SENATE OF THE UNITED STATES

JUNE 5, 1969

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

AN ACT

To amend the provisions of the Public Health Service Act relating to the construction and modernization of hospitals and other medical facilities by providing separate authorizations of appropriations for new construction and for modernization of facilities, authorizing Federal guarantees of loans for such construction and modernization and Federal payment of part of the interest thereon, authorizing grants for modernization of emergency rooms of general hospitals, and extending and making other improvements in the program authorized by these provisions.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; DEFINITION

SECTION 1. (a) This Act may be cited as the "Medical Facilities Construction and Modernization Amendments of 1969".

(b) As used in the amendments made by this Act, the term "Secretary", unless the context otherwise requires, means the Secretary of Health, Education, and Welfare.

LOAN GUARANTEES AND INTEREST SUBSIDIES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

SEC. 2. Title VI of the Public Health Service Act is amended by redesignating part B as part D; by redesignating sections 621, 622, 623, 623A, and 625 (42 U.S.C. 291k–291o), and all references thereto, as sections 641, 642, 643, 644, and 645, respectively; and by inserting after section 610 (42 U.S.C. 291j) the following new part:

"PART B—LOAN GUARANTEES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

"AUTHORIZATION OF LOAN GUARANTEES

"SEC. 621. (a) In order to assist public or nonprofit private agencies to carry out needed projects for the construction or modernization of public or nonprofit private hospitals, facilities for long-term care, diagnostic or treatment centers, and rehabilitation facilities, and of public

health centers, the Secretary may, during the period July 1, 1970, through June 30, 1973, and subject to the limitations contained in this part, guarantee, to non-Federal lenders making loans to such agencies for such projects, payment when due of principal of and interest on loans approved under this part.

"(b) No loan guarantee under this part with respect to any construction or modernization project may apply to so much of the principal amount thereof as, when added to the amount of any grant or loan under this title with respect to such project, exceeds 90 per centum of the cost of such project.

"ALLOCATION AMONG THE STATES

"SEC. 622. (a) For each fiscal year, the total amount of principal of loans which may be guaranteed under this part shall be allotted by the Secretary among the States, in accordance with regulations, on the basis of each State's relative population, financial need, need for construction of the facilities referred to in section 601, and need for modernization of such facilities.

"(b) Any amount allotted to a State for a fiscal year ending prior to July 1, 1973, and remaining unobligated at the end of such year shall remain available to such State, for the purposes for which made, for the next two fiscal years (and for such years only), and any such amount shall be in

addition to the amounts allotted to such State for such purpose for each of such next two fiscal years; except that, with the consent of the State, any such amount remaining unobligated at the end of the first of such next two fiscal years may be reallotted (on such basis as the Secretary deems equitable and consistent with the purposes of this title) to other States which have need therefor. Any amount reallotted to a State under this subsection shall be available for the purposes for which made until the close of the second of such next fiscal years and shall be in addition to the amounts allotted and available to such State for the same period.

"(c) Any amount allotted or reallotted to a State under this section shall not, until the expiration of the period during which it is available for obligation, be considered as available for allotment.

"APPLICATIONS AND CONDITIONS

"SEC. 623. (a) For each project for which a loan guarantee is sought under this part, there shall be submitted to the Secretary, through the State agency designated in accordance with section 604, an application by a public or nonprofit private agency. If two or more such agencies join in the project, the application may be filed by one or more such agencies. Such application shall set forth all of the descriptions, plans, specifications, assurances, and information which would be required under the third

sentence of section 605 (a) (other than clause (6) thereof) with respect to applications submitted under that section, such other information as the Secretary may require to carry out the purposes of this part, and a certification by the State agency of the total cost of the project, and the amount of the loan with respect to which a guarantee is sought under this part.

"(b) The Secretary may approve such application only if (1) there remains sufficient balance in the allotment determined for such State pursuant to section 622 to cover the amount of the loan with respect to which a guarantee is sought under this part, (2) he makes each of the findings which would be required under clauses (1) through (4) of section 605 (b) for the approval of applications for projects thereunder and he finds that there is compliance with section 605 (e), (3) he obtains assurances that the applicant will keep such records, and afford such access thereto, and make such reports, in such form and containing such information, as the Secretary may reasonably require, and (4) in the case of an application made by a nonprofit private agency, he also determines that the applicant is otherwise unable to secure the amount of such loan upon reasonable terms and conditions, and that the terms, conditions, maturity, security (if any), and schedule and amounts of repayments with respect to the loan are sufficient to protect the financial interest of

the United States and are otherwise reasonable and in accord with regulations, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States.

"(c) No application under this section shall be disapproved until the Secretary has afforded the State agency an opportunity for a hearing.

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

"(e) (1) The United States shall be entitled to recover from the applicant the amount of any payments made pursuant to any guarantee under this part, unless the Secretary for good cause waives its right of recovery, and upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

"(2) Guarantees under this part shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this part will be achieved, and, to the extent permitted by subsection (f), any of such terms and conditions may be

modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

"(f) Any guarantee made by the Secretary pursuant to this part shall be incontestable in the hands of an applicant on whose behalf such guarantee is made, and as to any person who makes or contracts to make a loan to such applicant in reliance thereon, except for fraud or misrepresentation on the part of such applicant or such other person.

"PAYMENT OF INTEREST ON GUARANTEED LOANS

"SEC. 624. (a) Subject to the provisions of subsection (b), in the case of a guarantee of any loan under this part with respect to a nonprofit private hospital or other medical facility, the Secretary shall pay to the holder of such loan, for and on behalf of such hospital or other medical facility, the interest which becomes due and payable on the guaranteed loan at an interest rate of 3 per centum per annum. Each holder of a loan guaranteed under this part shall have a contractual right to receive from the United States interest payments required by the preceding sentence.

"(b) Contracts to make the payments provided for in this section shall not carry an aggregate amount greater than such amount as may be provided in appropriations Acts.

"LIMITATION ON AMOUNT OF LOANS GUARANTEED

"SEC. 625. The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this part may not exceed the lesser of—

"(1) such limitations as may be specified in appropriations Acts, or

"(2) in the case of loans covered by allotments for the fiscal year ending June 30, 1971, $300,000,000; for the fiscal year ending June 30, 1972, $600,000,000; and for the fiscal year ending June 30, 1973, $900,000,000.

"LOAN GUARANTEE FUND

"SEC. 626. (a) There is hereby established in the Treasury a loan guarantee fund (hereinafter in this section referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation to enable him to discharge his responsibilities under any guarantee issued by him under this part and for payment of interest under this part on the loans so guaranteed. There are authorized to be appropriated to the fund from time to time such amounts as may be necessary to provide capital for the fund.

"(b) If at any time the moneys in the fund are insufficient to enable the Secretary to discharge his responsibilities under guarantees issued by him under this part and for

payment of interest on the loans so guaranteed, he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury, but only in such amounts as may be specified from time to time in appropriations Acts. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury is authorized and directed to purchase any notes and other obligations issued hereunder and for that purpose he is authorized to use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, as amended, and the purposes for which securities may be issued under that Act, as amended, are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this subsection. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public

debt transactions of the United States. Sums borrowed under this subsection shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from such fund."

GRANTS FOR MODERNIZATION OF EMERGENCY ROOMS OF GENERAL HOSPITALS

SEC. 3. Title VI of the Public Health Service Act is amended by inserting after part B (inserted by section 2 of this Act) the following new part:

"PART C—MODERNIZATION OF EMERGENCY ROOMS

"AUTHORIZATION

"SEC. 631. In order to assist in the provision of adequate emergency room service in various communities of the Nation for treatment of accident victims and handling of other medical emergencies through special project grants for the modernization of emergency rooms of general hospitals, there are authorized to be appropriated $10,000,000 each for the fiscal year ending June 30, 1971, and the next two fiscal years.

"ELIGIBILITY FOR GRANTS

"SEC. 632. Funds appropriated pursuant to section 631 shall be available for grants by the Secretary for not to exceed 50 per centum of the cost of modernization of emergency rooms of public or other nonprofit general hospitals. In order to be eligible for a grant under this part, the project,

and the applicant therefor, must meet such criteria as may be prescribed by regulations. Such regulations shall be so designed as to provide aid only with respect to projects for which adequate assistance is not readily available from other Federal, State, local, or other sources, and to assist in providing modern, efficient, and effective emergency room service needed to care for victims of highway, industrial, agricultural, or other accidents and to handle other medical emergencies, and to assist in providing such service in geographical areas which have special need therefor.

"PAYMENTS

"SEC. 633. Grants under this part shall be paid in advance or by way of reimbursement, in such installments and on such conditions, as in the judgment of the Secretary will best carry out the purposes of this part."

EXTENSION OF DURATION OF EXISTING GRANT PROGRAMS; SEPARATE AUTHORIZATION FOR MODERNIZATION GRANTS

SEC. 4. (a) Section 601 of the Public Health Service Act (42 U.S.C. 291a) is amended by adding at the end thereof and below paragraph (b) the following new sentence:

"In order to assist the States in carrying out such purposes, there are authorized to be appropriated—

"(c) (1) for grants for the construction of public or other nonprofit hospitals and public health centers, $135,000,000 each for the fiscal year ending June 30, 1971, and the next two fiscal years;

"(2) for grants for the construction of public or other nonprofit facilities for long-term care, $70,000,000 each for the fiscal year ending June 30, 1971, and the next two fiscal years;

"(3) for grants for the construction of public or other nonprofit diagnostic or treatment centers, $20,000,000 each for the fiscal year ending June 30, 1971, and the next two fiscal years;

"(4) for grants for the construction of public or other nonprofit rehabilitation facilities, $10,000,000 each for the fiscal year ending June 30, 1971, and the next two fiscal years; and

"(5) for grants for modernization of the facilities referred to in the preceding subparagraphs, $50,000,000 for the fiscal year ending June 30, 1971, $55,000,000 for the fiscal year ending June 30, 1972, and $60,000,000 for the fiscal year ending June 30, 1973."

STATE ALLOTMENTS

SEC. 5. (a) Effective with respect to appropriations pursuant to section 601 of the Public Health Service Act for fiscal years beginning after June 30, 1970, section

602 (a) of such Act (42 U.S.C. 291b) is amended to read as follows:

"SEC. 602. (a) (1) For each fiscal year, the Secretary shall make allotments among the States from the sums appropriated for such year under subparagraphs (1), (2), (3), and (4) of section 601 (c) as follows: Each State shall be entitled to an allotment bearing the same ratio to the sums appropriated for such year under subparagraphs (1), (2), (3), and (4), respectively, of section 601 (c), as the product of—

"(A) the population of such State, and

"(B) the square of its allotment percentage,

bears to the sum of the corresponding products for all of the States.

"(2) For each fiscal year, the Secretary shall, in accordance with regulations, make allotments among the States, from the sums appropriated for such year under subparagraph (5) of section 601 (c), on the basis of the population, the financial need, and the extent of the need for modernization of the facilities referred to in section 601, of the respective States."

(b) Effective with respect to allotments from such appropriations, section 602 (b) (1) of such Act is amended by—

(1) striking out "$50,000" in subparagraph (A) and inserting in lieu thereof "$100,000";

(2) striking out "$100,000" in subparagraph (B) and inserting in lieu thereof "$200,000";

(3) striking out "$200,000" in subparagraph (C) and inserting in lieu thereof "$300,000";

(4) striking out "or for the modernization of facilities referred to in paragraph (a) or (b) of section 601," in subparagraph (C); and

(5) adding after and below subparagraph (C) the following new subparagraph:

"(D) $100,000 for the Virgin Islands, American Samoa, Guam, or the Trust Territory of the Pacific Islands and $200,000 for any other State in the case of an allotment for grants for the modernization of facilities referred to in paragraph (c) of section 601,".

(c) Effective with respect to allotments from such appropriations, section 602 (e) of such Act is amended to read as follows:

"(e) Upon the request of any State that a specified portion of any allotment of such State under subsection (a), other than an allotment for grants for the construction of public or other nonprofit rehabilitation facilities, be added to another allotment of such State under such subsection, other

than an allotment for grants for the construction of public or other nonprofit hospitals and public health centers, and upon simultaneous certification to the Secretary by the State agency in such State to the effect that--

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

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

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

RURAL AREA PRIORITY

SEC. 6. Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1970, section 603(a)(1) of such Act (42 U.S.C. 291c) is amended by striking out "rural communities and areas with relatively small financial resources" and inserting in lieu thereof "areas with relatively small financial resources and, at the option of the State, rural communities".

CLARIFICATION OF MEANING OF DIAGNOSTIC OR TREATMENT CENTER

SEC. 7. Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1970, so much of the section of such Act herein redesignated as section 645 (f) (42 U.S.C. 291o) as precedes clause (1) is amended by inserting "(whether as inpatients or outpatients)" after "ambulatory patients".

AVAILABILITY OF EXTENDED CARE SERVICES TO PATIENTS OF GENERAL HOSPITALS

SEC. 8. Section 604 (a) of the Public Health Service Act (42 U.S.C. 291d) is amended by striking out "and" at the end of paragraph (11), by striking out the period at the end of paragraph (12) and inserting in lieu thereof "; and", and by adding after paragraph (12) the following new paragraph:

"(13) Effective July 1, 1971, provide that before any project for construction or modernization of any general hospital is approved by the State agency there will be reasonable assurance of adequate provision for extended care services (as determined in accordance with regulations) to patients of such hospital when such services are medically appropriate for them, with such services being provided in facilities which (A) are structurally part of, physically connected with, or in immedi-

ate proximity to, such hospital, and (B) either (i) are under the supervision of the professional staff of such hospital or (ii) have organized medical staffs and have in effect transfer agreements with such hospital. If the State agency determines that it would be inadvisable to require that such extended care services be provided in facilities that are structurally part of, physically connected with, or in immediate proximity to, such hospital, the Secretary may waive the requirement that such services be provided in such facilities."

PORTION OF ALLOTMENT AVAILABLE FOR STATE PLAN ADMINISTRATION

SEC. 9. Effective with respect to expenditures under a State plan approved under title VI of the Public Health Service Act which are made for administration of such plan during any fiscal year beginning after June 30, 1970, the first sentence of subsection (c) (1) of section 606 of such Act (42 U.S.C. 291f) is amended by striking out "2 per centum" and "$50,000" and inserting in lieu thereof "3 per centum" and "$75,000", respectively.

FEDERAL SHARE OF COST OF CONSTRUCTION

SEC. 10. Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1970, the section of such Act herein redesignated

as section 645(b) (42 U.S.C. 291o) is amended to read as follows:

"(b) (1) The term 'Federal share' with respect to any project means the proportion of the cost of such project to be paid by the Federal Government under this title.

"(2) With respect to any project in any State for which a grant is made from an allotment from an appropriation under section 601, the Federal share shall be the amount determined by the State agency designated in accordance with section 604, but not more than 66⅔ per centum or the State's allotment percentage, whichever is the lower, except that, if the State's allotment percentage is lower than 50 per centum, such allotment percentage shall be deemed to be 50 per centum for purposes of this paragraph.

"(3) Prior to the approval of the first project in a State during any fiscal year the State agency designated in accordance with section 604 shall give the Secretary written notification of the maximum Federal share established pursuant to paragraph (2) for projects in such State to be approved by the Secretary during such fiscal year and the method for determining the actual Federal share to be paid with respect to such projects; and such maximum Federal share and such method of determination for projects in such State approved during such fiscal year shall not be changed after such approval."

WAIVING OF RIGHT OF RECOVERY

SEC. 11. Section 3(b) of the Hospital and Medical Facilities Amendments of 1964 (Public Law 88–443) is amended by striking out the period at the end of paragraph (5) and inserting in lieu thereof a semicolon, and by adding after such paragraph the following new paragraph:

"(6) the provisions of clause (b) of section 609 of the Public Health Service Act, as amended by this Act, shall apply with respect to any project whether it was approved, and whether the event specified in such clause occurred, before, on, or after the date of enactment of this Act, except that it shall not apply in the case of any project with respect to which recovery under title VI of such Act has been made (or judicially ordered) prior to the enactment of this paragraph."

INCLUSION OF THE TRUST TERRITORY OF THE PACIFIC ISLANDS

SEC. 12. (a) Subparagraphs (A), (B), and (C) of paragraph (1) of subsection (b) of section 602 of the Public Health Service Act (42 U.S.C. 291b) are each amended by inserting "the Trust Territory of the Pacific Islands," after "American Samoa,".

(b) Paragraph (2) of such subsection is amended by

inserting "the Trust Territory of the Pacific Islands," after "American Samoa,".

(c) Paragraph (1) (B) of subsection (c) of such section is amended by inserting "the Trust Territory of the Pacific Islands," after "American Samoa,".

(d) Paragraphs (1) and (2) of subsection (d) of such section are each amended by inserting "the Trust Territory of the Pacific Islands," after "American Samoa,".

(e) The section of such Act herein redesignated as section 645 (a) (42 U.S.C. 291o) is amended by inserting "the Trust Territory of the Pacific Islands," after "American Samoa,".

(f) The amendments made by this section shall apply for purposes of parts B and C of title VI of the Public Health Service Act and with respect to allotments (and grants therefrom) from appropriations pursuant to section 601 (c) of the Public Health Service Act.

AREAWIDE AND STATE HEALTH PLANNING AGENCIES

SEC. 13. (a) Effective with respect to applications approved under title VI of the Public Health Service Act after June 30, 1970, clause (4) of the first sentence of section 605 (b) of such Act (42 U.S.C. 291e) is amended by striking out "State agency and" and inserting in lieu thereof "State agency, opportunity has been provided, prior to such approval and recommendation, for consideration of the proj-

ect by the public or nonprofit private agency or organization which has developed the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) covering the area in which such project is to be located or, if there is no such agency or organization, by the State agency administering or supervising the administration of the State plan approved under section 314(a), and the application is for a project which".

(b) Section 314(b) of such Act (42 U.S.C. 246) is amended by adding after the first sentence the following new sentence: "No grant may be made under this subsection after June 30, 1970, to any agency or organization to develop or revise health plans for an area unless the Secretary determines that such agency or organization provides means for appropriate representation of the interests of the hospitals, other health care facilities, and practicing physicians serving such area, and the general public."

DEFINITION OF HOSPITAL

SEC. 14. (a) Effective with respect to applications approved under title VI of the Public Health Service Act after June 30, 1970, the section of such Act herein redesignated as section 645(c) is amended—

(1) by inserting after "nurses' home facilities," the following: "extended care facilities, facilities re-

lated to programs for home health services, self-care units,"; and

(2) by inserting a comma immediately before "operated" and inserting immediately before "but does not include" the following: "and also includes education or training facilities for health professions personnel operated as an integral part of a hospital,".

(b) Effective with respect to applications approved under title VI of the Public Health Service Act after June 30, 1970, the section of such Act herein redesignated as section 645(h) (42 U.S.C. 291o) is amended by inserting after "means a facility" the following: "(including an extended care facility)".

(c) Effective July 1, 1970, section 604(a)(3) of such Act (42 U.S.C. 291d) is amended—

(1) by inserting "(A)" after "shall include", and

(2) by inserting after "rehabilitation services, and" the following: "representatives particularly concerned with education or training of health professions personnel, and (B)".

FINANCIAL STATEMENTS FOR FACILITIES ASSISTED UNDER TITLE VI OF THE PUBLIC HEALTH SERVICE ACT

SEC. 15. Title VI of the Public Health Service Act is amended by adding at the end thereof the following new section:

"FINANCIAL STATEMENTS

"SEC. 646. In the case of any facility for which a grant, loan, or loan guarantee has been made under this title, the applicant for such grant, loan, or loan guarantee (or, if appropriate, such other person as the Secretary may prescribe) shall file at least annually with the State agency for the State in which the facility is located a statement which shall be in such form, and contain such information, as the Secretary may require to accurately show—

"(1) the financial operations of the facility, and

"(2) the costs to the facility of providing health services in the facility and the charges made by the facility for providing such services,

during the period with respect to which the statement is filed."

Passed the House of Representatives June 4, 1969.

Attest: W. PAT JENNINGS,

Clerk.

91ST CONGRESS
1ST SESSION

S. 269

IN THE SENATE OF THE UNITED STATES

JANUARY 16 (legislative day, JANUARY 10), 1969

Mr. JAVITS (for himself, Mr. DOMINICK, and Mr. MURPHY) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act to provide for the making of guaranteed loans for the modernization of hospitals and other health facilities and otherwise to facilitate the modernization and improvement of hospitals and other health facilities.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Hospital Modernization and Improvement Act of 1969".

SEC. 2. Title VI of the Public Health Service Act is amended by redesignating part B as part C and by redesignating sections 621 through 625, and references thereto, as

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sections 631 through 635, respectively, and by inserting after section 610 the following new part:

"PART B—LOAN GUARANTEES FOR MODERNIZATION OF HOSPITALS AND OTHER HEALTH FACILITIES

"AUTHORIZATION OF LOAN GUARANTEES

"SEC. 621. (a) In order to assist public and other nonprofit agencies to carry out needed projects for the modernization of facilities referred to in paragraphs (a) and (b) of section 601, the Secretary is authorized (subject to the limitations contained in this part) to guarantee, to non-Federal lenders making loans to such agencies for such purpose, payment when due of principal and interest on loans approved under this part.

"(b) No loan guarantee under this part with respect to any modernization project may apply to so much of the principal amount thereof as, when added to the amount of any grant or loan under part A with respect to such project, exceeds 90 per centum of the cost of such project.

"ALLOCATION AMONG THE STATES

"SEC. 622. (a) The Secretary, after consultation with the Federal Hospital Advisory Council, shall allot among the States the amounts available for each fiscal year to cover loans which may be guaranteed under this part. Such amounts, for any fiscal year, shall be allotted among the States in a manner which is fair and equitable to each State

after taking into consideration the population, financial need, and need for modernization of facilities referred to in paragraphs (a) and (b) of section 601, of each State, as compared to the population, financial need, and need for the modernization of such facilities, of all States.

"(b) Any amount allotted to a State prior to the fiscal year ending June 30, 1973, for a fiscal year and remaining unobligated at the end of such year shall remain available to such State, for the purposes for which made, for the next fiscal year (and for such year only), and any such amount shall be in addition to the amounts allotted to such State for such purpose for such next fiscal year. Any amount so allotted to a State for a fiscal year shall not (even though remaining unobligated at the close thereof) be considered as available for allotment for the next fiscal year.

"APPLICATIONS AND CONDITIONS

"SEC. 623. (a) For each project for which a loan guarantee is sought under this part, there shall be submitted to the Secretary, through the State agency designated in accordance with section 604, an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the project, the application may be filed by one or more such agencies. Such application shall set forth all of the descriptions, plans, specifications, assurances, and information

which would be required under clauses (1) through (5) of section 605(a) with respect to applications for projects under that section, such other information as the Secretary may require to carry out the purposes of this part, and a certification by the State agency of the total cost of the project for which the application is approved and recommended by such agency, and the amount of the project cost with respect to which a loan guarantee is sought under this part.

"(b) The Secretary may approve such application only if (1) there remains sufficient balance in the allotment determined for such State pursuant to section 622 to cover the cost of the project, (2) he makes each of the findings which would be required under clauses (1) through (4) of section 605(b) for the approval of applications for projects thereunder (but with appropriate modifications, for this purpose, in the regulations concerning priority of projects), (3) he obtains assurances that the applicant will keep such records, and afford such access thereto, and make such reports, in such form and containing such information, as the Secretary may reasonably require, and (4) he also determines that the terms, conditions, maturity, security (if any), and schedule and amounts of repayments with respect to the loan are reasonable and in accord with regulations, and that the rate of interest of such loan does not exceed such per

centum per annum on the principal obligation outstanding as he deems to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States.

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

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

"(e) (1) The United States shall be entitled to recover from the applicant the amount of any payments made pursuant to any guarantee under this part, unless the Secretary for good cause waives its right of recovery, and, upon making any such payments, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

"(2) Guarantees under this part shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this part will be achieved, and, to the extent permitted by subsection (f), any of such terms and conditions may be modified by the Secretary if he determines such modification is necessary to protect the financial interest of the United States.

"(f) Any guarantee made by the Secretary pursuant to this part shall be incontestable in the hands of an applicant on whose behalf such guarantee is made, and as to any person who makes or contracts to make a loan to such applicant in reliance thereon, except for fraud or misrepresentation on the part of such applicant or such other person.

"PAYMENT OF INTEREST ON LOANS

"SEC. 624. (a) The Secretary shall pay to each holder of a loan guaranteed under this part, for and on behalf of the hospital to which such loan was made, (1) one-half of the interest which becomes due and payable on such loan, or (2) if lower, the interest which would become so due and payable at an interest rate of 3 per centum. Each holder of a loan guaranteed under this part shall have a contractual right to receive from the United States interest payments required by the preceding sentence.

"(b) There are hereby authorized to be appropriated for each fiscal year such amounts as may be necessary to carry out the provisions of subsection (a).

"(c) Contracts to make the payments provided for in this section shall not carry an aggregate amount greater than such amount as may be provided in appropriation Acts.

"LIMITATION ON AMOUNT OF LOANS GUARANTEED

"SEC. 625. The cumulative total of the principal of the loans outstanding at any time with respect to which guar-

antees have been issued under this part may not exceed the lesser of—

"(1) such limitations as may be specified in appropriation Acts,

"(2) in the case of loans covered by allotments for the fiscal year ending June 30, 1970, $400,000,000; for the fiscal year ending June 30, 1971, $800,000,000; and for the fiscal year ending June 30, 1972, $1,200,000,000.

"LOAN GUARANTEE FUND

"SEC. 626. (a) There is hereby established in the Treasury a loan guarantee fund (hereinafter in this section referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation to enable him to discharge his responsibilities under any guarantee issued by him under this part. There are authorized to be appropriated to the fund from time to time such amounts as may be necessary to provide capital for the fund.

"(b) If at any time the moneys in the fund are insufficient to enable the Secretary to discharge his responsibilities under any guarantees issued by him under this part, he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions as may be prescribed by the Secretary with the

approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury is authorized and directed to purchase any notes and other obligations issued hereunder and for that purpose he is authorized to use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, as amended, and the purposes for which securities may be issued under that Act, as amended, are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this subsection. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this subsection shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from such fund."

SEC. 3. Subsection (k) of section 625 (redesignated as section 635 by section 2 of this Act) of the Public Health Service Act is amended by inserting immediately before the

period the following: "; and, for purposes of part B of this title only, such term includes the expansion of a hospital or other health facility so as to increase the number of beds therein by not more than 10 per centum, if such expansion is in conformity with the applicable State plan".

SEC. 4. (a) Section 604 (a) of the Public Health Service Act is amended (1) by striking out "and" at the end of paragraph (11) thereof, (2) by striking out the period at the end of paragraph (12) thereof and inserting in lieu of such period "; and", and (3) by adding at the end thereof the following new paragraph:

"(13) provide that, whenever the need is the same for two or more hospital modernization projects, priority shall be accorded under part B of this title to modernization projects by hospitals which are teaching hospitals. For the purposes of the preceding sentence, a 'teaching hospital' is a hospital that allocates a substantial part of its resources to conduct, in its own name, or in formal association with a college or university, one or more formal educational programs or courses of instruction in the health disciplines that lead to the granting of recognized certificates, diplomas, or degrees, or that are required for professional certification or licensure."

(b) The amendment made by subsection (a) shall

take effect on the first day of the second month following the month in which this Act is enacted.

SEC. 5. Section 621 (redesignated as section 631 by section 2 of this Act) of the Public Health Service Act is amended by adding at the end thereof the following new subsection:

"(f) The Council shall conduct an evaluation of the effectiveness (including innovation of new methods) of modernization projects under this title, and shall submit annually to the Secretary and the Congress a report of findings and recommendations with respect to such evaluation."

SEC. 6. Section 302(c)(2)(B) of the Federal National Mortgage Association Charter Act is amended to read as follows:

"(B) The Department of Health, Education, and Welfare, but only with respect to loans (i) made by the Commissioner of Education for construction of academic facilities, and loans to help finance student loan programs, and (ii) made under part B of title VI of the Public Health Service Act for modernization of hospitals and other health facilities."

91ST CONGRESS
1ST SESSION

S. 1589

IN THE SENATE OF THE UNITED STATES

MARCH 20, 1969

Mr. MAGNUSON (for himself, Mr. CHURCH, Mr. DODD, Mr. EAGLETON, Mr. GRAVEL, Mr. HARRIS, Mr. HARTKE, Mr. HUGHES, Mr. INOUYE, Mr. JACKSON, Mr. KENNEDY, Mr. METCALF, Mr. MOSS, Mr. RANDOLPH, Mr. TYDINGS, Mr. WILLIAMS of New Jersey, and Mr. YOUNG of Ohio) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To establish an emergency program of direct Federal assistance in the form of direct grants and loans to certain hospitals in critical need of new facilities in order to meet increasing demands for service.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act shall be known as the Hospital Emergency Assistance Act of 1969.

EMERGENCY ASSISTANCE FOR COMMUNITY HOSPITAL SERVICES

SEC. 2. (a) Section 314 of the Public Health Services Act is amended by redesignating subsection (g) as subsection (h) and by inserting immediately after subsection (f) the following new subsection:

"EMERGENCY GRANTS TO HOSPITALS

"(g) (1) FINDINGS.—The Congress finds that certain public and nonprofit private hospitals in the several States are unable to meet the present urgent health service needs of the communities served by the hospitals or to participate in comprehensive health services programs or planning to meet future needs due to a critical lack of adequate facilities and services; that there do not now exist adequate sources of public or private financing to provide the direct emergency assistance needed to resolve this critical condition; and, that this results in a serious threat to the health, welfare, and safety of the communities involved and of the Nation.

"(2) AUTHORIZATION.—In order to provide emergency assistance to those hospitals found to be in critical condition as provided in paragraph (3) of this subsection and in the cases where the communities they serve would otherwise be deprived of needed health services, the Secretary of Health, Education, and Welfare (hereinafter "Secretary") is author-

ized to make direct emergency grants of up to 66⅔ per centum of the cost of any project to provide necessary facilities and services in accordance with the provisions of this subsection: *Provided*, That no grant of assistance for any single project under this subsection may exceed 7½ per centum of the amount appropriated under this paragraph. For the purpose of making emergency grants as provided in this subsection there is hereby authorized to be appropriated $100,000,000 for the fiscal year ending June 30, 1970. Sums appropriated pursuant to the preceding sentence shall remain available for obligation for two fiscal years following the fiscal year for which they are appropriated.

"(3) ELIGIBILITY.—Public and nonprofit private hospitals may qualify as critical hospitals and be eligible for assistance under this Act if the Secretary finds that—

"(A) the average rate of occupancy or the demand for necessary and essential facilities and services of such a hospital so far exceeds reasonable capacity that the community served is deprived of health services of a type and quality conforming to generally accepted standards;

"(B) full and effective use is being made of the existing facilities of the hospital and of other health facilities available to the community;

"(C) the needed assistance is not available from other public or private resources; and

"(D) the failure to provide the needed facilities or services constitutes a threat to the health, welfare, or safety of the community.

"(4) APPLICATIONS.—Any hospital seeking emergency assistance under this subsection shall apply to the Secretary, declaring itself to be in critical need of emergency assistance and setting forth—

"(A) evidence of eligibility under the provisions of paragraph (3) of this subsection in such manner and detail and with such supporting data as the Secretary shall require;

"(B) a detailed description of the project for which emergency assistance is being requested, specifying the deficiencies in health services that the project will correct, and how the project, if approved and completed, will—

"(i) meet the health services needs of the community it serves,

"(ii) be coordinated with existing health services available to such community, and

"(iii) be integrated with health services programs approved or planned for the community, State, or region in which the hospital is included;

"(C) the estimated cost of completing the project,

set forth in such manner and detail as the Secretary shall require;

"(D) the amount of emergency assistance, under this subsection, that will be required to complete the project; the period of time during which such assistance will be utilized; the source and the amount of funds, other than the grant assistance requested under this subsection, but including any emergency loan requested under paragraph (7) of this subsection, which will be used to complete the project;

"(E) reasonable assurance that adequate financial assistance will be available to support and maintain the added or expanded facilities or services after the project requested under this subsection is completed;

"(F) reasonable assurance that wherever any project for which assistance under this subsection is requested involves construction, all laborers and mechanics employed by contractors or subcontractors in the performance of such construction will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a–276a(5)); and the Secretary of Labor shall have with respect to the labor standards specified in

this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c) ; and

"(G) agreement that the Secretary may exercise such review authority as he deems advisable in accordance with the provisions of paragraph (6) of this subsection.

"(5) APPROVAL OF APPLICATION.—The Secretary may approve such application if he determines that—

"(A) the hospital making application for assistance is eligible for assistance under the terms of paragraph (3) of this subsection, and that the hospital has complied with all relevant provisions of this subsection;

"(B) the project described in accordance with paragraph (4) of this subsection will help to correct existing deficiencies in health services available to the community, will help to enable the hospital to provide health services of a type and quality conforming to generally accepted standards and conforms to local, State, or regional health planning and programs;

"(C) sufficient funds are available from amounts appropriated pursuant to paragraph (2) of this subsection to make the grants of assistance covered by such applications; and

"(D) the project covered by such application is entitled to priority over other projects for which applications have been received under this subsection but which have not been approved under this paragraph: *Provided*, That in making such determination special consideration shall be given to hospitals participating in health services development programs authorized under section 304 of this Act.

"(6) REVIEW AUTHORITY.—For the purpose of determining whether a hospital is eligible for assistance under paragraph (3) of this subsection and whether an application conforms to the conditions for approval under paragraphs (4) and (5) of this subsection, the Secretary is authorized to visit any hospital submitting an application for assistance, to review any relevant records and to make or request surveys of health facilities and services of the community served by the hospital.

"(7) EMERGENCY LOANS TO CRITICAL HOSPITALS.—Any hospital unable to secure adequate funds to pay that portion of the project cost not covered by the emergency grant requested under this subsection, may apply to the Secretary for an emergency loan and the Secretary is authorized to loan such a hospital up to 90 per centum of that portion of the project cost not covered by the grant provided under this subsection if (A) the Secretary determines that

the hospital is unable to secure the needed funds from other public and private sources and (B) the Secretary approves the requested emergency grant under this subsection: *Provided,* That no emergency loan shall exceed 90 per centum of 33⅓ per centum of the total project cost as defined under paragraph (4) of this subsection and approved by the Secretary. Each such loan authorized by this paragaph shall bear interest at the rate of 2½ per centum per annum on the unpaid balance thereof and shall be repayable over a period determined by the Secretary to be appropriate, but not exceeding fifty years. In order to make the loans provided for in this paragraph, there are hereby authorized to be appropriated $45,000,000 for the fiscal year ending June 30, 1968. Sums appropriated pursuant to the preceding sentence shall remain available for obligation for two fiscal years following the fiscal year for which they are appropriated.

"(8) SURVEY OF HOSPITALS AND COMMUNITY HEALTH SERVICES NEEDS.—To aid in fulfilling the goals of this section and carry out the purposes of this subsection, the Secretary shall conduct a survey of public and nonprofit private hospitals in the Nation and shall evaluate the type and quality of facilities and services available from such hospitals. Based upon this study the Secretary shall establish and maintain criteria for determining generally accepted standards of health services and shall report the results of the sur-

vey and his determinations to Congress and the President no later than June 1, 1968. Thereafter the Secretary shall revise the survey and his determinations annually and shall report to the President and Congress at the beginning of each session of Congress. Such reports shall include estimates of the cost of meeting the emergency needs of critical hospitals, the availability of funds from public and private sources to meet such costs and recommendations for additional appropriations under this subsection if he finds that such are needed to meet emergency situations. For the purpose of preparing and maintaining the survey according to the provisions of this paragraph, the Secretary is authorized to cooperate with and utilize the resources of such public and private organizations as he deems necessary and advisable.

"(9) DEFINITIONS.—As used in this subsection—

"(A) The term 'State' includes the Commonwealth of Puerto Rico and the District of Columbia.

"(B) The term 'hospital' includes facilities furnishing domiciliary care.

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

"(D) The term 'project' includes additions to exist-

ing hospital plant, alterations, enlargement, or remodeling of existing buildings, equipment, instruments, furnishings, and programs involving personnel."

(b) This section may be cited as the "Hospital Emergency Assistance Act of 1969".

91ST CONGRESS
1ST SESSION

S. 1733

IN THE SENATE OF THE UNITED STATES

APRIL 1, 1969

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

A BILL

To amend the Public Health Service Act to provide for grants for the construction and modernization of public health centers and public and nonprofit private facilities for long-term care, rehabilitation facilities, and diagnostic or treatment centers, to provide for loan guarantees for nonprofit private hospitals and other medical facilities, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Medical Facilities Construction and Modernization Amendments of 1969".

DEFINITION OF SECRETARY

SEC. 2. As used in the amendments made by this Act, the term "Secretary" means, unless the context otherwise requires, the Secretary of Health, Education, and Welfare.

FINDINGS AND DECLARATION OF PURPOSE

SEC. 3. (a) (1) Since 1946, the Hill-Burton program has been the principal Federal instrument for construction and modernization of private nonprofit health facilities. The program was originally designed to assist in the construction of hospitals, especially in rural areas. Over the last two decades these needs have been substantially met, and other more urgent priorities have arisen.

(2) Most critical is the need for modernization or replacement of health facilities, particularly in urban and densely populated areas. Such facilities include those for ambulatory care, rehabilitation, and extended care, and diagnostic or treatment centers and emergency rooms. Modernization needs alone are estimated at $11,000,000,000. Yet the Hill-Burton program continues to give priority to construction of general hospitals serving rural communities.

(3) The present Hill-Burton program is not directed to and, even if tremendously expanded, could not begin to meet such an overwhelming national need. A new approach is essential.

(4) Rapidly rising costs of medical care lend added

urgency to a redirection of the Hill-Burton program. New emphasis must be placed on coordinated planning for adequate care and treatment under conditions less costly than acute hospital care. Emphasis must also be placed on providing medical care for persons in urban or rural poverty areas through diagnostic or treatment centers and other appropriate facilities.

(b) It is, therefore, the purpose of this Act to revise the Hill-Burton program so that it will provide this new approach and new emphasis and will help to deliver medical care where it is most needed and in ways which can help to reduce the cost of the care and make the delivery thereof more efficient and effective.

TITLE I—LOAN GUARANTEES FOR CONSTRUCTION AND MODERNIZATION OF NONPROFIT HOSPITALS AND OTHER MEDICAL FACILITIES

LOAN GUARANTEES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

SEC. 101. Title VI of the Public Health Service Act is amended by redesignating part B as part D; by redesignating sections 621 through 625 (42 U.S.C. 291k–291o), and all references thereto, as sections 641 through 645, respectively; and by inserting after section 610 (42 U.S.C. 291j) the following new part:

"PART B—LOAN GUARANTEES FOR MODERNIZATION AND CONSTRUCTION OF NONPROFIT HOSPITALS AND OTHER MEDICAL FACILITIES

"AUTHORIZATION OF LOAN GUARANTEES

"SEC. 621. (a) In order to assist nonprofit private agencies to carry out needed projects for the modernization or construction of private nonprofit hospitals, facilities for long-term care, diagnostic or treatment centers, and rehabilitation facilities, the Secretary, during the period July 1, 1969, through June 30, 1972, may guarantee in accordance with this part, to non-Federal lenders making loans to such agencies for such projects, payment when due of the principal of and interest on loans approved under this part. The Secretary is also authorized to make commitments, on behalf of the United States, to make such guarantees prior to the making of such loans.

"(b) No loan guarantee under this part with respect to any modernization or construction project may apply to so much of the principal amount thereof as, when added to the amount of any grant or loan under this title with respect to such project, exceeds 90 per centum of the cost of construction of such project; nor may any such guarantee apply to more than 90 per centum of the loss of principal of and interest on such loan.

"MAXIMUM ON LOANS GUARANTEED

"SEC. 622. (a) For the purpose of determining the total of the principal of the loans which may be guaranteed under this part during any fiscal year, and the portions thereof which may be guaranteed during such year with respect to construction or modernization projects in each State—

"(1) The cumulative total specified in section 624 for such year shall be reduced by (A) the total of the loans guaranteed under this part prior to the beginning of such year, and (B) the unused portions of the amounts previously allocated to the States under this section and still available for the guarantee of loans under this part with respect to projects in such States.

"(2) The cumulative total so reduced shall then be divided by the Secretary among the States and allocated by him to them on the basis of their relative population, financial need, need for modernization of the facilites referred to in section 601, and need for construction of such facilities.

The amount allocated to a State under subparagraph (2) for a fiscal year (which shall be known as the State's allocation for such year) shall (except as provided in subsection (b)) be the maximum of the principal of the loans which may be

guaranteed under this part with respect to projects in such State during such year.

"(b) (1) The excess of the allocation so resulting for any State, other than the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands, for any fiscal year over the total of the loans guaranteed during such year under this part with respect to projects in such State shall remain available to such State, for the purpose for which made, for the next fiscal year (and for such fiscal year only), in addition to the allocation determined for such State for such next fiscal year under subsection (a).

"(2) The excess of the allocation so resulting for the Virgin Islands, Guam, American Samoa, or the Trust Territory of the Pacific Islands for any fiscal year over the total of the loans guaranteed during such year under this part with respect to projects therein shall remain available to it, for the purpose for which made, for the next two fiscal years (and for such fiscal years only), in addition to the allocation determined for it for each of such next two fiscal years under subsection (a).

"APPLICATIONS AND CONDITIONS

"SEC. 623. (a) For each project for which a loan guarantee is sought under this part, there shall be submitted to the Secretary, through the State agency designated in accordance with section 604, an application by a nonprofit

private agency. If two or more such agencies join in the project, the application may be filed by one or more such agencies. Such application shall (1) set forth all of the descriptions, plans, specifications, assurances, and information which are required by the third sentence of section 605 (a) (other than clause (6) thereof) with respect to applications submitted under that section, (2) contain such other information as the Secretary may require to carry out the purposes of this part, and (3) include a certification by the State agency of the estimated cost of the project and the amount of the loan for which a guarantee is sought under this part.

"(b) The Secretary shall approve such application if—

"(1) the applicable allocations determined for such State pursuant to section 622 would not be exceeded by the amount of the loan for which a guarantee is sought in such application, when added to the amount of the loans with respect to which guarantees have already been issued during the year with respect to projects in such State;

"(2) he makes each of the findings which are required by clauses (1) through (4) of section 605 (b) for the approval of applications for projects thereunder;

"(3) he finds that opportunity has been provided prior to approval and recommendation by the State

agency as provided in such clause (4), for consideration of the project by the public or nonprofit private agency or organization which has developed the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) and covering the area in which such project is to be located or, if there is none, by such other public or nonprofit private agency or organization (if any) which performs, as determined in accordance with criteria included in regulations, similar functions;

"(4) he finds that there is compliance with section 605(e);

"(5) he obtains assurances that the applicant will keep such records, and afford such access thereto, and make such reports, in such form and containing such information, as the Secretary may reasonably require;

"(6) he obtains assurances that the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant;

"(7) he also determines that the terms, conditions, maturity, security (if any), and schedule and amounts of repayments with respect to the loan are sufficient to protect the financial interest of the United States and are otherwise reasonable, including a determination that the

rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States; and

"(8) he determines that the loan would not be available on reasonable terms and conditions without the guarantee under this part.

The Secretary may, to the extent he determines it would not interfere with the objectives of this title, base his findings and determinations under this subsection on certifications by the State agency.

"(c) No application under this section shall be disapproved until the Secretary has afforded the State agency an opportunity for a hearing.

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

"(e) (1) The United States shall be entitled to recover from the applicant the amount of any payments made pursuant to any guarantee under this part, unless the Secretary for good cause waives its right of recovery, and upon making any such payment, the United States shall be subrogated to

all of the rights of the recipient of the payments with respect to which the guarantee was made.

"(2) To the extent permitted by subsection (f), any terms and conditions applicable to a loan guarantee under this part may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

"(f) Any guarantee made by the Secretary pursuant to this part shall be incontestable in the hands of an applicant on whose behalf such guarantee is made, and as to any person who makes or contracts to make a loan to such applicant in reliance thereon, except for fraud or misrepresentation on the part of such applicant or such other person.

"CUMULATIVE TOTAL OF PRINCIPAL OF LOANS

"SEC. 624. The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this part, may not exceed the amount specified in appropriation Acts; nor may such total exceed—

"(1) in the case of loans made before June 30, 1970, $500,000,000;

"(2) in the case of loans made before June 30, 1971, $1,000,000,000; and

"(3) in the case of loans made before June 30, 1972, $1,500,000,000.

"PREMIUMS

"SEC. 625. The Secretary shall fix premium charges for the guarantee of loans under this part, but such charges shall not be more than one-half of 1 per centum per annum of the amount of the principal of the loan outstanding at any time, without taking into account delinquent payments or prepayments. If the principal of any loan guaranteed under this part is paid in full prior to the maturity date, the Secretary is authorized to require the payment by the lender of an adjusted premium charge. This charge shall be in such amount as the Secretary determines to be equitable, but not in excess of the aggregate amount of the premium charges that the lender would otherwise have been required to pay if the loan had continued until the maturity date. If such prepayment occurs, the Secretary is authorized to refund to the lender for the account of the borrower all, or such portion as he shall determine to be equitable, of the current unearned premium charges theretofore paid. Amounts collected under this section shall be deposited in the fund established by section 626, and any refunds required by this section shall be made from such fund.

"LOAN GUARANTEE FUND

"SEC. 626. (a) There is hereby established in the Treasury a loan guarantee fund (hereinafter in this section referred to as the 'fund') which shall be available to the

Secretary without fiscal year limitation to enable him to discharge his responsibilities under any guarantee issued by him under this part. There are authorized to be appropriated to the fund from time to time such amounts as may be necessary to provide capital for the fund.

"(b) If at any time the moneys in the fund are insufficient to enable the Secretary to discharge his responsibilities under guarantees issued by him under this part, he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury is authorized and directed to purchase any notes and other obligations issued hereunder and for that purpose he is authorized to use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, as amended, and the purposes for which securities may be issued under that Act, as amended, are extended to include any purchase of such notes and obli-

gations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this subsection. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this subsection shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from such fund.

"USE OF DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT IN ADMINISTRATION

"SEC. 627. In performing his functions under this part, the Secretary shall, with the consent of the Secretary of Housing and Urban Development, utilize the facilities and services of the Department of Housing and Urban Development to the maximum extent practicable in order to avoid duplication of the functions and personnel of that Department."

TERMINATION OF DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT HOSPITAL MORTGAGE INSURANCE PROGRAM

SEC. 102. No mortgage may be insured under section 242 of the National Housing Act except pursuant to a commitment therefor made prior to the date of enactment of the first appropriation Act in which an amount is, as provided in section 624 of the Public Health Service Act, specified.

TITLE II—GRANTS FOR CONSTRUCTION AND MODERNIZATION OF PUBLIC AND OTHER NONPROFIT MEDICAL FACILITIES

GRANTS FOR FACILITIES

SEC. 201. Title VI of the Public Health Service Act is amended by inserting after part B (inserted by section 101 of this Act) the following new part:

"PART C—GRANTS FOR MODERNIZATION AND CONSTRUCTION OF MEDICAL FACILITIES

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 631. In order to assist in the modernization and construction of public or other nonprofit facilities for long-term care, diagnostic or treatment centers, and rehabilitation facilities, and public health centers, there are authorized to be appropriated for the fiscal year ending June 30, 1970, the sum of $150,000,000, and for each of the next two fiscal years such sums as may be necessary, for grants for projects for modernization or construction of such facilities and centers.

"STATE ALLOTMENTS

"SEC. 632. (a) For each fiscal year the Secretary shall, in accordance with regulations, allot 80 per centum of the sums appropriated for such year pursuant to section 631 among the States on the basis of the relative population, financial need, need for modernization of the facilities and

centers referred to in such section and need for construction of such facilities and centers, of the respective States.

"(b) Any amount so allotted to a State, other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands, and remaining unobligated at the end of such year shall remain available to such State, for the purposes for which made, for the next fiscal year (and for such year only), and any such amount shall be in addition to the amounts allotted to such State for such purpose for such next fiscal year; except that any such amount, remaining unobligated at the end of the sixth month following the end of such year for which it was allotted, which the Secretary determines will remain unobligated by the close of such next fiscal year may be reallotted by the Secretary, to be available for the purposes for which made until the close of such next fiscal year, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this title, and any amount so reallotted to a State shall be in addition to the amounts allotted and available to the States for the same period. Any amount allotted under subsection (a) to the Virgin Islands, American Samoa, Guam, or the Trust Territory of the Pacific Islands for a fiscal year and remaining unobligated at the end of such year shall remain available to it, for the purposes for which made, for the next two fiscal years (and for such

years only), and any such amount shall be in addition to the amounts allotted to it for such purpose for each of such next two fiscal years; except that any such amount, remaining unobligated at the end of the first of such two additional years, which the Secretary determines will remain unobligated at the close of the second of such additional years may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such additional years, to any other of such four States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this title, and any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period.

"APPLICATIONS AND CONDITIONS

"SEC. 633. (a) For each project for which a grant is sought from an allotment under section 632, there shall be submitted to the Secretary, through the State agency designated in accordance with section 604, an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the project, the application may be filed by one or more such agencies. Such application shall set forth all of the descriptions, plans, specifications, assurances, and information which would be required under the third sentence of section 605 (a) with respect to applications submitted under that section,

such other information as the Secretary may require to carry out the purposes of this part, and a certification by the State agency of the estimated cost of the project for which the application is approved and recommended by such agency and the Federal share for the project.

"(b) The Secretary shall approve such application if (1) there remains sufficient balance in the allotment (available for the purpose) determined for such State pursuant to section 632 to cover the Federal share of the cost of the project; (2) he makes each of the findings which would be required under clauses (1) through (4) of section 605(b) for the approval of applications for projects thereunder and he finds that there is compliance with section 605(e); (3) he finds that opportunity has been provided, prior to approval and recommendation by the State agency as provided in such clause (4), for consideration of the project by the public or nonprofit private agency or organization which has developed the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) and covering the area in which such project is to be located or, if there is none, by such other public or nonprofit private agency or organization (if any) which performs, as determined in accordance with criteria included in regulations, similar functions; (4) he obtains assurances that the facility or portion

thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant; and (5) he obtains assurances that the applicant will keep such records, and afford such access thereto, and make such reports, in such form and containing such information, as the Secretary may reasonably require. The Secretary may, to the extent he determines it would not interfere with the objectives of this title, base his findings and determinations under this subsection on certifications by the State agency.

"(c) No application under this section shall be disapproved until the Secretary has afforded the State agency an opportunity for a hearing.

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

"(e) The provisions of sections 606 (a) and (b), 607, 608, and 609 shall apply with respect to the preceding provisions of this part and projects approved hereunder to the same extent and in the same way as they would apply to part A and projects approved thereunder.

"DIRECT GRANTS FOR PROJECTS OF SPECIAL NATIONAL SIGNIFICANCE

"SEC. 634. (a) Of the sums appropriated pursuant to section 631 for any fiscal year, 20 per centum shall be available for grants by the Secretary to pay up to 90 per centum

of the cost of construction of those projects for the modernization or construction of public health centers and public or other nonprofit facilities for long-term care, diagnostic or treatment centers, and rehabilitation facilities which in his judgment are of special national significance because they will assist in meeting the needs of the disadvantaged for health care or demonstrate new or particularly effective or efficient methods of delivery of health care.

"(b) No such grant may be made for a project in any State if the State agency designated in accordance with section 604(a)(1), within thirty days after the application for such grant has been referred to it, notifies the Secretary that it disapproves of such application.

"(c) Grants under this section may be paid in advance or by way of reimbursement, and in such installments and on such conditions, as the Secretary may determine."

TERMINATION OF PRESENT PROGRAM

SEC. 202. (a) Subsection (a) of section 601 of the Public Health Service Act (42 U.S.C. 291a) is amended by striking out "next five" and inserting in lieu thereof "next four".

(b) Subsection (b) of such section is amended by striking out ", and $195,000,000 for the fiscal year ending June 30, 1970" and by inserting "and" before "$180,000,000".

(c) The last sentence of subsection (a) (1) of section 602 of such Act (42 U.S.C. 291b) is amended by inserting "and" before "twenty-five-thirty-sixths" and by striking out ", and two-thirds thereof in the case of the fifth fiscal year thereafter".

(d) Subsection (e) (2) of such section is amended by striking out subparagraph (E) and by striking out "; and" at the end of subparagraph (D) and inserting in lieu thereof a period.

TITLE III—MISCELLANEOUS

INCLUSION OF TRUST TERRITORY OF THE PACIFIC ISLANDS

SEC. 301. Effective with respect to loan guarantees under part B, allotments (and grants therefrom) under part C, and grants under section 634 of title VI of the Public Health Service Act, the section of such Act redesignated (by section 101 of this Act) as section 645 (a) (42 U.S.C. 291o) is amended by inserting "Trust Territory of the Pacific Islands," after "American Samoa,".

PORTION OF ALLOTMENT AVAILABLE FOR STATE PLAN ADMINISTRATION

SEC. 302. Effective with respect to expenditures under a State plan approved under title VI of the Public Health Service Act which are made for administration of such plan during any fiscal year beginning after June 30, 1969, the

first sentence of subsection (c) (1) of section 606 of such Act (42 U.S.C. 291f) is amended by striking out "this part" the first time it appears therein and inserting in lieu thereof "this title", and by striking out "2 per centum" and "$50,000" and inserting in lieu thereof "4 per centum" and "$100,000", respectively.

FEDERAL SHARE OF COST OF CONSTRUCTION

SEC. 303. Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1969, the section of such Act redesignated (by section 101 of this Act) as section 645 (b) (42 U.S.C. 291o) is amended to read as follows:

"(b) (1) The term 'Federal share' with respect to any project means the proportion of the cost of such project to be paid by the Federal Government under this title.

"(2) With respect to projects in any State, the Federal share shall be the amount determined by the State agency designated in the State plan, but, except as provided in paragraph (4), not more than 66⅔ per centum or the State's allotment percentage, whichever is the lower; except that, if the State's allotment percentage is lower than 50 per centum, such allotment percentage shall be deemed to be 50 per centum for purposes of this paragraph.

"(3) Prior to the approval of the first project in a State during any fiscal year the State agency designated in the

State plan shall give the Secretary written notification of the maximum Federal shares established pursuant to paragraph (2) for projects in such State to be approved by the Secretary during such fiscal year and the method or methods for determining the actual Federal share to be paid with respect to such projects; and such maximum Federal shares and such method or methods of determination for projects in such State approved during such fiscal year shall not be changed after such approval.

"(4) In the case of any facility which provides or will, upon completion of the project for which application has been filed for a grant under part A or part C, provide services primarily for persons in an urban or rural poverty area, as determined in accordance with criteria in regulations, and in the case of any other project for which there is a special need and special circumstances justifying a higher Federal share, as so determined, the maximum Federal share shall, instead of 66⅔ per centum, be 90 per centum."

MEANING OF DIAGNOSTIC OR TREATMENT CENTERS

SEC. 304. (a) Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1969, so much of the section of such Act herein redesignated as section 645(f) as precedes clause (1) is amended by striking out "a facility" and inserting in lieu thereof "a community center, or any other facility,",

and by inserting "(whether as inpatients or outpatients)" after "ambulatory patients".

(b) Effective with respect to projects so approved after June 30, 1969, section 605(e) of such Act (42 U.S.C. 291e) is amended by inserting before the period at the end thereof ", or (3) a nonprofit private agency which provides or will, on completion of the project for which such application has been filed, provide services primarily for persons in urban or rural poverty areas, as determined in accordance with criteria in regulations".

WAIVING OF RIGHT OF RECOVERY

SEC. 305. Section (3) (b) of the Hospital and Medical Facilities Amendments of 1964 (Public Law 88–443) is amended by striking out the period at the end of paragraph (5) and inserting in lieu thereof a semicolon, and by adding after such paragraph the following new paragraph:

"(6) the provisions of clause (b) of section 609 of the Public Health Service Act, as amended by this Act, shall apply with respect to any project whether it was approved, and whether the event specified in such clause occurred, before, on, or after the date of enactment of this Act, except that it shall not apply in the case of any project with respect to which recovery under title VI of such Act has been made prior to the enactment of this paragraph."

INCLUSION OF CONTRIBUTIONS

SEC. 306. Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1969, the section of such Act redesignated (by section 101 of this Act) as section 645(j) (42 U.S.C. 291o) is amended by adding at the end thereof the following new sentence: "For purposes of determining the extent of a guarantee of a loan for any project under part B of this title, the extent of Federal payments with respect to a project under section 634, and the Federal share for a project to which paragraph (4) of subsection (b) applies, contributions of materials, facilities, equipment, and (notwithstanding section 605(a) (5) services for the project shall, subject to and in accordance with criteria included in regulations, be included in determining the cost of construction of such project."

APPROVAL OF STATE PLAN BY OVERALL STATE PLANNING AGENCY

SEC. 307. Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1969, section 604 of such Act (42 U.S.C. 291d) is amended by adding at the end thereof the following new subsection:

"(c) No such plan of any State shall be approved or considered approved under this section unless it has been approved by the State agency of such State designated or established pursuant to section 314(a) (2) (A)."

REPEAL OF PROVISIONS FOR REGULATIONS ON DETERMINING NEED FOR AND PRIORITY OF PROJECTS

SEC. 308. (a) Title VI of the Public Health Service Act (42 U.S.C. 291, et seq.) is amended by striking out section 603.

(b) Section 604 (a) of such Act (42 U.S.C. 291d) is amended by—

(1) striking out "in accordance with criteria established in regulations prescribed under section 603 and" in paragraph (4) and striking out "such" in the parenthetical clause in so much of such paragraph as precedes subparagraph (A).

(2) striking out "regulations prescribed under section 603 and" in paragraph (5).

(3) striking out ", with respect to each of such types of medical facilities," and ", determined in accordance with regulations prescribed under section 603," in paragraph (6).

(4) inserting "in order to carry out his functions under this title" after "require" in paragraph (10).

(5) striking out "and" at the end of paragraph (11), striking out the period at the end of paragraph (12) and inserting in lieu thereof "; and", and inserting after paragraph (12) the following new paragraph:

"(13) show the methods by which the construc-

tion and modernization program referred to in paragraph (5) is to be developed and the relative need referred to in paragraph (6) determined, which methods provide reasonable assurance that projects will be approved in the order of relative need for various types of facilities and that the purposes of the Medical Facilities Construction and Modernization Amendments of 1969 will be furthered."

(c) Section 605(a) (42 U.S.C. 291e) of such Act is amended by striking out ", in accordance with regulations prescribed under section 603" in paragraph (2).

(d) Section 605(b) of such Act is amended by—

(1) striking out "prescribed pursuant to section 603" in clause (2) and inserting in lieu thereof "prescribing general standards of construction and equipment for facilities of different classes and in different types of locations".

(2) striking out "with the applicable requirements of the regulations prescribed under section 603(e), and" in clause (3).

(3) striking out "regulations prescribed pursuant to section 603(a)" in clause (4) and inserting in lieu thereof "State plan".

(e) The amendments made by this section shall apply in the case of projects approved under title VI of such Act after June 30, 1969.

91ST CONGRESS
1ST SESSION

S. 2037

IN THE SENATE OF THE UNITED STATES

MAY 1, 1969

Mr. PERCY (for himself, Mr. ANDERSON, Mr. BROOKE, Mr. CRANSTON, Mr. GOODELL, Mr. GOLDWATER, Mr. GRAVEL, Mr. HARRIS, Mr. HART, Mr. HARTKE, Mr. HATFIELD, Mr. JORDAN of Idaho, Mr. KENNEDY, Mr. MATHIAS, Mr. MONDALE, Mr. MOSS, Mr. NELSON, Mr. PACKWOOD, Mr. RIBICOFF, Mr. SCHWEIKER, Mr. SCOTT, Mr. STEVENS, Mr. TYDINGS, and Mr. YOUNG of Ohio) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend title VI of the Public Health Service Act to include within the scope of part A thereof comprehensive ambulatory health services, and otherwise to extend and improve the program established by such part A.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Neighborhood Health Center Act of 1969".

SEC. 2. (a) Section 600(a) of the Public Health Service Act is amended by inserting ", including compre-

hensive ambulatory care centers," immediately after "other medical facilities".

(b) Section 601 of such Act is amended to read as follows:

"SEC. 601. In order to assist the States in carrying out the purposes of section 600, there are authorized to be appropriated, for grants for the construction or modernization of public or other nonprofit hospitals, public health centers, comprehensive ambulatory care centers, facilities for long-term care, diagnostic or treatment centers, and rehabilitation facilities, $295,000,000 for the fiscal year ending June 30, 1970."

(c) (1) Section 602 (a) of such Act is amended to read as follows:

"(a) Each State shall be entitled for each fiscal year, beginning with the fiscal year which ends June 30, 1970, to an allotment which bears the same ratio to the sums appropriated for such year pursuant to section 601 as the number of medically indigent individuals in such State bears to the sum of the medically indigent individuals in all the States. If, in the case of any State, the amount of the allotment as determined under the preceding sentence is less than the amount which would have been allotted to such State if the allotment formula, as in effect under this section for the fiscal year which ended June 30, 1969, had remained in

effect, then there shall be added (out of the funds appropriated pursuant to the succeeding sentence) to the allotment of such State such amount as may be necessary to cause its allotment to be equal to the amount it would have been allotted under such formula, if such formula had remained in effect. There are hereby authorized to be appropriated for each fiscal year such sums as may be necessary to make additions to the allotments of States as provided for in the preceding sentence."

(2) Section 602 (b) (1) of such Act is amended to read as follows:

"(1) The allotment to any State under subsection (a) for a fiscal year which is less than $175,000 for the Virgin Islands, American Samoa, or Guam and $450,000 for any other State shall be increased to that amount, the total of the increases thereby required being derived by proportionately reducing the allotment for such fiscal year to each of the remaining States, but with such adjustments as may be necessary to prevent the allotment of any of such remaining States from being thereby reduced to less than that amount."

(3) Section 602 (c) of such Act is hereby repealed.

(4) Section 602 of such Act is further amended by striking out subsections (e) and (f) thereof and by adding after subsection (d) thereof the following new subsection:

"(e) In accordance with regulations, any State may file with the Secretary a request that a specified portion of its allotment under this part be added to the allotment under this part of another State for the purpose of meeting a portion of the Federal share of the cost of a project, in such other State, which is designed to carry out one or more of the purposes set forth in section 600. Any such request shall contain or be supported by a certification, by the State, that the appropriate areawide health planning agency in such State has been informed of and consulted with respect to such request, and by a statement as to whether any such planning agency approves of such request. If it is found by the Secretary that the completion of the project with respect to which the request is made would meet the needs of the State making the request and that use of the specific portion of such State's allotment, as requested by it, would assist in carrying out the purposes of this title, such portion of such State's allotment shall be added to the corresponding allotment of the other State, to be used for the purpose referred to above."

(d) Section 603 (a) of such Act is amended by inserting after paragraph (3) thereof the following new paragraph:

"(4) in the case of projects for the construction of comprehensive ambulatory care centers, to facilities located

in areas of low physician accessibility, as determined by the Secretary; and".

(e) (1) Section 604(a)(4) of such Act is amended (A) by redesignating subparagraph (E) thereof as subparagraph (F), (B) by striking out "and" at the end of subparagraph (D) thereof, and (C) by inserting after subparagraph (D) thereof the following new subparagraph:

"(E) the comprehensive ambulatory care centers needed to provide adequate health services for people residing in the State, and a plan for the distribution of such centers throughout the State; and".

(2) Section 604(a)(5) of such Act is amended by inserting "comprehensive ambulatory health centers" immediately after "diagnostic or treatment centers".

(3) Section 604(a) of such Act is further amended (A) by striking out "and" at the end of paragraph (11) thereof, (B) by redesignating paragraph (12) thereof as paragraph (13), and (C) by adding after paragraph (11) thereof the following new paragraph:

"(12) provide that the State agency shall furnish to the Secretary with respect to each application for a project, detailed information regarding the costs of services to be provided by the proposed health facility; and".

(f) (1) The first sentence of section 605 (b) of such Act is amended (A) by striking out "and (4)" and inserting in lieu thereof "(4)", and (B) by inserting immediately before the period at the end thereof the following: ", and (5) that such project is in furtherance of or consistent with any comprehensive health plan carried out by the State agency, referred to in section 314 (a) (2) (A) of the State in which such project is to be located".

(2) Section 605 of such Act is further amended by adding at the end thereof the following new subsection:

"(f) An application for a project shall be approved under this section only if—

"(1) the applicant supplies the Secretary with such data as may be necessary in order for him to determine the efficiency and effectiveness of operation of any other health facilities operated by such applicant;

"(2) the Secretary determines that such other health facilities operated by the applicant are being operated efficiently and effectively; and

"(3) the Secretary determines that it is, or has the potential to be, the most efficient and effective project operated in the area.

In determining, for purposes of this subsection, the efficiency of any health facility which is an accredited teaching institution, there shall be deducted from the total costs of such

facility all costs attributable to the training of medical personnel."

(g) Section 607 (f) of such Act is amended by striking out "any one or more subparagraphs or paragraphs of".

(h) (1) Section 625 (b) of such Act is amended to read as follows:

"(b) The term 'Federal share' with respect to any project means the proportion of the cost of construction of such project to be paid by the Federal Government, and shall be whichever of the following the State elects—

"(1) the share determined by the State agency in accordance with standards included in the State plan, which provide equitably for variations between projects on the basis of objective criteria related to the economic status of areas and, if the State so elects, such other factor or factors as may be appropriate and be permitted by regulations, except that such standards may not be provided for a Federal share of more than 66⅔ per centum, or less than 33⅓ per centum;

"(2) the amount (not less than 33⅓ per centum and not more than 66⅔ per centum) established by the State for all projects in the State; or

"(3) 50 per centum of the cost of construction of the project.

The State agency shall, prior to the approval by it, under the

State plan approved under part A, of the first project in the State during any fiscal year, give written notification to the Secretary of the Federal share which it has elected pursuant to the preceding sentence of this subsection for projects in such State to be approved by the Secretary during such fiscal year, and such Federal share or shares for projects in such State approved by the Secretary during such fiscal year shall not be changed after approval of such first project by the State."

(2) Section 625 of such Act is further amended by adding at the end thereof the following new subsection:

"(m) The term 'comprehensive ambulatory care center' means a clinic which (i) is associated with an accredited hospital center, (ii) is staffed by a formal or informal group of licensed medical doctors of various specialties, some of whom have admitting privileges in such hospital, (iii) provides a wide range of diagnostic and treatment services for patients who are primarily ambulatory, and (iv) provides personal preventative services including health education.

"(n) The term 'medically indigent' means, in the case of any State which has a State plan for medical assistance which has been approved under title XIX of the Social Security Act, an individual eligible for medical assistance under such State plan; and, in the case of any other State, an

individual determined to be medically indigent in accordance with regulations prescribed by the Secretary."

SEC. 3. The amendments made by this Act shall take effect July 1, 1969.

The CHAIRMAN. Now, this bill for $5 billion spread over 5 years, a billion dollars each year, does not meet this need of $10.5 billion. It is more realistic in terms of what we can be sure to appropriate now. Some people will say the budget is overextended, that we have no money, that this is a wild dream; we cannot afford it. I think it is a matter of priorities. If we spend $3 billion a month in South Vietnam, $36 billion a year, and let our people—the ill, the afflicted, and those in pain—suffer uncared for in this country, I think the Nation ought to reexamine its priorities. I think we ought to shoot at an expenditure of $16 billion that is needed now in health care and facilities. That is not helping us in the shortage of doctors, nurses, vocational nurses, dentists, X-ray technicians, and many other health technicians. But we would at least get the needed facilities so people would not have to wait in line for beds. If they want a bed or a private room—some have mental problems recovering when other people are sick around them in beds—they ought to be able to get them. They ought not to have to pay $100 a day, the national average being $64 a day around the Nation, for hospital rooms; the shortage is so great and the need is so much. I have been told some people in New York have been disappointed in trying to get into a hospital.

Some affluent people can get a hospital bed only if they have certification that they are critically ill; they think they have influence enough to get into a hospital and find they have to have a certificate. So having money is not enough to insure your getting into a hospital because there is such a great shortage of rooms. This is one of the critical, unmet needs of this country, shuffled aside, ignored, while we pump money down the drain in wild military adventures over 10,000 miles away at the rate of $3 billion a month.

I hope this country will reorient its priorities, and combat this problem of malnutrition and hunger in America which leads to disease and illness as part of the health care problem. I think we could eliminate malnutrition and hunger in 6 months if we had the will to do it. That would not eliminate the ill effects from the past, but it would go a long way toward preventing future ill effects. I think that is one of the prime needs of this country. If we had everything, domestic, foreign, military, and civil, I think one of our prime needs is the cure of hunger and malnutrition of the people in this country.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Mr. Chairman, I am pleased that we have today commenced hearings on various legislative proposals—including two bills I sponsored, the Hospital Modernization and Improvement Act of 1969 (S. 269), and the administration's Medical Facil ties Construction and Modernization Act of 1969 (S. 1733)—to extend and modify the Hill-Burton hospital and medical construction and modernization program. I am particularly gratified that the administration bill, the House-passed Hill-Burton program, H.R. 11102, and the chairman's Hill-Burton proposal, S. 2182, all incorporate the concept of a guaranteed loan program called for by my bill, S. 269, and similar to legislation I sponsored last year which passed the Senate as part of the health services and facilities amendments but which was deleted in conference—because no hearings had been held in the House.

It appears that we now all accept the principle of making loans available, especially for modernization, which will have a Government guarantee—and some, though not all the Hill-Burton legislative proposals, except the proposition of loan guarantees for public as well as nonprofit hospitals and include an interest subsidy.

The Hospital Modernization and Improvement Act of 1969 which I introduced together with Senators Brooke, of Massachusetts, Dominick, of Colorado, Murphy, of California, and Prouty, of Vermont, would guarantee up to 90 percent on $400 million in loans to public and private nonprofit hospitals for modernization for each of the next 3 years—$1.2 billion in guarantees—and provide Federal payments on interest charges of up to 3 percent on these loans. This measure is aimed at correcting the condition of intolerable obsolescence afflicting one-third of the Nation's hospital capacity which is seriously impairing our ability to deliver up-to-date health services at a reasonable cost and which is seriously limiting medical education and research centered in hospitals.

To give impetus to facilities contributing toward easing the dire shortage of trained health personnel, the bill provides that where the need is equal between two or more institutions, priority will be given to a teaching hospital.

To strengthen the effort toward innovation and modernization, the b'll gives the Federal Hospital Council responsibility for the evaluation of the effectiveness of the hospital modernization supported by this legislation and other Public Health Service Act programs—principally Hill-Burton—with special emphasis on innovation and improvement of procedures and hospital techniques. This provision will help make more productive the $2 billion spent annually in hospital construction and the $19.1 billion spent each year in hospital care. As was pointed out in the report of the National Advisory Commission on Health Facilities—the Boisfeuillet Jones report:

"The cost of services within health care facilities is affected significantly by the planning and design of the facilities and systems employed to deliver health care."

I ask that a section-by-section analysis of the Hospital Modernization and Improvement Act be included at the end of my testimony.

In my testimony this year before the House Subcommittee on Public Health and Welfare, I urged, as called for by the administration bill, the elimination of the rural priority language now in the Hill-Burton Act. The great need that originally existed when this was enacted to enable rural areas to catch up with the cities has dissipated. City needs are great and are difficult to meet as center cities face up to increased demands on all fronts with limited financial resources. I am pleased to note that the House-passed bill and the chairman's bill both no longer require a State to give special consideration to projects for hospitals serving rural areas.

My concern that we revise the allocation formula which discriminates against highly urbanized States has not abated. Only the administration bill which I sponsored has deleted the present complex Hill-Burton allocation formula by which the population of each State is weighted with the inverse ratio, not of per capita income alone, but of the square of per capita income. This "square" factor should be removed, for it loads the allocation formula too far in one direction

and has the effect of prejudicing States which need Hill-Burton aid the most now. That the allotment to the States should be on the basis of financial need, population and need for health care facilities is recognized in all proposed loan guarantee sections of Hill-Burton legislation. However, with the exception of modernization grants, the present annual appropriation for health facilities construction is allotted to the States on the basis of a formula using State population and per capita income of the United States. In addition, the Hill-Burton Act requires that the per capita income factor be squared. This squaring method results in an inordinately large allotment to those States with relatively stable populations and relatively low incomes. It was adopted at the inception of the program for lack of any better method for determining definitive need for health facilities by type and number.

Further, I urge that a flat matching requirement be substituted for the present 33⅓–66⅔ percent variable matching formula. Variable matching, while on its face complementary to the purpose of a per capita income allocation formula, actually serves to further multiply its effect. Not only is a State with a higher per capita income reduced to a smaller share of Federal funds, but to utilize that share it must raise an even larger percentage of its own funds to match the Federal money. For example, New York State received only 39.68 percent Federal matching money. For example, New York State received only 39.68 percent Federal matching funds while Alabama received 65.52 percent Federal matching funds. Thus, Alabama's matching share is 62.5 percent greater than New York's. This is hardly equitable.

As called for by the administration bill which I introduced, I support the concept of providing bloc grants to the States to replace the present Hill-Burton categories. This would not only have the advantage of encouraging State initiative and planning, but also would enable State government to concentrate on their most urgent needs. The best understanding of the relative need for general hospitals, outpatient, long-term care, rehabilitation, diagnostic, and treatment facilities is at the State level. The health care system of the country, in my judgment, would be strengthened if States could set their own priorities for the allocation of these resources. In addition, I share the concern expressed by the administration's bill and I especially wish to emphasize the need for enactment of legislation to facilitate hospital modernization. One-third of the Nation's hospital capacity is outmoded, outdated and obsolete. Modernization is the great need in health facility programing for the future. While the need is most pressing in metropolitan centers, there is also great need in smaller communities and rural areas for modernization.

The burden of these deteriorating facilities is borne by the patient as well as by the health care team and stands as a principal barrier to innovation; to the development of alternatives to intensive hospital care; to optimum use of skilled, scarce and expensive personnel; to lower costs, and to delivery of the best possible health service that an ever-advancing body of medical knowledge can devise. This situation has not crept silently upon us, but has for the past several years been the subject of a series of public pronouncements from public officials and medical authorities alike as well as a series of governmental and professional reports sufficient to stock a large library staff.

Should we continue to postpone this needed hospital modernization, the Nation could well face a major crisis in the delivery of adequate health care to our people, a crisis which would be measured in economic as well as social dimensions.

In closing, I should like to suggest that we give due consideration to enlarging the concept of health facility beyond the scope of a building and its equipment, inherent in the administration's Hill-Burton legislation which I sponsored, which calls for a set-aside for innovative programs reflecting central needs of national significance with project grants eligible for assistance up to 90 percent of project cost. I would agree that "a health facility is an instrumentality designed, financed, equipped, supplied, staffed, organized, and operated as an integral part of a comprehensive health care system"—called for by the December 1968 report to the President by the National Advisory Commission on Health Facilities. The health care services of a health facility must relate to the people's needs in the community served and should:

1. Provide continuing care of persons and families, rather than solely episodic treatment of categorical disease;
2. Provide care that is accessible and available regularly;
3. Offer enough flexibility so that care can be adapted to each individual's physical and social needs and to changing medical technology; and
4. Encourage development of a continuing relationship between the patient, the physician, and the other professional and supporting health personnel who provide health services.

I believe we must design health facilities that emphasize their roles as elements of multiple health care systems that significantly contribute to the goal of health services for people.

The CHAIRMAN. I call as a witness this morning for hearings on this important legislation the Honorable Richard L. Ottinger, U.S. Congressman from the State of New York.

Congressman Ottinger, we welcome you here. We know of your great interest in the health care field. We will place your prepared statement in the record following your testimony. Please proceed as you wish.

STATEMENT OF HON. RICHARD L. OTTINGER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. OTTINGER. Thank you, Senator Yarborough. I am very pleased to have this opportunity to testify before your distinguished subcommittee on this vital piece of legislation. I congratulate you on your leadership in this field. I certainly support your legislation which you have just described to put more money in one of the highest priority items before our Nation to provide people with adequate health care.

I think we have fallen down exactly where you say in the critical areas of need emphasis. The first of those is to see that our health care gets to the people who really need it. Nobody has to tell us in Congress today that we have limited resources. It is just vital that we put those resources where the need really is. We find today the resources in health are not being spent as efficiently as they should be.

The other critical factor is that we have to do something about the soaring costs of health care, as you have pointed out. This is one of the very fastest-growing costs of living factors in the United States

today. I think we can literally say that the average American cannot afford to be sick. In my own State of New York, the Blue Cross insurance people just proposed a 49.5 percent increase in the cost of hospital care. We have to do a great deal more than we have in the past to see that very expensive hospital facilities are used efficiently. Some people who are in the hospitals, as you have pointed out, should not be there. We have people in hospitals who ought to be in extended care facilities or nursing homes. You have people being taken care of in hospitals that ought to be seen in clinics that are much less expensive. Hospital facilities, that are the most expensive, ought to be reserved for those people who really need the expensive facilities that are available.

Let me say at the outset that I am in many ways pleased with the bill that was reported out of the House. It has broken important new ground in a number of areas. Perhaps most important, it makes a small start toward seeing that Federal aid is used to improve the delivery of health services to people, whereas earlier measures addressed themselves to assisting hospitals, assisting doctors, without much regard to how they in turn delivered services to the people.

Another important advance is extending the definition of "hospital" under the legislation to include extended care facilities. Many of our hospitals today are overcrowded because acute care beds are being occupied by people who should not be there. There is simply no other place to put them. The expansion of extended care facilities which will be encouraged under this bill is one of the most effective and economical ways of relieving this burden. If we are going to attack the costs of medical care throughout this country, one of the critical things that we have to do, as I mentioned earlier, is to see to it that those expensive hospital facilities, are only used for those who need them.

In my opinion, however, there are five serious defects in this bill which should be remedied—five areas in which the House simply did not go far enough to keep up with the rapidly changing conditions in our Nation.

Perhaps the most serious failing is the extension of the old Hill-Burton formula which gives such tremendous advantage to rural States and rural areas in those States and seriously slights our growing urban areas.

The old formula made sense in 1946—when the Hill-Burton Act was passed, when the crying need was for medical facilities to serve rural areas. But it has done its job. We have met the rural need to the point where we have satisfied 90 percent of the needs of the country in terms of hospital facilities. Parenthetically, I think it wise to point out that many and perhaps most of the facilities that have been built are already obsolete and in desperate need of modernization.

In reporting the bill to the House, the Interstate and Foreign Commerce Committee, of which I am privileged to be a member, admitted the rural emphasis of the program saying, "The program, therefore, provided priorities in construction of new hospital bed capacity for facilities serving rural areas * * *."

However, the committee attempted to claim that the rural emphasis of the Hill-Burton program had been shifted. The fact is that it has not. It cannot be until the old, loaded formula is changed. The facts are that some 70 percent of Hill-Burton funds go to communities that

are rural and serve rural constituencies. In point of fact, Mr. Chairman, the large majority of those funds go to communities of under 15,000 population. The large majority of hospitals that have been built under this program are small and relatively inefficient hospitals of 30 to 50 beds. There has been a lot of misunderstanding about this, and I think it is important that it be cleared up now. In its report, the House committee provided a table intended to show that Hill-Burton money is being spent with an urban emphasis. I submit a copy for your information.

In order to make the point that Hill-Burton emphasis had shifted, the report adopts one of the most remarkable definitions of "urban" that I have ever seen. You will note from the footnote that it includes, under the category "other urban," communities of 2,500 and above. The upper limit is not given in the table, but I can tell you that it is 50,000.

"Rural" it defines as only communities of 2,500 and under. Using that definition, the report purports to show that the majority of funds has been spent in "urban" areas—busy metropolitan centers of over 2,500 "citified" souls. I think that is clearly misleading. The vast preponderance of communities of under 50,000 population are really rural communities and any facility in such a community serves primarily a rural population.

If you take the figures for "other urban" and put them where they belong, with those that are labeled "rural," it proves conclusively and dramatically that the great majority—some 70 percent of Hill-Burton funds—do in fact still go to rural communities.

Not only does the bill retain this obsolete and inequitable formula in the hospital construction program, it actually extends it to all the new grant programs with the exception of modernization. It extends the biased rural formula to the diagnostic and treatment centers program and to the programs for extended care and rehabilitation services. It extends it to the programs for extended care and rehabilitation facilities. Thus, the effort to meet the real health needs of the Nation is diverted and frustrated by a 20-year-old special-interest formula that has by now outlived its usefulness.

In the House I offered an amendment to replace this formula to a simple equitable formula that will give no special advantage to any region. This is the formula that is presently in force with respect to modernization.

I would like to submit for the record a report prepared by the Health Facilities Planning and Construction Service Office of Program Planning and Analysis which shows the effect of this proposed reform on a State-by-State basis. Column A represents the distribution of funds as presently proposed in H.R. 11102. Column C represents the distribution of funds if the bill were modified by the adoption of formulas that I suggest. My amendment was narrowly rejected in the House largely because the people who have the greatest unmet health need had no lobby to support their interest.

I urge the committee to adopt a similar provision.

Another deficiency in this bill is the failure to recognize the changed health priorities in this Nation. The House committee conceded in its report that 90 percent of the need for new hospitals in the country has been met. It admitted in its report that the need for modernization

is the overwhelming need all over the country. Every witness before the Health Subcommittee who addressed himself to the issue testified that the need was 2 to 1 for modernization over new construction.

Furthermore, as the report shows, itself, the burden is growing at an appalling rate, with 41,000 additional hospital beds every year being added to the obsolete category.

The House report, itself, shows that the need for all new construction in the country is $5.3 billion, whereas the need for modernization is almost doubl that or $10.5 billion, with some 455,130 hospital beds requiring modernization.

Yet, the House set exactly the opposite priorities in its authorization. It actually reduced the funds for modernization from $65 million last year to only $50 million next year and increased the amount for new hospital construction from $130 to $135 million. It also added another $100 million for new construction programs for other types of health facilities.

The need is 2 to 1 for modernization; the program is more than 4 to 1 construction. If that is not topsy-turvy in the sense of priorities of which you spoke, I do not know what it is.

Now, in its report, the House committee justified this approach by pointing to an expanded provision under which State agencies can switch funds from new construction to modernization. That is an improvement, but it certainly is not enough. In the first place, the State agencies naturally are going to follow the priority set by the Congress. We have not got the right to ask then to do otherwise. In the second place, setting priorities is a responsibility that Congress should exercise. To rely on a State agency to correct our misset priorities is an abrogation of our constitutional responsibility.

I am submitting for this distinguished committee's consideration an amendment which would reverse these priorities without changing the total authorization.

A third problem with the bill is the failure to make a meaningful start toward meeting the health needs of our impoverished urban areas. One of the greatest needs throughout the country is for facilities that can deliver health services where the people are and where the need is greatest—the metropolitan areas. I pointed out quite correctly that we have poured millions of dollars into medical research and developing new devices for curing disease and for rehabilitating people cured of diseases, being able to mend their bones when they have had accidents, and yet we have been woefully deficient in making the advantages of this knowledge available to the people who need it. Hill-Burton made a good start with respect to this in the poor rural communities, especially in the South, when the need was greatest there. I have no quarrel with that. Now the need is in our urban centers, and particularly in the economically deprived sections of those centers, North, South, East, and West. Can we do less than help our cities as we helped the rural areas before—especially since our program would not favor the urban areas but would only treat all areas equally.

While there are funds for diagnostic and treatment facilities provided in the House bill, they are tied to the Hill-Burton formula with its rural bias. In addition, the diagnostic and treatment facilities that are provided have to be constructed in connection with an actual hospital.

And there is the rub. Hospitals are not built in the impoverished urban centers.

The diagnostic and treatment facilities that are really needed should be built where the people are—not where the hospitals are. The House bill does have a waiver provision for special situations. But what they consider as a special situation is in fact the rule. And the only way to meet the conditions as they are is to provide diagnostic and treatment centers separate from hospitals to serve our urban poor.

I submit for this committee's consideration a third amendment that will add $15 million earmarked specifically for urban diagnostic and treatment centers that will be administered by hospitals but need not be physically connected with hospitals. This again, I would like to point out, is a measure which will provide the health services where the need is the greatest at the lowest possible cost. It is a lot cheaper to put up one of these diagnostic centers near to the people than it is to build another hospital.

A fourth problem with this bill is its failure to coordinate effectively with existing health legislation.

In 1966, we provided for comprehensive health planning agencies to develop community-oriented plans for meeting the health needs of our States. These agencies are now set up in every State of the country. In some States they are doing a good job in coordinating the needs for new hospitals and other kinds of facilities. In other areas, they are getting started in this job. Everywhere, they need to be strengthened if they are going to succeed in their important job.

One of the major causes of the soaring hospital costs that we are experiencing all over the country today is the inefficient use we make of so much of our health resource.

One of the best answers is strengthened coordination.

We have situations today where small communities build hospitals as a matter of community pride when in fact, there exists a hospital in a neighboring community that is underutilized and could adequately service the area where the hospital is proposed to be built.

Now, in an area where coordination is so important, mere consultation with comprehensive health planning groups, as provided in the House bill, is not enough. These comprehensive health planning groups were created by Congress to give local communities a greater role in developing their health facilities and services. The expressed purpose of the program is to coordinate health programs, to do away with waste and inefficiency in the delivery of our health facilities. Having established this program, it is important that we really use it. What should be required is not just consultation, but a clear finding that any program funded under this act is "consistent" with the comprehensive health plan, if any, adopted by the area comprehensive health planning group.

I submit a fourth amendment for this committee's consideration which would rectify this situation.

Finally, I believe the House bill is deficient in failing to provide a program of direct emergency aid to meet critical situations that cannot be resolved under any of the aid programs we have today.

There is no question that in the line of priorities, we simply have not provided enough money to meet the critical health needs of our country. With today's financial situation and difficulties, it is very

doubtful that we can get massive new program started and through this Congress. That is unfortunate, but, as I say, I would support them.

I think that it is important that we, at least, provide some money to meet the most critical situations throughout the country, where they are actually—you see this in the papers—dying while they are waiting in line in an urban hospital to get the services they need. And people, of course, are losing paychecks by having to wait 7 and 8 hours in the line in the hospital to be able to get attention. So we have provided $100 million in new funds in grants and $54 million in complementary loans. I think in providing this additional money, it ought to go to the areas which the Secretary of Health, Education, and Welfare and the Surgeon General find in fact are in the most critical stage.

There are many communities of the United States today which face really desperate situations with respect to the delivery of health services. The Public Health Service released a survey during the last Congress which showed that 143 communities were in such critical situation. They, of course, have not gotten any better in the meantime. These communities were served by health facilities reporting annual occupancy rates of better than 90 percent— in many cases better than 100 percent. They had no alternative service and were unable to use any of the existing aid programs. There is a tremendous need for alleviating these emergency situations through a program of direct grants and loans. Last year I suggested an emergency program which would provide $100 million in grants and $43 million in low-interest loans which could be made directly to the communities in most critical need. This proposal was approved by the House Interstate and Foreign Commerce Committee in the last Congress and was added to the administration's "partnership for health" bill. Unfortunately, it was defeated in floor action.

I am submitting for this committee's consideration a fifth and final amendment which would establish this much-needed program.

I would like to point out that the five amendments that I am proposing conform to the program requested by the present administration. In his testimony before the Subcommittee on Public Health and Welfare of the House Interstate and Foreign Commerce Committee on March 25 of this year, Under Secretary of Health, Education, and Welfare John G. Veneman called specifically for legislation which would accomplish each of the goals set forth in these amendments. I am submitting for the record a copy of Mr. Veneman's testimony.

In closing, I would like to raise one other question. I am very much concerned about the guaranteed loan program provided in this bill. This loan program has a number of good features but the principal difficulty, which was recognized by the House committee itself in its report, is the same as with all loan programs—the burden of interest. Under this program, the person who will be paying the additional cost of interest on the loan is the patient. He has to pay these added costs at a time when he can least afford to pay them. I think this is a grave fault, and I hope that this committee will consider ways of alleviating the burden, principally by accentuating grants and diminishing the accent on loans. While it seems cheaper for the Federal Government to guarantee loans, in the long run, what this does is to benefit the banks that get the interest on the loans and to hurt the communities that have to pay the interest and ultimately the patient who has to pay

the bills. This program was also questioned by Mr. David Kennedy in a letter to Secretary Finch on June 4 which I would like to bring to the committee's attention.

Thank you very much for the privilege of testifying on this very important legislation.

I will appreciate your consideration of the matters on which I have testified.

The CHAIRMAN. Mr. Ottinger, I read your entire statement prior to the hearings, and as it was presented. You have presented your statement well, followed by the recommendation of the amendments to the House bill. Your prepared statement and the amendments will be printed at this point in the record.

(The amendments referred to follow:)

PREPARED STATEMENT OF HON. RICHARD L. OTTINGER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman. I am pleased to have this opportunity to testify before this distinguished Subcommittee on this very important legislation extending and expanding the Federal hospital aid program.

Let me say at the outset that I am, in many ways, pleased with this bill. It has broken important new ground in a number of areas. Perhaps most important it makes a start toward seeing that Federal aid is used to improve the delivery of health services to people, where earlier measures addressed themselves to assisting hospitals and the medical profession without much regard to how they in turn delivered services to people.

Another important advance is in extending the definition of "hospital" to include extended care facilities. Many of our hospitals today are overcrowded because acute care beds are being occupied by people who should not be there. There is simply no other place to put them. The expansion of extended care facilities which will be encouraged under this bill is one of the most effective and economical ways of relieving this burden.

In my opinion, however, there are five serious defects in this bill which should be remedied—five areas in which the House simply did not go far enough to keep up with the rapidly changing conditions in our nation.

Perhaps the most serious failing is the extension of the old Hill-Burton formula which gives such tremendous advantage to rural states and seriously slights our growing urban areas.

The old formula made sense in 1946 when the crying need was for medical facilities to serve rural areas. But it has done its job. We have met the rural need to the point where we have satisfied 90 percent of the needs of the country in terms of hospital facilities. Parenthetically, I think it wise to point out that many and perhaps most of the facilities that have been built are already obsolete and in desperate need of modernization.

In reporting the bill to the House, the Interstate and Foreign Commerce Committee, of which I am a member, admitted the rural emphasis of the program saying "The program, therefore, provided priorities in construction of new hospital bed capacity for facilities serving rural areas * * *."

However, the Committee attempted to claim that the rural emphasis of the Hill-Burton program had been shifted. The fact is that it has not. It cannot be until the old, loaded formula is changed. The facts are that some 70 percent of Hill-Burton funds go to communities that are rural and serve rural constituencies. There has been a lot of misunderstanding about this and I think it is important that it be cleared up now. In its report, the House Committee intended to show that Hill-Burton money is being spent with an urban emphasis. I submit a copy for your information.

In order to make the point that Hill-Burton emphasis had shifted the report adopts one of the most remarkable definitions of "urban" that I have ever seen. You will note from the footnote that it includes, under the category "other urban," communities of 2,500 and above. The upper limit is not given in the table but I can tell you that it is 50,000.

"Rural" it defines as only communities of 2,500 and under. Using that definition, the report purports to show that the majority of funds has been spent in "urban" areas—busy metropolitan centers of over 2,500 "citified" souls. I

think that is clearly misleading. The vast preponderance of communities of under 50,000 population are really rural communities and any facility in such a community serves primarily a rural population.

If you take the figures for "other urban" and put them where they belong, with those that are labeled "rural," it proves conclusively and dramatically that the great majority—some 70 per cent of Hill-Burton funds—do in fact still go to rural communities. In fact, a large majority of the funds go to communities of under 15,000 population and go to build small, inefficient 30 to 50-bed hospitals.

Not only does the bill retain this obsolete and inequitable formula in the hospital construction program, it actually extends it to all the new grant programs with the exception of modernization. It extends the biased rural formula to the diagnostic and treatment centers program. It extends it to the programs for extended care and rehabilitation facilities. Thus, the effort to meet the real health needs of the nation is diverted and frustrated by a 20-year-old special-interest formula that has long outlived its usefulness.

In the House I offered an amendment to replace this formula to a simple equitable formula that will give no special advantage to any region. That formula is based simply on *population, per capita income,* and *need.* I would like to submit for the record a report prepared by the Health Facilities Planning and Construction Service Office of Program Planning and Analysis which shows the effect of this proposed reform on a state-by-state basis. Column A represents the distribution of funds as presently proposed in H.R. 11102. Column C represents the distribution of funds if the bill were modified by the adoption of my formula. My amendment was narrowly rejected in the House largely because the people who have the greatest unmet health need had no lobby to support their interest.

I urge the Committee to adopt a similar provision.

Another deficiency in this bill is the failure to recognize the changed health priorities in this Nation. The House Committee conceded in its report that 90 per cent of the need for new hospitals in the country has been met. It admitted in its report that the need for modernization is the overwhelming need all over the country. Every witness before the Health Subcommittee who addressed himself to the issue testified that the need was two to one for modernization over new construction.

Furthermore, the burden is growing at an appalling rate with 41,000 additional hospital beds every year being added to the obsolete category.

The House report itself shows that the need for all new construction in the country is $5.3 billion whereas the need for modernization is almost double that or $10.5 billion, with some 455,130 hospital beds requiring modernization.

Yet, the House set exactly the opposite priorities in its authorization. It reduced the funds for modernization from $65 million last year to only $50 million next year and increased the amount for new hospital construction from $130 million to $135 million. It also added another $100 million for new construction programs for other health facilities.

The need is two to one for modernization; the program is more than four to one construction. If that is not topsy-turvey, I do not know what is.

Now, in its report the House Committee justified this approach by pointing to an expanded provision under which state agencies can switch funds from new construction to modernization. That is an improvement, but it certainly is not enough. In the first place, the state agencies naturally are going to follow the priority set by the Congress. We have not got the right to ask them to do otherwise. In the second place, setting priorities is a responsibility that Congress should exercise. To rely on a State agency to correct *our* mis-set priorities is an abrogation of our constitutional responsibility.

I'm submitting for this distinguished Committee's consideration an amendment which would reverse these priorities without changing the total authorization.

A third problem with the bill is the failure to make a meaningful start toward meeting the health needs of our impoverished urban areas. One of the greatest needs throughout the country is for facilities that can deliver health services where the people are and where the need is greatest—the metropolitan areas. That was what Hill-Burton did for the poor rural communities, principally in the South, when the need was greatest there. Now the need is in our urban centers and particularly in the economically deprived sections of those centers. Can we do less than help our cities as we helped the rural areas before—especially since our program would not *favor* the urban areas, but would only treat all areas equally.

While there are funds for diagnostic and treatment facilities provided in the House bill, they are tied to the Hill-Burton formula with its rural bias. In addition, the diagnostic and treatment facilities that are provided have to be constructed in connection with an actual hospital.

And there is the rub. Hospitals are not built in the impoverished urban centers.

The diagnostic and treatment facilities that are really needed should be built where the people are—not where the hospitals are. The House bill does have a waiver provision for special situations. But what they consider as a special situation is in fact the rule. And the only way to meet the conditions as they are is to provide diagnostic and treatment centers separate from hospitals to serve our urban poor.

I submit for this Committee's consideration a third amendment that will add $15 million earmarked specifically for urban diagnostic and treatment centers that will be administered by hospitals but need not be physically connected with hospitals.

A fourth problem with this bill is its failure to coordinate effectively with existing health legislation.

In 1966 we provided for comprehensive health planning agencies to develop community oriented plans for meeting the health needs of our states. These agencies are now set up in every state of the country. In some states they are doing a good job in coordinating the needs for new hospitals and other kinds of facilities. In other areas, they are getting started in this job. Everywhere, they need to be strengthened if they are going to succeed in their important job.

One of the major causes of the soaring hospital costs that we are experiencing all over the country today is the inefficient use we make of so much of our health resource.

One of the best answers is strengthened coordination.

Now, in an area where coordination is so important, mere consultation with comprehensive health planning groups, as provided in the House bill, is not enough. These comprehensive health planning groups were created by Congress to give local communities a greater role in developing their health facilities and services. The expressed purpose of the program is to coordinate health programs, to do away with waste and inefficiency in the delivery of our health facilities. Having established this program, it is important that we really use it. What should be required is not just consultation but a clear finding that any program funded under this act is "consistent" with the comprehensive health plan, if any, adopted by the area comprehensive health planning group.

I submit a fourth amendment for this Committee's consideration which would rectify this situation.

Finally, I believe the House bill is deficient in failing to provide a program of direct emergency aid to meet critical situations that cannot be resolved under any of the aid programs we have today.

There are many communities of the United States today which face really desperate situations with respect to the delivery of health services. The Public Health Service released a survey during the last Congress which showed that 143 communities were in such critical situation. These communities were served by health facilities reporting annual occupancy rates of better than 90 per cent—in many cases better than 100 per cent. They had no alternative service and were unable to use any of the existing aid programs. There is a tremendous need for alleviating these emergency situations through a program of direct grants and loans. Last year I suggested an emergency program which would provide $100 million in grants and $35 million in low interest loans which could be made directly to the communities in most critical need. This proposal was approved by the House Interstate and Foreign Commerce Committee in the last Congress and was added to the Administration's "Partnership for Health" bill. Unfortunately, it was defeated in floor action.

I am submitting for this Committee's consideration a fifth and final amendment which would establish this much needed program.

I would like to point out that the five amendments that I am proposing conform to the program requested by the present Administration. In his testimony before the Subcommittee on Public Health and Welfare of the House Interstate and Foreign Commerce Committee on March 25th of this year, Undersecretary of Health, Education, and Welfare, John G. Veneman called specifically for legislation which would accomplish each of the goals set forth in these amendments. I am submitting for the record a copy of Mr. Veneman's testimony.

In closing, I would like to raise one other question. I am very much concerned about the guaranteed loan program provided in this bill. This loan program has a number of good features but the principal difficulty, which was recognized by the House Committee itself in its report, is the same as with all such guaranteed loan programs—the burden of interest. Under this program, the person who will be paying the additional cost of interest on the loan is the patient. He has to pay these added costs at a time when he can least afford to pay them; when he is sick or hurt and in no position to meet them. I think this is a grave fault, and I hope that this Committee will consider ways of alleviating the burden. This program was also questioned by Mr. David M. Kennedy in a letter to Secretary Finch on June 4 which I would like to bring to the Committee's attention.

Thank you very much for the privilege of testifying on this very important legislation.

AMENDMENT NO. 1

AMENDMENT TO H.R. 11102, AS REPORTED

Page 15, lines 2 and 5, insert "(A)" immediately after "(3)".

Page 15, line 10, insert after the period the following: "For each fiscal year, the Secretary shall, in accordance with regulations, make allotments among the States, from the sums appropriated for such year under subparagraph (3)(B) of section 601(c), on the basis of the population of each State that is residing in metropolitan areas."

Page 14, strike out line 24 and all that follows down through and including line 17 on page 15 and insert in lieu thereof the following:

"Sec. 602. (a) For each fiscal year the Secretary shall, in accordance with regulations, make allotments among the States, from the sums appropriated for such fiscal year under subparagraphs (1), (2), (3), (4), and (5), respectively, of section 601(c), on the basis of the population, the extent of the need for construction of the facilities referred to in such section (or, in the case of allotments from appropriations under such subparagraphs (5), the extent of the need for modernization of such facilities), and the financial need, of the respective States."

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AMENDMENT NO. 2

AMENDMENTS TO H.R. 11102, AS REPORTED

Page 13, line 23, strike out "$135,000,000" and insert in lieu thereof "$60,000,000"; and on page 14, strike out lines 13 through 17 and insert in lieu thereof the following:

> "(5) for grants for modernization of the facilities referred to in the preceding subparagraphs, $135,000,000 each for the fiscal year ending June 30, 1971, and the next two fiscal years."

Page 16, beginning in line 20 strike out "other than an allotment for grants for the construction of public or other nonprofit hospitals and public health centers,".

Page 17, after the comma at the end of line 6 insert "or to transfer a portion of an allotment for grants for modernization to an allotment for grants for the construction of public or other nonprofit hospitals and public health centers,".

Page 14, strike out lines 13 through 17 and insert in lieu thereof the following:

> "(5) for grants for modernization of the facilities referred to in the preceding subparagraphs, $100,000,000 for the fiscal year ending June 30, 1971, $110,000,000 for the fiscal year ending June 30, 1972, and $120,000,000 for the fiscal year ending June 30, 1973."

AMENDMENT NO. 3

AMENDMENT TO H.R. 11102, AS REPORTED

Page 14, line 5, insert "(A)" after "(3)"; and in line 8, insert before the semicolon the following: ", and (B) for grants for the construction of public or other nonprofit diagnostic or treatment centers (whether or not physically connected to a hospital) that will be located in, and will provide services for residents of, any area determined by the Secretary to be a metropolitan area with low per capita income, $15,000,000 each for the fiscal year ending June 30, 1971, and the next two fiscal years".

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AMENDMENT NO. 4

AMENDMENT TO H.R. 11102, AS REPORTED

Page 23, strike out lines 2 through 10 and insert in lieu thereof the following: "State agency, the application is for a project (A) which is consistent with the comprehensive regional, metropolitan area, or other local area plan or plans, developed under section 314(b), that cover the area in which such project is to be located, or (B) if there is no such plan or plans, which is consistent with the comprehensive State health plan (if any) developed under section 314(a) by the State in which such project is to be located,".

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AMENDMENT NO. 5

AMENDMENTS TO H.R. 11102, AS REPORTED

Page 12, at the end of line 2 add "; EMERGENCY FINANCIAL ASSISTANCE FOR COMMUNITY HOSPITAL SERVICES"; and at the end of line 6 add "AND EMERGENCY ASSISTANCE FOR COMMUNITY HOSPITAL SERVICES".

Page 12, line 21, strike out "under this part" and insert in lieu thereof "from appropriations made under section 631".

Page 13, line 8, strike out "under this part" and insert in lieu thereof "from appropriations under sections 631 and 634".

Page 13, line 11, strike out "of this part.'" and insert in lieu thereof "of those sections."; and after line 11, insert the following:

"EMERGENCY GRANTS FOR COMMUNITY HOSPITAL SERVICES

"SEC. 634. (a) The Congress finds that certain public and nonprofit private hospitals in the several States are unable to meet the present urgent health service needs of the communities served by the hospitals or to participate in comprehensive health services programs or planning to meet future needs due to a critical lack of adequate facilities and services; that there do not now exist adequate sources of public or private financing to provide the direct emergency assistance needed to resolve this critical condition; and that this results in a serious threat to the health, welfare, and safety of the communities involved and of the Nation.

"(b) In order to provide emergency assistance to those hospitals found to be in critical condition as provided in subsection (c) and in the cases where the communities they serve would otherwise be deprived of needed health services, the Secretary is authorized to make direct emergency grants of up to 66⅔ per centum of the cost of any project to provide necessary facilities and services in accordance with the provisions of this section. No grant of assistance for any single project under this section may exceed 7½ per centum of the amount appropriated under this subsection. For the purpose of making emergency grants as provided in this section there is authorized to be appropriated $100,000,000 for the fiscal year ending June 30, 1970. Sums appropriated under this subsection

shall remain available for obligation for the two fiscal years following the fiscal year for which they are appropriated.

"(c) Public and nonprofit private hospitals may qualify as critical hospitals and may be eligible for assistance under this section if the Secretary finds that—

"(1) the average rate of occupancy or the demand for necessary and essential facilities and services of such a hospital so far exceeds reasonable capacity that the community served is deprived of health services of a type and quality conforming to generally accepted standards;

"(2) full and effective use is being made of the existing facilities of the hospital and of other health facilities available to the community;

"(3) the needed assistance is not available from other public or private resources; and

"(4) the failure to provide the needed facilities or services constitutes a threat to the health, welfare, or safety of the community.

"(d) Any hospital seeking emergency assistance under this section shall apply to the Secretary, declaring itself to be in critical need of emergency assistance and setting forth—

"(1) evidence of eligibility under the provisions of subsection (c) in such manner and detail and with such supporting data as the Secretary shall require;

"(2) a detailed description of the project for which emergency assistance is being requested, specifying the deficiencies in health services that the project will correct, and how the project, if approved and completed, will—

"(A) meet the health services needs of the community it serves,

"(B) be coordinated with existing health services available to such community, and

"(C) be integrated with health services programs approved or planned for the community, State, or region in which the hospital is included;

"(3) the estimated cost of completing the project, set forth in such manner and detail as the Secretary shall require;

"(4) the amount of emergency assistance, under this section, that will be required to complete the project; the period of time during which such assistance will be utilized; the source and the amount of funds, other than the grant assistance requested under this section, but including any emergency loan requested under section 635, which will be used to complete the project;

"(5) reasonable assurance that adequate financial assistance will be available to support and maintain the added or expanded facilities or services after the project requested under this section is completed;

"(6) reasonable assurance that wherever any project for which assistance under this section is requested involves construction, all laborers and mechanics employed by contractors or subcontractors in the performance of such construction will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a–5); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c); and

"(7) agreement that the Secretary may exercise such review authority as he deems advisable in accordance with the provisions of subsection (b).

"(e) The Secretary may approve such application if he determines that—

"(1) the hospital making application for assistance is eligible for assistance under subsection (c), and that the hospital has complied with all relevant provisions of this section;

"(2) the project described in accordance with subsection (d) will help to correct existing deficiencies in health services available to the community, will help to enable the hospital to provide health services of a type and quality conforming to generally accepted standards and conforms to local, State, or regional health planning and programs;

"(3) sufficient funds are available from amounts appropriated under subsection (b) to make the grants of assistance covered by such applications; and

"(4) the project covered by such application is entitled to priority over other projects for which applications have been received under this section but which have not been approved under this subsection. In making the determination under paragraph (4), the Secretary shall give special con-

sideration to hospitals participating in health services development programs authorized under section 304.

"(f) For the purpose of determining whether a hospital is eligible for assistance under subsection (c) and whether an application conforms to the conditions for approval under subsections (d) and (e), the Secretary is authorized to visit any hospital submitting an application for assistance, to review any relevant records, and to make or request surveys of health facilities and services of the community served by the hospital.

"EMERGENCY LOANS

"SEC. 635. Any hospital unable to secure adequate funds to pay that portion of the project cost not covered by the emergency grant requested under section 634, may apply to the Secretary for an emergency loan and the Secretary is authorized to loan such a hospital up to 90 per centum of that portion of the project cost not covered by the grant provided under that section if (1) the Secretary determines that the hospital is unable to secure the needed funds from other public and private sources, and (2) the Secretary approves the requested emergency grant under section 634. No such emergency loan shall exceed 90 per centum of 33⅓ per centum of the total project cost approved by the Secretary. Each such loan authorized by this section shall bear interest at the rate of 2½ per centum per annum on the unpaid balance thereof and shall be repayable over a period determined by the Secretary to be appropriate, but not exceeding fifty years. In order to make the loans provided for in this section, there are authorized to be appropriated $45,000,000 for the fiscal year ending June 30, 1970. Sums appropriated under this section shall remain available for obligation for the two fiscal years following the fiscal year for which they are appropriated.

"SURVEY OF HOSPITALS AND COMMUNITY HEALTH SERVICES NEEDS

"SEC. 636. To carry out the purposes of sections 634 and 635, the Secretary shall conduct a survey of public and nonprofit private hospitals in the Nation and shall evaluate the type and quality of facilities and services available from such hospitals. Based upon this study, the Secretary shall establish and maintain criteria for determining generally accepted standards of health services and shall report the results of the survey and his determinations to Congress and the President no later than January 1, 1970. Thereafter the Secretary shall revise the survey and his determinations annually and shall report to the President and Congress at the beginning of each session of Congress. Such reports shall include estimates of the cost of meeting the emergency needs of critical hospitals, the availability of funds from public and private sources to meet such costs, and recommendations for additional appropriations under sections 634 and 635 if he finds that such are needed to meet emergency situations. For the purpose of preparing and maintaining the survey according to the provisions of this section, the Secretary is authorized to cooperate with and utilize the resources of such public and private organizations as he deems necessary and advisable.

"DEFINITIONS

"SEC. 636. As used in section 634 and 635—

"(1) The term 'hospital' includes facilities furnishing domiciliary care.

"(2) The term 'project' includes additions to existing hospital plants, alterations, enlargement, or remodeling of existing buildings, equipment, instruments, and furnishings, and programs involving personnel."

The CHAIRMAN. You have also referred to various other matters: David M. Kennedy's letter to Secretary Finch and other data. Do you want Mr. Veneman's testimony placed in the record here?

Mr. OTTINGER. I think it should be brought to the committee's attention.

The CHAIRMAN. We will order the gentleman's testimony and other material printed in the record.

(The material referred to follows:)

STATEMENT OF HON. JOHN G. VENEMAN, UNDER SECRETARY, HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY JAMES F. KELLY, ASSISTANT SECRETARY COMPTROLLER; CREED C. BLACK, ASSISTANT SECRETARY FOR LEGISLATION; JAMES H. CAVANAUGH, DIRECTOR, OFFICE OF PLANNING AND PROGRAM COORDINATION; AND IRVING J. LEWIS, DEPUTY ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mr. VENEMAN. Thank you very much, Mr. Chairman.

First of all, let me express the regret of Secretary Finch who had planned to present this testimony himself but went home yesterday at the doctor's orders as a result of a virus that he encountered over the weekend.

Also, Surgeon General Stewart has undergone surgery and had planned to be here.

I think the first application we will make for a Hill-Burton grant will be for a facility in HEW.

May I introduce the gentlemen who are with me this morning.

To my left is Creed C. Black, the Assistant Secretary for Legislation. To my immediate right is James H. Cavanaugh, Director of the Office of Planning and Program Coordination, and Jim Kelly, the Assistant Secretary Comptroller for HEW. Also with me today is Irving J. Lewis, Deputy Administrator, Health Services and Mental Health Administration.

Mr. Chairman, I think in your opening statement that you have reflected the many benefits that the Hill-Burton program has provided the people of this Nation during the time that it has been in existence since 1946.

I think the two charts to our left and right also give us a visual indication of the types of project and the effectiveness of the entire program.

When Hill-Burton program was initiated, the country had less than 60 percent of the general hospital beds needed for the care of its people. The most critical shortages existed in rural areas, where many families lived hours away from livesaving care. As a consequence, the program acquired a rural emphasis. It has served its purpose well. Today, despite rapid population growth, 90 percent of the Nation's need for general hospital beds is fulfilled—thanks in large measure to Hill-Burton.

We believe that now the priorities have changed and the needs for today are basically twofold:

1. Modernization or replacement of existing and obsolete acute-care facilities in the hospitals;

2. Expansion of other kinds of medical facilities which can reduce the pressure on hospitals and thus help curb skyrocketing medical costs.

It is for this reason that we are proposing a radical redirection of the Hill-Burton program.

Looking first at the need for modernization of acute-care facilities, there is a national requirement estimated by the States at $11 billion. It is obvious that a program of Federal grants cannot meet a backlog of such proportions.

We are, therefore, proposing a guaranteed loan program which we believe would stimulate the private capital it will take to bring about the modernization of acute-care facilities.

With hospital needs met in this way, we would then propose a program of block grants to encourage the States to expand such other facilities as outpatient clinics, neighborhood health centers, skilled nursing homes, and structures designed to increase efficient sharing of hospital resources.

Facilities for ambulatory care services such as those provided by hospital outpatient clinics and separate health centers will help balance our entire health delivery system. The distances traveled and hours spent in waiting for such services by millions of our people testify to the critical nature of this need in almost every community. The experience to date with the neighborhood health center indicates that this model is only highly productive way of serving individuals and families.

It is my understanding that under the OEO program we have practically 29 neighborhood health centers in operation and approximately 50 that have been funded which will be in operation within a short period of time.

Grant funds to encourage shared facilities should go a long way toward maximum utilization of scarce manpower and the prevention of unnecessary duplication of expensive equipment that is necessary.

A related need is far greater availability of long-term-care facilities, especially skilled nursing homes. This need has been and continues to be accentuated by

the growing numbers of our citizens in the older age groups, and by their increased capacity to pay for the care they require.

The resources to meet these and other needs of the health care system are large but ultimately limited. Therefore, it is imperative that they be invested wisely and used efficiently. It is essential that we prevent wasteful duplication and encourage cooperation and shared use of facilities.

This requirement imposes upon the health enterprise another important need—that of thorough and coordinated planning. The planning processes must involve not only all elements of our complex public-private health care system, but related sources as well.

As the members of this subcommittee well know, there are a multiplicity of such resources among Federal programs alone. Our estimates report that $295 million was paid for depreciation reimbursement to hospitals and other facilities through the medicare and medicaid programs in fiscal year 1968. This payment relates directly to capital financing. Above and beyond these are the great sources of strength in the private economy which are or can be devoted to health purposes.

It is against this broad backdrop that we project our considerations of legislative proposals to amend title VI of the Public Health Service Act. Further, we project our urgent concerns for strengthening the health care system against the background of fiscal reality and responsibility.

H.R. 6797, which has been introduced by the distinguished chairman of the full committee, Mr. Staggers, and H.R. 7059, which has been introduced by Mr. Rogers, both address themselves to the needs I have discussed. Both recognize the magnitude of health facility capital financing requirements, as well as the necessity for greater local involvement in health facility planning.

However, the major thrust of H.R. 6797 and H.R. 7059 would continue the categorical grant support under the existing Hill-Burton Act. We have serious doubt that such a continuation would assure the construction, replacement, or modernization of other health facilities which are more urgently needed than general hospital beds: facilities for ambulatory care, including neighborhood health centers, extended care, rehabilitation, and shared facilities. We believe that continued application of grant funds to projects within the existing Hill-Burton categories would divert limited funds away from these specific needs.

In addition, H.R. 6797, which recognizing the need for multiple sources of Federal financial assistance, would have an impact on the Federal budget which is not consonant with this administration's efforts to stem inflationary forces and establish patterns of greater Federal fiscal responsibility. Moreover, it would continue the existing legislative requirement of priority to projects in rural areas, even though our greatest needs are for modern facilities in the urban areas.

Section 130 of the bill would extend for three additional years the provisions of Section 304 of the PHS Act, authorizing grants and contracts for the support of research and demonstrations relating to health facilities and services. We are now in the process of evaluating program accomplishments and future requirements in the field of health services research and development, with particular attention to the program functions administered through the National Center for Health Services Research and Development which was activated only last June.

Pending the completion of this program evaluation, therefore, at this time we would recommend deferment of any legislative action to extend or otherwise amend the provisions of section 304 of the act.

Mr. Chairman, to achieve the goals outlined earlier, a redirected Federal effort is essential. Specifically, we would propose that grant funds be allotted to the States as a block, rather than earmarked for specific categories. A grant authorization of $150 million, limited to construction, replacement, or modernization of the most critical types of health facilities, would result in the most effective use of Federal funds. We have not included the construction and modernization of acute hospital beds because we believe these needs can better be met through a guaranteed loan program. Additionally, we recommend the removal of the existing Hill-Burton categories to provide, a better balance of health care facilities in the community by assisting those kinds of facilities which have traditionally been neglected or in short supply.

The proposed redirection of grant funds would afford an opportunity whereby limited Federal resources could most beneficially influence the organization and delivery of health care. Such redirection would relieve the pressures on acute-care inpatient facilities by encouraging the use of other types of facilities

under conditions less expensive than the use of acute-care hospital beds. While firm estimates are not available for all health facility needs, there is a known need for an additional 164,000 extended care beds, 177 additional facilities for rehabilitation, and 872 ambulatory care facilities. The well-documented health problems of the Nation's disadvantaged compels a further development of the comprehensive health services currently being provided by neigborhood health centers.

We propose that 80 percent of the $150 million grant program be allotted to the States for these purposes on the basis of population, per capita income, and the need for the construction or modernization of these facilities.

We further propose that before annual allotments are made to the States, 20 percent of the grant funds appropriated by the Congress be reserved for direct project grants to be made by the Secretary, after consultation with the States, for innovative projects or projects reflecting critical needs of national significance. Such projects would be eligible for assistance up to 90 percent of project cost. They could include those facilities described earlier, as well as projects of an innovative nature which would materially improve the organization and delivery of health care. The judicious use of this project grant authority would permit program flexibility in taking advantage of changing health facility relationships and would encourage new relationships among health facility construction and health services as they evolve.

Our recommendations would authorize maximum Federal support up to 66⅔, except for projects serving areas of greatest financial need where the maximum would be 90 percent. In addition to the increased Federal share, we recommend that the applicants for the latter projects be allowed to include in their matching participation the current value of equipment, services, and facilities dedicated by them to the project. This is a reasonable adjustment to provide greater opportunity for participation by those least able financially to produce local matching funds. At the same time, it recognizes the value of local participation in funding projects.

In order to stimulate the maximum amount of needed health facility construction and modernization, we would add to the grant program a Federal loan guarantee authority which would guarantee a maximum of $550 million in loans annually. Within each State, the aggregate of loans to be guaranteed annually would be determined in the same manner as the allotment of grant funds. All privately owned nonprofit health facility modernization or construction projects would be eligible for loan guarantees. Projects would be eligible to receive 90-percent guarantees on any loan. No loan, nor any combination of loan and grant under the grant program, could exceed 90 percent of the total cost of the project.

In addition to the proposed annual grant authorization of $150 million for health facilities other than hospitals, the $500 million loan guarantee authorization for nonprofit hospitals provides a substantially increased level of Federal support for facility construction beyond what Hill-Burton now provides. The repayment by hospitals of interest and loan principal will be especially assisted by the increasing and substantial Federal payments for depreciation under medicare and medicaid. Our estimates of these amounts are $295 million for fiscal year 1968. These payments are also available to public hospitals for repayment of tax-exempt public borrowings for the construction and modernization of such hospitals.

This administration is pledged to consolidate, wherever possible, related programs. Last year the Congress enacted a program of guaranteed loans for the construction of hospitals. We recommend that this program, which is administered by the Department of Housing and Urban Development, be replaced by a broader authority covering the needs of all types of health facilities.

With the exception of modernization grants, the present annual appropriation for health facilities construction is allotted to the State on the basis of a formula using State population and per capital income related to the per capita income of the United States. In addition, the Hill-Burton Act requires that the per capita income factor be squared. This squaring method results in an inordinately large allotment to those States wth relatively stable populations and relatively low incomes. It was adopted at the inception of the program for lack of any better method for determining definitive need for health facilities. However, a more accurate basis now exists for determining need for health facilities by type and number. We propose that grant funds and loan guarantees be allotted to the States on the basis of financial need, population, and need for construction and modernization of health care facilities.

As you know, the existing Hill-Burton legislation further requires that the States, in approving projects, give special consideration to health facilities serving rural communities. Although this provision does not apply to determining the priority among facilities in need of modernization, it does cover the construction of new facilities or additions to existing facilities. The provision had substantial validity during the early years of the program when the major national health facility problem was to provide additional health facilities for rural communities. However, as the population has shifted in the last two decades from rural to urban areas, so has the greatest need for health facility financial assistance shifted from rural to urban areas. We, therefore, recommend that the rural area priority requirements be eliminated, since it is no longer responsive to the health facility needs of today.

Mr. Chairman, the extension and revision of title VI of the Public Health Service Act now pending before this subcommittee must be considered, and its final form determined, in the light of the fact that it is but one part, though an important part, of the Nation's overall health program. It is the point of departure in this Congress in our joint efforts to increase the efficiency, strengthen the capacity, and control the alarming rise in cost of our country's health care delivery system. The directions charted by this legislation can have a positive impact on each of these areas of legitimate Federal concern far beyond the initial impact of the dollars directly authorized.

The maximum utilization of local and State health planning agencies must be included in this legislation in such fashion as to anticipate the equivalent utilization of such agencies in other Federal programs. Accordingly, each project seeking financial assistance under this title should be submitted for review and comment to the appropriate areawide planning agency created under the provisions of section 314(b) of the PHS Act. The State Hill-Burton plan should be approved by the State health planning agency created under section 314(a) before awards from the State allotment are approved and funded.

We also have under consideration legislation that would provide for reimbursement through medicare and medicaid only to institutions whose future capital expenditures are in conformance with State and local health plans. These provisions will strengthen and reinforce the role of our local and State partners who have primary responsibility for planning their own health systems. This will be consistent with public statements in support of planning recently made by the Blue Cross Association and the American Hospital Association.

The success of the Hill-Burton program is attributable in large part to the competence and integrity of the State agencies in formulating and implementing their plans. The States have proved that they are able to develop plans responsive to the needs of their citizens, and we therefore, propose that the statute no longer require issuance of Federal regulations setting Federal criteria that the States must follow in the formulation or modification of their State plans. The State plan would include methods of determining need and priority which provide reasonable assurance that projects would be approved in the order of need and that the purposes of the proposal would be met. In addition to uniform construction standards, we would, of course, continue to require uniform data criteria for use in the development of the formula grant equation in distributing grants among the States.

Mr. Chairman, we have learned a lot about the Nation's changing health facility needs in recent years, and we now have both the opportunity and the responsibility to fulfill those needs. Legislation within the substantive and fiscal framework which I have outlined to the subcommittee would go a long way toward achieving the maximum benefits for the American people in the most efficient and effective manner. The circumstances are too compelling to warrant delay in obtaining a better health return on the dollars we are spending in the health facility field. Accordingly, I am recommending that we not wait until expiration of the current Hill-Burton authorization, but that the Congress enact a redirected program along the foregoing lines effective with the fiscal year commencing July 1, 1969.

I would be pleased to answer any questions that any member of the subcommittee may have, and again appreciate the opportunity to submit our proposal for redirection of a program which, as you indicated, has been most effective in helping meet the health care needs of this country.

THE SECRETARY OF THE TREASURY,
Washington, June 4, 1969.

The Honorable ROBERT H. FINCH,
Secretary of Health, Education, and Welfare,
Washington, D.C.

DEAR BOB: I am deeply concerned with the proposal by the House Committee on Interstate and Foreign Commerce that the Federal Government guarantee the payment to private investors of interest on obligations of public bodies which is exempt from Federal income taxation. Such a provision appears in the proposed new section 621(a) of the Public Health Service Act, which is incorporated in the Medical Facilities Construction and Modernization Amendments of 1969 (H.R. 11102) reported by the Committee on May 20, 1969.

The report of the Committee recognized that the Treasury Department opposes such Federal guarantees of tax-exempt obligations, and the report cited the arguments made against such guarantees in the 1962 report of the President's Committee on Federal Credit Programs: (1) the cost in tax revenues to the Federal Government would generally exceed the benefits of tax exemption received by borrowers; (2) such Federally-guaranteed tax-exempt securities would be superior to direct Federal obligations themselves, and their increasing volume would adversely affect Treasury financing; and (3) the availability of increasing amounts of high-grade, tax-exempt issues would tend to attract funds from investors that should appropriately seek risk-bearing opportunities. The House Committee stated that it agrees with the substantial validity of these arguments, but was of the opinion that competing considerations outweighed them. In light of the problems in the tax-exempt market and the undesirable precedent which would be set by acceptance of this legislation, I feel that I must recommend against this action.

Encouragement by the Federal Government of an additional volume of tax-exempt obligations will add to the present extreme pressures on the tax-exempt bond market and will tend to increase the interest rates which all State and local borrowers will be required to pay. The municipal bond market is especially vulnerable to such competition from Federal programs because of the limited nature of that market.

Moreover, as you know, there is currently a great deal of sentiment in the Congress and elsewhere for tax reform, including the problem of tax-exempt interest on municipal bonds. While it is a very complicated problem, which I will not attempt to discuss here, I am sure you would agree that the Federal Government should not be adding to the problem by encouraging an additional volume of tax-exempt bonds through the device of a Federal guarantee.

My concern with tax-exempt guarantees goes beyond the hospital financing program. There have been many recent proposals for Federal guarantees of municipal bonds for a wide variety of capital projects for health, education, transportation, housing, and other public facilities. The Treasury Department has successfully resisted this proposed method of financing new programs, and it would be extremely difficult to approve this financing device for one purpose and at the same time hold the line against its widespread use in other areas—which I am firmly convinced would not only be bad tax and debt management policy but would be a great disservice to the States and localities themselves.

As you know, we have under active consideration a number of proposals to assist States and localities, ranging from revenue sharing plans to specific assistance to high priority programs such as the financing of health facilities. Moreover, we are considering other means of alleviating pressures on State and local financing in the tax-exempt bond market, and I believe it would be counter tto our efforts in this regard if new programs of guaranteed tax-exempts were authorizednow.

Sincerely,

DAVID M. KENNEDY.

The CHAIRMAN. You have raised a number of good points. You are the first witness on this legislation. After we have heard from the other witnesses, we may want to recall you to ask some questions. Your testimony stimulated inquiries in my own mind. I intend to take it up with the staff. That is a matter of information on which to base whatever this committee recommends.

I would be prepared to give the administration's recommendations greater weight than I now give them had it not been for the recommendation that we close the two narcotic treatment and research centers, the only two in the country, at Fort Worth, Tex., and Lexington, Ky. When the administration started out by abolishing the only two in the Nation and saying it is a State and local function, when no place else in the country has such facilities and in the face of an explosion in the use of narcotics among our young people, it seems to me a dangerous move in this field. I trust they are sounder than they were on closing those two narcotics hospitals.

I want to congratulate you on your knowledge in these matters. I was listening; you were speaking so I think everybody in the room could hear you. I want to raise a number of points that would be right at the core of interest in this legislation.

Senator Saxbe?

Senator SAXBE. No questions.

The CHAIRMAN. Thank you very much, sir.

The next witness is from the Association of State and Territorial Health Officers, and happens to be a man from my own State, Dr. James E. Peavy.

Dr. Peavy, we did not put you on here because you were commissioner of health in Texas and a personal friend of mine, but because you are president of this national association. You have with you, I think, some others. To show it is a truly national organization, would you introduce the distinguished doctors who accompany you here and give their present position in your organization and their official capacities in their respective States?

STATEMENT OF DR. JAMES E. PEAVY, PRESIDENT, ASSOCIATION OF STATE & TERRITORIAL HEALTH OFFICERS; ACCOMPANIED BY DR. ROBERT N. BARR, SECRETARY AND EXECUTIVE OFFICER, MINNESOTA STATE DEPARTMENT OF HEALTH; AND DR. ROY L. CLEERE, DIRECTOR OF PUBLIC HEALTH, STATE OF COLORADO

Dr. PEAVY. Thank you very much, Senator Yarborough. I am James E. Peavy, and I serve as commissioner of health of the Texas Department of Health. I am also president of the Association of State & Territorial Health Officers. My testimony today is not in behalf of my own State, but in behalf of the association representing all States. With me is Dr. Robert N. Barr, secretary and executive officer of the Minnesota State Department of Health, and chairman of our association's committee on hospital and medical facilities planning and construction. Dr. Cleere is the dean of the association and director of public health for the State Colorado. He has been the director of public health there since 1935.

The CHAIRMAN. Would you pause for just a moment, please? We have a distinguished member of this subcommittee, Senator Dominick, who wants to say a word for the man from his State.

Senator DOMINICK. I am glad I arrived at just the right time, Dr. Cleere. We are dealing with matters that are of enormous interest to you, to us, to the chairman and all members of this subcommittee and

to the country as a whole. We need someone with your experience in the Public Health Service. We really welcome you here as an expert witness. I think you are going to be very helpful.

Dr. CLEERE. Thank you, Senator.

The CHAIRMAN. Thank you.

Proceed, sir.

Dr. PEAVY. Thank you, Senator.

We of the Association of State & Territorial Officers appreciate the opportunity to appear before you on this very important subject. We fully support the sound principles of the Hill-Burton Act. We feel it is an outstanding example of effective legislation designed to enhance close and effective cooperation between Federal and State government. A vital aspect of this legislation, and one that should be preserved in its extension, is the decentralization of the decisionmaking function to the State level where the most complete information regarding plans, needs, resources, and priorities is available. Indeed, we could improve our utilization of limited health resources if more Federal health programs were similarly decentralized.

Our Federal investment to date in the construction and modernization of health care facilities amounts to $3 billion. This investment has attracted $7 billion of State and local funds on a matching basis. The 9,800 projects that have been approved provide more than 425,000 additional inpatient beds in hospitals and nursing homes and 2,800 other health facilities, such as public health centers, diagnostic or treatment centers, and rehabilitation centers.

Despite this progress, we must expand our investment in the construction and modernization of health care facilities if we are to meet today's needs and satisfy the demand of our citizens for health services. The States report an urgent need for the construction of new health care facilities at an estimated cost of $6.1 billion and an urgent need to modernize or replace obsolete health care facilities at an estimated cost of $10.5 billion. These needs will continue to grow unless we take action now.

Since the backlog in new construction and modernization of health care facilities amounts to almost $16 billion, the present level of Federal financial assistance should be substantially increased. The Association of State & Territorial Health Officers endorses S. 2182, the Hospital and Medical Facilities Construction and Modernization Amendments of 1969, that was introduced by Senator Yarborough, the chairman of this committee. This is an excellent bill and one that our association strongly supports. We urge its enactment. I will not set forth all of the reasons for our supporting this measure, but I do want to mention our support for the 5-year program that S. 2182 authorizes. In addition, the authorizations for appropriations under S. 2182 are more realistic in terms of the existing needs for construction and modernization than those of H.R. 11102 or S. 1733. Furthermore, our Association strongly supports the 5-year extension of grants for research and demonstrations relating to health facilities and services.

There is, however, one aspect of S. 2182 that we do not endorse—the new program of project grants for the modernization of emergency rooms of general hospitals. A similar program would be authorized by H.R. 11102. Under both measures the Secretary of Health, Education, and Welfare rather than the individual States would be responsible for the award of funds. S. 2182, but not H.R. 11102, would

require the Secretary to consult with the State agency that is responsible for health facility construction and modernization.

Our association believes that our Federal investment in the construction and modernization of health care facilities should be administered by the State agencies that have responsibility for establishing plans and priorities. Such decentralization in administration results in effective Federal-State cooperation with a minimum of administrative duplication. As a result, we recommend against the project grant provisions of S. 2182 and H.R. 11102.

We also oppose the provisions of S. 1731 that would set aside 20 percent of the funds for modernization and construction to be awarded as project grants by the Secretary of Health, Education, and Welfare. To administer one-fifth of the grants funds outside the plans and priorities of the States would greatly weaken the strong and effective program of Federal-State cooperation that now exists.

Another serious deficiency in S. 1733 is its failure to provide any financial assistance for the construction or modernization of publicly owned hospitals. Only privately owned nonprofit hospitals are eligible for the loan guarantees that are authorized by S. 1733. Furthermore, there is no interest subsidy under S. 1733. As a result this Association supports S. 2182 that authorizes loan guarantees for private nonprofit hospitals and direct Federal loans for public hospitals. Both categories would be eligible for an interest subsidy. Over 25 percent of the hospital beds in the United States are in publicly owned facilities.

PRIORITIES

Under the provisions of S. 2182 there would be seven priorities to be observed by the States in the award of funds for the construction and modernization of hospitals and other health care facilities. We anticipate problems in administering a construction program with this many priorities and suggest that the committee give consideration to the consolidation or elimination of some priorities. The relative importance of the priorities might be incorporated in the Senate report.

Both S. 2182 and H.R. 11102 would require consultation with the areawide health planning agency with jurisdiction over the appropriate regional or local area as a part of the approval process, in the case of applications for construction or modernization of title VI of the Public Health Service Act. Our association fully endorses this requirement which should greatly assist in preventing unnecessary duplication in hospital and medical facilities and services. Under H.R. 11102, however, there is language included to amend the authorization for project grants for areawide planning to prohibit grants unless the Secretary determines that the grantee provides means for appropriate representation of the interests of the hospitals, other health care facilities, and practicing physicians serving such area, and the general public. Representation of these interests and other interests is inherent in the award of such grants. For this reason this association recommends against citing the interest of any specific health care groups in the legislation. We assume that by being cited, the interests of those health care groups are intended to have more representation than those not cited. This should not be the case.

We do think that the States should be given flexibility in working with the areawide planning group. Its recommendations should be

taken into consideration, but they should not be binding nor the ultimate authority.

Under existing law the Federal share in the case of grants for the construction or modernization of health care facilities ranges between one-third and two-thirds of the cost of construction. Some States, however, pay less than the maximum Federal share by limiting the project to only a portion of the construction. For example, in constructing a $10 million hospital a State may elect to participate in only $3 million of construction costs and use $1 million of Federal funds for a one-third Federal share. By decreasing the Federal contribution, the States are able to require a greater community effort in fundraising and thereby construct a greater volume of health facilities with the limited Federal funds that are available. In some cases, however, a higher Federal share might serve as an incentive to reduce the cost of medical care through projects that make changes in patterns of organizing and delivering health care. Obviously, such projects should be encouraged. That is why our association endorses S. 2182 that gives States the option of increasing the Federal share as an incentive to reducing medical care costs through greater utilization of home health services, extended care services, and such shared services as laboratory, radiology, dietary, and outpatient care.

The Association of State & Territorial Health Officers appreciates having this opportunity to submit recommendations on legislation to extend and expand our Federal investment in constructing and modernizing hospitals and other health care facilities. We will be glad to answer any questions you might have.

(The prepared statement of Dr. Peavy follows:)

PREPARED STATEMENT OF DR. JAMES E. PEAVY, PRESIDENT, ASSOCIATION OF STATE & TERRITORIAL HEALTH OFFICES

Mr. Chairman, I am James E. Peavy and I serve as Commissioner of Health of the Texas State Department of Health. I am also the president of the Association of State and Territorial Health Officers. My testimony today is presented on behalf of the Association.

With me are Dr. Robert N. Barr and Dr. Roy L. Cleere. Dr. Barr is the Secretary and Executive Officer of the Minnesota State Department of Health and Chairman of the Committee on Hospital and Medical Facilities Planning and Construction of the Association of State and Territorial Health Officers. Dr. Cleere is the Director of Public Health for the State of Colorado.

The Association of State and Territorial Health Officers fully supports the sound principles of the Hill-Burton Act. It is an outstanding example of effective legislation designed to enhance close and effective cooperation between Federal and State government. A vital aspect of this legislation, and one that should be preserved in its extension, is the decentralization of the decision-making function to the State level where the most complete information regarding plans, needs, resources and priorities is available. Indeed, we could improve our utilization of limited health resources if more Federal health programs were similarly decentralized.

Our Federal investment to date in the construction and modernization of health care facilities amounts to $3 billion. This investment has attracted $7 billion of State and local funds on a matching basis. The 9,800 projects that have been approved provide more than 425,000 additional inpatient beds in hospitals and nursing homes and 2,800 other health facilities, such as public health centers, diagnostic or treatment centers and rehabilitation centers.

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care facilities at an estimated cost of $10.5 billion. These needs will continue to grow unless we take action now.

Since the backlog in new construction and modernization of health care facilities amounts to almost $16 billion, the present level of Federal financial assistance should be substantially increased. The Association of State and Territorial Health Officers endorses S. 2182, the Hospital and Medical Facilities Construction and Modernization Amendments of 1969, that was introduced by Senator Yarborough, the chairman of this Committee. This is an excellent bill and one that our Association strongly supports. We urge its enactment. I will not set forth all of the reasons for our supporting this measure, but I do want to mention our support for the five year program that S. 2182 authorizes. In addition, the authorizations for appropriations under S. 2182 are more realistic in terms of the existing needs for construction and modernization than those of H.R. 11102 or S. 1733. Furthermore, our Association strongly supports the five-year extension of grants for research and demonstrations relating to health facilities and services.

FEDERAL-STATE COOPERATION

There is, however, one aspect of S. 2182 that we do not endorse—the new program of projects grants for the modernization of emergency rooms of general hospitals. A similar program would be authorized by H.R. 11102. Under both measures the Secretary of Health, Education and Welfare rather than the individual States would be responsible for the award of funds. S. 2182, but not H.R. 11102, would require the Secretary to consult with the State agency that is responsible for health facility construction and modernization.

Our Association believes that our Federal investment in the construction and modernization of health care facilities should be administered by the State agencies that have responsibility for establishing plans and priorities. Such decentralization in administration results in effective Federal-State cooperation with a minimum of administrative duplication. As a result, we recommend against the project grant provisions of S. 2182 and H.R. 11102. We also oppose the provisions of S. 1733 that would set aside 20 percent of the funds for modernization and construction to be awarded as project grants by the Secretary of Health, Education and Welfare. To administer one-fifth of the grant funds outside the plans and priorities of the States would greatly weaken the strong and effective program of Federal-State cooperation that now exists.

PUBLIC HOSPITALS

Another serious deficiency in S. 1733 is its failure to provide any financial assistance for the construction or modernization of publicly-owned hospitals. Only privately-owned nonprofit hospitals are eligible for the loan guarantees that are authorized by S. 1733. Furthermore, there is no interest subsidy under S. 1733. As a result this Association supports S. 2182 that authorizes loan guarantees for private nonprofit hospitals and direct Federal loans for public hospitals. Both categories would be eligible for an interest subsidy. Over 25 percent of the hospital beds in the United States are in publicly owned facilities.

PRIORITIES

Under the provisions of S. 2182 there would be seven priorities to be observed by the States in the award of funds for the construction and modernization of hospitals and other health care facilities. We anticipate problems in administering a construction program with this many priorities and suggest that the Committee give consideration to the consolidation or elimination of some priorities. The relative importance of the priorities might be incorporated in in the Senate Report.

AREAWIDE PLANNING

Both S. 2182 and H.R. 11102 would require consultation with the areawide health planning agency with jurisdiction over the appropriate regional or local area as a part of the approval process, in the case of applications for construction or modernization under Title VI of the Public Health Service Act. Our Association fully endorses this requirement which should greatly assist in preventing unnecessary duplication in hospital and medical facilities and services. Under H.R. 11102, however, there is language included to amend the authorization for project grants for areawide planning to prohibit grants unless the Secretary determines that the grantee provides means for appropriate representation of

the interests of the hospitals, other health care facilities, and practicing physicians serving such area, and the general public. Representation of these interests and other interests is inherent in the award of such grants. For this reason this Association recommends against citing the interest of any specific health care groups in the legislation. We assume that by being cited, the interests of those health care groups are intended to have more representation than those not cited. This should not be the case.

FEDERAL SHARE

Under existing law the Federal share in the case of grants for the construction or modernization of health care facilities ranges between one-third and two-thirds of the cost of construction. Some States, however, pay less than the maximum Federal share by limiting the project to only a portion of the construction. For example, in constructing a $10 million hospital a State may elect to participate in only $3 million of construction costs and use $1 million of Federal funds for a one-third Federal share. By decreasing the Federal contribution the States are able to require a greater community effort in fund raising and thereby construct a greater volume of health facilities with the limited Federal funds that are available. In some cases, however, a higher Federal share might serve as an incentive to reduce the cost of medical care through projects that make changes in patterns of organizing and delivering health care. Such projects should bee encouraged. That is why our Association endorses S. 2182 that gives States the option of increasing the Federal share as an incentive to reducing medical care costs through greater utilization of home health services, extended care services, and such shared services as laboratory, radiology, dietary, and outpatient care.

The Association of State and Territorial Health Officers appreciates having this opportunity to submit recommendations on legislation to extend and expand our Federal investment in constructing and modernizing hospitals and other health care facilities. We will be glad to answer any questions you might have.

The CHAIRMAN. Dr. Peavy, you make a very strong case for continuing the State decision under hospital construction and for continuing to give them responsibility so that they can stretch the Federal dollars out to the public.

I believe, since Dr. Barr has a prepared statement and you are here as a panel, we will hear him before I ask any questions—if that is satisfactory to the other members of the committee.

I hear no objection.

Dr. Barr?

Dr. BARR. Senator Yarborough, I have presented you with a prepared statement and also with a table that illustrates some of the problems that I think we face. I would be pleased to skip through this and not take up too much of your time.

The CHAIRMAN. I ordered your statement printed in full at this time and you, Doctor, being an expert in such matters, can condense it in whatever manner you feel will be most effective to the committee.

Dr. BARR. Thank you, sir.

The CHAIRMAN. Do all the members of the committee have the tables?

I think they do.

Dr. BARR. At first I think I should say that in my opinion, there is public recognition of Hill-Burton as probably one of the finest pieces of legislation that has ever been presented in this whole field. It has been accepted. You will find that the Mental Retardation and the Community Mental Health Centers Construction Act, known as Public Law 88–164, has been modeled after it. You will find that the outgrowth is the Comprehensive Health Planning Act known as 89–749, is modeled after this. You will note that section 314(b) of 89–749, the

Comprehensive Health Planning, and Public Health Services Amendments, was really started under the Hill-Burton Act.

In Minnesota, less than 10 percent of the construction money comes out of Hill-Burton. The rest of it has come out of the communities and out of the pockets of individuals. We have no privately owned hospitals in the entire State. They are all publicly owned or voluntary groups.

Sixty percent of our nursing home beds and our boarding care beds are either publicly owned or nonprofit. Only 40 percent are private. I think this is one State which is an exception. In most States, 80 or 90 percent of the nursing beds are privately owned or operated for profit. Maybe that is due to the fact that we have a lot of Norwegians in my State. If it had not been for the interest of the people in Metropolitan Minneapolis, which some 15 years ago raised $17 million to assist in developing and improving the 13 hospitals in that city on a voluntary basis, we would be in real trouble today. We still have real problems of modernization and replacement in our metropolitan areas. I agree that emphasis should be placed on the modernization and the replacement and the development of related health facilities and services with emphasis in the metropolitan areas. They have been neglected in the past. There should also be an emphasis on poverty pockets in urban and rural areas.

I think all of our people agree that we should leave the Hill-Burton program as flexible as possible. The Hill-Burton agency should make the determinations as to priorities. This is the reason I am strongly in favor of the provisions of the act that allow a transfer of dollars from modernization to new construction or new construction to modernization. I am strongly in favor of the seven priorities listed in your bill, sir. But I think these priorities should be written into the plan by the States. We have been doing that for years and giving priorities to those facilities that provide out-patient services, to those facilities that provide training for nurses, physical therapists and others, over and above those who do not.

We have been giving priorities, because of the way it is written, to more rural areas. With the present language you do not even have to change the emphasis on the rural.

Now, there is one thing I want to point out: I do not think that we should require the State planning agencies to clear everything we do under Hill-Burton. I do not think either the areawide planning group or the State planning agency should be given the authority or the veto power over the construction of any single facility that is being planned. Some planning agencies are well organized, some of them are just getting started. But essentially all of them, as I said before, are in swaddling clothes as far as planning. They should not be given direct authority over Hill-Burton agencies, which represent all the people, because we have consumers on our planning committees as well.

If the planning agency is in the Governor's office there may be political control over the development of hospital and health-service planning. In many of the States, the health officer is not politically controlled because he has a board of health that makes the decisions. Some people say we ought to give the Governor responsibility to appoint all department heads, health as well as education, and to fire them if they do not agree with him. This is for the birds as far

as I am concerned because no single person can possibly have at his beck and call all of the things that have to be done in government. If you change your health department authority every time you change your government, you are going to have chaos in that health activity.

The CHAIRMAN. It seems to me that the larger your population in the State, the more accurate and applicable your statement would become.

Dr. BARR. I think that is correct.

The CHAIRMAN. The more millions of people you deal with, the more difficult it is to find a man for all of their problems.

Dr. BARR. We need modernization in our hospitals. We find that the labs, the X-rays and other services in many of the hospitals today, because of the increased outpatient loads in these areas, are not adequate. They need to be improved.

We have pushed the development of nursing home units of hospitals to the point where we have in the planning of over 77 units or separate facilities tied into hospitals that are nursing homes—we call them convalescent care units—nursing home units of a hospital. These, in your terminology, essentially will be ECF facilities. They represent about 4,000 beds out of something like 26,000 nursing home beds in the State of Minnesota. We think about a third of the beds probably should be units of hospitals where they take care of the more difficult cases, where they take care of the convalescent care and all of this type of thing. We have been pushing that for a long time and it is the reason we have this many. I think the provisions under your act, S. 2182, permit supervision for these types of things. I want to commend your act for this.

The fact is I want to commend the whole thing, right down the line, all the way through, because it fits into our thinking very adequately. I think you had some excellent advice when you drew this up, sir.

The CHAIRMAN. We have worked on this bill for quite a while. As you know, we consulted with many organiaztions in the health field. Not being in the health field myself, I have conferred with many people and got the benefit of much advice. Not all of it was consistent with other advice. We tried to resolve conflicts as best we could within the scope of our knowledge and information and judgment, realizing that in any particular provision there was nothing sacrosanct about the bill because we introduced it. But we studied this and we did not introduce the bill until May. In fact, since I became chairman of this subcommittee, the staff claims that I have practically put them in the hospital, pushing them on this bill to get it introduced. But it is a very important measure. I see they do not deny it, sitting back there. But there has been much consultation and advice from many officers like yourself. We hope it is a good bill and where there are weaknesses and deficiencies and things that should be improved, we will keep open mind on that. We realize there are differences on the subject.

You have made a very powerful statement here. It is a very knowledgeable statement and I appreciate having it here.

(The prepared statement of Dr. Barr follows:)

PREPARED STATEMENT OF ROBERT N. BARR, M.D., M.P.H., SECRETARY AND EXECUTIVE OFFICER, MINNESOTA STATE BOARD OF HEALTH, REPRESENTING THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

Mr. Chairman and members of the committee, my name is Doctor Robert N. Barr. I am Secretary and Executive Officer of the Minnesota State Board of Health. I am appearing before you today to present the views of the Association of State and Territorial Health Officers on the proposals to improve the public health through extending and expanding the Hospital and Medical Facilities Survey and Construction Act, commonly referred to as the Hill-Burton Program, particularly with regard to the modernization of obsolete hospitals.

I am sure that you recognize the significance of this program to the total public health programs of our respective states. It has always been strongly supported by our Association, and the public recognition of its great value has steadily increased since its inception. Subsequent health legislation, such as P.L. 88–164, the Mental Retardation and Community Mental Health Centers Construction Act of 1963 and P.L. 89–749, the Comprehensive Health Planning and Public Health Services Amendments of 1966—has embodied the basic principles included in the Hospital and Medical Facilities Survey and Construction Act and testifies to the national acceptance and endorsement of its accomplishments and to the recognition of its keystone position in public health.

Of all Federal Grant-in-Aid programs, none has been more carefully geared to needs or planned to enlist initiative and investment by people at the local level than the Hill-Burton Program. Federal funds up to 45% of project costs are granted in Minnesota, but only after responsible State and Federal officials have checked the justification for specific projects in the light of health requirements and have reviewed the architectural plans in accordance with recognized standards.

When Congress decided that the construction of new hospitals, rehabilitation centers and long-term care facilities was worthy of financial assistance, it made the wise decision that the funds should go where they would do the most good. Accordingly, each Hill-Burton Agency is involved continuously in the development of a Statewide, annual plan revision with priorities established for each category of facility. The resultant record of accomplishment speaks for itself.

As this Program has progressed over the past twenty-two (22) years, many changes have developed as to recognized needs. Other than the need for extension of the Program, none is more pressing than the need for funds to provide assistance for the modernization, or replacement of the large acute hospitals in the more urban areas of the various States.

The modernization requirements of hospitals are enormous and it is urgent that a large scale program of modernization and replacement of obsolete hospitals be undertaken quickly. The Hill-Burton Program has accomplished a great deal to improve the Nation's hospitals but this has been primarily new construction and has left largely untouched a serious and rapidly-growing need for modernization of our larger, older hospital facilities.

While the functions of many buildings have remained essentially the same, these of the hospital have changed radically. Advance in medical practice and the development of new services have made possible new patterns of diagnosis and treatment but these have placed such heavy demands on existing hospital plants that many of them require costly alterations and in some instances, complete replacement to keep abreast of progress. Chronic underfinancing has limited the ability of many local hospitals to overcome the growing backlog of modernization needs. The quality of care rendered in hospitals cannot be separated from the condition of the facilities in which that care is rendered.

A significant increase in the number of outpatients is occurring in most hospitals resulting in overloading in the laboratory, x-ray and other diagnostic services. In some areas of the country, hospitals have reported increases of more than 500% in emergency room use in the last twenty (20) years.

Many hospitals do not meet the present standards of fire safety. Stairways may not be located properly or may not permit safe exit to the street. Some hospitals still have transoms above doors to patient rooms or improperly protected vertical shafts that provide pathways for the spread of fire and smoke from one floor to another. Many do not have fire barriers so arranged that, in case of fire on one part of a floor, the patients can be moved to a safe area on the same level.

Some hospitals have not acquired enough property for expansion. Others have had two or three additions, usually shortsighted attempts that have made it essentially impossible to adapt the plant to subsequent needs. This reflects the

shortage of capital funds, curbs efficiency and increases the costs of operation substantially.

A recent report by the Public Health Service [1] states that of a total of 796,140 general hospital beds 292,206 or 37% do not conform to minimum standards for safety and functional design. In Minnesota, the 5,863 nonconforming general hospital beds represent 31% of the total of 18,833 beds. The problem of hospital obsolescence exists through the country. In bed count, New York has the greatest modernization need—26,181 beds, followed closely by Pennsylvania with 24,758 beds.

Survey data regarding long-term care facilities showed a need nationally for modernization or replacement of 208,000 of the 700,000 existing beds (30%). Minnesota has a total of 28,367 existing long-term care beds and 5,177 (18%) are nonconforming.

The following table shows the dollar value of projects which *could be approved* for Hill-Burton funds in Minnesota at 45% of participation. Essentially all of these projects involve modernization or replacement.

	Number of beds	Total estimated cost	Anticipated Federal share at 45 percent
General hospitals	3,013	$142,000,000	$63,900,000
Long-term care facilities	4,167	36,900,000	16,600,000
Diagnostic and treatment centers		7,550,000	3,400,000
Rehabilitation facilities		220,000	100,000
Subtotal	7,180	186,670,000	84,000,000
Additional general hospital beds which need modernization where sponsor has not yet engaged an architect	2,876	86,280,000	38,830,000
Total	10,056	272,950,000	
Grand total, Federal share needed at 45 percent participation			122,830,000

To date, Minnesota has received a total of $71,106,849 in Hill-Burton funds and has allocated funds to 187 projects. Less than one in four facilities constructed in Minnesota receives Hill-Burton assistance. The ratio of the total Hill-Burton allotment to Minnesota as compared with the total estimated cost of construction completed and underway in the State since 1948 ($721 million) is slightly less than 10%.

The metropolitan areas in Minnesota contain approximately one-half of the total population of the State (estimated at 3,640,000 as of July 1, 1968) and the population of these locations (Minneapolis, St. Paul, Duluth and their suburbs) is expected to increase substantially. There are 8,914 general hospital beds in these metropolitan areas as compared with 8,776 general hospital beds in the remaining portion of the State.

Thirty-five (19%) of the total of 187 Hill-Burton projects in Minnesota are located in the metroplitan areas and have received 27% of the total Hill-Burton funds allocated to Minnesota with an average of approximately 21% participation in each project. Of these 35 projects, four have been for new acute hospitals or additions and only three for modernization. The remaining 28 projects involved psychiatric, long-term care, rehabilitation, public health or diagnostic and treatment facilities. In addition, the University of Minnesota located in Minneapolis has received $4,836,375 in Hill-Burton funds of nine projects which provide services on a Statewide basis.

	Total projects	New acute hospitals or additions	Hospital modernization projects	Hill-Burton funds	Percent of total [1] Hill-Burton funds
Minneapolis [2]	15	1	1	$8,536,114	12.0
University of Minnesota	9	3	1	4,836,375	6.8
St. Paul	14	1	2	6,050,822	8.5
Duluth	6	2	0	4,595,806	6.5
Total	44	7	4	24,019,117	33.8

[1] Total Hill-Burton funds allocated to Minnesota equals $71,106,849.
[2] Excludes University of Minnesota projects.

[1] Hill-Burton State Plan Data, a National Summary as of January 1, 1967. Publication No. 930–F–2 (Revised 1968).

The remaining 66.2% ($47,087,732) was allocated to rural areas.

It is recommended that additional Federal financial assistance be provided to help cover the cost of administering the Hospital and Medical Facilities Program at the State level and that such funds be over and above existing State appropriations. The role of the State Hill-Burton agency has become increasingly important in the total picture of health facilities and services. Considerable time is involved in discussing community needs, coordination of services, the importance of avoiding duplication of facilities and the many other Federal programs involved in the construction of care facilities. Increasing requests for assistance and guidance in solving local and statewide problems is evidence of the real service rendered.

Impetus must be given to planning and projection in order to keep abreast of the rapid developments in all areas of care facilities and services. All projects, whether Hill-Burton funds are provided or not, have the same need for assistance in planning and in the review of architectural plans for improving functional design in the interests of efficiency of operation. Similarly, the same assistance should be available to all licensed care facilities in improving the quality of services, avoiding unnecessary duplication and fragmentation or gaps in services and promoting coordination with other services in the community. Financial support is needed on a continuing basis for the careful evaluation of the complex needs for modernization versus replacement as well as for the need for the construction of new facilities in areas of rapid population growth. Adding to the complexity is the importance of these larger hospitals as centers of medical research and professional training. Only a few of these large hospitals should provide the highly complex and specialized services which are developing as a result of modern medical research. With the increasing complexity of our needs and the variety of resources which will be expanded to serve a growing population, continuous planning and projections are essential to assure proper use of all funds expended. There is a need to develop long-range plans which include coordination between contiguous states and which will assure the development and coordination of hospitals and related facilities and services with all other health activities in order to best meet the public need and utilize the health care dollar most efficiently.

Recent legislative proposals for modernization have included Federal grants, guaranteed loans and direct federal loans at low interest. Whatever programs or combination of programs are enacted, they should be adequate to cope with this critical problem of modernization that exists in the hospitals of our health care system. It is well recognized by the State authorities that each state plan must be tailored to meet specific needs. Therefore, it is essential that this legislation retain maximum flexibility. The legislation should also allow for long-range planning which will permit the complex integration of all health and health-related plans, facilities and services in the community.

We are convinced, along with other states and the national agencies concerned with health care, that this major problem of modernization cannot be solved without immediate, massive federal and local effort.

The CHAIRMAN. We will order this table printed in the record.

(The table referred to follows:)

MINNESOTA DEPARTMENT OF HEALTH, DIVISION OF HOSPITAL SERVICES, JUNE 8,1969—FIXED CHARGES PER PATIENT-DAY (HOSPITAL OR NURSING HOME) TO AMORTIZE LOANS AT VARIOUS RATES OF OCCUPANCY AND LENDING PERIODS

Annual amortization cost [1] per thousand dollars borrowed per bed	Amortization cost per patient-day [2] with various rates of occupancy					
	50 percent	60 percent	70 percent	80 percent	90 percent	100 percent
20-year loan at 8 percent [3] equals $100.44	$0.55	$0.46	$0.39	$0.34	$0.31	$0.28
30-year loan at 8 percent equals $88.08	.48	.40	.34	.30	.27	.24
40-year loan at 8 percent equals $83.52	.46	.38	.33	.29	.25	.23
Example:						
A nursing home constructed at $15,000/bed 20-year loan at 8 percent interest:						
(a) 100 percent borrowed	8.25	6.90	5.85	5.10	4.65	4.20
(b) 90 percent borrowed	7.43	6.21	5.27	4.59	4.19	3.78
Example:						
A hospital constructed at $40,000/bed, 40-year loan at 8 percent interest:						
(a) 100 percent borrowed	18.40	15.20	13.20	11.60	10.00	9.20
(b) 90 percent borrowed	16.56	13.68	11.88	10.44	9.00	8.28

[1] Amortization includes principal and interest.
[2] Determined by dividing annual amortization cost by average number of days bed is used per year.
[3] Current FHA rate at 7½ percent plus ½ percent for insurance.

The CHAIRMAN. One thing I have been intrigued by aside from your basic recommendations is the situation in your own State of Minnesota, with no private hospitals or for profit. That is an astounding statistic you have given us, I think. Would you like to comment further on this table?

Dr. BARR. I would like to comment on this table because it has reference to loans. If you will look at the example of the 20-year loan with 8 percent interest. I understand that interest has gone higher than that. If you were in a nursing home that had this kind of a loan you would have to pay $4.19 per day merely to pay off the loan apart from your payment for all of the other operational expenses.

If you were in a hospital with a 40-year loan, you can see on the table, that if the hospital had borrowed 90 percent of the construction cost, that it would cost the patient $10.40 per day just to pay off the interest and principal.

What I am saying is this: We are concerned today about the increased costs of nursing home care and hospitals. I am in favor of a guaranteed loan along with grants. But this does increase the costs.

I am also concerned about the fact that we are hearing so much about cutting back and reducing the amount of funds in Hill-Burton, when actually, we ought to be, as your bill provides, constantly increasing this amount of money.

If you look at other kinds of grants like highways and other facilities, you find that the Federal Government is putting up from 50 to 90 percent of the cost of the building.

I would never advocate 90 percent of the cost of building a hospital or nursing home, but I think if we had a 50-percent underwriting from both the State and Federal Government from all nursing homes and hospitals, we could make a real impact on both the construction and other costs.

One of the reasons there have been so many nursing homes built in Minnesota in the last few years is because something like 15 years ago, there was a proposal made that the State put up 50 percent of the cost of building a nursing home and the lid blew off. They nearly went wild.

It didn't pass, but as a result of it, the voluntary people as well as private enterprise started building nursing homes at the rate of 2,500 or 3,000 beds a year. We have built almost 30,000 nursing home and boarding care home beds in the State of Minnesota since 1950. I think this is enough said. We have 36,000 nursing home and boarding care beds in the State.

The CHAIRMAN. Is that adequate for your needs at this time?

Dr. BARR. I wish I knew the answer to that, Senator. This is considerably in excess of 4.5 beds per thousand, but we are not sure, because the two new programs, medicare and medicaid, have made some real changes. We have to sit back and analyze this to see whether or not it is adequate to meet the demand.

The CHAIRMAN. It had been adequate because people just did not have money to get in them.

Dr. BARR. I think that is true, sir, and also because we have still not completed developing home health services and the rest of the things through the entire State. We really need help in getting this rolling. I think it is moving fast. We have done a lot, but we have a lot still to do.

The CHAIRMAN. You mean you have enough money for this project or—you have more money than you know how to spend or more paperwork than you know how to do?

Dr. BARR. We have enough jobs, sir.

The CHAIRMAN. What about money? Is there enough money being funded through your programs for your needs in Minnesota?

Dr. BARR. We could use more, but personnel is also important. Everybody has the problem of developing more doctors and more nurses. We are planning for expanded medical schools. I would say we have not anywhere near enough money for Hill-Burton. We do not have enough money for some other fields.

The CHAIRMAN. How many medical schools do you have in Minnesota?

Dr. BARR. We have just one.

The CHAIRMAN. How many students does it admit each year?

Dr. BARR. Right at the present time, it is admitting 167. It is proposed to expand to 200 next year, 250 in 3 or 4 years and a second or third medical school is being proposed of somewhere around 60 to 100 each, one in Rochester, in connection with the Mayo Clinic, and one in Duluth or probably St. Paul. There is a great emphasis on training doctors for family services.

The CHAIRMAN. Thank you very much, Dr. Barr.

Dr. Cleere, did you have a prepared statement?

Dr. CLEERE. Senator Yarborough, I wish to speak from notes. I do have just a short written statement.

The CHAIRMAN. We will be happy to have your written statement and in the interest of brevity, we will order it filed. Do you wish to speak from notes now?

Dr. CLEERE. Yes, sir.

The CHAIRMAN. Go right ahead.

Dr. CLEERE. Senator Yarborough, Senator Dominick, members of the committee, I wish to thank you for affording me this opportunity.

Mr. Chairman, I do wish to say that I am proud that I was born, raised, and educated in the Republic of Texas. I took out my first naturalization papers in Colorado in 1930.

The CHAIRMAN. Well, since 1865, we have quit calling it the Republic and we call it the Commonwealth or the Empire now.

Senator DOMINICK. Doctor, we are always glad to have Texas cream come into Colorado.

Dr. CLEERE. Yes, sir.

I have been director of the Colorado Department of Health since 1935 and I have been afforded the opportunity to participate in the administration of the Hill-Burton program in Colorado since its inception in 1946.

Senator DOMINICK. Doctor, let me interrupt you right there with reference to what some of the other panelists said. You have been there since 1935. How many Governors have you served under?

Dr. CLEERE. This is the 10th one, sir.

Senator DOMINICK. And they are all different parties, right?

Dr. CLEERE. Yes, sir.

Senator DOMINICK. And you have had no problems? I mean no more than the usual problems?

Dr. CLEERE. Correct, sir.

Senator DOMINICK. Dr. Cleere, of course, is subject to the Governor's appointment and they have all reappointed him, which I think is an indication of the high respect in which he is held in his field.

Dr. CLEERE. Thank you.

In my opinion, the Hill-Burton program is a greatly needed, most worthwhile, widely utilized, and popular governmental health program. No doubt, this program should be continued, not necessarily in its present form, but with indicated modifications or revisions. It is truly a partnership-for-health program.

I have a brief statement with respect to the situation in Colorado which I think is rather typical of other States, in particular those States with comparable populations and similar economic wealth.

The Federal funds allotted to Colorado for the construction of hospitals, public health centers, long-term care facilities, diagnostic and treatment centers, rehabilitation centers, and for modernization since the inception of the Hill-Burton program amounts to $32,736,000, which has been matched by sponsors' funds of $83,964,000, resulting in total construction expenditures of $116,700,000.

The total projects number 143; total beds in hospitals, 4,606; long-term care beds, 1,116; chronic disease beds, 42; tuberculosis beds, seven. A recent review of activities of the last 5 years shows that 183 additional hospital beds were constructed and 1,090 existing beds were brought up to current standards, either by renovation or replacement.

In long-term care beds, out of a total of 718 authorized in the last 5 years, approximately half were additional and half were replacement.

This review revealed the need for 10,556 hospital beds. To reach this figure, 1,049 new beds must be added and 3,128 beds require modernization by renovation or replacement of existing beds. There is a need in Colorado for 12,298 long-term care beds. To reach this figure, 2,420 new beds must be added and 1,382 new beds require modernization by renovation or replacement of existing beds. An estimate of projects in Colorado which would be eligible for participation indicates approximately $81 million, with the State's matching ratio approximately $35 million, and Federal support will be required. Of $81 million total, approximately $2.5 million will be utilized for public health centers,

$5 million for D. & T. centers, $64.6 million for hospitals, $6.3 million for long-term care, and $2.5 million for rehabilitation centers. We have not had an opportunity at this time to give final consideration to the needs for emergency room facilities in the State. This will be done, however, at an early date.

In conclusion, I wish to say that in my opinion, S. 2182 is an excellent bill and should be supported. If I had any adverse criticism at all to offer with respect to the bill, I think it would be against Federal control over the allotment of funds for emergency rooms. In my opinion, the administration of this new category should be vested in the State Hill-Burton agency and not in HEW.

I feel confident that S. 2182 will meet the needs and objectives for construction of health facilities in the future.

Thank you very much.

The CHAIRMAN. Thank you. We will now have questions addressed to the entire panel or to any one of you three gentlemen.

Senator Dominick, do you have questions?

Senator DOMINICK. Thank you, Mr. Chairman.

Dr. Cleere, do you have any record, or does anybody on the panel have any record, of the percent of public-supported hospitals as opposed to the private, nonprofit hospitals, broken down by States?

Dr. CLEERE. I can give you general information, Senator Dominick, with respect to Colorado. There has been a decreasing number of publicly owned hospitals in the State over a period of 20 years. There are, however, several large publicly owned hospitals now serving some of the more populous areas in the State. Denver General Hospital is an example and the Weld County General Hospital at Greeley. There are comparatively, however, few in number considering the State as a whole.

Senator DOMINICK. This is particularly true in the rural areas, is it not? They are mostly private hospitals in the rural areas.

Dr. CLEERE. That is correct, sir. They are mostly private, nonprofit hospitals.

(The information subsequently supplied for the record follows:)

PUBLIC AND OTHER NON-FEDERAL GENERAL HOSPITALS AND BEDS, BY STATE, FISCAL YEAR 1968

State	Non-Federal general hospitals [1]					
	Total		Public		Other non-Federal [2]	
	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds
United States and territories	6,589	812,574	1,888	190,859	4,701	621,175
United States	6,460	804,623	1,804	185,794	4,656	618,829
Alabama	130	14,225	75	6,924	55	7,301
Alaska	18	562	9	200	9	362
Arizona	72	7,261	8	1,247	64	6,014
Arkansas	112	7,089	50	2,920	62	4,169
California	539	65,804	125	17,617	414	48,187
Colorado	83	9,815	24	1,850	59	7,965
Connecticut	36	10,949	2	206	34	10,743
Delaware	7	1,834			7	1,834
District of Columbia	14	5,524	1	959	13	4,565
Florida	178	25,069	67	9,649	111	15,420
Georgia	180	16,500	112	11,538	68	4,962
Hawaii	23	2,064	5	396	18	1,668
Idaho	47	2,570	27	1,122	20	1,446
Illinois	262	48,969	48	7,350	214	41,618
Indiana	113	18,232	54	6,215	59	12,017
Iowa	146	13,988	65	4,242	81	9,746
Kansas	156	10,593	84	3,790	72	6,803
Kentucky	130	12,547	27	2,486	103	10,061
Louisiana	144	15,134	54	6,862	90	8,272
Maine	61	4,301	3	108	58	4,193
Maryland	45	11,656	5	1,883	40	9,773
Massachusetts	132	25,155	11	2,996	121	22,159
Michigan	245	36,727	56	7,832	189	28,895
Minnesota	182	18,535	77	4,570	105	13,965
Mississippi	124	9,269	86	6,412	38	2,857
Missouri	169	19,934	47	3,980	122	15,954
Montana	64	3,424	3	108	61	3,316
Nebraska	113	6,983	36	1,359	77	5,624
Nevada	20	1,599	13	902	7	697
New Hampshire	30	2,658	3	186	27	2,472
New Jersey	104	23,095	6	2,121	98	20,974
New Mexico	48	3,329	21	1,228	27	2,101
New York	360	73,632	46	14,661	314	58,971
North Carolina	137	18,389	30	4,176	107	14,213
North Dakota	61	3,667	3	69	58	3,598
Ohio	216	40,265	33	4,408	183	35,857
Oklahoma	149	10,390	61	3,391	88	6,999
Oregon	86	7,546	23	1,320	63	6,226
Pennsylvania	262	52,932	11	2,586	251	50,346
Rhode Island	16	3,615	1	161	15	3,454
South Carolina	78	9,111	35	4,276	43	4,835
South Dakota	65	3,348	16	447	49	2,901
Tennessee	174	16,837	58	6,078	116	10,759
Texas	572	45,837	161	13,148	411	32,689
Utah	41	3,878	19	854	22	3,024
Vermont	20	2,262			20	2,262
Virginia	99	15,534	5	1,669	94	13,865
Washington	119	10,499	36	2,368	83	8,131
West Virginia	81	7,991	19	1,955	62	6,036
Wisconsin	169	21,790	20	3,490	149	18,300
Wyoming	28	1,706	23	1,479	5	227
Guam	1	137	1	137		
Puerto Rico	125	7,591	80	4,705	45	2,886
Virgin Islands	3	223	3	223		

[1] Includes facilities under construction.
[2] Includes proprietary and voluntary nonprofit general hospitals.

Source: Hill-Burton State plans, fiscal year 1968.

Senator DOMINICK. There has been a rather well-placed objection, I feel, to the idea of guaranteeing loans to publicly supported hospitals. In other words, the Federal Government guaranteeing the State and local government bonds creates a hierarchy which seems unpalatable to a lot of people, particularly in view of the fact that these bonds are normally tax exempt. This is one of the primary methods of financing

hospital construction and it has been one of the major resources of funds. How do you feel about that?

Dr. CLEERE. I can realize that the question is controversial. However, I do feel that publicly owned hospitals and other health facilities should be included in the overall allocation of funds or eligibility for allocation of funds and I do feel they are entitled to some type of loan guarantee and interest subsidy. I feel confident that the publicly owned hospitals in Colorado will remain in this category as publicly owned institutions for years to come, and I realize that they are as hard pressed for funds for construction as some of the private, nonprofit hospitals.

Senator DOMINICK. I am trying to distinguish between the loan guarantees or the bond guarantees, whatever you may call them, and the interest subsidy, because I tend to agree with you that at an 8-percent rate, which we now have, or 8.5-percent prime rate, all financing becomes pretty difficult. It is not only difficult for all of the construction industry, but it is difficult for almost anybody who is trying to get a loan anywhere at this time.

But on a guarantee of local bond issues which are already tax exempt, I really have problems accepting this. I just wanted to get your viewpoint on it.

How about you, Dr. Barr? Do you have any comments on that? Or Dr. Peavy?

Dr. BARR. In my particular State, I happen to have a figure here, I have 105 nonprofit hospitals, with 13,442 beds, and 79 publicly owned hospitals, with 4,501 beds. Out of that 79, there are really only four of those in the large metropolitan areas. There is the Minnesota General Hospital, St. Paul Ramsey—Minneapolis General is really in Hennepin County now and we are planning to build a new hospital in Minneapolis. Cities are in real dire straits as far as resources go, as you know. We have a bond coming up in 2 months to build a 500-bed hospital. There are a few things that public hospitals do that the others do not do. It provides emergency medical services for the fellow who gets knocked down on the street. It provides the care for the drunks and the rest of the people who are rather unacceptable in your private nonprofit hospitals. It provides for the training of interns and fellows. It is one of the big resources of doctors practicing in the State of Minnesota, who come from the university and other universities as well.

Senator DOMINICK. My understanding from your testimony, though, is that only about 10 percent Federal funding has been used in the construction of your overall hospital facilities in the State?

Dr. BARR. Yes.

Senator DOMINICK. Would you give me some reaction to your feeling about the Federal Government guaranteeing obligations of the local areas, as to whether this is a good philosophical approach, particularly when those bonds are tax exempt?

Dr. BARR. Basically, I think they are operated identically the same as a nonprofit hospital. From an economic standpoint, I am not smart enough to tell you all these things about bond issues that are tax exempt, all these things that go into it. But they do need help. They need it seriously. And I know that we are going to put grant money into the Minneapolis General Hospital.

Senator DOMINICK. But grant money or a Federal interest subsidy would pretty well take care of the problem as opposed to a guarantee of the bond issues, right?

Dr. BARR. I suspect it would. I wish I knew the real answer to that, sir.

Senator DOMINICK. How do you feel about that, Dr. Peavy?

Dr. PEAVY. I do not have a breakdown on public facilities by State. On a nationwide basis, however, 25 percent of the hospital beds in the country are publicly owned. Many of our public facilities do need help. We think that it would be a good thing, to offer construction assistance. As you know, many of the publicly owned facilities in cities and counties are having difficulty making ends meet. We think this affords them an opportunity to go ahead and build and that this would give better hospital facilities available to all the people.

The CHAIRMAN. I bring that up for a variety of reasons. Just for the record, let me say this: There has been a move to cut out the ability of local municipalities and States to issue tax-free incentive build and lease back provisions for industries. We have stopped that, but there is a strong incentive in Congress to prevent this on the ground that it makes for pirating from one or the other. There has been a good deal of discussion as to whether or not tax-exempt local obligations should be made subject to taxation as opposed to being free from taxation as they now are. It has always struck me at least that the tax-exempt features of the local obligations that are issued for schools and hospitals and other things of a public nature are the one thing that really bring in the money for the purpose of accomplishing the job. So I have been strongly opposed to the concept of reducing that tax exemption. I am afraid, however, that if we pile on top of that a guarantee of the loans as well and that we only have the Federal Government guaranteeing a local situation, you really have a problem in the jurisdiction which could be detrimental to the bill on the floor. I just want to get your reaction to that particular point. Do you think there is any logic to that?

Dr. CLEERE. Senator, I can't speak more authoritatively on this question. I certainly appreciate the point you have made.

If you wish, Senator Dominick, we will be pleased to submit a written statement to you with respect to the Colorado situation as to publicly owned facilities in the State as opposed to privately owned or privately administered nonprofit organizations, and the problem that these publicly owned institutions are facing at the present time with respect to financing either replacement, modernization, or new buildings.

The CHAIRMAN. I think this would be very helpful. If you would, I would appreciate it very much.

(The information subsequently supplied for the record follows:)

STATE OF COLORADO,
DEPARTMENT OF PUBLIC HEALTH,
Denver, Colo., June 23, 1969.

Hon. PETER H. DOMINICK,
U.S. Senator, Senate Office Building,
Washington, D.C.

DEAR SENATOR DOMINICK: In response to questions during the recent hearing on Hill-Burton legislation, for data with respect to public hospitals in Colorado. I am providing you the following information:

There are thirty (30) public hospitals with a total of 4,800 beds. Four (4) of these hospitals are state sponsored and have a total of 3,155 beds. (List of hospitals attached).

The remaining twenty-six (26) hospitals are city, county or hospital district sponsored hospitals.

There are fifty-six (56) non-profit hospitals with a total of 7,929 beds.

Percentages of beds are as follows: 36.9% of all beds are public; 60.8% are non-profit, and 2.3% are proprietary.

I recommend that public hospitals be continued in the program as eligible recipients of grants and included in new legislation for direct loans at low interest rates. Prior approval by the state agency should be mandatory and such approval be obtained by the Surgeon General prior to his approval of such a direct loan. I think the Emergency Room allocations should be the responsibility of the State agency.

If a proposed new formula using need is adotped the Colorado allotment would be reduced by approximately $112,000. From our viewpoint in Colorado the squaring factor should be retained.

I am enclosing a copy of a memorandum which I am sure will be of interest to you.

Many thanks for the courtesies you and members of your staff extended to me during my participation in the hearing conducted by your Subcommittee on Health.

Sincerely,

ROY L. CLEERE, M.D., M.P.H.,
Executive Director.

Enclosure.

LIST OF PUBLIC HOSPITALS

Counties in which the only hospital in the county is a public hospital:

City and county:	*Number of beds*
Akron, Washington	26
Aspen, Pitkin	30
Burlington, Kit Carson	44
Craig, Moffat	34
Cripple Creek, Teller	15
Eads, Kiowa	18
Fairplay, Park	8
Gunnison, Gunnison	20
Hugo, Lincoln	14
Julesburg, Sedgwick	26
La Jara, Conejos	32
Las Animas, Bent	15
Montrose, Montrose	56
Steamboat Springs, Routt	20
Sterling, Logan	136
Walsenburg, Huerfano	38

The balance of the public hospitals are in the following counties which also have other hospital facilities:

City and county:	*Number of beds*
Denver, Denver	311
Fort Collins, Larimer	128
Loveland, Larimer	49
Greeley, Weld	350
Holyoke, Phillips	24
Meeker, Rio Blanco	20
Rangeley, Rio Blanco	28
Yuma, Yuma	20
Colorado Springs, El Paso	158
Walsh, Baca	25
Denver, Denver, Fort Logan Mental Health Center (State institution)	301
Denver, Denver, Colorado General Hospital (State institution)	529
Pueblo, Pueblo, Colorado Mental Hospital (State institution)	2,250
Canon City, Fremont (State penitentiary)	75

THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS,
June 16, 1969.

MEMORANDUM

To: State Hill-Burton Directors.
From: J. E. Peavy, M.D., President, ASTHO.
Subject: Senate Hill-Burton hearings.

On Thursday, June 12, 1969, the ASTHO presented testimony to the Committee on Labor and Public Welfare regarding the extension of the Hill-Burton Act. Our witnesses were Dr. Barr, Dr. Cleere and myself. During the course of the hearings, we were asked to supply information through a survey of our membership. I would greatly appreciate your completing this questionnaire for your State and sending it to our Washington Office *by return mail.*

1. No. of public hospitals, 30*.
No. of beds in public hospitals, 4,800*.
No. of private nonprofit hospitals, 56.
No. of beds in private nonprofit hospitals, 7,929.

2. How many hospitals or other health facilities will be ready to start either new construction or modernization in 1970 under your Hill-Burton plan?
No. 4.
Beds, 200.
Assuming availability of unlimited Hill-Burton funds—
No. 9.
Beds, 568.

3. Do you believe that we could meet new construction and modernization needs of hospitals and health facilities if the existing grant program were replaced by a new program of Federally guaranteed loans with an interest subsidy?
Yes —.
No —.
Need both X.

4. Senator Javits asked about the relative needs for health facilities with respect to inpatient care and outpatient care. Please check the appropriate spaces:

	Inpatient facilities (percent)	Outpatient facilities (percent)
No change (correct balance)		
Should be increased by:		
10 percent	13	
20 percent		
30 percent		
40 percent		40
50 percent		

Other comments:

ROY L. CLEERE.

*Of the 30 public hospitals, 4 hospitals are state sponsored institutions as follows:
1. Colorado State Hospital, Mental Hospital, 2250 beds, Pueblo, Colorado.
2. Fort Logan Mental Health Center, 301 beds, Denver, Colorado.
3. University of Colorado Medical Center, Denver, Colorado, Colorado General Hospital, 450 beds, Psychiatric Hospital, 79 beds.
4. Colorado State Penitentiary Hospital, general hospital, 75 beds, Canon City, Colorado.
The remaining 24 hospitals are city, county or hospital district—sponsored hospitals.

The CHAIRMAN. Dr. Barr, if you have any ideas on this, or Dr. Peavy, either one of you, this would be helpful if you would just send them on in.

Dr. BARR. We would be pleased to.

Senator DOMINICK. There is a change in the formula which has been suggested by two of the four bills which we are considering. Two bills retain the squaring formula and two do not. It changes the allocation

of funds. The two bills which do not have squaring provide for a change in the formula. They seem to be based more on need than the bills which require squaring. What's your feeling on this?

Dr. PEAVY. Senator, we have discussed this, of course, with our association and as I mentioned earlier, we represent all the States. We have discussed this at quite some length. Some of the States with a lower economic index do benefit from this squaring factor. Other States, and this is particularly the States that have a higher-than-average economic index are certainly at some disadvantage with this squaring factor. So as an association, we have not taken a stand on changing the formula. We left it alone. We do feel that any change that is made in the allocation of funds to the respective States should in all fairness take into account the economic index of individual States.

Now, whether this particular formula or some other formula would be more fair and equitable to all the States, we feel that this is something that our association can't take a definite stand on.

Senator DOMINICK. I have a couple of questions here which might be a little sensitive. How many hospitals, in Colorado, Dr. Cleere, are ready to start construction in fiscal 1970 with Hill-Burton funds? Are there any?

Dr. CLEERE. There are either five or six communities or counties that do wish to begin construction during the next fiscal year. Whether they can complete all the arrangements and plans, I couldn't state definitely at this time.

You are familiar, of course, with the situation at Trinidad.

Senator DOMINICK. Yes.

Dr. CLEERE. They are trying to raise money to match Hill-Burton since they have been approved for a Hill-Burton grant. I attended a meeting last Thursday evening in which they had plans developed for construction of a new hospital that would be a replacement of the old building now located at Kremmling. Those are two that I can think of offhand.

But Yuma is another example of plans, that have plans definitely for construction during this next fiscal year. I am sure I could add two or three more to that particular list of hospitals.

Senator DOMINICK. Do we have any figures on a nationwide basis as to how many hospitals are ready to start construction, talking about construction in fiscal 1970?

Dr. PEAVY. Yes, sir; I am sure we can provide that for you, Senator. Our State always has three times as many applications for Hill-Burton funds as we are able to fund. We do not have quite as many applications this year as we had in the past, for several reasons, apparently. One might be the loan factor. At this time, we have applications for something like $29 million. Last year we had applications for well over $40 million, but we only had $8 million available for general construction.

(The information subsequently supplied for the record follows:)

HOSPITALS READY TO START CONSTRUCTION, FISCAL YEAR 1970

A survey of State health authorities revealed that 455 projects, including 30,678 inpatient beds, would be ready to start new construction or modernization in 1970 under the Hill-Burton Act. If there were no restriction on Federal funds the number of projects would be increased fourfold.

Senator DOMINICK. Without trying to be difficult, I would say no matter what we pass by way of authorization, you are not going to get the amount of money you are asking for under this budget. We just can't do it. We just do not have the Federal funds available for it. We are all going to get cut somewhere along the line.

Let me ask you this question which I have been concerned about, and I suspect that the chairman, although his bill does not include it, may also be concerned about it.

Previously, we have had provisions requiring priorities for the rural areas, for both modernization and construction. Every one of the bills here have cut that out, leaving it up to the States themselves to determine where the money should be put. Now, occasionally, you can get a situation, as you know, in which not only research grants but also funding goes into the metropolitan areas. The rural areas, in which I am very interested, as I know the chairman is, find themselves out in the blue somewhere with no opportunity of exercising enough influence in order to be able to get the funds put into their area. I feel we must keep these areas alive and going. How do you feel about this?

Dr. CLEERE. I certainly feel there should be nothing in any new Federal legislation that would prevent the State from establishing priorities for construction of needed facilities in rural areas.

Again, I do not want to dwell too much on the Colorado situation, but we are certainly working with three communities—Creede, Westcliffe, Triple Creek, to try to help them develop what's needed with respect to a diagnostic and treatment center or a community clinic. Those are communities and counties that are hard pressed financially. I think, however, that there would be sufficient flexibility in the priorities that have been included in the present, pending legislation so the States could establish needed priorities for rural areas.

I feel, I am sure, as strongly as you do that there should not be overemphasis on urban and metropolitan area needs as related to rural needs.

Senator DOMINICK. All the hospitals that you have mentioned up to date have been the rural areas. This is somewhat encouraging to me. I know we do need more support for Denver General and support for Colorado Medical Center and of course, the Pueblo State Hospital. But it strikes me that as we try to decentralize some of these urban areas that the question of whether the local areas are going to get adequate treatment in the various States is going to depend upon the board that decides where the funds are going to go. The question again is who is going to appoint those boards and how are they going to be made up and how are the funds going to be divided eventually as a result of this.

Dr. CLEERE. May I just use another example? In the early days of the Hill-Burton program, practically all of the money was channeled to rural areas. There was obvious need on a priority basis for the rural areas. Denver was in a low priority. With its continuing increase in population, it did reach a high priority several years ago and it was obvious that we could not fully match the applications for funds for

construction of new hospitals in addition to existing hospitals in the Denver area. We had applications on file that totaled approximately $70 million for construction of facilities in the Denver metropolitan area.

In order to be fair and equitable to the applicants that were all in the same priority, it was necessary to scale those applications down to approximately 15 percent matching Hill-Burton funds. In the rural areas, it has been possible for the Department to fully fund the maximum amount to which the applicant was entitled, 45 percent. Practically every rural hospital in the State has received the full 45 percent funding, except in the early days, when it was limited to one-third national participation.

So I feel it would be possible to continue this full matching for the needed facilities in the rural areas, but I doubt seriously whether it will be possible to fully fund, that is up to the maximum amount to which the applicant is entitled under the Hill-Burton law, in the urban areas.

Senator DOMINICK. Are you a satisfied, then, that the need for placing in the legislation a provision for priorities for rural areas is outdated and that we can take care of it now by the boards that are set up for the allocation of funds in the respective States?

Dr. CLEERE. I certainly feel this would be done in Colorado. It could be done under the provisions of these priorities as established. I certanly would not wish to see anything in any legislation that would prohibit priorities from being established for rural area needs.

Dr. PEAVY. I might just comment that I feel exactly the same way as Dr. Cleere. Our demand for rural and urban areas is about 50–50. As you know, we do have advisory boards that screen all these projects. I think we have adequate representation from the rural areas and I feel quite confident that in our own State, they will be given as much consideration as the urban areas.

I personally think and I believe our association is on the record as feeling that this does help the State to determine what their own priorities should be. Some States, no doubt, should put more emphasis on the construction of rural hospitals. In other States with large metropolitan areas, I think the demand is probably greater than in urban areas. So we would much prefer that this flexibility remain in the bill, if at all possible, Senator.

Senator DOMINICK. I wonder if one of the three of you would comment on your reaction to the administration proposal of a block grant concept? This would permit the distribution of Federal funds within the States under the individual State's own ideas of what they need for their own health facilities to take care of their own particular problems. How do you feel about that?

Dr. PEAVY. Are you referring to Senate bill 1733?

Senator DOMINICK. Yes.

Dr. BARR. Mr. Chairman, I can say for Minnesota, we should allow the Hill-Burton agency to make the determination of where the greatest needs are. Up to the present time, 33 percent of our Hill-Burton money has gone into metropolitan areas. However, the metropolitan areas represent 50 percent of the population of the State of Minnesota and the greatest need right now is in the metropolitan areas.

As Dr. Cleere pointed out, we funded those rural areas at 45 percent. We funded the metropolitan hospitals where we did help at only a portion of full entitlement, something like 12 or 15 percent.

Senator DOMINICK. Dr. Barr, then, you would have no objection to this block grant idea where the States could determine their own priority?

Dr. BARR. I would not, sir. I would approve it.

Senator DOMINICK. Is that true of you, Dr. Peavy?

Dr. PEAVY. No, sir, I really prefer Senate bill 2182. I think most people in our association would prefer the present type of allocation of funds to the bloc grant approach of S. 1733. This program has worked extremely well.

Senator DOMINICK. What's your concern about the bloc grant concept?

Dr. PEAVY. As I understand S. 1733, 80 percent of the funds would be awarded among the States and 20 percent would be awarded by HEW. We do not feel that this particular method of allocation would be as effective as the present Hill-Burton program, which has been extremely well conducted and received throughout the United States. We feel the present method of allocating the funds for construction of hospitals is preferable to the S. 1733 approach.

Senator DOMINICK. The purpose, as I understand it, of the 20-percent reservation for HEW direct grants is in order to take care of cases where States decide they are not going to move for particular reasons, whatever it may be, racial or otherwise. That is the purpose of that reservation. It does not mean that the money is not going to be used, but it does mean they have some money to be used in the event there is such a cross-hatch of ideas within the State that you can't get something effective going.

Dr. CLEERE. Personally, I would not like to see the present grant program for hospital construction discontinued or suspended. I feel confident that the greater demand for Federal funds for construction of health facilities for a number of years in the future will be directly related to hospital needs. I think there will be an increasing emphasis on the need for facilities that will provide out-of-hospital care, such as long term care facilities and diagnostic treatment centers. But I think this trend will be rather slow to come to fruition.

Now, I am not attempting to place blame for this present increasing demand for hospital beds other than to say that practically all of the insurance plans at the present time, including, I would say, certain sections of medicare, are related to increasing demands for hospital utilization. Most of the insurance plans—private, Blue Cross, governmental—are not oriented to preventive and diagnostic services. So I think some of these programs should be reviewed carefully with respect to the total needs for construction of health facilities, thinking of services as related to facilities. So I feel that the greater demand for a number of years to come will be related to hospital construction. Therefore, I feel that the grant system to assist in construction of hospitals is still greatly needed.

With respect to bloc grants, if I cuold speak frankly, based on my own experience, in principle, it sounds good. But sometimes, it is difficult to uphold principles without money. At times, I can see the bloc grant system proposed for economy purposes—not that I am opposed

to economy, knowing some of your problems related to tight financial situations at the Federal level. But to use an example, the bloc grant under the partnership for health legislation is theoretically sound, but at the same time it is not practical when appropriations are not adequate.

I do not know if I have answered your question, Senator Dominick, but I think this is something that should be seriously and carefully considered. I do not think, however, it is timely at the present time to discontinue our grant-in-aid system for construction of hospitals.

Senator DOMINICK. Your concern, then, is not with the principle of this type of authorization, but on the effect it might have an overall appropriation?

Dr. CLEERE. That is my primary concern.

Again, with reference to section (d) of Public Law 749, as you know, there is a requirement that 70 percent be spent for community health services. Well, if the (d) money had been adequate, as was the original intention of the proponents of Public Law 749, we could have channeled an increasing amount of money to the communities in greatest financial need, particularly in some of the rural areas. Without an increase in the (d) money, it is not possible to meet the demands and needs for health services in the rural areas.

Senator DOMINICK. This is true in health and education and true in almost everything else. The answer is we just do not have enough funds here without increasing the inflationary cycle.

Dr. BARR. Senator Dominick, I was talking about the flexibility of S. 2182 as compared to S. 1733. I am not in favor of turning 20 percent of the dollars over to the Federal Government and let them come in and make a decision for Minnesota. I have said that for 22 years.

Senator DOMINICK. I would agree with that. I think the holdback is in order to avoid the situation with regard to potential problems in the Civil Rights field, or where a State just decides it is not going to do anything, for one reason or another, or doesn't want it.

Dr. BARR. We do not have that problem in our State, as you know.

Senator DOMINICK. We do not have that problem in our State, as you know.

Senator DOMINICK. I agree with you. I understand that. We do not have it in ours, either, but you may have it in some of the others around the country.

Dr. BARR. Yes.

Senator DOMINICK. But even if that was cut to 5 or 10 percent what you are saying in general is that any holdback in the hands of the HEW tends to centralize the authority there and, therefore, creates a problem in the ability of the States to move forward on their own. Is that right?

Dr. BARR. My reaction is that there are enough pressures put on the States from all levels, both at the local level and the Federal level, so that it is not necessary holdback funds.

Senator DOMINICK. Suppose we did not have a 20-percent holdback, did not have any, just put in a bloc grant, let the State do what it wants to.

Dr. BARR. If you put the same amount of money in as you are putting in on S. 2182, I am not going to object to it, except for one basic thing. That is this: As soon as you do this, you know what happens.

You start getting the bloc grant squeezed down. We had a good instance of that in Public Law 749, where the bloc grant was set up. Then the proposals to finance that bloc were cut way back by Congress.

The people in Congress have interests in certain types of activities. When you throw them all together into a bloc grant you have the hazard of a reduced appropriation. Actually, we need a great deal more money in the whole hospital facilities field rather than a reduction.

Senator DOMINICK. All right. That is clear.

Now, what about the loan guarantee program which, under S. 1733, commences in fiscal year 1970? Would this not be a help all the way through in your construction of facilities? The other one, S. 2182, does not provide for that, as I understand it, until 1971.

Dr. PEAVY. I was under the impression that it did provide for loan guarantees in both S. 2182 and——

Senator DOMINICK. Both provide for loan guarantees, but it does not start until 1971.

Dr. PEAVY. That is true.

Senator DOMINICK. Under S. 1733, it starts in 1970. Would this not be helpful?

Dr. CLEERE. From the viewpoint of your question, Senator, I would say the sooner the better. But this particular provision, of course, could be added to S. 2182, if the committee so chooses.

Senator DOMINICK. Thank you, Mr. Chairman. That is all I have at the moment.

The CHAIRMAN. Thank you.

Senator Javits?

Senator JAVITS. Thank you very much, Mr. Chairman.

Gentlemen, I was not here when you made your basic testimony, but I have been briefed on it. Together with my colleague, Senator Dominick, our ranking member on this subcommittee, as well as Senators Murphy and Prouty, members of the committee. I have offered S. 269, which is our idea as to the way the guaranteed loan program under Hill-Burton ought to go. I would welcome your examination of that bill and your letting me have your comments on it.

I ask unanimous consent that the comments be made part of the testimony of the witnesses expressly directed to S. 269.

Is that agreeable to you, gentlemen?

Dr. BARR. Yes, sir.

The CHAIRMAN. They will be made part of the record.

(The comments referred to follow:)

COMMENTS ON S. 269 BY THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

The Association of State and Territorial Health Officers fully supports the objective of S. 269 that would provide Federal financial assistance through guaranteed loans and an interest subsidy for the modernization of public and other nonprofit hospitals and health care facilities. Two suggestions are offered. First, the assistance should be extended to new construction as well as modernization. Second, the substitution of direct Federal loans for guaranteed loans in the case of publicly-owned hospitals should be considered. The complete statement of the Association is included in the preceeding pages.

Senator JAVITS. Gentlemen, I have a few questions to ask you.

One, you have already testified that you believe that a grant program, as well as a guarantee program, is essential. It that correct?

Dr. PEAVY. Yes, sir; that is correct.

Senator JAVITS. Do you consider the guarantee program feasible along the general lines that you referred to—that is, a 90-percent guarantee of the principal, and an interest underwriting above some percent? We do not wish to tie you down to the percentage. In our bill we use a figure of 3 percent, the administration has no interest underwriting, and the House-passed bill also uses a figure of 3 percent. However, it is not necessary to deal with a specific figure, it is just the general idea upon which I would like to get your views: Is a guarantee provision plus an interest underwriting feasible and will it produce resources outside of the grant program for hospital construction and hospital modernization?

Dr. PEAVY. We feel that it will, Senator Javits. It will certainly help in some areas. We feel that the addition of this particular feature does actually add quite a lot and we think this is a desirable feature of, really, both bills.

Senator JAVITS. Now, this is an innovation.

Dr. PEAVY. Yes, sir; I understand that.

Senator JAVITS. Last year we tried with it and it was terribly gratifying to me that the committee supported me in this. We tried in conference under the most loyal, ardent support of my Democratic colleagues as well as my Republican colleagues. The House could not see it, because it had not had hearings. Now the House itself has done it. So you are on the threshold of really innovative programs, because frankly, you will never get the amount of grants that you will in the amount of guarantees. You are going to run up to the multi-billion-dollar figure in guarantees no matter whose views prevail. Thus, this is a tremendous new opportunity.

The real question involved is, Can securities of hospitals be marketed or loans be made? Is that feasible with these kinds of terms—that is, a 90-percent Federal guarantee, plus an interest subsidy?

This is too serious to ask for your views off the top of your heads. I would prefer, unless you now wish to advance a view, that you look into the subject very carefully in all sections of the country. We are anxious to learn, too. We want to know what this is going to amount to practically and for you then to give us your report.

Dr. PEAVY. We appreciate the opportunity.

Senator JAVITS. We want to know if this will really work and under what conditions.

Dr. PEAVY. We are in complete accord. We appreciate the opportunity of studying it and clearing with some of the other members.

(The information subsequently supplied for the record follows:)

GRANT PROGRAM VS. FEDERALLY GUARANTEED LOANS WITH AN INTEREST SUBSIDY

The overwhelming majority of state health officers report that States would not meet new construction and modernization needs of hospitals and health facilities if the existing grant program were replaced by a new program of Federally guaranteed loans with an interest subsidy. (Only two replied affirmatively.) The Association recommends that grants, guaranteed loans, and direct Federal loans be authorized for the construction and modernization of hospitals and other health care facilities.

Senator JAVITS. We think it is a very gifted method of financing and avoids major budgetary impact, which is our whole idea. But it does require the cooperation of the private sector, either for loans or for the purchase of bonds or other indebtedness. This is what we want to get all the expertise we can on.

I speak of "we." I am sure my colleagues on the bill feel just as I do. We are not interested in just doing something that looks good on paper but does not have tangible practical relevance.

Dr. CLEERE. Dr. Peavy is president of our association, Senator Javits, and has stated that all of us will cooperate generally in getting this needed information to you.

If I could make just one or two remarks again pertinent to Colorado. I am thinking of Trinidad. The community, county seat, community of a county 15 to 20 years ago had a population of 33,000 to 35,000. The population has decreased to approximately 17,000. The primary source of income and economic wealth was coal mining. They need a new hospital. The hospital there is approximately 80 years old. They have been trying to raise money for over a year. They were in high priority because all the beds in that particular institution, a 75-bed hospital, were nonconforming according to Hill-Burton standards, which placed that hospital in a high-priority area.

We approved the 45-percent grant to the applicant, a nonprofit association. They have been trying desperately to raise 55 percent. If they go on the open market and have to pay the present high interest, the rates they will need to charge will almost be prohibitive in that particular area of the State.

Senator JAVITS. Now, are you saying, and I want to get this very clear, that if we do give you a guarantee program, and it certainly looks like we will—the administration is at least for that—that we had better give the flexibility to combine grants with the guarantee program?

Dr. CLEERE. Yes, sir.

Dr. BARR. That is right.

Dr. CLEERE. Definitely so.

Senator YARBOROUGH. Again, as Senator Dominick said about the block grant idea, this would be a block authority to deal with the different financing media that may be adaptable to a local situation.

Dr. CLEERE. Correct, sir.

Senator JAVITS. I think that is very helpful.

The other question I have to ask you is this: We have a distinct impression that there ought to be an emphasis on modernization in respect to hospitals. There is a great deal that can be done in modernization in view of the exigency of time and of cost; we ought to have that in mind. One of the provisions of Hill-Burton that is interesting is if the State gets money for construction, it can use it for modernization, but if it gets money for modernization, it cannot use it for construction. What is your feeling on that?

Dr. PEAVY. Senator, this is going to vary quite a lot for different areas of the country. In some areas, I am sure modernization is needed more than new construction. In other areas, it is just the opposite picture. In my own State, it is about 50–50 between modernization and new construction.

We can switch funds between modernization and new construction. So we now do have that flexibility, switching funds between modernization and new construction.

As I emphasize, though, this varies quite a lot in different areas. I think in some of the more urban areas, modernization may be needed more than new construction; in other areas, quite the opposite. So I think if the State has the flexibility to determine which one to give priorities to, either new construction or modernization, it would be extremely helpful.

Dr. CLEERE. Personally, I think there should be flexibility from the viewpoint of transfer from one to the other, based on the particular needs of the State.

Senator JAVITS. Good.

Now, do you think you would be able to help us by utilizing your extensive network of information, which is always so valuable to the Congress, to find out and give us some overall national view of the demands of modernization, as contrasted with the demands of new construction?

Dr. PEAVY. Yes, sir; we would be glad to do this.

Senator JAVITS. Don't you think that would be quite helpful?

Dr. PEAVY. We can do this quite rapidly, Senator.

(The information subsequently supplied follows:)

DEMANDS OF NEW CONSTRUCTION VERSUS DEMANDS OF MODERNIZATION

[In millions of dollars]

Category	New	Modernization
Total	6,055	10,540
General hospitals	2,975	7,220
Long-term care	1,645	2,145
Tuberculosis	160	30
Public health centers	400	315
Outpatient clinics	525	695
Rehabilitation facilities	350	135

Senator JAVITS. Good. We hear a lot here about keeping the patient ambulatory, especially older people, who are some of the main patients, and therefore there is some question about the mix of authorizations—that is, as between ambulatory facilities, like health centers, and bed facilities, like traditional hospitals. Any advice that you can give us, again bearing in mind that you have a very extensive network of information, would be very helpful to us as to what would be the proper mix.

It might be that we would be able to go for block grants, as Senator Dominick says, in which case, each State can handle its own mix. And perhaps that would be your recommendation. But I do think we ought to have your help and expertise on the question of the mix of the modernization concept.

For example, the administration feels strongly that we should lean heavily on keeping the patient ambulatory, and to encourage that approach give an edge, perhaps even a priority, to that type of facility which gives an incentive to the patient to stay ambulatory, rather than an incentive to a patient to get into a bed in a hospital.

Dr. CLEERE. Yes, sir.

(The information subsequently supplied follows:)

INPATIENT VERSUS OUTPATIENT FACILITIES

A survey of State health authorities reveals that the majority believe the need for additional outpatient facilities is relatively greater than the need for additional inpatient facilities. The actual demand for outpatient facilities, however, can be more adequately measured by the reports of Hill-Burton agencies on the composition of the backlog of new construction and modernization for medical care facilities.

Dr. CLEERE. As I mentioned previously, Senator Javits, I feel strongly that our first approach should be toward seeking more extensive coverage under insurance plans for preventive and diagnostic services. For the most part, these services are not provided for.

Let me just cite one example. I do not want to take too much of your time. For instance, under one provision of medicare, if a physician is to send a patient to an extended care facility, he must first send that patient to a hospital for 3 days. I have discussed this with some of my physician friends in Colorado and at times, if it were not for this requirement in the Federal act, they would not send their patients to a hospital for a minimum period of 3 days.

I'm just using this as one example.

So I think we should become more oriented to preventive and diagnostic services in the present insurance plans. I think right at the present time, we might be putting the cart before the horse in trying to more or less bring this about by a shift in emphasis on facility construction.

I agree that we need to devote more time and attention to defining what we mean at times by a health center in a community. We talk about mental health centers, mental retardation centers, rehabilitation centers, public health centers—well, we are working toward bringing those units together in one comprehensive structure, one comprehensive physical facility, where they would truly be community health centers, and not have different centers scattered in different locations in some of the larger urban areas, in particular.

Senator JAVITS. Very good.

Do you think that we ought to do something in the program to encourage innovation? Sometimes, for example, in education programs, we reserve a modest percentage of what we make available to finance innovative projects, such as what we're now talking about, the idea of finding new ways to deal with what is becoming almost a prohibitively expensive operation when confined with the hospital.

Dr. CLEERE. I agree with that.

Dr. PEAVY. I do, too, Senator. Very early in my testimony, I pointed out that in S. 2182, there are provisions for research and development funds. We think this is really important to determine what particular type of health care services should be more beneficial to the entire population. For this reason we are very strong for this type of activity.

Senator JAVITS. The administration calls for the same general approach.

Dr. PEAVY. Yes, sir; I recognize that.

Senator JAVITS. Do you see any distinction between public and private hospitals? When I use the word "private" I do not mean private for profit. That is a kind of very specialized thing. I mean private nonprofit and public hospitals. Do you see any reason for any distinction in eligibility between these hospitals?

Now, the administration bill, which is primarily a loan guarantee bill—I am not going along with only loan guarantees. We are going to have some construction grant money. But I do think the loan guarantee idea is great, a real new breakthrough—especially if we get the factual backing from the country, as I hope we will learn from you and other witnesses.

However, the administration does not make its loan guarantee program available to public hospitals. The same is not true of the House passed bill or Senator Yarborough's bill which do make it available to public hospitals. My bill, S. 269, also makes guaranteed loans available to public hospitals. I just wondered what your view is on that subject.

I might tell you that the administration's argument against inclusion of public hospitals in the guaranteed loan program is that the public hospitals have different finance bases and different opportunities for financing and, therefore, that they should not figure in the new technique of guarantees, because they have governmental credit of their own, as it were, on the municipal level.

What do you think about that?

Dr. PEAVY. We discussed this at quite some length, I believe, Senator Javits, before you came in. This is all, I believe, in the testimony.

Senator JAVITS. Yes; Senator Dominick tells me this.

Dr. CLEERE. I might just comment. I think many of the city and county hospitals that are in Colorado, and there are quite a few in Colorado, although most of them serve quite sizable population groups, will become community hospitals. I think there is a definite trend in that direction, from the viewpoint of eligibility, admissions, and so forth. I think that is something we should keep in mind.

I'll cite just one other example. There is a study being conducted in Colorado at the present time for converting the mental hospital located at Pueblo in southern Colorado into a community hospital. The Governor appointed a special commission for the purpose of conducting a special study to determine the feasibility of such a plan.

Senator JAVITS. Do I gather—because I asked Senator Dominick, and I do not want to belabor a question you have already dealt with—that you are or are not for the inclusion of public as well as private nonprofits in this whole program?

Dr. PEAVY. We are in favor of it.

Senator JAVITS. For public?

Dr. PEAVY. Yes, sir.

Senator JAVITS. Finally, I am told that you are for retaining the squaring factor in the construction grant formula. As you know, this works very adversely against major industrial States. It has always seemed to me that the squaring factor is an arbitrary way of assisting States which do not have the per capita competency of other States.

I know our chairman is also very interested in this. What is the logic of the squaring? As I say, it has always struck me as being strictly an arbitrary way of getting some more money for nonindustrial States and so-called poor States.

Dr. PEAVY. Senator, as you know, we represent all of the States. We have already indicated that some of the States, particularly the Southern States, do benefit from the squaring factor. Some of the other large States that have an economic index above the average have their funds

decreased by the squaring factor. So as an association, we have not taken a stand on the squaring factor.

We have taken a stand to indicate that there should be an economic factor taken into consideration in the allocation of funds. Whatever formula is used, we do feel that some weight should be given to the fact that one State is not able to put up as many funds as another State.

In other words, we take a neutral standpoint on this, except to emphasize that we do think the economic index is a valid method of allocating the funds, and some formula should be devised that takes this into account.

Senator JAVITS. That is a good point. I am with you, because I think this economic index is valuable.

But one other thing, I think, is maintenance of effort. I think what the industrial States suffer from is the fact that the guise of having some claim to the national indulgence or the national favor, is ridden to the point where the industrial States find themselves bested in the competition, which is always true in respect to tax rates and other matters, and also true as to whether business locates in New York or some other State.

So I am with you in the sense that I have always been willing to vote for measures that did not necessarily bring back a dollar to my State for every dollar it paid in taxes and I have never been intimidated by that argument. But, I also think that maintenance of effort is very important and that this national favor or indulgence should not get arbitrary and out of hand, in terms of the understandable competition that exists between the States.

I do not want to trap you into getting into this argument, but would you say that maintenance of effort is a fair consideration, just as you have said the economic indicator, to wit, per capita income, et cetera, is a fair one?

Dr. BARR. My experience has been that the biggest job we have is to keep the effort down. Every small town in the State would like to build a hospital whether they have Hill-Burton money or not. We try to persuade them not to do so, because it is a liability. They would be better off traveling 15 or 20 miles to a good hospital rather than staying right at home in a small one.

Senator JAVITS. I understand.

Dr. BARR. We spend half our effort in trying to stop the effort of these local communities.

Senator JAVITS. I do not think you understand me.

Dr. BARR. We know what you mean.

Senator JAVITS. The maintenance of effort only means the aggregate amount of local budget which is spent for hospital construction, overall. I thoroughly agree with you about the lack of desirability of a "chamber of commerce" approach in seeking to build hospitals or medical centers generally.

Dr. BARR. When Hill-Burton money accounts for only 10 percent of all of the construction that takes place in the State of Minnesota, and the rest of it has to come from local effort, you can see that we do not have a problem with effort.

Senator JAVITS. I should say not. However, I do advance the judg-

ment that I think maintenance of effort—considering the State's competence—that is, competence on a per capita income basis—is also a criterion. That is all I say.

Thank you very much, gentlemen. You have been extremely helpful, and I hope that you will do a good job for us on this survey. I think you can be very helpful to us there.

Dr. PEAVY. Senator, I will say that we shall get this information as soon as possible.

The CHAIRMAN. I would like to say on behalf of all three of us that we very much appreciate your being here and presenting the thinking of the Association of State and Territorial Health Officers. I think we all have the same thing in mind; we are interested in the health of the people of this country.

The CHAIRMAN. Dr. Barr, you have something you wanted to add?

Dr. BARR. I only want to add one thing. You talked about publicly owned hospitals. Publicly owned hospitals will be run the same as any other community hospital, with a hospital board, not a city council running it or a board of county commissioners, but a hospital board operating that hospital the same as any other community hospital.

We are seeing this combination of hospitals in communities, as well as in metropolitan areas, to provide better services, to provide more outpatient services, more rehab, more psychiatric services, all of these things going together on a voluntary basis; in fact, more rapidly than we as a State agency can keep up with them.

As an example, I have five communities outside of the large cities which have a Catholic and either a Lutheran or community hospital and, in every instance, they are combining to develop a better facility. Now, this is unusual and was almost unheard of 10 years ago, but it is happening right now. We are seeing the same combination of hospitals in our large metropolitan areas to develop high quality services for the people, where three or four hospitals are going together and combining their services, maybe retaining their identity, but operating as a medical center to give better facilities and better care and better service to people in that area.

This is being done voluntarily.

The CHAIRMAN. I think it is remarkable that only 25 percent of the hospitals in America are public tax-supported hospitals. Of course, we started in this country where most educational institutions were privately owned and sponsored. It is often overlooked that Harvard University was founded by the Massachusetts General Court, or the legislative body of the State of Massachusetts, and the State of Massachusetts contributed to Harvard until 1828.

But as the American people crossed the mountains and went west, they began to found State universities. That received further impetus with the Land Grant College Act of 1862, signed by President Lincoln, so that today, most universities in America are public supported universities, and the percentage of public supported universities is increasing very rapidly.

In the field of health, too, we have had very few public hospitals. In the area in which I grew up, there were no public hospitals. The nearest thing to it was that the railroads generally built a hospital to take care of their personnel up and down the line.

The ones the railroads operated were the biggest hospitals in the whole eastern half of my State, in Texarkana and Houston. Most of the other hospitals in most cities were private, small hospitals for profit.

I think hospitals have come the route in America like education. I expect to see them expanded greatly because of the demand for health care by the people, in that if they had the means, they would get hospital care. I think that health care, like education, is going to come to all the people and going to come very fast now, because the American people have waked up to the fact that this is something that should go to all people and not merely to the affluent.

Well, that 25 percent you mentioned, is that 25 percent of the hospitals, or 25 percent of the hospital beds, that are public?

Dr. PEAVY. That is hospital beds.

The CHAIRMAN. What is that in beds?

Dr. PEAVY. I do not know. I shall have to get that.

Senator JAVITS. We ought to have that.

Dr. PEAVY. Yes, sir.

The CHAIRMAN. Gentlemen, the questions my colleagues have asked here have stimulated many questions, but it is 12:25. We had planned to finish this session by 12. We have many witnesses who have come here.

I am going to ask the staff, are the other witnesses in the city of Washington or out of the city?

(Whereupon, there was a short discussion off the record.)

Senator JAVITS. I think that it would be a good idea to hear the AMA. I suggest a unanimous consent request—I suggest it, not make it—that the witnesses be limited to 10 minutes and that the examination by the committee be limited to 10 minutes.

Mr. Chairman, I shall remain with the two witnesses, because I think it is important to accommodate witnesses.

The CHAIRMAN. Gentlemen, I have some questions, too. I am going to submit them in writing, because this is such an important subject. Maybe we shall call you back again. In view of the exigencies in which we all work, we are going to excuse you and ask the AMA to come up.

Dr. PEAVY. Thank you, sir.

The CHAIRMAN. Gentlemen, you will have 5 minutes. Is that satisfactory to you gentlemen from the AMA? You have 5 minutes for presentation, we have 5 minutes for questioning.

Senator JAVITS. Mr. Chairman, I ask unanimous consent that my remarks which I proposed to make this morning at the opening of the hearing and could not, due to the lateness of my plane, be accepted for the record as if made.

The CHAIRMAN. We shall order the remarks of Senator Javits printed in the record immediately after my opening remarks.

Gentlemen, you may proceed in your own way.

STATEMENT OF H. PHILLIP HAMPTON, M.D., MEMBER, COUNCIL ON LEGISLATIVE ACTIVITIES, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY PAUL R. M. DONELAN AND HARRY N. PETERSON, LEGISLATIVE DEPARTMENT, AMERICAN MEDICAL ASSOCIATION

Dr. HAMPTON. Mr. Chairman and members of the committee, I am Dr. H. Phillip Hampton, a practicing physician in Tampa, Fla., and a member of the Council on Legislative Activities of the American Medical Association. With me, on my right, are Mr. Paul R. M. Donelan, and Mr. Harry N. Peterson, attorneys in the association's legislative department.

The CHAIRMAN. Dr. Hampton, would you pardon me just a moment?

Dr. HAMPTON. Yes, Senator.

The CHAIRMAN. I find that, due to other emergencies, I must go now. I appreciate Senator Dominick's and Javits' taking over.

I must say that one thing you have said that I am impressed with is the need for more money in modernization of facilities. I realize that personally, from hearing people talking about it, saying that is an old hospital, antique—whether we have the money or not, everybody wants to be in the newest, most modern hospital; and by modernization, we can make an old hospital just as desirable to the patient as a new one. I am very much impressed with this point, and I think it is common in most of the States of the witnesses.

I have read your statement and I regret that I do not have time to hear you; I regret it very much, but I must go.

Thank you very much.

Dr. HAMPTON. Thank you, sir.

Mr. Chairman, we believe we can be most helpful at this time if in addition to stating our general support of the extension of the Hill-Burton program, we offer pertinent comments to certain provisions of H.R. 11102, and where appropriate, to S. 2182.

The American Medical Association has on numerous occasions in the past voiced its approval of the principle of assisting hospital construction through the mechanism of grants-in-aid, the last occasion before this committee being in 1964, when Hill-Burton was extended. At that time AMA reiterated the association's support for construction grants, but at the same time, it urged a shift in emphasis from new construction to grants for the modernization of hospitals and related facilities.

In our opinion, the major need that exists today is for the improvement and effective use of existing facilities.

According to information developed by the Health Services and Mental Health Administration of the U.S. Public Health Service, the Nation's gravest health facilities problem is to modernize or replace health facilities containing some 471,000 acute and long-term beds, with the need being especially severe in densely populated areas. Of these, 263,000 are found in about 3,300 general hospitals and 208,000 in 4,850 long-term care facilities, including nursing homes.

In recent years, the shift of emphasis has been to modernization. We believe that this emphasis should continue, with further emphasis on rehabilitation, renovation, and modernization, so that the major share of the funds will be used to upgrade existing facilities. This

opinion is shared by many, and it is buttressed by the concern for existing shortages in health manpower. Priority for modernization and the upgrading of existing facilities will lessen the strain on the available supply of health personnel needed to provide services obtained in hospitals and related facilities.

The need for emphasizing modernization and grants for more densely populated areas many also be seen from data which compares the gains in existing general hospital beds since 1948. In 1948, the eight highest income States had an average 3.92 beds per 1,000 population. The eight States with the lowest income had an average of 2.61 beds per 1,000 population. By 1966, the average in the eight highest income States had remained at 3.92 beds per 1,000 population, but the average in the eight lowest income States had risen to 3.93. In effect, by emphasis and a system of priority in the earlier years of the Hill-Burton program, the construction needs of the lower income and more rural States have been substantially met. Today, the major concern has shifted to modernization and replacement, especially in densely populated areas.

In summary, the American Medical Association supports the continuation of the grant program for construction and modernization. In this respect, we find that both bills under consideration by the committee seek the same end. In addition, we support the provisions which permit a transfer of certain funds, upon the request of any State, from one allocation to another. Although there appears to be an overlapping of definitions with respect to modernization and construction which has enabled States to meet their needs for modernization, rehabilitation, and additions, the provisions which formalize this flexibility merit support.

In view of current needs, such a provision will provide further elasticity to the transfer of funds from construction to modernization.

The law now requires the Surgeon General to give special consideration to projects for the construction of hospitals and facilities serving rural communities and areas with small financial resources; projects for construction of rehabilitation facilities operated in connection with a teaching program; and projects for the modernization of facilities serving densely populated areas.

H.R. 11102 amends the priority provisions of the law by allowing a priority to rural communities at the option of the State. We believe this flexibility is desirable.

Both S. 2182 and H.R. 11102 contain provisions that extended care facilities be affiliated with hospitals. We believe that adding a priority for grants to hospitals with affiliated extended care facilities is appropriate. However, we suggest that this priority be related to the construction of general hospitals and not to modernization. The need for moderization funds should be met without regard to any requirement for affiliated extended care facilities.

We not that S. 2182 would add additional prirorities for projects for construction or modernization of outpatient facilities in metropolitan areas with low per capita income, and projects which will provide comprehensive health care.

We do not believe that it is necessary to provide priorities for the construction or modernization of outpatient facilities or for facilities which will provide "comprehensive health care."

Title V of the Demonstration Cities and Metropolitan Development Act of 1966—Public Law 89–754—provides for Federal assistance through mortgage insurance, for group practice facilities. A 1968 amendment adds Federal assistance by way of supplementary loans for such facilities. The need for free-standing facilities whose purposes are to provide ambulatory medical care could be met through Public Law 89–754 as amended by Public Law 90–448.

We hope to make this point clear: we understand the part played by hospital outpatient departments in providing a place for necessary services to a community, and the role played in teaching and training. But we believe that any need for outpatient facilities, separate and apart from the hospital, or for free-standing diagnostic and treatment centers—or whatever they may be called—can be met through other programs which provide Federal assistance. Most importantly, nothing has been demonstrated which indicates either public benefit or public acceptance for a concept of providing ambulatory medical care through hospital operated, rather than physician operated neighborhood clinics.

In the administration of the Hill-Burton program there currently exists cooperation between the State agencies and the local, State, or areawide planning agency. H.R. 11102 and S. 2182 would provide the areawide planning agency with an opportunity to "consider" a proposed Hill-Burton project. We support the action of the House in rejecting a proposal requiring the application to be approved by the areawide agency. At the same time, we believe that even the requirement for consideration by the areawide planning agency may not be necessary, since the State Hill-Burton agency is charged with the allocation of funds in a manner which best meets the needs of the State.

The legislation before you indicates a special need for improvement of emergency room facilities. We recognize that there has been an increased use of such facilities over the past several years and that there may be a special need for grants for their modernization. At the same time, however, we believe it would be advisable not to diminish the role of the State Hill-Burton agency, and recommend that the granting of such funds be channeled through that agency.

We support a program for loan guarantees. We believe that through the guaranteed loan mechanism there will be an incentive for the greater use of local funds, and thus provide a broader base of local participation in the Hill-Burton program. In this manner, too, available Federal funds will not be depleted but can provide a revolving base of support. We believe that emphasis in the loan guarantee program should be given to modernization, since this is the area of greatest current need.

Mr. Chairman, at this point, I would like to offer a comment about the situation in Puerto Rico in which, according to information received from the Puerto Rico Medical Association. During the last 20 years that the Hill-Burton program has been in operation in that territory, 89 percent of all funds available have been used for Government hospitals. As a result, 60 percent of the general hospital beds in Puerto Rico are in Government-owned and operated institutions where the medically indigent are cared for by salaried physicians.

According to this information, with the rapid increase in the per capita income in Puerto Rico, the indigent population has been reduced to 40 percent. In effect, the non-Government hospital beds—40 percent of the total—take care of 60 percent of the population. We are further informed that the Government-owned facilities are closed to non-salaried physicians as well as to patients able to pay.

Senator DOMINICK (presiding pro tempore). Without objection, that will be put in the record.

Dr. HAMPTON. Thank you.

(The document referred to follows:)

HILL-BURTON PROGRAM IN PUERTO RICO

Mr. Chairman, at this point I would like to briefly discuss a matter that is not in my formal testimony. It is concerned with the operation of the Hill-Burton program in Puerto Rico.

According to information received from the Puerto Rico Medical Association, during the last 20 years that the Hill-Burton program has been in operation in that territory, 89% of all funds available have been used for government hospitals. As a result, 60% of the general hospital beds in Puerto Rico are in government owned and operated institutions where the medically indigent are cared for by salaried physicians. According to this information, with the rapid increase in the per capita income in Puerto Rico, the indigent population has been reduced to 40%. In effect, the non-government hospital beds (40% of the total) take care of 60% of the population. We are further informed that the government owned facilities are closed to non-salaried physicians as well as to patients able to pay.

It would seem, Mr. Chairman, that this would have the effect of denying to many patients in that territory the privilege of choosing the source of their medical care. It is our understanding that the law intends that the state plan should provide for adequate hospitals for all persons residing in the state and that any facility would be made available to all persons in the area served by the facility.

We point this out, Mr. Chairman, for the attention of the Committee when it considers the implementation of the program in that territory.

Dr. HAMPTON. Mr. Chairman, we appreciate your consideration of our comments. We now will be pleased to attempt to answer questions which the committee may have.

(The prepared statement of Dr. Hampton follows:)

PREPARED STATEMENT OF H. PHILLIP HAMPTON, M.D., MEMBER, COUNCIL ON LEGISLATIVE ACTIVITIES, AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and members of the committee, I am Doctor H. Phillip Hampton, a practicing physician in Tampa, Florida, and a member of the Council on Legislative Activites of the American Medical Association. With me is on my right, Mr. Paul R. M. Donelan and Mr. Harry N. Peterson, attorneys in the Association's Legislative Department.

Mr. Chairman, we appreciate the opportunity provided to the American Medical Association to present its views on legislation before the Committee to extend and expand the program of federal aid for the construction and modernization of hospitals and other medical facilities.

The American Medical Association has supported the Hill-Burton program since its inception, and we believe the program has been administered effectively and in the best interests of the American people. One of its significant characteristics is the on-going federal and state government cooperation which has encouraged the states in their efforts to meet their construction and modernization needs for hospitals and other facilities. We think it is important, to the continuing accomplishments of this program, that legislation maintain the mechanisms that have proven their merit in promoting state and local initiative.

The American Medical Association continues in its long-standing support of the Hill-Burton program. When the Association appeared before the House Interstate and Foreign Commerce Committee on March 26, 1969, we testified

in support of the extension of Hill-Burton. Many of the provisions which received our support are embodied in the House passed bill, H.R. 11102, which is now before this Committee. Your bill, Mr. Chairman, would also extend the program.

Mr. Chairman, we believe we can be most helpful at this time if in addition to stating our general support of the extension of the Hill-Burton program, we offer pertinent comments to certain provisions of H.R. 11102, and where appropriate, to S. 2182.

CONSTRUCTION AND MODERNIZATION GRANTS

The American Medical Association has on numerous occasions in the past voiced its approval of the principle of assisting hospital construction through the mechanism of grants-in-aid, the last occasion before this Committee being in 1964, when Hill-Burton was last extended. At that time AMA reiterated the Association's support for construction grants, but at the same time, it urged a shift in emphasis from new construction to grants for the modernization of hospitals and related facilities.

In our opinion, the major need that exists today is for the improvement and effective use of existing facilities.

According to information developed by the Health Services and Mental Health Administration of the U.S. Public Health Service, the nation's gravest health facilities problem is to modernize or replace health facilities containing some 471,000 acute and long-term beds, with the need being especially severe in densely populated areas. Of these, 263,000 are found in about 3,300 general hospitals and 208,000 in 4,850 long-term care facilities, including nursing homes.

In recent years, the shift of emphasis has been to modernization. Assistant Surgeon General Harald M. Granning, Director of the Division of Hospital and Medical Facilities, Health Services and Mental Health Administration, in an October 1, 1968, release, stated that more than 80% of the Hill-Burton funds have been used in recent years to modernize or add to the capacity of existing facilities. In the fiscal year beginning July 1, 1967, and ending June 30, 1968, according to information received from the Office of Program Planning and Analysis, Health Facilities Planning and Construction Service, U.S. Public Health Service, the allocation of the federal share of Hill-Burton funds has been 8% to new facilities and 92% to additions, alterations, and replacement of existing facilities.

We believe that this emphasis should continue, with further emphasis on rehabilitation, renovation and modernization, so that the major share of the funds will be used to upgrade existing facilities. This opinion is shared by many, and it is buttressed by the concern for existing shortages in health manpower. Priority for modernization and the upgrading of existing facilities will lessen the strain on the available supply of health personnel needed to provide services obtained in hospitals and related facilities.

The need for emphasizing modernization and grants for more densely populated areas may also be seen from data which compares the gains in existing general hospital beds since 1948. In 1948, the 8 highest income states had an average of 3.92 beds per 1,000 population. The 8 states with the lowest income had an average of 2.61 beds per 1,000 population. By 1966, the average in the 8 highest income states and remained at 3.92 beds per 1,000 population, but the average in the 8 lowest income states had risen to 3.93. In effect, by emphasis and a system of priority in the earlier years of the Hill-Burton program, the construction needs of the lower income and more rural states have been substantially met. Today, the major concern has shifted to modernization and replacement, especially in densely populated areas.

In summary, the American Medical Association supports the continuation of the grant program for construction and modernization. In this respect, we find that both bills under consideration by the Committee seek the same end. In addition, we support the provisions which permit a transfer of certain funds, upon the request of any state, from one allocation to another. Although there appears to be an overlapping of definitions with respect to modernization and construction which has enabled states to meet their needs for modernization, rehabilitation and additions, the provisions which formalize this flexibility merit support.

In view of current needs, such a provision will provide further elasticity to the transfer of funds from construction to modernization.

The law now requires the Surgeon General to give special consideration to projects for the construction of hospitals and facilities serving rural communities and areas with small financial resources; projects for construction of rehabilitation facilities operated in connection with a teaching program; and projects for the modernization of facilities serving densely populated areas.

H.R. 11102 amends the priority provisions of the law by allowing a priority to rural communities at the option of the state. We believe this flexibility is desirable.

Both S. 2182 and H.R. 11102 contain provisions that extended care facilities be affiliated with hospitals. We believe that adding a priority for grants to hospitals with affiliated extended care facilities is appropriate. However, we suggest that this priority be related to the construction of general hospitals and not to modernization. The need for modernization funds should be met without regard to any requirement for affiliated extended care facilities.

We note that S. 2182 would add additional priorities for projects for construction or modernization of outpatient facilities in metropolitan areas with low per capita income, and projects which will provide comprehensive health care.

We do not believe that it is necessary to provide priorities for the construction or modernization of outpatient facilities or for facilities which will provide "comprehensive health care."

Title V of the Demonstration Cities and Metropolitan Development Act of 1966 (P.L. 89–754) provides for federal assistance through mortgage insurance, for group practice facilities. A 1968 amendment adds federal assistance by way of supplementary loans for such facilities. The need for free-standing facilities whose purposes are to provide ambulatory meical care could be met through P.L. 89–754 as amended by P.L. 90–448.

We hope to make this point clear: We understand the part played by hospital outpatient departments in providing a place for necessary services to a community, and the role played in teaching and training. But we believe that any nee for outpatient facilities, separate and apart from the hospital, or for free-standing diagnostic and treatment centers—or whatever they may be called—can be met through other programs which provide federal assistance. Most importantly, nothing has been demonstrated which indicate either public benefit or public acceptance for a concept of providing ambulatory medical care through hospital operated, rather than physician operated, neighborhood clinics.

In the administration of the Hill-Burton program there currently exists cooperation between the state agencies and the local, state or area-wide planning agency. H.R. 11102 (and S. 2182) would provide the area-wide planning agency with an opportunity to "consider" a proposed Hill-Burton project. We support the action of the House in rejecting a proposal requiring the application to be approved by the areawide agency. At the same time, we believe that even the requirement for *consideration* by the areawide planning agency may not be necessary, since the state Hill-Burton agency is charged with the allocation of funds in a manner which best meets the needs of the state.

In this regard, I would quote from a report of the Council on Medical Service which was approved by the American Medical Association House of Delegates at its 1968 Annual Meeting.

"The AMA and the constituent and component societies [should] give unstinted, diligent attention to the process of comprehensive health planning which, at present, places priority on local initiative and decision making.

"The AMA at all levels [should] endeavor to assure through all appropriate means, a system of checks and balances so that state and area planning agencies are not given authority to subordinate local planning efforts and dictate local decisions on health planning."

EMERGENCY ROOMS

The legislation before you indicates a special need for improvement of emergency room facilities. We recognize that there has been an increased use of such facilities over the past several years and that there may be a special need for grants for their modernization. At the same time, however, we believe it would be advisable not to diminish the role of the state Hill-Burton agency, and recommend that the granting of such funds be channeled through that agency.

LOAN GUARANTEES

We support a program for loan guarantees. We believe that through the guaranteed loan mechanism there will be an incentive for the greater use of local funds, and thus provide a broader base of local participation in the Hill-Burton program. In this manner, too, available federal funds will not be depleted but can provide a revolving base of support. We believe that emphasis in the loan guarantee program should be given to modernization, since this is the area of greatest current need.

Mr. Chairman, in behalf of the American Medical Association, I wish to once again express our appreciation for the privilege of presenting our views on this important legislation. We have included as addenda to our statement, Exhibits A through D developed from information obtained, for the most part, from the Office of Program Planning and Analysis, Health Facilities Planning and Construction Service, U.S. Public Health Service. We have also attached, as Exhibit E, a copy of the full report of the Council on Medical Service adopted by the AMA House of Delegates in 1968.

We appreciate your consideration of our comments and now will be pleased to attempt to answer whatever questions the Committee may have.

EXHIBIT A

GAINS IN EXISTING GENERAL HOSPITAL BEDS, 8 HIGH AND 8 LOW PER CAPITA INCOME STATES (ACCORDING TO HILL-BURTON STATE PLANS)

	Existing beds per 1,000 population	
	1948	1966
High income:		
1. District of Columbia	4.61	6.10
2. Nevada	5.91	3.51
3. Connecticut	3.90	3.87
4. Delaware	4.00	3.75
5. California	3.72	3.51
6. New York	4.10	4.14
7. New Jersey	3.95	3.38
8. Illinois	3.70	4.44
Average	3.92	3.92
Low income:		
51. Mississippi	2.13	4.04
50. South Carolina	3.01	3.57
49. Arkansas	2.37	3.69
48. Alabama	2.31	4.02
47. Tennessee	2.43	4.21
46. West Virginia	3.67	4.31
45. North Carolina	2.74	3.80
44. Kentucky	2.47	3.85
Average	2.61	3.93

EXHIBIT B

FEDERAL SHARE OF HILL-BURTON PROJECTS BY TYPE OF FACILITY, TYPE OF CONSTRUCTION, AND THOUSANDS OF DOLLARS

Type of facility	Federal share, July 1, 1947, to June 30, 1968	Federal share, July 1, 1947, to June 30, 1967	Federal share, July 1, 1967, to June 30, 1968
New facilities	[1] 1,039,006	[2] 1,018,942	[3] 20,064
General hospitals	753,134	747,002	6,132
Long-term care	101,118	91,767	9,351
Mental hospitals	29,597	28,995	602
TB hospitals	14,231	14,231	
D or T centers	28,842	28,289	553
Rehabilitation facilities	31,905	29,842	2,063
Public health centers	70,148	68,802	1,346
State health labs	10,031	10,014	17
Additions, alterations, and replacements	2,069,410	1,840,399	[4] 229,011
General hospitals	1,492,813	1,331,779	161,034
Long-term care	294,161	251,878	42,283
Mental hospitals	48,826	48,542	284
TB hospitals	13,146	12,894	252
D or T centers	128,958	116,229	12,729
Rehabilitation facilities	75,015	66,459	8,556
Public health centers	14,559	10,856	3,703
State health labs	1,932	1,762	170

[1] 33 percent.
[2] 36 percent.
[3] 8 percent.
[4] 92 percent.

EXHIBIT C

TABLE 1.—TOTAL PROJECTS APPROVED, BY FISCAL YEAR OF APPROPRIATION, JULY 1, 1947, TO JUNE 30, 1968

Fiscal year	Number of projects	Facilities provided: Inpatient beds	Facilities provided: Other health facilities	Total cost	Federal funds obligated
Total	9,549	413,797	2,737	$10,048,248,922	$3,108,415,721
1948	448	22,015	74	283,087,023	74,404,235
1949	366	18,354	59	283,191,272	74,869,859
1950	536	27,332	101	459,286,727	149,722,023
1951	266	12,849	62	250,002,856	84,704,994
1952	250	11,374	67	271,405,635	82,184,988
1953	263	11,559	76	244,715,424	74,912,105
1954	215	8,761	72	179,835,760	64,915,444
1955	458	13,869	187	367,698,035	95,529,871
1956	428	17,296	136	276,518,736	109,424,927
1957	501	18,801	165	413,801,212	122,671,582
1958	448	18,375	139	440,866,625	119,025,688
1959	636	23,941	215	584,514,417	184,266,475
1960	558	23,836	165	558,224,627	183,752,993
1961	538	23,345	149	552,330,235	183,919,623
1962	562	25,604	158	666,737,518	208,902,749
1963	600	24,987	186	680,819,976	216,703,976
1964	541	23,153	172	687,961,342	216,318,620
1965	571	23,407	194	776,634,123	217,883,348
1966	595	29,071	169	893,080,154	256,780,891
1967	594	27,892	152	838,751,320	267,426,877
1968	175	7,976	39	238,785,905	105,902,543
1969 [2]					14,191,910

[1] Federal funds obligated from annual appropriations based on 2-year availability for each State and 3-year availability for territories.

[2] Funds allocated to "split" projects approved in previous fiscal years, subject to availability of allotments.

EXHIBIT D

NEW CONSTRUCTION AND MODERNIZATION FOR HOSPITALS AND PUBLIC HEALTH CENTERS, FISCAL YEAR 1969

State	New construction		Modernization	
	Adjusted allotment	Percent distribution	Adjusted allotment	Percent distribution
Total	$119,285,000	100.0000	$52,485,000	100.0000
Alabama	3,445,191	2.8933	847,499	1.6356
Alaska	200,000	.0887	200,000	.0975
Arizona	1,158,241	.9727	397,272	.7667
Arkansas	1,974,617	1.6583	362,348	.6993
California	6,833,227	5.7386	2,565,295	4.9508
Colorado	1,126,924	.9464	668,580	1.2903
Connecticut	923,068	.7752	960,665	1.8540
Delaware	200,000	.1497	200,000	.3590
District of Columbia	203,261	.1707	200,000	.3551
Florida	4,256,686	3.5748	1,337,417	2.5811
Georgia	3,825,278	3.2125	848,328	1.6372
Hawaii	365,441	.3069	200,000	.2647
Idaho	528,454	.4438	204,517	.3947
Illinois	4,064,975	3.4138	2,358,136	4.5510
Indiana	2,733,243	2.2954	1,454,262	2.8066
Iowa	1,728,132	1.4513	1,052,120	2.0305
Kansas	1,375,314	1.1550	750,604	1.4486
Kentucky	2,863,987	2.4052	684,176	1.3204
Louisiana	3,232,881	2.7150	629,458	1.2148
Maine	771,009	.6475	342,606	.6612
Maryland	1,717,535	1.4424	738,478	1.4252
Massachusetts	2,383,639	2.0018	2,158,127	4.1650
Michigan	4,153,687	3.4883	2,351,660	4.5385
Minnesota	2,189,904	1.8391	1,051,550	2.0294
Mississippi	2,674,301	2.2459	435,045	.8396
Missouri	2,815,285	2.3643	1,490,533	2.8766
Montana	485,587	.4078	302,396	.5836
Nebraska	918,662	.7715	487,898	9416
Nevada	200,000	.1163	200,000	.2520
New Hampshire	435,099	.3654	200,000	.3669
New Jersey	2,594,164	2.1786	2,143,049	4.1359
New Mexico	798,754	.6708	200,000	.3775
New York	6,544,589	5.4962	4,571,136	8.8219
North Carolina	4,517,460	3.7938	1,515,922	2.9256
North Dakota	515,951	.4333	209,854	.4050
Ohio	5,627,356	4.7259	2,423,942	4.6780
Oklahoma	1,963,663	1.6491	560,647	1.0820
Oregon	1,117,160	.9382	438,931	.8471
Pennsylvania	6,594,362	5.5380	4,206,612	8.1184
Rhode Island	484,277	.4067	203,377	.3925
South Carolina	2,655,369	2.2300	643,138	1.2412
South Dakota	577,036	.4846	246,695	.4761
Tennessee	3,564,147	2.9932	1,404,208	2.7100
Texas	8,078,987	6.7848	2,600,894	5.0195
Utah	727,904	.6113	224,155	.4326
Vermont	322,692	.2710	200,000	.2287
Virginia	3,272,771	2.7485	1,227,724	2.3694
Washington	1,548,925	1.3008	794,751	1.5338
West Virginia	1,636,326	1.3742	715,213	1.3803
Wisconsin	2,463,658	2.0690	949,887	1.8332
Wyoming	200,000	.1646	200,000	.1676
American Samoa	36,675	.0308	3,678	.0071
Guam	119,908	.1007	100,000	.0483
Puerto Rico	3,439,238	2.8883	922,217	1.7798
Virgin Islands	100,000	.0600	100,000	.0510

Comprehensive Health Planning

(The following report of the Council on Medical Service of the American Medical Association was approved by the House of Delegates of the American Medical Association at its 1968 Annual Meeting.)

The Council on Medical Service and its Committee on Medical Facilities submitted at the AMA Clinical Convention in 1967, CMS Report A—"Comprehensive Planning of Health Facilities and Services." That Report and the recommendations contained therein, as amended and adopted by the AMA House of Delegates stressed that "the planning, organization and distribution of health facilities and services are prime responsibilities of organized medicine-responsibilities that should be given a higher priority among the varous activities of medical societies at the state and local level."

In recent months, the Council has conducted a survey of state medical associations' activities in relation to comprehensive health planning and is pleased that the majority of medical associations intend to support, cooperate with, and assert leadership in comprehensive health planning. Cooperative efforts have been initiated between one-half of the state associations and state agencies in such activities as joint discussion, formulation of general policies, recommending programs and drafting appropriate legislation.

The Council finds, however, that some medical societies are apprehensive lest areawide and statewide planning agencies will subordinate local planning efforts and dictate local decisions. The Council has also noted a wide variance among physicians in their interpretation of the legislation. Thus, it seems timely to review the purported intent of the legislation, particularly as regards the manner by which we may expect that it will be implemented. For clarification, the Council suggests consideration of a significant statement by Surgeon General William H. Stewart. Pertinent excerpts follow:

". . . there is no how-to-do-it manual for comprehensive health planning—either prepared or capable of preparation. There is no recipe to follow, no magic button to push. P.L. 89–749 is a genuine expression of faith in a process of planning to meet different priority needs in different ways. It is an invitation to initiative from States and communities. To offer this invitation and then prescribe a formula which must be followed would be to deny the entire purpose."

". . . . *it must be emphasized that comprehensive health planning does not represent the imposition of a Master Plan by government upon the people.*" [Emphasis added]

"As for the role of government in the process, it is the servant and not the master . . . *the operating decisions are made by those who are charged with doing the work. Government can synthesize and catalyze; it cannot dictate.* [Emphasis added]

"*The accent is on process. The process requires dynamic partnership.*" [Emphasis added] [1]

Speaking of process of planning, James H. Cavanaugh, Ph. D., Office of Comprehensive Health Planning, J. S. Public Health Service, stated:

"*This process is not intended to replace existing decision-making mechanisms nor to make decisions for any planning or operating institutions.*" [Emphasis added]

"The key to the effective operation of the planning process is the concept of involvement . . . The Federal administrative requirements seek only to assure involvement." [2]

It seems abundantly clear that federal officials responsible for administration of health planning legislation are committed to a policy—a process of planning—designed to promote local initiative and decision making. The Council believes, however, there is no justification for complacency. For, indeed, there are opposing schools of thought as to the nature and intent of health planning.

The school of thought reflected in the cited statements of Surgeon General Stewart underwriting local initiative and decisionmaking—to a "process of planning" is analogous to the "self-regulating, self-appraising" philosophy of the Joint Commission on Accreditation of Hospitals. The JCAH program may be

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[1] William H. Stewart, M.D., "Comprehensive Health Planning," read before the National Health Forum, Chicago, Illinois, March 21, 1967.

[2] James H. Cavanaugh, Ph. D., "Administrative Requirements for Comprehensive Health Planning," read before the Association of Management in Public Health, Miami Beach, Florida, October 26, 1967.

said to be "process-oriented." It seeks through its survey and accreditation program to insure that conditions obtain that are essential to the achievement of excellence: rational organization; proper protocol; evidence of an ongoing assessment of problems and resources; cooperation and involvement. The JCAH recognizes that the science of medicine and its end product—patient care—are essentially dynamic in nature. Thus, the JCAH assesses the process and not the product.

The opposing school of thought places little credence in the vitality or effectiveness of local initiative and decisions on health planning. This attitude is reflected in the Report of the Secretary's Advisory Committee on Hospital Effectiveness which proposes federal legislation that would vest state agencies with the responsibility for:

". . . *prior review and approval of any change in physical facilities which significantly affects the nature or magnitude of the programs of any health care legislation* . . ." [Emphasis added]

Further, this recommendation would make federal grants to states contingent on such "prior review and approval . . ."

This proposal is in sharp contrast to assurance offered by the U.S.P.H.S. that "This [planning] process is not intended to replace existing decision-making mechanisms nor to make decisions for any planning or operating institutions." Instead, the recommendation cited from the Report on Hospital effectivenes has a "Master Plan" approach, subjecting local decisions to a requirement of compliance and conformity that apparently was denied by the Surgeon General.

The Council also has found among agencies responsible for payment for health services proponents of centralization of planning decisions. Further, it has become evident that some hospital authorities are prepared to concede authority to state agencies in return for assurance of a protected service area, i.e., a "Franchise" and other financial concessions.

In assessing current circumstances, the Council notes the increasing involvement of government in planning of health facilities and services. In this regard the Council wishes to specially note Paragraph (1) of section 51.4 of the Partnership for Health Amendments of 1967 which provides that:

"The State program shall provide for assisting each health care facility in the State to develop a program for capital expenditures for replacement, modernization, and expansion which is consistent with an overall State plan . . ."

This provision does not appear to abrogate local decisions. It appears designed to ensure that the process of planning at the local level actually occurs. The AMA has previously adopted the Council's recommendation calling for "participation by members of the hospital medical staffs in the long-range planning of the hospitals they attend; and coordination of institutional planning with community-wide planning." The Council concludes that maintenance of the current federal policy which endorses a "process of involvement" rather than a "master plan" is dependent on vigorous voluntary efforts.

The Council on Medical Service, therefore, recommends that:

The AMA and the constituent and component societies give unstinted, diligent attention to the process of comprehensive health planning which, at present, places priority on local initiative and decision-making, and that

The AMA at all levels endeavor to assure through all appropriate means, a system of checks and balances so that state and area planning agencies are not given authority to subordinate local planning efforts and dictate local decisions on health planning.

Senator DOMINICK. Doctor, I think you have made an excellent statement. I have just a couple of questions I want to ask.

One of them is the question of whether you would feel that the guaranteed loans to public hospitals should not be part of the bill.

Dr. HAMPTON. We feel that guaranteed loans to public hospitals should be part of the bill.

Senator DOMINICK. But it should be part of the bill?

Dr. HAMPTON. Yes, we believe so. These hospitals are in great need of renovation. Today, their need is probably greater than many of the private hospitals. They are in urban areas that serve many of the poverty sections of the country.

I thought at first, in reading these bills, that the simple thing to do would be to transfer the management of such public-owned hospitals to nonprofit community public service corporations so that they could be run by such corporations. I thought they would be eligible for the loan guarantees as nonprofit hospitals are. However, I have been informed that since the ownership would remain with public bodies, they would not be eligible for loan guarantees. So the change in the bills which now permit loan guarantees to public hospitals, I believe, is necessary in order to make this sort of financing available to these very vital parts of the hospital system.

Senator DOMINICK. I can say to you, with all due respect, that in view of the questions you have heard asked here today, this is going to be quite a sticky point.

Dr. HAMPTON. Yes, I can understand how the double enhancement of the salability of such financing, with tax exemption plus Federal guarantee, would be a sticky point. I do not feel that this is really necessary. Perhaps there is some way that loans made to such public-owned facilities could be excluded from the tax exemption. But the present financing methods for public-owned facilities are not adequate to provide the renovation and the modernization that are needed. They are often complicated by limitations at the local level, referendum requirements, and many other impediments to proper financing.

Senator DOMINICK. Did I not gather from what you said with respect to Puerto Rico, that because there were so many publicly supported hospitals down there with salaried physicians, that you found that because they are publicly supported, they are taking care of less than the majority of patients?

Dr. HAMPTON. Yes, that is a peculiar situation in Puerto Rico, which apparently is a matter of local determination about the use of funds.

Senator DOMINICK. You see, part of the problem is the question that if you get a local community—let us take a county anywhere in the country and the county decides to build a countywide public hospital. Then you have the Federal Government directly guaranteeing local county obligations without having intervention of the State or anything else.

If this also is done in a city, you jump jurisdictions all over the place.

That is a really difficult problem to try to deal with in terms of Federal jurisdiction.

Mr. DONELAN. There is one other factor, Senator. The public hospitals are eligible for grants. That is a complete outlay by the Federal Government.

Senator DOMINICK. That is correct.

Mr. DONELAN. The guaranteed loan is a much, much cheaper operation. I realize there is the question of the enhancement of the municipal bond. I am not well enough acquainted with the financial situation to make a judgment as to how the loss of revenue from municipal bonds compares to the loss of Federal revenue by using the grant route. But as Dr. Hampton said, the need for aiding and improving the public hospitals is great.

Senator DOMINICK. Let me say to begin with that I am in great sympathy with the idea of having grants for the public hospitals, whether it is for construction or modernization. I think this is im-

portant, and I think we shall get it. I do not think there is any doubt about that.

The question in my mind is just on this one point, on the guarantee of the loan which underwrites tax-free bonds. That does create some problems.

Gentlemen, because of the extreme time urgency that we are all under, I am going to forgo any questions. Your whole statement will be admitted into the record with the accompanying tables.

I want to compliment you. Even with the brief scanning I have done, I note you have given some figures that I think are going to be helpful.

I want to ask one more question, which is along the line that Senator Javits asked: assuming that you need some kind of a formula for the purpose of taking care of the low per capita income States, it is my understanding that you feel that construction needs of the lower income States have been met and that, therefore, the squaring which was the purpose of that to begin with is not necessarily the formula that needs to be followed at this point.

Is that correct?

Dr. HAMPTON. That is correct. We believe that the squaring formula has accomplished its purpose, and the major need now is in the urban areas for modernization. If there were some means whereby this emphasis could be funded without, at the same time, removing or diminishing the amount of funds available to the rural areas, this might solve the dilemma.

Senator DOMINICK. Do you have any position with respect to the block grant approach of the administration?

Dr. HAMPTON. We do not oppose the block grant approach. We feel, however, that the present Hill-Burton mechanism has worked so well, we are a little hesitant to too drastically change the present method.

Senator DOMINICK. Thank you very much.

This has been very helpful. We appreciate your testimony.

Dr. HAMPTON. Thank you, Senator.

Senator DOMINICK. If Mrs. MacVicar will now come forward, I might say I had the honor of including the nurse's college in the medical facilities bill when I was in the House. I was the author of that amendment.

I regret exceedingly that I am not going to be able to stay and hear your testimony. Senator Javits will take over now.

Senator JAVITS (presiding pro tempore). All right, ladies; proceed. Without objection, your statement, the statement of the American Nurses' Association, will be made a part of the record.

Would you be good enough to give us any highlights or comments you wish?

STATEMENT OF MRS. JEAN THOMSON MacVICAR, CHAIRMAN, COMMITTEE ON LEGISLATION, AMERICAN NURSES' ASSOCIATION; ASSOCIATE PROFESSOR, SCHOOL OF NURSING, UNIVERSITY OF MARYLAND

Mrs. MacVicar. Yes, sir. I shall start at the top of page 2.

We believe there is a need for new approaches toward meeting the health needs with respect to utilization of hospital beds and for a more creative use of the related health care facilities. We believe that we expend as much effort in caring for the vertical patient as we have always in the past expended in caring for the patient who is horizontal. There is a need for preventive facilities providing medical and nursing care.

We know that many of our present facilities need extensive repair and remodeling if they are to adapt to new health care patterns in keeping with community goals. Even more important is the fact that improvement and modernization of existing plants can result in the more effective and efficient utilization of scarce health manpower. There is considerable evidence that valuable nurse manpower is poorly utilized because of totally ineffective and outdated facilities.

There is ample evidence of need for certain categories of new facilities embracing long-term care, extended care, ambulatory services, and centers offering comprehensive health care. We concur in favoring support of programs which show promise of innovation into new methods of delivering care and in reducing the cost of such care. Specifically, diagnostic and treatment centers must receive consideration for heavily populated urban areas.

We believe that the use of extended care facilities increases the probability that the cost of illness to the patient will be decreased and at the same time it increased the probability that the hospital beds in acute general hospitals will be used more appropriately.

It also allows for better utilization of the available professional nurse. We are experimenting in nursing with new approaches to the utilization of the professional nurse. For example, reducing the levels in the hierarchy so that the professional nurse can be at the operational level where we believe she is required to be.

The National Center for Health Services, Research, and Development could be a strong force in giving direction toward means for improving the available health services to the public.

Of major concern to the American Nurses' Association is the problem of shortages of health personnel. Professional nursing service is an essential component of modern medical care whether that care is provided in a small rural hospital, in a large metropolitan medical center, in extended care or long-term care facility. Without qualified nurses these facilities cannot provide the services which communities need and demand from them. Effective implementation of health legislation such as is being proposed, as well as measures enacted by the Congress in the last few years, place new strains on the available nurse supply.

Well in advance of the building of new or expanded facilities, communities both large and small, should plan realistically for staffing those facilities. Such planning should include consideration of needs

for nurses. Consideration, of course, should also be given to the resources of all health personnel, both available and potential, and to the resources for basic and continuing education of all types of personnel.

This committee of the Senate was generous in its authorization of funds for nurses' programs, but the administration request, is far below the authorization. This matter is now before the House Appropriations Subcommittee for Labor and Health, Education, and Welfare. We would like to emphasize, however, Senator, that in the face of the burgeoning health services expected by the public and the need for nurse leaders to administer the aspects of this service, this is a matter of real concern.

Any reduction of funds will work a hardship on the respective schools of nursing, and may serve only to deter the number of young people entering these programs. Construction of health facilities, of itself, does not guarantee delivery of these services. There must be concommitant concern for the preparation of health service personnel.

We strongly endorse the principle of comprehensive health planning provision in the proposed legislation. The areawide health planning agency should consider projects to be funded in terms of careful estimate and projection of needs for the whole spectrum of health services.

Lack of planning and control in the health services has resulted in fragmentation, unnecessary and costly duplication and disunity. Communities, by deliberate planning, must develop patterns of quality comprehensive health services.

I think I am agreeing with people who preceded me in saying I believe the State should have much to say about the allocation of funds. Such planning must include appropriate representation and involvement of the consumer as well as the professional and business and labor interests in the community.

Speaking for one member of the health team, the nurse, we would like to stress the advisability of including the nurse in the master planning for communities as well as planning within the individual institution or agency.

While planning has been built into the hospital and medical facilities construction and modernization program since its inception, more sophisticated planning techniques are required today as the number and complexity of facilities and needs has increased.

In other words, beds of a different nature are needed, including those presently available in the acute general hospital. For example, the extended care and nursing homebeds as well as the before mentioned, and an increase in availability ambulatory services. We believe that initially sufficient funds should be made available to permit construction and modernization so that we can move forward as rapidly as possible.

I thank you for the opportunity to testify.

(The prepared statement of Mrs. MacVicar follows:)

PREPARED STATEMENT OF MRS. JEAN THOMSON MACVICAR, CHAIRMAN, COMMITTEE ON LEGISLATION, AMERICAN NURSES' ASSOCIATION, AND ASSOCIATE PROFESSOR, SCHOOL OF NURSING, UNIVERSITY OF MARYLAND

I am Mrs. Jean Thomson MacVicar, Associate Professor of Nursing, School of Nursing, University of Maryland. I am Chairman of the Committee on Legisla-

tion of the American Nurses' Association in whose behalf I have the privilege of appearing before this Committee today. The American Nurses' Association is the professional organization of over 200,000 registered nurses in 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands and the Canal Zone.

The fundamental purposes of the American Nurses' Association are to foster high standards of nursing practice, advance nursing education and the delivery of nursing services, and promote the welfare of nurses to the end that all people may have better nursing care. These purposes are unrestricted by consideration of nationality, race, creed, color, or sex.

In keeping with these purposes, the American Nurses' Association over the years has supported legislation to extend and improve the delivery of health services. We accept the concept of health care as a right, not a privilege, and the concept of illness as caused by multiple factors. We are concerned with the enormous numbers of persons in the lower socioeconomic stratum of our society for whom there is a desperate need to make health services more easily accessible both in terms of geography and finances. We endorse the proposed emphasis on ambulatory services and the neighborhood health centers.

We believe there is a need for new approaches toward meeting the health needs with respect to utilization of hospital beds and for a more creative use of the related health care facilities. We believe that we must expend as much effort in caring for the vertical patient as we have always in the past expended in caring for the patient who is horizontal. There is a need for preventive medical and facilities providing medical and nursing care.

Nurses, the largest group engaged in the delivery of health services are dedicated to the idea that equal opportunity for good health must exist for all people regardless of where they might live, whatever their economic circumstances, their race, or other situation.

We recognize the Committee members have access to a mass of data developed in various studies involving the delivery of health services, hospitals and other health care facilities, including cost factors. My remarks today will focus on those aspects of S. 2182 and H.R. 11102 which properly fall within our purview.

The American Nurses' Association supports the intent of the proposed legislation which would extend and expand the hospital and medical facilities construction and modernization assistance program for public and private nonprofit hospitals with new approaches toward meeting needs with respect to hospital beds and related health care facilities.

The hospital is a central force in the health care system of the community whose services in one way or another affect all those it is designed to serve. What happens in hospitals is thus a matter of major public concern.

We know that many of our present facilities need extensive repair and remodeling if they are to adapt to new health care patterns in keeping with community goals. Even more important is the fact that improvement and modernization of existing plants can result in the more effective and efficient utilization of scarce health manpower. There is considerable evidence that valuable nurse manpower is poorly utilized because of totally ineffective and outdated facilities. Nursing stations are too small to handle today's traffic flow. There is no room for patient intercoms or automatic tube systems, and there is certainly no room for the coming computer consoles on every nursing division.

There is ample evidence of need for certain categories of new facilities embracing long-term care, extended care, ambulatory services, and centers offering comprehensive health care. We concur in favoring support of programs which show promise of innovation into new methods of delivering care and in reducing the cost of such care. Specifically, the use of extended care facilities increases the probability that the cost of illness to the patient will be decreased and at the same time it increases the probability that the hospital beds in acute general hospitals will be used more appropriately. It also allows for better utilization of the available professional nurse. We are experimenting in nursing with new approaches to the utilization of the professional nurse. For example, reducing the levels in the hierarchy so that the professional nurse can be at the operational level where we believe she is required to be.

The National Center for Health Services research and development could be a strong force in giving direction toward means for improving the available health services to the public.

At this time we wish to share with members of this Committee certain concerns in efforts to bring about change and improvement in the health care system.

HEALTH FACILITIES AND HEALTH MANPOWER

Of major concern to the American Nurses' Association is the problem of shortages of health personnel. Professional nursing service is an essential component of modern medical care whether that care is provided in a small rural hospital, in a large metropolitan medical center, in extended care or long-term care facility. Without qualified nurses these facilities cannot provide the services which communities need and demand from them. Effective implementation of health legislation such as is being proposed, as well as measures enacted by the Congress in the last few years, place new strains on the available nurse supply.

Well in advance of the building of new or expanded facilities, communities both large and small, should plan realistically for staffing those facilities. Such planning should include consideration of needs for nurses. Consideration of course, should also be given to the resources of all health personnel, both available and potential, and to the resources for basic and continuing education of all types of personnel.

Traditionally, the American Nurses' Association has supported legislation which provides financial assistance to schools preparing practitioners for the health field and to those seeking to enter the field. Our special interest is that the supply of nurses be sufficient to meet the public's demand for nursing care of high quality.

Educational measures such as the Nurse Training Act make it possible for more young people to enter the profession. This Committee of the Senate was generous in its authorization of funds for nursing programs, but the Administration request for 1970 is markedly reduced from the sums authorized. This matter is now before the House Appropriations Subcommittee for Labor-Health, Education, and Welfare.

Any reduction of funds will work a definite hardship on the respective schools of nursing and may serve only to deter the number of young people entering basic nursing programs and also seriously affect the number of nurses undertaking graduate study in colleges and universities. Students of nursing need help to complete programs of study. Schools of nursing need to enlarge or renovate their facilities in order to increase enrollments. It is our understanding that requests from schools of nursing for construction grants greatly exceed the amounts appropriated thus far under the Nurse Training Act.

Construction of health facilities of itself does not guarantee delivery of services. There must be concomitant concern for the preparation of health personnel.

COMPREHENSIVE HEALTH PLANNING

We strongly endorse the principle of comprehensive health planning and the provision in the proposed legislation for authorized areawide health planning agency consideration of projects to be funded in terms of careful estimate and projection of needs for the whole spectrum of health services.

Lack of planning and control in the health services has resulted in fragmentation, unnecessary and costly duplication and disunity. Communities, by deliberate planning, must develop patterns of quality comprehensive health services and assure their availability, accessibility and acceptability to all.

Such planning must include appropriate representation and involvement of consumer as well as professional and business and labor interests in the community. Speaking for one member of the health team, the nurse, we would like to stress the advisability of including the nurse in the master planning for communities as well as planning within the individual institution or agency.

Evidence of ANA interest in and concern for comprehensive health planning and direct nurse involvement is reflected in action taken by the House of Delegates in May 1968 when it adopted the following Statement Regarding Nurses in Comprehensive Health Planning:

> Whereas, Nurses have broad and diversified knowledge and competencies with a strong sense of responsibility for the health needs of the community, and
>
> Whereas, Nurses represent the largest health manpower group, and
>
> Whereas, Comprehensive health planning legislation has serious implications for nursing and health care, therefore, be it
>
> Resolved, That the American Nurses' Association support comprehensive health planning and recognize the necessity for providing effective leadership and participation, and

Resolved, That this House of Delegates urge state and district nurses associations to strive for official representation on the Advisory Councils for comprehensive health planning, and

Resolved, That this House of Delegates urge state and district nurses associations to take active steps insuring the participation of nurses as consultants or staff in state and regional planning agencies, and

Resolved, That all levels of this Association utilize educational opportunities for preparing nurses to participate in comprehensive health planning.

While planning has been built into the hospital and medical facilities construction and modernization program since its inception, more sophisticated planning techniques are required today as the number and complexity of facilities—and needs—increase. In other words, beds of a different nature are needed, including those presently available in the acute general hospital. For example, the extended care and nursing house beds as well as the before-mentioned, and an increase in available ambulatory services. We believe that initially sufficient funds should be made available to permit construction and modernization so that we can move forward as rapidly as possible.

Furthermore, in recent years the Congress has enacted several pieces of legislation calling for planning efforts that concern the health care system. Particularly pertinent are the Partnership for Health Program, Regional Medical Program, the Demonstration Cities and Metropolitan Development Act, and the Economic Opportunity Act.

While there are significantly different major thrusts to these federally sponsored programs, with opportunities for overlapping and competition, they are, or should, in many respects, be complementary and mutually reinforcing in their local, state and Federal manifestations. In the aggregate these programs add significant resources. With proper coordinated planning these should enhance the capacity of states, regions and local communities to provide more comprehensive health services.

Comprehensive metropolitan planning and comprehensive health planning go hand in hand. The association of poor health and poor physical and social environment is well known. It is, therefore, necessary that metropolitan development and comprehensive health planning proceed together with the effective utilization of all resources—human and financial—working toward the reduction of poor housing, decaying neighborhoods, congestion, social decay, economic decline, and rising costs, with the view of improving the health and well-being of people.

I thank the Committee for this opportunity to appear and present the views of the American Nurses' Association.

Senator JAVITS. You are certainly very welcome. I am glad we did not delay you.

I have just one or two questions to ask you, and I shall also limit myself to the 5-minute rule.

There has been considerable talk here about public and private nonprofit hospitals. Do you think we ought to simply proceed across the board with all our programs, making them applicable, as they may deserve, but not making public hospitals ineligible?

Mrs. MACVICAR. Oh, I would hope that public hospitals would not be made ineligible. Most of my experience has been in the large medical centers in the public hospitals, and the need is desperate for some assistance, for the remodernization and for experimentation. We do get in the large public hospital a person who cannot afford it, most of the time. You know, the per diem rate is going up with the rising salaries which we have gotten.

Senator JAVITS. Would you agree that the problem is really indistinguishable, except for the original financing of the institution?

Mrs. MACVICAR. That is right, sir.

Senator JAVITS. There is also some feeling that the hospital-connected ancillary facilities should be the only ones declared eligible. For example, the so-called, long-term care, the nursing home, et

cetera. Do you believe that that is appropriate, or do you believe that we ought to take it where we find it and not necessarily require hospital affiliation?

Mrs. MACVICAR. I do not believe that we should require hospital affiliation.

Senator JAVITS. That was very kind, and I thoroughly agree with you. But as you know, there is a lot of feeling that everything has to be connected with a hospital.

The last question I have is this: As among hospitals, would you give priority consideration to the teaching hospital as contrasted with a nonteaching hospital?

Mrs. MACVICAR. I shall have to speak for myself. I think money is desperately needed for teaching hospitals. This is where the future member of the health disciplines, the medical nursing, pharmacy, the roentgenologists, and so forth, are learning, and they should have available facilities and the technological devices available for this learning. And this all costs money.

This is another reason why I think they need this.

Senator JAVITS. We have just another minute. May I ask you this? What do you think of this loan guarantee concept? You may know, this is essentially my idea. It has apparently now really caught on. I just wonder what, from the practical experience of nurses, you think?

Mrs. MACVICAR. I cannot speak for the American Nurses' Association. We have not discussed this.

The idea of a guaranteed loan appeals because of the rising costs. This is all I can feel competent to say at the moment. We can ask the association to give it some consideration.

Senator JAVITS. I think you ought to do more than that for us. I think that, like the regional and State organizations in the hospital field, you ought to use your extensive network to get for us the best information as to the feasibility of this approach, whether it really would be used, and whether it really would extend the ambit of our bill.

I would make you one promise: I shall not yield 1 penny in grant funds on that account, because no matter what we get in grant funds, it will be so far from adequate that we simply must have some technique for getting more. The only technique I have been able to come up with in the last couple of years is this one. But I would like to know about this from your organization; I really hope you will give us their opinion, in depth on a regional basis, as to what they think about a guaranteed loan program. They may have some ideas as to how we can improve it.

Mrs. MACVICAR. I am sure we have persons available in the organization who can do this for us.

Senator JAVITS. Thank you very much, ladies.

The hearing will stand in recess until 1:45 p.m.

(Whereupon, at 1 p.m., the committee recessed, to reconvene at 1:45 p.m., this same day.)

AFTERNOON SESSION

The CHAIRMAN. The Subcommittee on Health of the Committee on Labor and Public Welfare will come to order.

We resume hearings on S. 2182, H.R. 11102, and related bills on which hearings were begun this morning.

Senator Kennedy, we welcome you to testify before this committee as a member of this full committee and a member of the subcommittee. We realize from your previous experience and the bills you have introduced, the statements you have made, the votes you have cast, the positions you have taken, that you have had a tremendous interest in the health of this country.

We are glad to have the benefit of your advice and testimony on the Hospital and Health Facilities Construction and Modernization Act.

I would like to have you proceed in your own way.

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman and members of the subcommittee.

Today, the Subcommittee on Health begins consideration of some of the most important proposals for Federal health legislation that will come before the 91st Congress. Twenty-three years ago this summer, President Truman signed into law the Hill-Burton Act to promote hospital construction in the United States. Originally conceived during the early 1940's by the Senate Subcommittee on Wartime Health and Education, the act became one of the most popular and successful pieces of matching Federal grant legislation in the Nation's history.

In no small measure, the success of the act is attributable to the foresight and perception of the original subcommittee in accurately delineating the health needs of America a quarter of a century ago. Today, the subcommittee is challenged to demonstrate the same foresight and perception for present-day America.

Last year, Congress decided to extend the Hill-Burton program for only 1 year. It was the intent of the congressional committees considering this legislation that the 91st Congress and a new administration would thus have time to reexamine the entire program—its successes, its shortcomings, its gaps, and its overall relation to contemporary needs.

Major policy alternatives face us in considering our health care programs. We have allowed a wasteful, inefficient health system to perpetuate itself. The basic issue before us is the need for better organization and distribution of the fruits of medical science and technology, and the financing and maintenance of adequate levels of health care for all Americans.

Our health system must be reorganized. New patterns must be found. We must reexamine and overhaul our established practices and programs. We must begin with the recognition that we cannot proceed as we have in the past. The Hill-Burton program is a case in point. We need fresh ideas, innovations, and leadership in a program that affects every aspect of the health care field.

The proposals now pending before the subcommittee to revise and extend the Hill-Burton Act offer us in Congress the opportunity to reexamine what has become the cornerstone of Federal health assistance programs. In spite of the past success of the Hill-Burton Act,

there are far too many areas of the Nation in which health facilities are either nonexistent or grossly inadequate. To be sure, the Hill-Burton Act is but one among a variety of Federal health assistance programs now available to attack the twin problems of inadequate services and high costs in American medicine.

Nevertheless, because of the enormous popularity of the Hill-Burton Act, its pioneering status in the field of health assistance, and its broad acceptance as a workable method of providing Federal aid, these hearings offer us an extraordinary opportunity to reexamine the act in the light of contemporary needs, and to bring major new resources to bear on the solution of these difficult problems.

In addition, in considering our Nation's health care and the programs Congress has enacted to meet these needs, it is important to recognize that we have arrived at a critical juncture. In the course of the coming year—by June 30, 1970—most of our major health programs will expire: the partnership for health amendments; the heart, cancer, and stroke amendments; the major mental health programs; the Allied Health Professions Personnel Training Act; the Medical Library Assistance Act; and the public health training amendments.

Besides these major health programs, substantial revisions of the Social Security Act relating to the administration of medicare and medicaid will probably take place. What Congress and the new administration decide in the first of these important health programs—Hill-Burton—has significant ramifications for the rest. Moreover, the restructuring of the Hill-Burton program will have a significant impact on rising health costs, manpower utilization, the quality of medical care, and the delivery of health services to all Americans regardless of race, income, age, or residence.

The present hearings by the subcommittee and the coming debate in the Senate are a highly appropriate occasion to begin the assessment of our existing health legislation and to establish new priorities for the future. To me, the guarantee of adequate health facilities and health assistance to all Americans ranks as the very highest among domestic needs, and I intend to probe all aspects of our existing programs in an effort to insure that we make optimum use of the limited resources we have available.

In its hearings this morning and in the testimony by Congressman Ottinger, Dr. Hampton, and others, the subcommittee has already heard extensive evidence of the need for revision of the Hill-Burton Act in two critical areas, the need for greater financial assistance for urban hospital construction and modernization, and the need for a more equitable distribution of Federal funds between construction and modernization.

I shall not take further time from the subcommittee's schedule to go over these areas in detail. Many of the issues have been brought out in the House hearings and debates and, as the chairman has announced, our subcommittee is now assembling additional information that will allow us to treat these vital issues as comprehensively as possible.

For the present, let me say only that the crisis in our great city hospitals is as clear as today's headlines. Budgets are inadequate and critical health services are cut back far too drastically. We know the

situation is acute when the president of a major municipal hospital in our Nation's largest city charges that dozens of patients are dying because of obsolete and insufficient equipment and overburdened personnel.

In addition to the two major areas I have noted in which it is time for a fresh assessment of our national health priorities under the Hill-Burton Act, there are a number of other areas I would like to mention in closing my testimony today.

These areas include:

The need for greater coordination between the traditional State agencies carrying out Hill-Burton programs, and the new State and areawide agencies engaged in comprehensive health planning under other more recent Federal legislation.

The need to require each Hill-Burton State plan to cover a minimum geographic area commensurate with the population of the planning area. Such a plan would discourage unnecessary duplication of health services and prevent the dissipation of health manpower and health capital in cases where, for example, a particular hospital is found to be too small to render services capable of meeting the needs of the area's population.

The need for special new programs of loans, loan guarantees, and interest rate subsidies as alternative methods of encouraging construction and modernization of health facilities. Through such programs, it may be possible to stimulate substantial new private financing for hospitals and other facilities, at relatively little effect on our already overstrained Federal budget. In this connection we should give attention to the need for a revolving Federal loan fund established through the Treasury for making low-interest, long-term loans available to the public hospitals and other public health facilities serving the health needs of our urban poor. It appears that urban public hospitals, particularly the municipal and major teaching hospitals, have long been discriminated against under the existing Hill-Burton Act. We must see that these hospitals have the funds and opportunity to modernize and rebuild.

The need for increased assistance, whether through a program of emergency grants or otherwise, to relieve the critical overcrowding in many of our existing health facilities and to establish a broader range of new facilities, including community diagnostic and treatment centers in metropolitan area, extended care facilities, facilities for home health services, hospital training facilities, neighborhood health centers, and more comprehensive outpatient facilities in existing hospitals.

The need for a new program of combined urban-rural comprehensive health centers, capable of drawing support, from both the proponents of the existing Hill-Burton Act and the proponents of greater financial assistance to our urban hospitals. Such a program might begin with a large matching Federal share—on the order of 90 percent—with a diminishing Federal contribution over the remaining life of the program. The conditions of eligibility for such incentive grants might include efficiency, the provision of increased services, and other similar fac-

tors. Potential projects under such a program might include shared services, dispersed ambulatory care facilities, various types of jointly sponsored health services, and interfacility cooperation providing comprehensive health care services.

Finally, the need to build greater flexibility into the variable matching formula of the Hill-Burton program, under which the minimum Federal matching share for construction and modernization has been maintained at 33⅓ percent of the eligible cost. Although Federal sharing of the eligible cost is permitted in certain cases up to two-thirds of the shared costs, such sharing is the exception rather than the rule in most States. In order to increase the participation of public hospitals and rural health facilities in impoverished areas, the maximum Federal share of any project might well be raised to 80 percent.

I believe that new legislation may be desirable in each of these areas, as well as in a number of other areas that are likely to come to light during the subcommittee hearings and Senate debate. I look forward to examining these issues, so vital to the adequacy of our Nation's health facilities, and I commend the chairman and the members of the committee for their prompt action in launching these comprehensive hearings.

I would also like to ask, Mr. Chairman, if the further elaboration contained in my prepared testimony may be included in the record.

I attempted to capsulize my principal recommendations in order to conserve the time of the committee. Two of my principal points—the Hill-Burton formula and the inadequacy of funds for modernization—were heavily stressed by those who appeared in the morning hearings, and I am sure other witnesses will also testify on them.

I share their very deep and strong sense of urgency about those two considerations. Although I mentioned them only briefly, I want to stress my very deep concern with them. I know they will be of great interest to the members of this committee.

The CHAIRMAN. Thank you, Senator Kennedy.

Your entire statement will be printed in the record.

(The prepared statement of Senator Kennedy follows:)

PREPARED STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS, ON HOSPITAL AND HEALTH FACILITY CONSTRUCTION AND MODERNIZATION

Mr. Chairman: Today, the Subcommittee on Health begins consideration of some of the most important proposals for Federal health legislation that will come before the 91st Congress. Twenty-three years ago this summer, President Truman signed into law the Hill-Burton Act to promote hospital construction in the United States. Originally conceived during the early 1940's by the Senate Subcommittee on Wartime Health and Education, the Act became one of the most popular and successful pieces of matching Federal grant legislation in the nation's history. In no small measure, the success of the Act is attributable to the foresight and perception of the original Subcommittee in accurately delineating the health needs of America a quarter of a century ago. Today our Subcommittee is challenged to demonstrate the same foresight and perception for present day America.

In examining the Hill-Burton Act, we must consider the present role of hospitals and other health facilities in the context of the nation's overall health care programs. At the outset, certain initial observations can be made on the importance of health facilities to our health system:

The hospital is increasingly becoming the focal point for the delivery of medical care. In my view, this is the dominant trend in primary health care over the past 25 years;

The hospital has become a means in itself, a panacea for health ills, even though it is recognized that it should be an end, only providing services where other services and facilities do not meet particular needs;

Hospital costs and increased hospital utilization have been the most important single factors contributing to rising health costs. Such costs, in turn are a major factor in the existing inflationary trend of the total economy;

Our entire health system of patients, physicians, and health manpower is centered around the hospital. In fact, the hospital should be one, and only one, of many alternative facilities available for health services;

Hospitals serving the same population or community frequently provide unnecessary duplication of services and overlapping of specialties. Often such services are provided for reasons of prestige rather than need;

The Hill-Burton Program today is based on an antiquated notion of "bricks and mortar," population-bed ratios, and prescribed building standards. It should be restructured to meet new patterns for the delivery of comprehensive health services;

In particular, the Hill-Burton hospital construction and modernization program has been unresponsive to the special needs of our urban areas, hospitals and facilities. Many of these facilities are overcrowded and understaffed. They deliver inadequate services, and they are desperately in need of modernization;

The Hill-Burton program has not been sufficiently directed toward financing a broader range of health facilities and providing alternatives to expensive in-hospital care;

The Hill-Burton program, which allocates a quarter of a billion dollars annually, has not been tied to planning for the delivery of comprehensive health services and meeting the needs of particular communities or populations.

Last year Congress decided to extend the Hill-Burton Program for only one year. It was the intent of the congressional committees considering this legislation that the 91st Congress and a new Administration would thus have more time to reexamine the entire program—its successes, its shortcomings, its gaps, and its overall relation to contemporary needs.

Major policy alternatives face us in considering our health care programs. We have allowed a wasteful, inefficient health system to perpetuate itself. The basic issue before us is the need for organization and distribution of the fruits of medical science and technology, and the financing and maintenance of adequate levels of health care.

Our health system must be reorganized. New patterns must be found. We must reexamine and overhaul our established practices and programs. We must begin with the recognition that we cannot proceed as we have in the past. The Hill-Burton program is a case in point. We need fresh ideas, innovations, and leadership in a program that affects every aspect of the health care field.

The proposals now pending before the Subcommittee to revise and extend the Hill-Burton Act offer us in Congress the opportunity to reexamine what has become the cornerstone of our basic Federal health assistance programs. There can be no question today of the need for extensive Federal financial assistance to State and local governments for the construction and modernization of hospitals and a wide variety of other health facilities. What began in 1946 as an innovative and relatively experimental proposal has become a comprehensive program designed to insure the availability of adequate health facilities to all Americans.

We know, however, that in spite of the great success of the Hill-Burton Act in stimulating the construction of new health facilities and modernizing our old facilities, there are far too many areas of the nation in which health facilities are either non-existent or grossly inadequate. In addition, even where the existing facilities are adequate, the costs of providing satisfactory surgical, medical, and extended care treatment vastly exceed the ability of large numbers of our citizens to pay for the services they need.

To be sure, the Hill-Burton Act is but one among a variety of Federal health assistance programs now available to attack the twin problems of inadequate services and high costs in American medicine. Nevertheless, because of the enormous popularity of the Hill-Burton Act, its pioneering status in the

field of health assistance, and its broad acceptance as a workable method of providing Federal aid, these hearings offer us an extraordinary opportunity to reexamine the Act in the light of contemporary needs, and to bring major new resuorces to bear on the solution of these difficult problems.

In addition, in considering our nation's health care and the programs Congress has enacted to meet these needs, it is important to recognize that we have arrived at a critical juncture. In the course of the coming year—by June 30, 1970—most of our major health programs will expire: the Partnership for Health Amendments; the Heart, Cancer, and Stroke Amendments; the major Mental Health programs; the Allied Health Professions Personnel Training Act; the Medical Library Assistance Act; and the Public Health Training Amendments. Besides these major health programs, substantial revisions of the Social Security Act relating to the administration of Medicare and Medicaid will probably take place. What Congress and the new Administration decides in the first of these important health programs—Hill-Burton—has significant ramifications for the rest. Moreover, the restructing of the Hill-Burton Act will have a significant impact on rising health costs, manpower utilization, the quality of medical care, and the delivery of health services to all Americans regardless of race, income, income, age or residence.

The present hearings by the Subcommittee and the coming debates in the Senate are a highly appropriate occasion to begin the assessment of our existing health legislation and to establish new priorities for the future. To me, the guarantee of adequate health facilities and health assistance to all Americans ranks among the very highest of our domestic needs, and I intend to probe all aspects of our existing programs in an effort to insure that we make optimum use of the limited resources we have available.

First and most important, we must re-examine the existing provisions of the Hill-Burton Act for the allocation of Federal health funds to our major metropolitan areas. Perhaps the most important single area in which new legislation is essential is the provision of greater financial assistance for hospital construction and modernization in urban America. Today, as in the past, the Hill-Burton Act continues to place special emphasis on aid to the nation's rural communities. No one denies that the original focus of our health assistance program on rural comunities correctly reflected the nation's priorities in the aftermath of the Second World War, when the Hill-Burton statute was originally enacted. At that time, the plight of rural America was desperate. Many small communities and localities across the nation were known to be completely lacking in necessary health care facilities, and completely unable to afford them. The need for immediate and sustained Federal assistance were essential. In large part, the original Hill-Burton Act was passed to meet this need, and it has succeeded admirably in doing so.

At the same time, however, we must recognize that the priorities of World War II are no longer adequate to serve the nation's health needs as we enter the decade of the 70's. Although major assistance to rural and suburban communities continues to be essential, the crucial demand today is for the development of new and improved health facilities and programs for our central cities. In the view of many experts, no change short of a program of massive grants and loans will relieve the increasingly serious deterioration of our large city hospitals.

A number of significant proposals have already been made to revise the existing formula in the Hill-Burton Act by which construction funds are allocated among the States. I am convinced that major new steps must be taken to redirect the Act toward providing greater health assistance to the nation's cities.

It is not yet clear, however, that the formula for allocating construction funds must be altered. For example it may be sufficient simply to eliminate the mandatory priority that the States must give to rural areas in distributing hospital construction funds. Or, it may be possible to devise alternative proposals for urban health assistance that will not disturb the present allocation of construction funds under the basic provisions of the present Hill-Burton Act. Or, finally, it may be possible to alter the formulas allocating funds for modernization or for the newer loan programs that are now before the Subcommittee, in order to provide increased assistance to urban areas while preserving the traditional preference for rural areas in construction grants.

Unfortunately, much of the force of the case for greater health assistance to our cities has been dissipated by the controversy over whether the existing formula for the allocation of construction funds is better described as giving special emphasis to "rural" States or to "poor" States. The issue is too important for

us to become embroiled in such a controversy. The crucial questions are twofold: How strong is the case that can be made for greater assistance to urban areas? And, if the case is made, how can we devise the most effective allocation of funds to meet the urban need, consistent with the overall requirement that we maintain a fair and even-handed distribution of funds to all communities, large or small, rich or poor, urban or rural? It is these questions that must be answered in the present hearings and debates. My purpose now is merely to raise these questions, not to prejudge their answers or to propose arbitrary solutions. Too often, the debate on the questions has been resolved in the past on the basis of the bare number of States who would stand to gain or lose Federal funds under a given proposal. I urge the Congress to look beyond this philosophy of numbers, and to measure the health needs of modern America, and to appropriate and allocate the funds accordingly.

In addition, there are several other major areas in which the historic provisions of the Hill-Burton Act must be re-examined if we are to have confidence that the program is adequate for the construction and modernization of the nation's health facilities. One of the most significant areas involves the proper distribution of Federal funds between the construction of new health facilities on the one hand and the modernization of existing facilities on the other hand. In many of the proposals now pending before the Subcommittee, the Hill-Burton Act would provide twice as much assistance for construction as it provides for modernization, even though, as I understand it, the available evidence tends to show that the current need may be precisely the reverse—that twice as much funds are needed for modernization as for construction.

The growing need for modernization funds is closely related to the need for greater assistance to urban hospitals. Unlike the plight of the rural communities when the Hill-Burton statute was enacted, our big cities today have hospitals. What makes their plight critical is their lack of modern facilities. To a great extent, because the situation is so desperate, the distinction drawn by the Act between new construction and modernization may vanish. In many cases, the renovations needed to upgrade our big city hospitals may be so vast—their facilities so outmoded—that "modernization" is useless, and that we must begin again with new construction.

It is widely claimed that in fact the existing provisions of the Act for the distribution of funds between construction and modernization are adequate, since the statute gives broad leeway to the States to transfer their allocated funds from the construction category to the modernization category. Again, this is an area in which more data are essential. We need to know what the States are in fact doing under the statute. If the law contains sufficient flexibility in its present form, so that the States are making satisfactory use of its transfer provisions, no amendment may be necessary. On the other hand, if it becomes clear that the States are not actually using the transfer provisions to shift funds from the construction to the modernization category, then we must question whether in fact the existing provisions are adequate to meet the current need for modernization.

It may become clear, for example, that the States feel too constrained by the categories specified in the statute, and are unwilling to apply the letter of the law for fear of violating its spirit. The real point here is that we in Congress simply do not yet know the practices prevailing in the nation under this provision. One of the primary reasons for hearings such as these is to dispel the ambiguity clouding the judgments we are pressed to make. Once the facts are clear, I am convinced that we will be able to align the law in the light of current health realities, and insure that the flexibility intended by the Act is practiced by the States.

Other major areas in which it is time for a fresh assessment of our national health priorities under the Hill-Burton Act include the following:

The need for greater coordination between the traditional State agencies carrying out Hill-Burton programs, and the new State and areawide agencies engaged in comprehensive health planning under other more recent Federal legislation. Here again, there is a need for better facts and information before an accurate judgment on the issues can be reached. We must know more about the status and function of the planning agencies in the various states. We must determine whether they are capable of assuming a central supervisory role over the distribution of Hill-Burton funds at the present time. Even if they are not yet capable of assuming this role, we must at-

tempt to determine whether a statutory incentive should be given to such agencies to assume a greater coordinating role. At the very least, it seems clear that we must move in the direction of tying our health facility construction and modernization program into areawide and statewide planning. Planning cannot be separated from financing. When it is, planning will inevitably fail. Congress intended the Partnership for Health Act to be a strategy for effecting a partnership involving intergovernmental collaboration, official and voluntary efforts, and the participation of health consumers and health providers. We can no longer afford the luxury of inefficient utilization of our health resources. Therefore, it may be desirable to set a specific date, after which federal grants for health facility construction and modernization must receive prior approval from existing areawide or statewide planning groups.

The need to require each Hill-Burton State Plan to cover a minimum geographic area commensurate with the population of the planning area. Such a plan would discourage unnecessary duplication of health services and prevent the dissipation of health manpower and health capital in cases where, for example, a particular hospital is found to be too small to render services capable of meeting the needs of the area's population.

The need for special new programs of loans, loan guarantees, and interest rate subsidies as alternative methods of encouraging construction and modernization of health facilities. Through such programs, it may be possible to stimulate substantial new private financing for hospitals and other facilities, at relatively little effect on our already overstrained Federal budget. In this connection we should give attention to the need for a revolving federal loan fund established through the Treasury for making low-interest, long-term loans available to public hospitals and other public health facilities serving the health needs of our urban poor. It appears that urban public hospitals, particularly the municipal and major teaching hospitals, have long been discriminated against under the existing Hill-Burton Act. We must see that these hospitals have the funds and opportunity to modernize and rebuild.

The need for increased assistance, whether through a program of emergency grants or otherwise, to relieve the critical overcrowding in many of our existing health facilities and to establish a broader range of new facilities, including community diagnostic and treatment centers in metropolitan areas, extended care facilities, shared facilities, facilities for home health services, rehabilitaton facilties, hospital training facilities, neighborhood health centers, and more comprehensive out-patient facilities in existing hosptals. Here, we should place special emphasis on the development of relatively low cost medical facilities designed to relieve the heavy and frequently unnecessary pressure on our more expensive acute care facilities. In particular, we must make ample funds available for innovations in hospital care, including ambulatory clinics for single visits, and all-day diagnostic evaluation to convalescent hospital beds and wards with maximum patient self-help. Federal encouragement in this direction would greatly aid current efforts by third-party carriers to broaden their insurance coverage to include these facilities, and would encourage them to assist in financing such projects.

The need for a new program of combined urban-rural comprehensive health centers, capable of drawing support from both the proponents of the existing Hill-Burton Act and the proponents of greater financial assistance to our urban hospitals. Such a program might begin with a large matching Federal share—of the order of 90%—with a diminishing Federal contribution over the remaining life of the program. The conditions of eligibility for such incentive grants might include efficiency, the provision of increased services, and other similar factors. Potential projects under such a program might include shared services, dispersed ambulatory care facilities, various types of jointly sponsored health services, and interfacility cooperation providing comprehensive health care services. Special interfacility incentives could be applied both to rural, multi-county units and to urban hospitals, which are frequently located within a few blocks of one another.

Finally, the need to build greater flexibility into the variable matching formula of the Hill-Burton program, under which the minimum federal matching share for construction and modernization has been maintained at 33⅓ percent of the eligible cost. Although federal sharing of the eligible cost is permitted in certain cases up to two-thirds of the shared costs, such sharing

is the exception rather than the rule in most States. In order to increase the eligibility of public hospitals and rural health facilities in impoverished areas, the maximum federal share of any project might well be raised to 80 percent.

I believe that new legislation may be desirable in each of these areas, as well as in a number of other areas that are likely to come to light during the Subcommittee hearings and Senate debate. In the weeks to come, I look forward to the opportunity to examine these issues, so vital to the adequacy of our nation's health facilities, and I commend the Chairman for his prompt action in launching these comprehensive hearings.

The CHAIRMAN. As I was reading through, followed it, I noticed your rapid condensation. We are glad to have the statement, and congratulate you on the study that has gone into it, which is evident in the statement.

Another coauthor of this bill, along with you, myself, and others, is Senator Eagleton, who is with us now, from Missouri.

Do you have any questions, Senator Eagleton?

Senator EAGLETON. No questions.

The CHAIRMAN. Senator Dominick, who is here as a very active member of this subcommittee, is also present.

Senator Dominick?

Senator DOMINICK. Thank you, Mr. Chairman. I think the Senator brought up some very interesting points, some very worthwhile points.

One of the things that I wondered if you would comment on, you come, obviously, representing a highly industrialized State. In the bill which has been backed by the witnesses this morning, which was introduced by Senator Yarborough, the formula is retained as it presently is in existence, requiring squaring based on per capita income in order to determine how much money goes to each State.

Yet the American Medical Association indicated that the priority of need for rural areas, and so on, has probably been met insofar as construction is concerned. Would you be in favor of eliminating the squaring, or would you be in favor of retaining it?

I might say it makes a fairly substantial difference in the case of Massachusetts, as you probably know.

Senator KENNEDY. Mr. Chairman, I am flexible with regard to developing a specific formula. What we must do is come up with the fairest formula to meet the health needs of all parts of our country. I do think, however, that many parts of the Nation, especially our urban areas, have been disadvantaged under the present formula.

It has become more and more difficult to provide the kind of comprehensive health facilities in both urban and rural areas, where the need is so essential. I am reminded that in one of the important areas of Boston—Charlestown, Mass.—which is an older community, a population of about 24,000, they have two general practitioners. They are both about 65 years old, and both of them have been in residence for more than 20 years. There is very little hope that new doctors will move into the area. What we must do is to develop better devices for delivery of health services in such areas.

In my view, the existing Hill-Burton formula has hindered our efforts to meet the major health crisis in our urban areas. I think that we have to devise a new formula that will stick a better balance than the existing formula. We must find a formula that preserves our legitimate interest in the rural areas, but recognizes the critical health needs in the urban centers of our country.

Senator DOMINICK. One other question.

I find your answers very helpful on that.

My other concern, is the possibility of block grants, as has been recommended by the administration, so that the States themselves can determine in each particular instance where the major need is—what would be your reaction to that?

Senator KENNEDY. In general, I believe that the existing system of categorical grants under the Hill-Burton Act has worked fairly well and I would be reluctant to go to a system of block grants. A separate question raised by your observation, is, whether the States themselves should have the sole power to decide what is in the best interest of their varying communities, or whether the urban areas, by some kind of direct application procedure, should be apt to make their own judgment.

One recent example of the controversy is the Safe Streets Act, which passed the Congress in the last session. Eighty-five percent of the Federal action grants went directly to the States themselves, to be divided among various programs on the basis of applications to the States by the respective communities. Only 15 percent of the funds was left for direct grants by the administrator of the program in Washington.

I take issue with that approach of course. There is certainly a role for the States in drafting plans and recognizing health needs. I believe, however, that the political subdivisions within the State ought to have an opportunity to develop the kinds of programs which they feel are best equipped to meet their needs, and that they should have the opportunity to receive direct Federal funding.

So I would be inclined toward at least some direct funding to the political subdivisions of the various States, rather than have the funds go solely to the States, with the States making the determination as to how these funds are to be distributed to local communities.

Senator DOMINICK. Well, we always get, of course, different ideas on these subjects. As I understand the public health group which testified this morning, they were opposed in part to S. 1733 on the ground that it did reserve 20 percent of the total funds to HEW for direct grants. They wanted it all distributed so that the States could decide.

I would gather that you would not be in agreement on that, you would think that more of it ought to be reversed and allocated directly out of here.

Senator KENNEDY. That is correct.

Senator DOMINICK. That is all, Mr. Chairman.

Thank you.

The CHAIRMAN. Thank you, Senator Kennedy. I shall not have questions at this time, because you are a member of this subcommittee and you will be at all executive sessions drafting the bills. We shall have the benefit of your advice and your thinking at that time.

I thank you, though, for making this statement for the public record, so that all of the Senators can have the benefit of your views on this very important subject.

Thank you very much.

Senator KENNEDY. Thank you, Mr. Chairman.

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

Senator HUGHES. None at this time.

The CHAIRMAN. Senator Eagleton, I am glad you are here. I have to catch a plane and I am forced to leave. I am glad you are here to serve as chairman.

Senator EAGLETON (presiding pro tempore). Mr. Sherwin L. Memel, vice president of the Federation of American Hospitals, Inc. With Mr. Memel, Mr. Samuel Weems, chairman of the Legislative Committee of the Federation of American Hospitals, and Mr. Michael D. Bromberg, acting executive director of the federation.

STATEMENT OF SHERWIN L. MEMEL, VICE PRESIDENT, FEDERATION OF AMERICAN HOSPITALS, INC.; ACCOMPANIED BY SAMUEL WEEMS, CHAIRMAN, LEGISLATIVE COMMITTEE; AND MICHAEL D. BROMBERG, ACTING EXECUTIVE DIRECTOR

Mr. MEMEL. Mr. Chairman, members of the subcommittee, I am Sherwin L. Memel, a vice president of the Federation of American Hospitals and executive director and legal counsel of the United Hospital Association. The Federation of American Hospitals is a national nonprofit association representing the interests of proprietary hospitals throughout the United States.

Our organization is just 4 years old and this is our first opportunity to appear before this subcommittee. We appreciate this opportunity to testify on the proposed Hill-Burton Act Amendments of 1969. I am accompanied today by Mr. Sam Weems, chairman of the Legislative Committee of the federation, and by Mr. Michael Bromberg, who will become Washington representative for the federation this coming month. The federation has members in 21 States in the United States and represents through its own members and its affiliated State organizations over 450 of the Nation's proprietary hospitals.

I might mention at this point that I believe we have proprietary hospitals in the States of each of the members of the subcommittee who are here today.

The United Hospital Association, organized 8 years ago, is a nonprofit California association of proprietary hospitals having as members over 116 proprietary hospitals in the State of California representing over 80 percent of the proprietary beds in the State. The United Hospital Association joins in this testimony.

Senator EAGLETON. Mr. Memel, what is a proprietary hospital as opposed to a nonproprietary hospital?

Mr. MEMEL. A proprietary hospital is one which is built with private capital and is not only owned by the builders, as is a governmental hospital or a nonprofit hospital, but in addition, any surplus, which in this case would be considered a profit, would inure to the benefit of the owners. The term "proprietary hospital" has grown up in that connection.

In my remarks, I deal with that in a few moments.

Senator EAGLETON. Would Faith Hospital in St. Louis, would you happen to know whether that would be a proprietary hospital?

Do you have them by city or State?

Mr. MEMAL. I guess I do have them by State. Excelsior Springs Hospital in Missouri, a 206-bed hospital.

Senator EAGLETON. Any others in Missouri?

Mr. MEMAL. Oh, yes. Latham Hospital in California, Mo.; Clinton General Hospital in Clinton; Willows Maternity Sanitarium in Kansas City; Presnell Hospital in Kennett, Mo.

Senator EAGLETON. Any in the two big cities, St. Louis and Kansas City?

Mr. MEMAL. I mentioned the Maternity Hospital in Kansas City, and in St. Louis, we have Park Lane Memorial Hospital. We have one in St. Joseph, also.

Senator EAGLETON. How about in Colorado?

Mr. MEMAL. In Colorado, there are several. There would be one in Boulder, Colo., called Mesa Vista Sanitarium. Then there is Emory John Brady Hospital in Colorado Springs, Colo., a 120-bed hospital. There is Estes Park Hospital in Estes Park, Colo.

Those are the only ones in Colorado.

Senator EAGLETON. How about Iowa?

Mr. MEMEL. There are several more in Iowa than that. In Iowa, in Des Moines, there is Northwest Hospital; in Buffalo Center, Iowa, there is Buffalo Center Hospital and Clinic. In Dexter, Iowa, there is Clinic Hospital. In Knoxville, Iowa, there is Townes Memorial Hospital; in Lake City, Iowa, there is McVey Memorial Hospital. In Sibley, Iowa, there is Osceola Memorial Hospital.

Senator EAGLETON. Thank you. You may continue.

Mr. MEMEL. According to the latest available published statics of the American Hospital Association, the AHA, there are 821 acute short-term proprietary or investor-owned hospitals in the United States and 3,461 nonprofit, nongovernmental hospitals in the United States, a total of 4,282 nongovernmental hospitals.

Proprietary hospitals, therefore, represent over 20 percent of the total nongovernmental hospitals of the United States. This figure of 20 percent is, however, misleading in that in many areas of the United States the percentage is much higher, perhaps the only hopsital in a community or in a given region is a proprietary hospital. In that case, the proprietary hospital represents 100 percent of the hospital facilities in that area.

This figure is also misleading in that in various States of the United States, proprietary hospitals are a much more significant factor than the national average. For example, taking my State of California, based on the latest available information, there are approximately 260 nonprofit, nongovernmental hospitals and approximately 184 proprietary hospitals. Thus, of the approximately 444 nongovernmental hospitals in the State of California, proprietary hospitals represent over 40 percent.

In terms of total beds, proprietary hospitals, according to the same AHA sources, represent over 47,000 of the 597,000-plus beds in nongovernmental hospitals in the United States, or approximately 8 percent of the total.

Again, if you look at the State of California, there are approximately 54,500 nongovernmental beds in the State, of which 42,000 are in nonprofit, nongovernmental institutions and 12,500 are in proprietary institutions.

Therefore, proprietary hospitals contain approximately 23 percent of the nongovernmental beds in the State of California. I believe you will find a similar situation, for example, in the State of Texas. In

selected areas of States, however, proprietary hospitals represent up to 100 percent of the beds.

The statistical information which I have just given must be evaluated with a view to the fact that only hospitals registered with the AHA are included in these statistics. There are a number of proprietary hospitals around the United States, according to my information, which are not registered with the AHA and which, therefore, are not included in the statistics. The statistics of the AHA have shown that up until 1967 the number of proprietary hospitals in the United States have declined, although the number of beds overall have increased. My estimate is that today proprietary hospitals are increasing in number as well as in terms of beds.

Investor-owned proprietary hospitals throughout the United States provide emergency, maternity, pediatrics, and other specialized services, often as the only hospitals in their area providing such services and often without recouping the full cost of such services. They provide these services in recognition of the fact that they have an obligation to the community in which they are located.

The term "proprietary" or "for profit" has been applied historically to hospitals which have been financed other than on a nonprofit or governmental basis and where any net profits inure to the benefit of the owners. I prefer to term these hospitals "investor-owned hospitals," for, in fact, nonprofit and governmental hospitals are proprietary in the sense that they are owned by the organizations that operate them, and I believe the term "investor owned" is more appropriate than "for-profit hospital" because the latter term implies an exclusive purpose of operation for profit, which is absolutely untrue for the vast majority of investor-owned hospitals in the United States.

Many investor-owned hospitals were built completely without any profit motivation. Often a physician or a group of physicians in a community needed a place to care for their patients. The community could not provide them with such a place for a variety of reasons; therefore, they built a hospital solely to have a place to care for their patients.

I believe that in a report to the Interstate and Foreign Commerce Committee of the House, reference was made to this fact, as was reference made to this fact in the 1960 report of the Governor of the State of California, a commision appointed by the Governor, that the health needs of this State could never have been met without the help of these hospitals. Now, it might be said that without earning a profit, investor-owned hospitals would cease to exist. However, if earning a profit were the sole objective of the investor-owned hospitals, they would also cease to exist. Business with enlightened self-interest has increasingly recognized that it must give to a community before it can take from that community. In no other area is this more true than in the health field. The vast majority of owners and managers of investor-owned hospitals recognize that their primary mission is the delivery of quality health care.

It is the belief of those of us representing investor-owned hospitals that our methods of operation can be used as yardsticks against which to measure the efficiency of all hospitals in the delivery of quality health care at reasonable cost. Increasingly as our hospitals grow

larger, investor-owned hospitals will play a major role in leading the battle against escalation of health care cost.

Parenthetically, I might say that about 2½ or 3 years ago, the Chamber of Commerce of the United States, in its annual report, made a recommendation that 200- and 250-bed proprietary hospitals be encouraged in their development to be used as a yardstick against which to measure the performance of all other hospitals.

Investor-owned hospitals pay property taxes, income taxes, and all other taxes applicable to business in general and still have consistently been able to operate at a rate commensurate with or lower than the rates of other hospitals of other ownership in the community. It should be borne in mind that investor-owned hospitals are subject in general to the same licensing requirements as all other hospitals, to the same requirements for accreditation, to the same requirements for certification for participation in the medicare and medicaid programs, and for participation in various Blue Cross programs. The number of investor-owned hospitals which are accredited is rapidly increasing.

I request permission to have placed into the record for the consideration of this subcommittee an article entitled "Proprietary Capital" by Richard L. Johnson as it appeared in "Capital Financing of Hospitals—Sources and Concerns," a report of the 1967 National Forum on Hospital and Health Affairs. A copy has been provided to the staff.

Senator EAGLETON. It will be made part of the record.

(The article referred to follows:)

PROPRIETARY CAPITAL: A REPORT OF THE 1967 NATIONAL FORUM ON HOSPITAL AND HEALTH AFFAIRS

(By Richard L. Johnson)

CAPITAL FINANCES OF HOSPITALS—SOURCES AND CONCERNS

In examining the subject of proprietary hospitals and the way in which they are financed, one must begin by setting aside the stereotypes that are held concerning this segment of the health field. In many ways this group more closely fits the American way of life than does it larger, more typical colleague, the voluntary, nonprofit hospital. The proprietary institution uses risk capital to create a service desired by the public and from the sale of its service it creates funds which, in turn, are expended for producing the service, for replacement and expansion of facilities and for a return on investment. This concept is as American as a hamburger and a coke.

Delving into this field is not often attempted, largely due to the fact that it is not in the main stream of health care. Statisics are inadequate and many of the facets of its operation are known only in a general way by administrators of nonprofit hospitals. The purpose of this paper is to develop the statistics behind the fiscal operation of these hospitals. It is not an attempt to examine the level of the quality of care offered.

Basically, there are two reasons for the development of proprietary hospitals. In any given situation there are either:

1. A group of investors who believe that a satisfactory return on investment can be obtained through the operation of a proprietary hospital, or

2. One or more physicians in a community who are dissatisfied with their medical staff affiliations in voluntary nonprofit hospitals and believe that this situation will be corrected if they can more closely control the operations of the institution through ownership.

The extent to which these two reasons or beliefs has led to the development of proprietary hospitals can be seen from the following table:

TABLE I.—PERCENT, BY REGION, OF PROPRIETARY HOSPITALS

Region	Number of proprietary hospitals	Total short-term general hospitals	Percent of proprietary hospitals
New England	12	302	4.0
Mid-Atlantic	76	702	10.8
South Atlantic	105	722	14.5
East North Central	21	927	2.3
East South Central	94	455	20.7
West North Central	30	756	4.0
West South Central	302	802	37.6
Mountain	7	56	12.5
Pacific	197	729	27.0
Total	[1] 834	[1] 5,951	14.0

[1] Does not include U.S. possessions.

Source: AHA Guide Issue, 1966.

Over-all, in the United States, 14.0% of the short-term general and special hospitals are proprietary. Their impact, by region of the country, varies widely, from a low of 4.0% in New England and the West North Central regions to a high of 37.6% in the West South Central region.

When they are examined by bed size, an important difference between the voluntary nonprofit hospitals and the proprietary institutions is noted.

TABLE II.—SIZE OF HOSPITALS

Size	Voluntary, nonprofit hospitals		Proprietary hospitals		State and local Government hospitals	
	Number	Percent	Number	Percent	Number	Percent
Under 25 beds	196	5.7	261	25.2	150	10.3
25–49	667	19.5	324	37.8	454	31.2
50–99	848	24.7	207	24.2	427	29.4
100–199	799	23.3	89	10.4	220	15.2
200–299	441	12.9	19	2.2	81	5.6
300–399	267	7.8	2	0.2	37	2.5
400–499	109	3.2			20	1.4
500 and over	99	2.9			64	4.4
Total	3,426	100.0	857	100.0	1,453	100.0

Source: AHA Guide Issue, 1966.

TABLE III.—CUMULATIVE PERCENTAGES OF SIZE OF HOSPITALS

[In percent]

Size	VNP	Proprietary	S. & L. Government
Under 25 beds	5.7	25.2	10.3
49 beds and under	25.2	63.0	41.0
99 beds and under	49.9	87.2	70.9
199 beds and under	73.2	97.6	86.1
299 beds and under	86.1	99.8	91.7
399 beds and under	93.9	100.0	94.2
499 beds and under	97.0		95.6
500 beds and under	100.0		100.0

Source: Table II.

This difference is even more striking when cumulative percentages are used. These two tables indicate that there are only two proprietary hospitals of 300 beds or more and none in the 400+ beds categories. One quarter of the proprietary hospitals are 25 beds or less, but only one out of ten governmental hospitals, and approximately one out of twenty voluntary, nonprofit hospitals are in this bed category.

At the size of 199 beds or less, 39 out of 40 proprietary hospitals are found, 34 out of 40 state and local government general hospitals, and only 28 out of 40 voluntary, nonprofit hospitals. Nearly two-thirds of all of the proprietary hospitals (63.0%) are 49 beds or less. Thus, with an average investment of $8,886 per bed, the bulk of the proprietary hospitals have a total capital valuation of $435,414 or less. By contrast, the voluntary, nonprofit hospital has an average investment of $24,208 per bed and is approximately three times as large. In terms of total capital value, the $435,414 of the proprietary hospital is comparable to $3,631,200 in the voluntary, nonprofit hospital, which is over eight times higher. If the proprietary hospital of 150 beds is compared to the 150 voluntary, nonprofit hospitals, the investment is $1,332,900 which is 2.7 times less than the voluntary, nonprofit hospital of equal size.

When the proprietary hospitals are compared to the general hospitals operated by state and local governments, the investment per bed and per hospital still show a striking difference. In government hospitals the investment per bed is $19,372, which is 2.2 times higher than in the proprietary hosptials.

The quality of care as measured by the Joint Commission on the Acceditation of Hospitals may at first glance appear to reveal a major difference between the three categories of hospitals. Over-all, the results are:

TABLE IV.—NUMBER AND PERCENT OF ACCREDITED, SHORT-TERM, GENERAL AND SPECIAL HOSPITALS

Type of hospital	Number of hospitals	Accredited hospitals	Percent accredited hospitals
Voluntary, nonprofit	3,426	2,562	74.7
State and local governments	1,453	686	47.2
Proprietary	857	289	33.7

Source: AHA Guide Issue, 1956.

However, when like sizes of hospitals are compared, the results are considerably changed:

TABLE V.—NUMBER AND PERCENT OF ACCREDITED SHORT-TERM, GENERAL AND SPECIAL HOSPITALS OF 200 TO 299 BEDS

Type of hospital	Number of hospitals	Accredited hospitals	Percent accredited hospitals
Voluntary, nonprofit	441	437	99.0
State and local governments	81	72	88.9
Proprietary	19	19	100.0

Source: AHA Guide Issue, 1966.

It can be concluded that at the 200–299 bed size the proprietary hospital is as concerned about the quality of the care provided patients as are the voluntary, nonprofit hospitals. This table also indicates that both types are offering a higher quality of care than that received by patients in hospitals owned and operated by state and local governments, again as measured by the JCAH.

The same general pattern follows when the comprehensiveness of service is analyzed as to the services offered by hospitals. When the over-all figures are examined for laboratory and pharmacy services, the picture is as follows:

TABLE VI.—PERCENT OF LABORATORY AND PHARMACY SERVICES OFFERED BY SHORT-TERM, GENERAL HOSPITALS

Service	Voluntary, nonprofit	All proprietary hospitals	State and local governments
Clinical laboratory	97.94	96.56	97.38
Pathology laboratory	67.11	35.46	41.34
Blood bank	67.33	39.88	57.74
EEG	31.70	21.61	20.79
Pharmacy	66.74	43.23	46.04

Source: AHA Guide Issue, 1966.

Once again when only hospitals in the 200–299 bed size are studied, the results are:

TABLE VII.—PERCENT OF LABORATORY AND PHARMACY SERVICES OFFERED BY GENERAL HOSPITALS, 200 TO 299 BEDS

Service	Voluntary, nonprofit	All proprietary hospitals	State and local governments
Clinical laboratory	99.77	100.0	100.0
Pathology laboratory	99.54	94.12	93.67
Blood bank	86.67	88.24	79.75
EEG	52.64	58.82	44.30
Pharmacy	99.08	94.12	98.73

Source: AHA Guide Issue, 1966.

This trend is apparent in other services as well:

TABLE VII.—PERCENT OF SURGICAL AND OBSTETRICAL SERVICES OFFERED BY SHORT-TERM GENERAL HOSPITALS

Service	Voluntary, nonprofit	Proprietary hospitals	State and local governments
Operating rooms	41	98.48	97.15
Recovery rooms	86	54.95	61.74
I.C.U.	48	15.07	18.24
Delivery rooms	88	78.08	92.31
Premature nursery	63.71	42.31	59.30

Source: AHA Guide Issue, 1966.

Like the previous tables, the masking effect of mixing all bed sizes is apparent. When only the 200–299 bed category is used, the results again change:

TABLE IX.—PERCENT OF SURGICAL AND OBSTETRICAL SERVICES OFFERED BY GENERAL HOSPITALS, 200 TO 299 BEDS

Service	Voluntary, nonprofit	Proprietary hospitals	State and local governments
Operating rooms	100.00	100.00	96.20
Recovery rooms	99.08	100.00	92.41
I.C.U.	64.83	29.41	49.37
Delivery rooms	94.25	88.24	87.34
Premature nursery	85.29	52.94	73.42

Source: AHA Guide Issue, 1966.

In the above table the similarities are not as close as in others. It is particularly true with the services with a high unit cost, I.C.U. and the premature nursery. From this table, it can be concluded that proprietary hospitals are more reluctant to undertake high cost services that will be used by only a small percentage of the patients admitted to the hospital than are either of the other two categories of hospitals.

Turning next to X-ray, the following pattern emerges:

TABLE X.—PERCENT OF SHORT-TERM GENERAL HOSPITALS OFFERING X-RAY SERVICES

Service	Voluntary, nonprofit	Proprietary hospitals	State and local governments
Diagnostic X-ray	98.28	98.48	98.61
X-ray therapy	46.38	15.83	24.87
Radioactive isotopes	38.38	12.02	18.78
Cobalt therapy	13.12	3.65	7.54
Radium therapy	39.94	14.46	21.32
Admitting chest films	34.29	35.01	36.41

Source: AHA Guide Issue, 1966.

From this table it can be seen that nearly all hospitals offer diagnostic radiology services. However, when an unusually heavy investment is required for a low volume service, as is the situation for x-ray therapy, the proprietary hospitals are noticeably unwilling to provide for it.

To confirm this, the 200–299 bed size offers support for this notion.

In this table, what occurs for the entire group also occurs within the 200–299 bed category, except for cobalt therapy.

TABLE XI.—PERCENT OF SHORT TERM GENERAL HOSPITALS, 200 TO 299 BEDS, OFFERING X-RAY SERVICE

Service	Voluntary, nonprofit	Proprietary	State and local governments
Diagnostic X-ray	100.00	100.00	98.73
X-ray therapy	86.44	52.94	68.35
Radioactive isotopes	78.62	70.59	58.23
Cobalt therapy	20.23	47.06	22.78
Radium therapy	76.32	58.82	70.89
Admitting chest films	34.94	29.41	41.77

Source: AHA Guide Issue, 1966.

Among the outpatient and rehabilitation services, the pattern for both the voluntary, nonprofit hospitals and proprietary ones is similar, except that the latter group lags behind the former as illustrated in the following table:

TABLE XII.—PERCENT OF SHORT-TERM GENERAL HOSPITALS OFFERING OUTPATIENT AND REHABILITATION SERVICES

Service	Voluntary, nonprofit	Proprietary	State and local governments
Outpatient clinics	40.85	38.81	36.10
Emergency care	93.72	83.87	94.84
Home care	5.93	2.28	4.23
Occupational therapy	13.40	2.89	10.16
Physical therapy	60.18	37.44	38.18
Rehabilitation unit	8.37	1.22	6.77

Source: AHA Guide Issue, 1966.

The 200–299 bed size tends to reflect the over-all trend as seen below:

TABLE XIII.—PERCENT OF SHORT-TERM GENERAL HOSPITALS, 200 TO 299 BEDS, OFFERING OUTPATIENT AND REHABILITATION SERVICES

Service	Voluntary, nonprofit	Proprietary	State and local governments
Outpatient clinics	56.55	29.41	60.76
Emergency care	98.39	100.00	91.14
Home care	8.51	0	7.59
Occupational therapy	19.54	11.76	24.05
Physical therapy	93.33	64.71	78.48
Rehabilitation unit	13.10	11.76	17.72

Source: AHA Guide Issue, 1966.

And finally when a miscellaneous group of support services are examined, the pattern is:

TABLE XIV.—PERCENT OF SHORT-TERM GENERAL HOSPITALS OFFERING SUPPORT SERVICES

Service	Voluntary nonprofit	Proprietary	State and local governments
Dental	36.41	18.26	30.64
Chaplaincy service	48.09	11.72	28.48
Chapel or prayer room	57.03	8.22	40.34
Social service	21.11	1.83	15.86
Family planning service	5.25	1.07	5.62
Psychiatric inpatient clinic	14.87	2.28	14.93

Source: AHA Guide Issue, 1966.

Within the 200–299 bed size, this picture is:

TABLE XV.—PERCENT OF SHORT-TERM GENERAL HOSPITALS, 200 TO 299 BEDS, OFFERING SUPPORT SERVICES

Service	Voluntary nonprofit	Proprietary	State and local governments
Dental	53.79	35.29	59.49
Chaplaincy service	60.92	17.25	39.24
Chapel or prayer room	77.24	29.41	50.63
Social service	42.99	17.65	48.10
Family planning service	8.05	5.88	10.13
Psychiatric inpatient service	23.91	17.65	39.24

Sourch: AHA Guide Issue, 1966.

Turning from the scope of services offered by the three categories of hospitals to the relationship of plant assets to total assets, an interesting result is obtained:

TABLE XVI.—PERCENT RELATIONSHIP OF PLANT ASSETS TO TOTAL ASSETS IN SHORT-TERM GENERAL HOSPITALS

Size	Voluntary, nonprofit	Proprietary	State and local governments
All in category	73	74	84
100 to 199	76	73	82
200 to 299	74	65	85
300 to 399	74	58	88

Source: AHA Guide Issue, 1966.

This table indicates that in the voluntary, nonprofit hospitals about three-quarters of all assets are tied up in bricks and mortar for the category as a whole as well as at selected bed sizes. In state and local governmental hospitals, physical plant assets rise to four-fifths and a these institutions become larger the percentage increases even higher.

By contrast, the over-all percentage of proprietary hospitals is three-quarters, but at the larger sizes the ratio of plant assets to total asset declines substantially. The conclusion can be reached that the larger the proprietary hospital, the more reluctant it becomes to expend funds for constructing additional physical facilities and adding new services. The voluntary, nonprofit hospitals add additional services as they grow so that they offset any increases in efficiency that might otherwise be obtained.

Before discussing the ability of proprietary hospitals to finance construction from operating funds, it might be helpful to have the following facts in mind.

TABLE XVII.—COMPARATIVE DATA ON SHORT-TERM GENERAL HOSPITALS

Factor	Voluntary, nonprofit	Proprietary	State and local governments
Average occupancy	77.8%	68.6%	72.8%
Full-time personnel per 100 patients	252	218	234
Average expense per patient day	$45.40	$43.74	$41.84
Patient revenue per patient day	$43.96	$45.47	
Total revenue per patient day	$46.96	$47.31	
Total revenue less expense per patient day	$1.56	$3.57	
Payroll as percent of total expense	61.5% ($27.95)	50.9% ($22.27)	65.0% ($27.17)
Assets per bed	$24,208	$8,886	$19,372
Average length of stay	7.7	6.3	8.5
Average occupancy rate	77.8%	68.6%	72.8%

Source: AHA Guide Issue, 1966.

Looking at the two columns, VNP and Proprietary, it should be noted that the average occupancy of the proprietary hospital is about 9% lower than the average VNP hospital, but that the latter category has 14% more employees. When net surplus is compared to total expense, the VNP hospital is operating on a 3.4% margin, but the proprietary hospital operates on a margin of 8.2%, after depreciation.

This can be looked at from another viewpoint by considering the availability of funds for long-term indebtednes in a typical 100 bed hospital. A comparison of typical operating statistics is shown in the next table:

TABLE XVIII.—COMPARISON OF OPERATING STATISTICS IN TYPICAL 100 BED HOSPITALS

Item	VNP	Proprietary
Average daily census	78	69
Annual patient-days	28,470	25,185
Annual revenue, total	$1,337,351	$1,190,502
Annual operating expense	$1,292,538	$1,101,592
Net surplus	$44,813	$88,910

Source: AHA Guide Issue, 1966.

The most notable feature of this table is that the proprietary hospital has twice the surplus of the typical VNP hospital of the same size, and can, therefore, afford a larger long-term indebtedness. This ability to carry debt is enhanced even further when the cost of construction of new beds is concerned.

TABLE XIX.—COMPARISON OF COSTS OF CONSTRUCTION OF TYPICAL 100-BED HOSPITALS

Item	VNP	Proprietary
Assets per bed	$24,208	$8,886
Cost of construction per bed	33,527	11,374
Project cost per 100 beds	3,352,700	1,137,400

The construction cost per bed of a proprietary hospital is only 37% of the cost of constructing a bed in a VNP hospital. When the capital cost picture is coupled with the operating statement, it becomes understandable as to why a proprietary hospital can use long-term indebtedness to a much greater extent than can a voluntary, nonprofit hospital, because of the following:

1. Net surplus from proprietary hospitals is twice as much as in a VNP hospital.
2. The construction cost per bed of a proprietary hospital is about one-third that of a VNP hospital.

The combined effect of these two factors is that a proprietary hospital appears to have *six* times the leverage of a VNP hospital. This apparent leverage position needs further examination to determine if it reflects the actual situation.

To test the tentative conclusion, it becomes necessary to study the sources of funds generated from operations from depreciation costs and operating surpluses.

XX.—ANNUAL FUNDS AVAILABLE FOR LONG-TERM INDEBTEDNESS IN 100 BED HOSPITALS

Item	VNP	Proprietary
Net surplus annual	$44,813	$88,910
Depreciation	33,540	12,410
Medicare	8,383	10,660
Annual total funds available	86,736	111,980

This indicates the proprietary hospital has 29% more funds annually available than the VNP hospital of the same size that may be used to finance the construction for a project. When the cost of construction and the operating surplus effect is taken into account, the result is as follows:

XXI.—COMPARISON OF COSTS OF CONSTRUCTION AND ANNUAL AVAILABILITY OF FUNDS

Item	VNP	Proprietary	Relationship
Cost of construction of 100 beds	$3,352,700	$1,137,400	2.7
Annual funds available after operations	$86,736	$111,980	.8
Actual difference in leverage	1.0	+0	3.5

The financing implications between the two categories is clear. Given the set of conditions outlined in the previous tables, it can be concluded that a proprietary hospital can construct 3½ times more buildings through long-term debt than can a VNP hospital of equivalent size.

Because of the numerous tables required to present this picture of proprietary hospitals, a short review of the major points brought out along the way may be helpful.

1. The typical proprietary hospital has a capital investment eight times smaller than the typical voluntary, nonprofit hospitals and 2.7 times smaller than the typical hospitals operated by state and local governments.

2. Proprietary hospitals have 14% fewer employees than voluntary, nonprofit hospitals and 7% fewer than the governmental hospitals.

3. On an average proprietary hospitals have a surplus of 8.2% while the voluntary, nonprofit hospitals have a 3.4% surplus.

4. Payroll in a voluntary, nonprofit hospital is 61.5% of total expense, 65% in state and local government hospitals, but only 50.9% in proprietary hospitals.

5. The quality of care, as measured by the Joint Commission on the Accreditation of Hospitals, is slightly better in proprietary hospitals of 200 beds or more than in voluntary, nonprofit hospitals and both of these groups are considerably better than the care received in state and local government hospitals.

6. Proprietary hospitals have no hesitation in investing in expensive patient services (i.e., Operating Rooms) when the volume of usage is high.

7. Proprietary hospitals tend to avoid offering patient services requiring large investments and high operating costs when the volume of usage is low.

8. Proprietary hospitals shy away from offering services primarily used by patients who have long-term illnesses that makes their ability to pay for such service questionable.

9. Proprietary hospitals are likely to use outside contractors to provide services (i.e., housekeeping and laundry) if, by doing so, they avoid capital investment.

10. Proprietary hospitals are unlikely to use an outside contractor if they have to make a capital investment in facilities in spite of the contract service, such as the case in dietary departments.

11. The larger the proprietary hospital, the more reluctant it becomes to tie up funds in brick and mortar.

12. As proprietary hospitals increase in size, they increase in efficiency. By comparison, the voluntary, nonprofit hospital typically adds to the comprehensiveness of its service and does not increase its efficiency.

13. From the standpoint of a bond holder, the proprietary hospital is 3.5 times a better financial risk than a voluntary, nonprofit hospital.

In conclusion, it seems pertinent to observe that the image that voluntary, nonprofit hospital administrators have of proprietary hospitals is primarily based

on the large number of proprietary institutions that are 49 beds or less in size. Further, their opinion may be a reflection of the fact that the capital invesment in a proprietary hospital is only 37% of the amount invested in a voluntary, nonprofit hospital. At the 200 bed size and up, there is no objective data that will support the conclusion that the quality of care is superior in a voluntary, nonprofit hospital to that offered by a proprietary hospital, for the range of services that are made available. It can be speculated that as the 200+ bed voluntary, nonprofit hospitals increasingly turn to long-term indebtedness to finance construction, their characteristics will become more like the 200+ bed proprietary hospital. In order to use this financing mechanism effectively, the VNP hospital will have to reverse the trend in the construction cost per bed. To do so will require a degree of firmness about the use of space that has not been present for a number of years. The prediction can be made that the cost effectiveness approach now being applied by the Department of Defense under the prodding of Secretary McNamara will inevitably become a management technique adopted by hospitals. The question that will be debated by VNP hospitals in the next decade will not revolve around the suitability of its application to hospitals, but will rather be about the speed with which it should be applied.

APPENDIX A.—PERCENT OF AVERAGE OCCUPANCY BY BED SIZE

[In percent]

Bed size	VNP	Proprietary	S. & L. Government
Under 25 beds	53.2	55.7	49.4
25 to 49	61.4	65.0	61.6
50 to 99	68.8	69.4	65.2
100 to 199	75.6	71.4	71.8
200 to 299	80.2	76.8	76.9
300 to 399	82.2	81.0	74.3
400 to 499	82.9	----------	78.5
500 and over	82.9	----------	78.5
Average of all	77.8	68.6	72.8

Source: AHA Guide Issue, 1966.

APPENDIX B.—NUMBER OF SHORT-TERM GENERAL HOSPITALS IN UNITED STATES

Bed size	Voluntary, nonprofit	Proprietary	State and local Governments
Under 25 beds	196	216	150
25 to 49	667	324	454
50 to 99	848	207	427
100 to 199	799	89	220
200 to 299	441	19	81
300 to 399	267	2	37
400 to 499	109	----------	20
500 and over	99	----------	64
Total	3,426	857	1,453

Source: AHA Guide Issue, 1966.

APPENDIX C.—PERCENT USE OF OUTSIDE SERVICES BY SHORT-TERM GENERAL HOSPITALS

[In percent]

Type of service	VNP	Proprietary	S. & L. government
All in category:			
Dietary	8.24	3.50	4.70
Housekeeping	3.34	3.35	.31
Laundry	32.79	77.63	41.80
200 to 299 bed size:			
Dietary	13.56	5.88	6.33
Housekeeping	4.37	17.65	0.0
Laundry	15.40	64.71	22.22

Source: AHA Guide Issue, 1966.

ANALYSIS OF HOSPITAL PROJECTS ENDORSED 1963–65 BY HOSPITAL PLANNING COUNCIL FOR METROPOLITAN CHICAGO

	15 city hospitals	Percent of total cost	16 suburban hospitals	Percent of total cost	31 total projects	Percent of total cost
Beds added:						
Endorsed	1,844		2,076		3,917	
Actual	1,976		2,099		4,075	
Beds deleted:						
Endorsed	610		149		759	
Actual	777		194		971	
Total beds:						
Endorsed	6,869		4,726		11,595	
Actual	6,470		5,189		11,659	
Total cost:						
Endorsed	$64,763,619		$75,559,450		$140,323,069	
Actual	82,479,451	100	97,405,738	100	179,885,189	100
Hill-Burton grants:						
Endorsed	4,256,533		5,875,000		10,131,533	
Actual	3,413,415	4	6,270,701	7	9,684,116	5
NIH grants:						
Endorsed	2,350,000		0		2,350,000	
Actual	1,935,000	2	0		1,935,000	1
Contributions:						
Endorsed	22,005,805		23,337,450		45,343,255	
Actual	20,994,641	26	24,492,137	26	46,486,778	26
Endowment funds:						
Endorsed	4,200,000		1,000,000		5,200,000	
Actual	3,088,155	4	1,000,000	1	4,088,155	2
Accumulated reserves:						
Endorsed	12,045,748		18,619,000		30,664,748	
Actual	20,798,240	25	25,667,171	26	46,465,411	26
Religious communities:						
Endorsed	0		0		0	
Actual	0		2,838,000	3	2,838,000	2
Loans:						
Endorsed	20,005,533		24,687,000		44,692,533	
Actual	32,250,000	39	36,137,729	37	68,387,729	38

WHAT YOU SHOULD KNOW ABOUT THE AUTHOR

RICHARD L. JOHNSON, *Vice President*, A. T. Kearney & Company, Inc., Management Consultants, 100 South Wacker Drive, Chicago, Illinois 60606, (312) 782–2868.

Education: B.S. in Liberal Arts, Northwestern University, 1947. M.B.A. in Hospital Administration, University of Chicago, 1950.

Industry experience: Assistant Superintendent of University of Chicago Hospitals and Clinics, Chicago, Illinois; Associate Director of Graduate Program of Hospital Administration and Assistant Professor of Graduate School of Business, University of Chicago, Chicago, Illinois; Director of University of Missouri Teaching Hospitals, Columbia, Missouri, Associate Professor of School of Medicine; Assistant Director of American Hospital Association, Chicago, Illinois; Director of Hospital Counseling Program of American Hospital Association; Lecturer, Graduate Program of Hospital Administration of the University of Chicago.

Consulting experience: Type of Assignment, Organization study of a multi-hospital system. Long-range planning study for a hospital in an urban renewal development area. Reorganization of a medical staff in a voluntary hospital. Area-wide planning study of hospitals in a metropolitan area. Organization study of a large voluntary hospital. Planning health facilities for a small, semi-rural community. Review of physical plant. Review of a state operated alcoholic rehabilitation program. Board-medical staff-administrator relationships. Long-range plan for a County home emphasizing mental health programs. Merger of the two general hospitals in a community.

Professional associations: Beta Gamma Sigma; Fellow, American College of Hospital Administrators; Member, American Hospital Association; Member, American Public Health Association.

Mr. MEMEL. Additionally, I request permission to submit for the record a copy of a speech delivered by Philip D. Bonnet, M.D., at the

Association of Western Hospitals meeting in Anaheim, Calif., on May 1, 1969.

Senator EAGLETON. It will be filed with the subcommittee staff.

Mr. MEMEL. Dr. Bonnet is a past president of the American Hospital Association and professor in health care at Johns Hopkins University. These articles bring us to the heart of the matter on which we appear today—that is, the need of this Nation to adequately maintain and increase hospital facilities to serve the public.

As indicated by Dr. Bonnet in his remarks and as indicated in the issue on capital financing of October 16, 1968, of Hospitals, the official magazine of the American Hospital Association, the capital requirements of hospitals in this country cannot conceivably be met in the next decade by traditional methods of financing; that is, by philanthropy and by Government funds. Other sources must be looked to.

These sources, we in the investor-owned hospital field believe, must come from the private sector. There is a major role to be played by investor-owned hospitals in the future health care of this country, and investor sources can help provide the capital to build and modernize the hospitals.

On page 11 of House Report 91–262 on the Hill-Burton amendments, the following langauge appears:

> The committee wishes to emphasize its desire that in the administration of the hospital construction and modernization program, the State agencies and the Department of Health, Education, and Welfare be alert to opportunities wherever they exist to maximize the degree of private participation in the program. Where private enterprise wishes to construct or expand existing facilities, the committee feels that this development should be encouraged, subject, however, to the overriding concern that the interests of patients in receiving the best medical care be given primary emphasis.

Although this language appears under the title "Extended Care Facilities," we believe it is equally applicable to investor-owned acute general hospitals.

No hospital is debt financed 100 percent. To the degree that hospitals are not financed by loans, capital of investor owners can help meet future capital requirements. Consistent with normal business practices, it should not be expected that investor-owned hospitals will be built completely for cash of the investor owners. Borrowed sums will be required.

For the many investor-owned hospitals presently in need of expansion or modernization or yet to be built by investors, assistance is required in obtaining loans. The hospital is a single-purpose building, often little understood by the financial institutions from whom the loan is sought. This is one of the major reasons that Government guarantee programs have been adopted for proprietary or investor-owned convalescent facilities and for the nonprofit hospital.

The situation is no different for the investor-owned acute general hospital. It is to the best interest of the Federal Government and to the citizens it serves to provide a mortgage loan guaranty program for investor-owned hospitals to stimulate this method of providing capital for the development and maintenance of hospitals in the United States in the future.

The investor-owned hospitals recognize that they must conduct themselves as part of the general hospital community and participate under

Public Law 89–749 and other Federal acts in comprehensive health planning. Investor-owned hospitals must govern their development and growth consistent with national, regional, and State plans for hospital development. Throughout the United States, representatives of investor-owned hospitals are serving on planning councils and are participating in the growth and development of comprehensive health planning. The organizations I represent intend to continue to urge this cooperation with comprehensive health planning.

We urge the consideration of this subcommittee of our request to amend the legislation now before the subcommittee, to permit investor-owned hospitals to participate in the guaranteed mortgage loan program, without, however, any interest subsidy. We believe this recognition of the vital role of investor-owned hospitals will be in the public interest.

Mr. Chairman, Mr. Weems has a very brief example to give you that I think the committee might find of interest.

Senator EAGLETON. Mr. Weems, you may proceed.

Mr. WEEMS. Mr. Chairman and members of the committee, my name is Sam Weems. For the past 4 years I have served as a member of the board of directors of the Federation of American Hospitals. I am a smalltown lawyer from Des Arc, Ark.

I would like to discuss with you the situation of the Des Arc General Hospital. Shortly after World War II, a New York doctor was discharged from the U.S. Army and, after touring the country, he settled in a small rural section of Arkansas and opened his office. It was not long thereafter until our community became completely isolated because of the annual winter floods. It was a usual occurrence for Des Arc to be completely surrounded by water for 6 to 8 weeks at a time. In the event there was a serious illness, the only method of reaching the nearest hospital 50 miles away was by boat. This trip often took as long as 2 days.

The people in Des Arc lived in a poor section of our State. It was because of this need that our doctor founded his hospital. Because the people in Prairie County, Ark., could not help themselves, today this doctor has a substantial personal investment in our community hospital.

Today, our doctor would like to keep pace with the times. He would like to remodel, purchase new equipment, and even construct a new wing to this hospital. Yet because this building is useful only for a single purpose, it is difficult to secure private financing to update this institution.

All that our hospital asks, and asks on behalf of the investor-owned hospitals of America, is that our hospitals be included under the Federal guaranteed loan section of the Hill-Burton program. Currently, other privately owned institutions in other areas of endeavor receive Federal guaranteed loans. Thus precedents have been established.

I would point out that it is the official position of the investor owned hospitals of America that quality care must be given the people of our country at the lowest possible cost. The investor-owned hospital is a partner in the national health programs. It must be remembered that investor-owned hospitals have filled the health care needs in many communities which cannot afford to construct such institutions.

By personal investment, such as my example shows, the governmental agencies have not been compelled to expend large sums of money in specific areas. I would point out that there are many millions of dollars invested in investor-owned hospitals of our country.

During the 4 years I have served on the Board of Directors of the Federation of American Hospitals, I have learned of many other hospitals constructed with personal funds in many other poor sections of our Nation. These hospitals are providing a service to the society in these areas because the society cannot help themselves.

I submit to you for your consideration that privately owned hospitals should be allowed to qualify for Federal guaranteed loans in order to continue to give quality care to the people of our Nation.

Thank you.

Senator EAGLETON. Thank you very much, Mr. Weems.

Mr. Bromberg, do you have a statement that you wish to submit?

Mr. BROMBERG. No statement at this time, Senator, thank you.

Senator EAGLETON. Senator Dominick, do you have any questions?

Senator DOMINICK. Thank you, Mr. Chairman.

I think it would be helpful for the record if Mr. Memel would insert a record, State-by-State, of the proprietary hospitals that are within the Federation.

It is not included in your statement. If you have such a record, could you provide it for us?

Mr. MEMEL. Yes, we would be glad to provide that information, if granted permission to do so.

Senator EAGLETON. It may be submitted later and will become a part of the record at that time.

(The information referred to follows:)

FEDERATION OF AMERICAN HOSPITALS, INC.,
Little Rock, Ark., July 10, 1969.

HON. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare, New Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: Attached is the information requested from Messrs. Sherwin Memel and Samuel Weems at the time of their testifying before the Senate Labor and Public Welfare Subcommittee on Health.

Regarding the question of average per diem cost, we are only able to furnish figures on average expense per patient day not broken down into room charges and other charges.

The information I am providing you was obtained from "Hospitals," Journal of the American Hospital Association, Guide Issue, Part Two, August 1, 1968, pages 454 to 465.

The total average expense per patient day in 1967 for all hospitals was $54.08. The total average expense per patient day in 1967 for non-governmental, non-profit hospitals was $54.99.

The total average expense per patient day in 1967 for non-governmental, for-profit hospitals was $51.84.

Regarding your request for a region-by-region breakdown, I am taking the liberty of giving you the average cost per patient day of non-governmental, for-profit hospitals, as compared with non-governmental, non-profit hospitals for each of the states having for-profit hospitals (some states do not have for-profit hospitals) so far as these figures are available in the AHA Guide.

Also attached is a list of every investor-owned hospital in the United States presently known to us, which list was compiled primarily from the American Hospital Association Guide. This list includes the name of the hospital, the city in which located, the number of beds, whether or not it is accredited, and whether or not it is a member of the Federation of American Hospitals or one of its affiliated state associations.

If any other information is needed, please advise us and we will provide it for you immediately.

Sincerely,

PORTER BRIGGS, *Field Director.*

EXPENSE PER PATIENT-DAY[1]

Region and State	Nongovernmental nonprofit	Nongovernmental for-profit
Region 1:		
Connecticut	68.28	----
Maine	46.82	----
Massachusetts	69.67	43.43
New Hampshire	51.65	----
Rhode Island	66.23	----
Vermont	52.75	----
Region 2:		
New Jersey	54.61	50.02
New York	64.16	51.67
Pennsylvania	47.74	38.48
Region 3:		
Delaware	61.75	----
District of Columbia	70.28	----
Florida	53.69	54.39
Georgia	47.80	37.67
Maryland	62.78	46.82
North Carolina	42.96	46.17
South Carolina	40.52	37.20
Virginia	43.46	38.04
West Virginia	43.84	41.48
Region 4:		
Illinois	55.23	49.12
Indiana	47.34	42.29
Michigan	58.69	52.24
Ohio	51.92	35.13
Wisconsin	46.63	47.40
Region 5:		
Alabama	47.54	43.78
Kentucky	43.75	33.05
Mississippi	43.10	42.41
Tennessee	48.15	40.48
Region 6:		
Iowa	41.66	45.27
Kansas	41.44	31.51
Minnesota	51.04	----
Missouri	50.95	37.49
Nebraska	44.48	20.19
North Dakota	39.48	22.53
South Dakota	38.68	----
Region 7:		
Arkansas	39.69	42.70
Louisiana	52.92	44.81
Oklahoma	47.18	40.93
Texas	50.60	48.88
Region 8:		
Arizona	64.06	57.05
Colorado	53.96	46.70
Idaho	46.46	64.37
Montana	44.73	34.59
Nevada	54.89	79.64
New Mexico	51.06	50.37
Utah	54.74	51.38
Wyoming	31.65	47.57
Region 9:		
Alaska	65.85	----
California	77.06	70.61
Hawaii	62.51	66.35
Oregon	57.71	59.95
Washington	65.54	64.00

[1] Figures from Journal of the American Hospital Association, Aug. 1, 1968, Guide Issue, pt. 2.

Senator DOMINICK. Mr. Chairman, I have just a couple of questions here. I am probably not as knowledgeable in this subject as I should be, even though my father at one point was chairman of the board of one of the big hospitals in New York City, namely, the Roosevelt Hospital. I have never been able to get the differentiations in the associations clear in my mind.

You are a vice president of the Federation of American Hospitals. Is this a different group from the American Hospital Association?

Mr. MEMEL. It is a different group, Senator. I might add, however, that many of the members of our organization do also belong to the American Hospital Association. This parallels, for example, the Catholic Hospital Association. They have an organization that represents them.

I believe there also is a Protestant Hospital Association. Their members belong to the American Hospital Association.

However, many of our members do not belong to the American Hospital Association. Over the years, the American Hospital Association has primarily spoken, legislatively at least, on behalf of the nonprofit hospitals, which are its members. For that reason, the Federation of American Hospitals was formed to speak for the interests of the proprietary hospitals, as we are doing today.

Senator DOMINICK. So the Federation of American Hospitals is an organization of proprietary hospitals, is that correct?

Mr. MEMEL. That is correct.

Senator DOMINICK. You are also executive director and legal counsel of the United Hospital Association. What association is that? How do you fit that into the pattern?

Mr. MEMEL. Well, in California, Oregon, Texas, Louisiana, I believe Tennessee, New York, perhaps several other States, there are statewide associations or regional associations also exclusively of proprietary hospitals. There is a statewide association of proprietary hospitals in the State of California. All of our members, with rare exception, also do belong to a State association called the California Hospital Association, which is affiliated with the American Hospital Association.

The California Hospital Association, again, encompasses hospitals of all types of ownership. Again, paralleling the American Hospital Association, in the State of California, we have a District Hospital Association. I believe there is also a group for the county hospitals. Our State being exceptionally organization minded, we also have local hospital councils, to which our hospitals belong in several parts of the State.

To complicate it even further, Senator, there are regional hospital associations, such as the Association of Western Hospitals, which are primarily educational in character. They put on a trade show once a year; they have educational seminars, they cover seven or eight States. The hospital people are very organization minded, sir.

Senator DOMINICK. What you would like to have is a guarantee of a loan? A guarantee of the loan provisions to be included within that, even though you do not want an interest subsidy; is that correct?

Mr. MEMEL. Yes, sir; that is correct.

Senator DOMINICK. Let me ask you this, in the division of Hill-Burton funds at the present time, under the present act, are the proprietary hospitals included within that?

Mr. MEMEL. No, sir; they are not included. The language of the act specifically speaks of the nonprofit hospital and proprietary hospitals are not eligible for any of those funds.

Senator DOMINICK. And the House bill did not include proprietary hospitals?

Mr. MEMEL. It did not.

Senator DOMINICK. Are you asking provision of funds on terms of grants also be included on proprietary hospitals?

Mr. MEMEL. No, we are not seeking participation in the grant program.

Senator DOMINICK. You are asking only then to be included in the terms of the guarantee of the hospital loan program?

Mr. MEMEL. Yes, sir; we believe that if there is an area which is entitled to assistance, based on need, for modernization or expansion, then irrespective of the ownership, the hospital that is in that area should be entitled to the benefits of the act, because it is serving the community in that area.

Senator DOMINICK. Would there be any objection on your part if such an amendment were put in, to also require that the proprietary hospital be accredited and registered with the American Hospital Assocation?

Mr. MEMEL. No, sir.

Senator DOMINICK. One of the problems that we might have is that unless we have some such accreditation body, many people, who for one reason or another, might object strenuously to this type activity on behalf of private enterprise.

Mr. MEMEL. We have this situation, if I may comment, I do not believe that it is objectionable. The only problem that we have is up until this past year hospitals under 25 beds were not eligible for accreditation. Only this past year was this minimum reduced to the number of six.

Now, in California and New York we have large institutions, 150-300-bed proprietary institutions, but in many parts of the country, such as Des Arc, Ark., where Mr. Weins' hospital is located, and I believe your State, Iowa, and Texas, some places where there are vast distances between cities, or physicians are forced to build small hospitals and now they are in need of modernization, they were not previously accredited. Certain of the physical requirements for accreditation possibly could not be met, such as sprinkler systems, which have come along recently and were not early accreditation requirements, but they have been getting stronger and stronger and stronger, and presently there is a great revision of the Commission standard in prospect which will probably go into effect on January 1, 1970.

The very purposes for which one of these hospitals might need the loan, that is, to qualify for accreditation, to put in more emergency power systems or more sprinkler systems and things of that nature, which might preclude it from being accredited at this time, might also preclude it from participating in the loan program.

Now, that would not apply to all proprietary hospitals, but it would create certain situations possibly for some of those hospitals most in need of the privilege of participating.

Senator DOMINICK. In your breakdown that you are going to furnish us later of the State-by-State, investor-owned hospitals, would that also include the number of beds in each of the hospitals? Would that be shown?

Mr. MEMEL. Yes, we will also include the number of beds, hospital by hospital.

Senator DOMINICK. The number of beds, hospital by hospital.

Mr. MEMEL. We would also attempt to include those which are accredited. The problem on this, the statistics lag as much as a year and a half or 2 years that the American Hospital Association collects. They are the only body I am now aware of that is now collecting those statistics and have the staff to do it. We will do the best we can to provide the accurate picture.

Senator DOMINICK. You do your best, and put down a note saying where the figures may be unavailable or estimated.

Thank you, Mr. Chairman.

Senator EAGLETON. Mr. Memel, if I understand correctly, it is nearer to your request you be permitted to participate in the guaranteed mortgage loan program. Why is it you are not asking for us to consider that you be able to participate either in the grant program or interest subsidy program?

Mr. MEMEL. Proprietary hospitals are not governmental organizations and are not 501(c)(3), not tax-exempt charitable institutions, and possibly I think they have never been grant oriented. We have never been given grants, to my knowledge, although in rare cases there has been some philanthropy. There are some situations

where some proprietary hospitals set up nonprofit foundations and have been doing some research. I believe in New Jersey we have a hospital doing research on birth defects, and I am sure there are others around the country. But we believe that we are willing to pay our way, so to speak, under a loan program, and we are not asking the Federal Government for the privilege of grants although we believe there is merit to a grant program to the nonprofit hospitals in this country.

According to Mr. Ray Brown, who has written an article in this October issue of the American Hospital Association Journal of hospitals I referred to, at a very minimum—and it is an interesting article—at the very minimum you are going to need about $2.5 billion per year just to maintain the existing facilities that we have now, really no increase in beds, and that is a conservative figure. Even based on Senator Yarborough's bill, as I understand it, over the next 5 years there would not be much more than $5 billion available.

We believe that those grant funds, a substantial portion of which will not be going to hospitals, should be made available for purposes for which they are presently authorized. There are not sufficient funds, we believe, to go around under the grant program.

I am certain that proprietary hospitals would not object to being the beneficiaries of grant funds, but we have never regarded this as rather a practical approach. We also have no desire to incur the displeasure of our brethren in the nonprofit community field, they traditionally regard grantmanship as their domain and we are going to leave it to them, sir.

Senator EAGLETON. Do you know of any precedent, or rather than that word, an analogy to support your request to participate in the guaranteed mortgage loan program?

Mr. MEMEL. Yes. In 1959, amendments were adopted to the National Housing Act; section 232 was enacted authorizing mortgage insurance for the construction of proprietary nursing homes. Subsequently, this has been amended to now authorize the same thing for nonprofit nursing homes, but it still does include proprietary nursing homes. I believe up to 90 percent of the cost. This is referred to on pages 10 and 11 of the Report 91–262, which I previously mentioned, of the House Interstate and Foreign Commerce Committee.

Under the Small Business Administration, I might add although it is not exactly the same thing, they are entitled to make loans to proprietary hospitals. However, the loan limit is so small, and they require first deed of trust, that it is impractical. It might have been practical 25 years ago, but today it is just not a practicality.

And, of course, we have precedent in housing but not any other precedent in the health field that I am aware of.

I might add with respect to grants, Senator, what I said earlier is not totally true. For example, under the regional medical program, I am privileged to serve on one of the local advisory committees in our State—cancer, heart, and stroke. I can conceive of no reason why that program should be limited to participation on the part of nonprofit hospitals.

Take an area such as southern California, where maybe 60 or 70 percent of the hospitals in that area, both suburban and urban, are proprietary institutions, work very cooperatively in a joint purchasing program through our hospital council, with all of the other hospitals, governmental and nonprofit, and so forth; yet, there is serious

doubt that we can participate in any way with the regional medical program, because it is limited to nonprofit institutions. We do not see any reason for that whatsoever.

There is some thinking, well, maybe if the grant is made to a nonprofit hospital, and then we participate in experiments and no money on the surface, at least, is funneled to us, maybe we could participate. But without our participation any experimentation is really worthless.

The same holds true with some of the health manpower acts where funds are made available to nurses to pay part of their tuition, and are only allowable where they are being trained in nonprofit institutions. We cannot conceive of a reason for that. We have schools in many, many of our hospitals where we cooperate with junior colleges, where there are private educational organizations which conduct nurse training programs or equivalency programs, upgrading aides, and we are not allowed to participate in those Government benefits in carrying out these programs.

But to the degree grants are involved, technically in those programs, we certainly do believe permitting proprietary hospitals to participate would be of material benefit to the health field. If this whole subject were studied and if those programs are coming up for renewal and study, I would ask this committee to consider that question.

Senator EAGLETON. One final question from me, Mr. Memel. Would you envision some kind of a formula wherein if a proprietary hospital were a borderline case in terms of profit or loss, or just very small or negligible return on investment, that it might be considered for the guaranteed mortgage loan program, whereas a proprietary hospital that was doing rather well and was running at adequate or even maybe abundant profit would not qualify for such assistance?

Mr. MEMEL. I would hesitate to encourage that type of approach, for this reason. I think that the hospital that is operating marginally would not be that great a loan risk to the lender, or perhaps for the Government, in terms of its being able to meet its obligations.

Additionally, I do not know of any proprietary hospital—although there may be some, as in any group—which is making such a substantial sum of money that when we are now talking about going high-rise, multistory, and when we are talking about expanding, talking about investments of $3, $3.5, to $4 and $4.5 million, that it can go into its operating funds and build. It is going to have to go for financing and the hospital which is showing a fair return might be showing it because it is running a very high occupancy and must expand in an important area. So that is a subject we have to consider very carefully.

Senator EAGLETON. Senator Dominick?

Senator DOMINICK. I was interested in Mr. Weems' prepared statement, where he says that the building which was built by his doctor is useful only for a single purpose. What do you mean by that?

Mr. WEEMS. It is strictly a hospital, and it is not good for anything else but a hospital, the way it is designed. It would be difficult to make any other type of building out of it.

Senator DOMINICK. I see. But it is a general hospital?

Mr. WEEMS. It is a general hospital; yes, sir. In other words, when you have got an X-ray room and emergency room, say small treatment rooms, regular beds in it, and designed as it is, it would be virtually

impossible to use it and convert it to any other type of business, other than a hospital. As a result of this, it is difficult to get financing simply because this is the only possible use for it.

Senator DOMINICK. Now, let us suppose that the hospital goes broke and the Federal Government has to foreclose. Then what do we do with the building?

Mr. WEEMS. That is a good question.

Mr. MEMEL. Excuse me, Senator. The answer to that would be the same thing you would do with a nonprofit hospital that goes busted or a county hospital that goes busted. It happens to them much more frequently that it does to us. We have a rare, rare record of proprietary institutions going busted. We think that we are excellent loan risks as an industry.

The problem is that we are not understood by the investment community. Neither are the nonprofit hospitals, I am not singling out proprietary, they do not understand hospitals and they are afraid of them. They do not know what they can do with them.

And the term "single-purpose building" is really a word of art, or a term of art in the lending community. They talk about theaters that way, too, and hotels that way, too. It is true, the Government would have to come in and try and perhaps make it into a psychiatric center, or turn it over to more efficient operators, or make it into an outpatient center, something of that sort. There are alternative health uses which it might be put to.

But we have a rare record of failure of a proprietary hospital.

Senator DOMINICK. Most businesses do quite a lot of research in the process of expanding their business. Do these hospitals do research work?

Mr. MEMEL. Proprietary hospitals do do research work, but nowhere near the proportion that is done by the nonprofit hospital.

Normally, proprietary hospitals have not been university based or university connected, nor have they had the ability to build in size to do research.

I think now that we are finding private hospitals getting into the 200- and 300-bed categories, you will find them getting into many of these areas, and research is a strong possibility. Residency and intern training programs, for example, I know proprietary hospitals are beginning to have a great interest in that area. Also, in residency for hospital administrators. I know inquiry was recently made of the program in, I believe, Minnesota, in hospital administration, where they would begin to permit residents in hospital administration to work in proprietary hospitals.

So this is now in the horizon, but the size of the proprietary hospitals before did not permit it previously nor were they eligible, of course, for any grants or philanthropic gifts to permit research.

Senator DOMINICK. My staff wondered if you would be able to supply us later, for the record, with the figures on your average room cost per day, and your other average cost of operation which you find yourself charging in various areas of the country, as opposed to the nonprofit costs and charges. You said, I think, you ran, by and large, cheaper, less expense, et cetera, et cetera.

Mr. MEMEL. Yes, sir; that is true.

Senator DOMINICK. Would you have any trouble finding these figures and furnishing it for the record?

Mr. MEMEL. That is done by the American Hospital Association Guide Issue, and we can provide you with abstracts of that, or perhaps we can gather some of our own information. Additionally, there is a table in the American Hospital Association Guide Issue which shows over the past 4 or 5 years our costs have risen about 3 percent less in proprietary institutions than they have risen in the other hospitals.

Senator DOMINICK. That is still about a 150-percent increase.

Senator EAGLETON. Will you supply us then with those materials, Mr. Memel, they will be filed with the subcommittee staff.

Mr. MEMEL. Yes, Senator, thank you.

Senator EAGLETON (presiding pro tempore). Thank you, Mr. Memel, Mr. Weems, and Mr. Bromberg. We appreciate your being with us.

Our final witness is Mr. Paul A. Strachan, the president of the American Institute for Human Engineering, Inc., Brooksville, Fla.

Mr. Strachan, we are pleased to have you with us today, sir. You may proceed.

STATEMENT OF PAUL A. STRACHAN, PRESIDENT, AMERICAN INSTITUTE FOR HUMAN ENGINEERING, BROOKSVILLE, FLA.

Mr. STRACHAN. Mr. Chairman, and members of the committee, my name is Paul A. Strachan, president, American Institute for Human Engineering, Brooksville, Fla.

As a result of injury and disease, I am 95 percent physically disabled, and among 15 other disabilities, I am totally deaf. I ask, therefore, that I be permitted to make my statement, after which I will be glad to answer questions.

I am here to testify for S. 2182. If I may say, this is the most complete set of amendments I have seen in any Hill-Burton Act, for 22 years. I congratulate you, Mr. Chairman, and your cosponsors of S. 2182, because you have done a real workmanlike job on bolstering rehabilitation by filling in many gaps in present law.

I know that the many doctors, educators, and rehabilitation specialists will testify on other sections of the bill, and I will, therefore, confine my testimony in behalf of "inclusion of cost of acquisition of land," section 117 of S. 2182, which is, in our judgment, one of the most important sections of the bill, and which reads, as follows:

> Sec. 117. Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1970, so much of paragraph (i) of the Section of such Act redesignated (by section 201 of this Act) as section 655 (42 U.S.C. 2910) as follows the semicolon is amended to read "including architect's fees and the cost of the acquisition of land, but excluding the cost of off-site improvements.

The Hill-Burton Act has plugged along for 22 years, like a three-legged table, because, unquestionably, you must have land, as a start on building any rehabilitation facility.

I may say that the former chairman of your committee, former Senator Lister Hill, who was my friend for 40 years, declared to me that, last year, he would include "acquisition of land" in the Hill-Burton amendments, then pending. But as is known, the committee never held hearings on the bill. The committee never reported a bill, so we had no chance to include a section, like section 117 in S. 2182.

So, we hope, and pray that this committee will pass the bill, S. 2182, as written, and include section 117. You will help the millions of handicapped, by so doing. I thank you.

Mr. Chairman, I want to say I have been in and around the handicapped for 47 years. I have seen all phases of it. I had a dream, I dreamed that one day the handicapped will have an agency of their own, wherein all these farflung phases will be under one tent, and you will not have to spend a lifetime chasing down where they may be benefited and helped, and the children be helped.

I thank you very much.

Senator EAGLETON. Thank you, Mr. Strachan. May I say I am familiar by reputation with the great work you have done for so many years on behalf of the handicapped, and we are very pleased to have your testimony here today. We will give it every consideration, I assure you.

Thank you, sir.

This concludes the hearings on these bills for today.

(Whereupon, at 5:07 p.m., the hearing was adjourned subject to the call of the Chair.)

MEDICAL CARE FACILITIES CONSTRUCTION AND MODERNIZATION

TUESDAY, JUNE 17, 1969

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

The subcommittee met at 10:15 a.m., pursuant to call, in room 4232, New Senate Office Building, Senator Ralph Yarborough (chairman of the subcommittee) presiding.

Present: Senators Yarborough, Kennedy, Hughes, Javits, and Saxbe.

Committee staff present: Robert O. Harris, staff director; John S. Forsythe, general counsel; James Babin, professional staff member; Roy H. Millenson, minority staff director; and Jay Cutler, minority counsel.

The CHAIRMAN. The Subcommittee on Health of the Senate Committee on Labor and Public Welfare will come to order and hearings will be resumed on the legislation before the subcommittee on hospitals, hospital construction, and other related matters.

I regret that the witnesses have been delayed, but I have been presiding as chairman of another committee since 9:30. We had hoped to finish that work by 10, but there were six Senators there and by the time six Senators question a witness, we are a quarter of an hour late.

The first witness today is the Honorable John G. Veneman, Under Secretary of Health, Education, and Welfare.

Mr. Secretary, you may introduce, if you will, those gentlemen accompanying you as you testify.

STATEMENT OF HON. JOHN G. VENEMAN, UNDER SECRETARY; ACCOMPANIED BY DR. JAMES H. CAVANAUGH, DEPUTY ASSISTANT SECRETARY, HEALTH AND SCIENTIFIC AFFAIRS; DR. HARALD M. GRANING, DIRECTOR, HILL-BURTON PROGRAM; IRVING J. LEWIS, DEPUTY ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; AND CREED BLACK, ASSISTANT SECRETARY FOR LEGISLATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. VENEMAN. Thank you, Mr. Chairman. I would like to introduce Dr. Harald M. Graning, who is the Director of the Hill-Burton program.

To my immediate right is Mr. Lewis, Deputy Administrator, Health Services and Mental Health Administration.

To my left, Dr. James Cavanaugh, Deputy Assistant Secretary, Health and Scientific Affairs.

To my far left, Mr. Creed Black, who is Assistant Secretary for Legislation of the Department of Health, Education, and Welfare.

The CHAIRMAN. Thank you. Mr. Secretary, you may proceed.

Mr. VENEMAN. Thank you. Mr. Chairman, I have a prepared statement which I would like to read and then I would like to just highlight it, if I may.

Mr. Chairman and distinguished members of the committee, I am pleased to have the opportunity to appear before you today regarding legislation which would amend title VI of the Public Health Service Act so that the Federal Government may continue to assist in modernizing and constructing hospitals and other health facilities.

Enactment of the Hill-Burton legislation in August 1946 marked the beginning of a national partnership recognizing the responsibilities of Federal, State, and local public and private agencies and organizations in construction of needed health facilities. The products of this partnership are visible in virtually every city and community and have contributed significantly to the growth and strength of the Nation.

Within this partnership, the Federal role, after consultation with the States, is to develop broad requirements and to support State and community initiatives in planning and building the facilities where they are needed. As of December 31, 1968, a total of 9,780 Hill-Burton projects have been approved. The total cost of these projects was $10.44 billion, of which $3.21 billion has come from Federal funds. These funds have assisted in the modernization or construction of health facilities containing 425,000 general and long-term care beds. In addition, Hill-Burton funds have helped construct 2,780 facilities comprising public health centers; diagnostic and treatment centers; and rehabilitation facilities. As a result, almost 90 percent of the Nation's current needs for general hospital beds have been met, as compared with only 50 percent in 1948, despite the rapid increase in population.

Other developments since enactment of the original Hill-Burton program have also contributed to the situation which exists today and to what has to be done in the health care field.

First has been the growth of public and private third-party payments for hospital care which has generally enabled hospitals to count on receipts to contribute substantially toward meeting expenses, including construction and modernization costs.

Second, the increase in medical care costs and the increasing realization of the importance of assuring health care for all our people have highlighted the need to develop alternatives to hospital care in the case of services which can be better and more efficiently performed outside the hospital. This, in turn, has emphasized the need for experimentation to develop, and for demonstrations of, innovative approaches in the delivery of health care.

In the light of this, one of our most important objectives in the health facility field should be to achieve a better balance among health facilities. Some communities have adequate acute-care facilities, yet are in need of long-term facilities. Other communities have sufficient acute and long-term-care facilities, yet insufficient ambulatory-care facilities or home-care services.

A greater effort should be made to meet this objective by redirecting the program to providing more flexibility in the use of grant funds, which will, along with community-level planning, encourage the creation of a balanced health facility system. This need for redirection can be illustrated by the fact that even though long-term-care or extended-care facilities presently have a national bed complement of 723,000, there is need for an additional 164,000 beds and 214,000 of the existing beds are in need of modernization.

This redirection of effort can best be achieved through a single block grant to be used for the modernization and construction of those special health facilities described in S. 1733. This is now possible because of the level of development of Hill-Burton State plans—these not only reflect hospital needs, but also encourage a system of coordinated and interrelated health facilities. Only through such a system can the delivery of health services be comprehensive in nature, avoiding unnecessary duplication or fragmentation of health care resources. The objective of community level planning should be the development of comprehensive services related to changing needs. Each health facility should be willing to participate in the planning effort by complementing or fulfilling a part of the coordinated system of health care as conceived by the community planning process. This willingness for each health facility to participate can in part be encouraged by providing more flexibility to the States in the utilization of grant funds in order that they may more rapidly meet community needs which may vary from community to community.

In order to increase this flexibility, we recommend that, for the purposes set out in S. 1733, grant funds be allotted to each State in a single block grant, rather than earmarked for several categories, as under the existing legislation. Moreover, we believe it appropriate to limit extension of the program to 3 rather than 5 years.

A 3-year block grant authorization, starting with $150 million for fiscal year 1970, for those facilities would increase program flexibility and enable the States to deal more effectively with community-level imbalances that presently exist among different types of health facilities. Block grants would permit the States, consistent with their State plans, to use grant funds to assist in the modernization or construction of any health facility, other than acute care hospital beds. Providing block grants would also help meet the objective of the President as delineated in his message of April 30, that—

> In the administration of Federal programs, one of the principal needs today is to improve the delivery systems: to insure that the intended services actually reach the intended recipients, and that they do so in an efficient, economical, and effective manner.

We do not recommend that State grants be used for the construction and modernization of acute hospital beds because we believe these needs can better be met through other forms of assistance.

We support a plan for direct grants to projects of national significance as proposed in S. 1733. Specifically, we propose that before annual grant fund allotments are made to the States, a percentage of funds appropriated be reserved for use by the Secretary for special project grants which would be made available, after consultation with the appropriate State, for construction or modernization of innovative projects or of projects reflecting critical needs. Such proj-

ects could be assisted up to 90 percent of their cost and would include such critically needed health facilities as ambulatory-care facilities and long-term-care facilities serving the disadvantaged, as well as projects demonstrating innovative aspects which would improve the organization and delivery of health care. This special project grant approach would provide a mechanism by which the Hill-Burton program could stay abreast of changing health facility relationships and encourage new health facility relationships as their efficiency and effectiveness are developed and demonstrated.

Under the existing program, all grant funds except those under the modernization category are allotted to the States on the basis of a formula involving only two elements, population and per capita income. At the time of the establishment of the formulas, some 20 years ago, no adequate measure of health facility need existed.

Congress, accordingly, decided to substitute for a direct measure of health facility need, a compensatory measure. This was accomplished by using per capita income twice in the formula or, in effect, using per capita income squared. There was some logic to this approach at the time because the few existing studies on the subject did show an inverse relationship between per capita income and the availability of health care facilities.

The adopted formula had the effect of directing a proportionately greater percentage of available funds into the poorer States where the problem, at that time, was most acute. After 20 years of the Hill-Burton program the picture has changed.

Now there is no difference between the States with the highest per capita income and the States with the lowest per capita income in terms of available beds per 1,000 population. And, indeed, the facilities in the poorer States are, on the average, newer facilities.

Therefore, as in S. 1733, it is recommended that the population and per capita income squared formula should be replaced by one comprising population, per capita income, used only once, and an appropriate measure of health facility need as the elements that make up the formula for the allocation of all grant funds. This change will direct today's funds toward today's needs just as the original formula did for the needs of 20 years ago.

A problem of national significance which deserves special attention is the great lack of health facilities primarily serving urban or rural poverty residents where the near absence of local resources is acute. S. 1733 would authorize the State, if it chose to do so, to increase the Federal share of funding projects for construction or modernization of such facilities (other than hospitals) to a maximum of 90 percent. Such a program is essential if we are to give maximum encouragement to local efforts designed to improve health services to the disadvantaged. We urge your inclusion of such a provision in the bill which emerges from this committee.

Recognizing the pragmatic limits of assisting health facilities through the grant mechanism, and recognizing also the growth of payments from or on behalf of hospital patients as a means of providing funds to meet expenses, we recommend the authorization of a loan guarantee program which would guarantee annually $500 million for each of the 3 fiscal years, commencing in fiscal year 1970.

The aggregate of loans to be guaranteed annually within each State would be determined in the same manner as the allotment of grant funds. All privately owned nonprofit health facility modernization or construction projects would be eligible for loan guarantees.

We believe that loan guarantees will assure that privately owned nonprofit health facilities have adequate access to the capital markets; but we do not feel that interest subsidies should supplement these loan guarantees. Since medicare and medicaid, as well as private third party payment systems, do in fact reimburse for depreciation and interest expenses, the privately owned nonprofit health facility would receive, through these reimbursement mechanisms, adequate assistance to pay off their loans and the interest thereon. The Federal guarantee of payment, combined with these forms of reimbursement, enhance the marketability of and will reduce the market interest rate on those loans.

We are most strongly opposed to inclusion of guarantees for obligations of public agencies. These agencies already enjoy unique advantages over privately owned health facilities in acquiring needed capital, because of their ability to tax as well as their ability to sell bonds that are exempt from Federal income taxation. This exemption involves such a substantial subsidy from the Federal Treasury that it need not—indeed should not—be supplemented with a second subsidy.

Further, the guarantee of tax-free public obligations creates a higher quality investment than the Federal Government's own securities and would, therefore, have an adverse impact on Federal obligations as well as on other tax-free bonds of local governments.

We further recommend that the loan guarantee program include a premium charge to be paid by the health facility to the Federal Government at a rate not to exceed one-half of 1 percent of the amount to be guaranteed. This recommendation is being presented for two reasons:

First, it is consistent with the ongoing Federal programs of the same type which require the payment of premiums and, secondly, although the risk of defaults in our judgment is low, funds should be readily available to cover such defaults if and when they occur without necessitating recourse to the tax dollar.

There is understandable concern for giving special financial assistance in the form of direct Federal project grants to general hospitals to assist in the modernization of existing emergency rooms, as contained in S. 2182. However, we feel that a Federal project grant program of this sort is inappropriate because it would create another unnecessary special grant category.

Emergency rooms are presently eligible for assistance under the existing diagnostic or treatment center category and they would continue to be eligible under S. 1733 and under the extension of the regular grant program under S. 2182. It is our view that the ongoing health facility planning bodies of the States are best able to determine where assistance is most imperative, and their judgment should not be subverted through a direct Federal assistance program which may or may not be compatible with a particular State's health facility planning effort.

Further, the unnecessary proliferation of Federal health facility assistance programs, especially when not a part of a State's ongoing

planning efforts, can frequently impede the execution of rationally developed State and community-level health plans.

Several of the bills presently under consideration by the committee provide for some kind of local planning involvement over and above the health facility planning efforts required under the Hill-Burton program proper. In this respect, we support the provisions of S. 1733 which require that the State health facility plan must be approved by the comprehensive health planning agency of the State, and that the State Hill-Burton agency must consider recommendations of the area-wide health planning agency assisted under section 314(b) of the PHS Act with respect to individual project applications.

In those areas where no 314(b) agency has been activated, such consideration would be given to the recommendations of the local area-wide planning agency which is performing similar functions. As indicated previously, a balanced approach toward facilities to deliver health care is now needed. We feel that this overall health planning involvement at the State and community levels will help insure that the health facility construction program will be directed toward this balancing of facilities.

At this point, we would like to state that we agree with the primary objectives of S. 2037, as introduced by Senators Percy and Kennedy and several of their colleagues—to provide facilities for better medical care for the needy. However, we feel that those objectives can best be achieved under the provisions of S. 1733 which would authorize assistance for nonprofit agencies in the construction of free-standing diagnostic or treatment centers furnishing services primarily in rural or urban poverty areas. This provision will permit the Nation to continue to exploit the early successes of neighborhood health centers in providing health care in poverty areas through free-standing ambulatory care facilities.

Through such a provision, the program could become a vehicle by which rural as well as urban poverty areas could be assisted in constructing the needed free-standing ambulatory care facilities, sponsored by community nonprofit groups, thus bringing vitally needed health care to long neglected segments of the population.

The well-documented health problems of the Nation's disadvantaged compels a further development of the comprehensive health services currently being provided by neighborhood health centers.

We know that community level health facility planning can best determine the specific site on which a hospital or other health facility should be constructed. However, under the existing program Federal funds cannot participate in the cost of site acquisition.

The project sponsor often cannot acquire the funds necessary to purchase the recommended site. It follows that a less appropriate site is frequently selected and purchased. The same problem exists in cases where an existing health facility should be abandoned and replaced on a new and better location.

The inability of the project sponsor to purchase the land has forced the modernization of a facility at a location less suited to assisting all of the people in the area it served. Accordingly, it is recommended that the costs related to the acquisition of a site be considered eligible for Federal participation. Such authorization would strengthen the

ability of local planning agencies to exercise their best judgment in these matters.

In the same vein the existing program permits Federal participation in the cost of needed equipment in a health facility only if there is construction associated with the project. However, in many communities the purchase of the equipment only would provide a new and needed service at a relatively small cost to the Federal Government and the project sponsor. We recommend that equipment projects, whether or not associated with construction, be considered eligible for assistance.

Mr. Chairman, we have all learned a lot about the Nation's changing health facility needs in recent years, and we now have both the opportunity and the responsibility to fulfill those needs. Legislation within the substantive and fiscal framework which I have outlined to the subcommittee would go a long way toward achieving the maximum benefits for the American people in the most efficient and effective manner. The circumstances are too compelling to warrant delay in obtaining a better health return on the dollars we are spending in the health facility field.

Accordingly, I am recommending that we not wait until expiration of the current Hill-Burton authorization but that the Congress enact a redirected program along the foregoing lines effective with the fiscal year commencing July 1, 1969.

Mr. Chairman, the program I have recommended would move into new areas of support on a flexible basis providing greater freedom to the State to exercise their judgment in meeting their needs. It recognizes the dramatic changes in health care needs and would redirect the Federal program in the best way to meet those changes.

My colleagues and I would be pleased to answer any questions which you, Mr. Chairman, and the members of the subcommittee may have.

Mr. Chairman, on behalf of both Secretary Finch and myself, we are both very pleased for this opportunity to appear before the committee regarding the future of Hill-Burton legislation.

In the 21 years that the Hill-Burton Act has been in effect, approximately 9,780 projects have been approved up until the end of 1968, for a total cost of about $10.44 billion, of which $3.21 billion were from Federal funds. This amount of money assisted in the construction and modernization of some 425,000 hospital beds and long-term care beds and it provided assistance to some 2,780 public health diagnostic and treatment centers and rehabilitation facilities.

The program itself has provided sufficient support to meet approximately 90 percent of the Nation's needs in hospital beds and this is compared to approximately 59 percent of the needs in 1948. There have been some other developments since the enactment of the original Hill-Burton program.

First of all, we have seen a rather significant growth in third-party payments to health facilities which have generally helped the hospitals to count on receipts other than the specific Hill-Burton program to meet certain kinds of expenses, including the modernization and construction costs.

Second, we have seen a trend toward increasing medical care costs and increased realization of the importance of assuring health care for all our people and the highlighting of the need to develop alterna-

tives to acute hospital bed care in the case of services which can be better and more efficiently carried out in areas outside of the hospital.

I think one of the other significant objectives in the health facility field is the need to achieve a better balance among health facilities. We have communities that have sufficient acute bed care facilities but are in need of sufficient long-term care facilities or other outpatient type facilities.

We believe that there should be a greater effort in redirecting the program, and this redirection can best be achieved, we feel, through the single block grant to be used for the modernization and construction of those special health facilities which are described in S. 1733.

It is our belief that only through such a system can the delivery of health services be comprehensive in nature, avoid unnecessary duplication or fragmentation of the health care resources.

In order to increase this flexibility, we recommend for the purposes set out in S. 1733 that the grant fund be allocated to the States in a single-block grant rather than earmarked for single categories as is the case at the present time. We believe that it would be appropriate to limit the extension of the program to 3 years, rather than the 5-year period.

The legislation recommends a 3-year block grant authorization starting with $150 million for the fiscal year 1970, and for those facilities would increase program flexibility and enable the States to deal more effectively with community-level imbalances that presently exist among different types of health facilities.

These block grants then would permit the States to use the grant funds to assist in the modernization and construction of any health facility, other than acute care hospital beds.

We do not recommend that State grants be used for the construction and modernization of acute hospital beds because we believe there are other needs that can be better met through the grant program.

We support a plan for direct grants to projects of national significance as proposed in S. 1733. Specifically, we propose that before annual grant fund allotments are made to the States that a percentage of the funds appropirated be be reserved for use by the Secretary for special project grants which would be made available after consultation with the States for construction and modernization of innovative projects or projects reflecting critical needs.

We propose that these projects would be funded up to 90 percent of their cost and would include such critically needed facilities in some areas as long-term care facilities and ambulatory care facilities serving the disadvantaged, as well as projects demonstrating innovative aspects which would improve the organization and delivery of health care.

Under the existing program, all grant funds except those under the modernization category are allotted to the States on the basis of a formula involving only two elements: population and per capita income.

Some 20 years ago when these formulas were established, there was no adequate measure of health facility needs. Congress decided to substitute for a direct measure of health facility need, a compensatory measure, by using per capital income twice in the formula or, in effect, using per capital income squared.

We feel that things have changed in the past 20 years; that the area of critical need in some of the lower per capita income States has been met; that there is not the significant difference between the needs in those States with a low per capita income and those with a high per capita income as far as facility need is concerned.

Therefore, we are recommending that as in S. 1733 the population and per capita income squared formula should be replaced by one comprising population, per capita income, used only once, not squaring, and an appropriate measure of health facility need as the elements that make up the formula for the allocation of all grant funds.

Senator JAVITS. Mr. Chairman, I wonder if this is a good stopping place.

Mr. VENEMAN. Yes, of course, Senator.

Senator JAVITS. First let me say that I am very gratified that the administration has come to this view. For years we have been urgently complaining about the continuance of what may have once been a logical formula but which has since become illogical through time and experience.

I ask unanimous consent, Mr. Chairman, that a front page story in last night's Evening Star be inserted in the record. This story shows what happens when unneeded hospitals are constructed as compared with a lack of hospitals where they are urgently needed; and I would ask the witness to give me the Department's comments upon the facts disclosed in the article as a part of his testimony.

The CHAIRMAN. Yes. I assume that the witness is familiar with the article.

Mr. VENEMAN. I am familiar with the article, Mr. Chairman.

The CHAIRMAN. It will be inserted in the record at this point.

(The material referred to follows:)

[From the Washington, D.C., Evening Star, June 16, 1969]

SENATE FIGHT BREWING OVER HOSPITAL AID BILL

(By James R. Polk)

More than 150 hospitals built or expanded with federal aid are standing half-empty in the nation's rural areas while overcrowded urban hospitals plead for more money.

A fight is boiling up in the Senate to try to chop the rural favortism out of the Hill-Burton air program and channel more cash into the outdated, overcrowded hospitals of America's major cities. But the House has already voted against such a shift.

An Associated Press examination of the hospital aid program found examples like these:

Soda Springs, Idaho, got $800,000 to help build a new and bigger Caribou County Hospital to replace an old one that was only one-third full. The new hospital, which opened in March, remains half-empty.

In Boise, Idaho, aging St. Alphonsus Hospital, the most crowded in the state, was turned down four times for federal aid even though the danger of a disastrous fire is so great that officials keep extending its license only a few weeks at a time.

Bay Minette, Ala., has just received federal aid to pay for half of a $1.5 million hospital even though there are two other hospitals in the same rural county, the nearby city of Mobile has five major hospitals, and another million-dollar hospital was built with federal aid three years ago at Atmore, only 20 miles away.

No federal aid has been spent in the last 20 years to enlarge or improve New York's crowded Harlem Hospital in one of the poorest ghettos in the nation's largest city. Harlem is getting a new 777-bed hospital soon, but all the money is coming from state and local funds.

A total of 173 hospitals that have received $50 million in Hill-Burton aid over the past two decades are listed as half-empty or worse in the latest available American Hospital Association figures on occupancy rates. All but a handful are in rural areas.

The occupancy statistics had to be taken from the AHA's 1968 "Hospitals" guide because Hill-Burton officials in Washington don't keep track of whether the facilities they build are filled.

The Hill-Burton program feeds federal aid to the states which, in turn, pass out the money to hospitals to pay anywhere from one-third to more than half of construction or expansion costs.

The law favors the rural areas with an aid formula that squares the low-income level for a state. This means a rural state twice as poor as New York will get four times as much money per person.

The program was set up in the late 1940s to fill the critical need of rural America for adequate hospitals. It has done the job well. But critics say the need today has shifted to the cities and the program has not kept pace.

A Senate Health subcommittee will continue hearings tomorrow on proposals to pump more cash into the overcrowded and antiquated hospitals of the nation's cities.

However, the House already has rejected 75–51 this month an effort to change the aid formula and distribute the funds evenly according to population and income. Opponents complained the change would mean 32 rural states would get less money.

From his window, Carver looks out on Boise's aging St. Alphonsus Hospital, one of the victims of the way Hill-Burton works. He said he checks each morning to make sure the hospital is still standing.

St. Alphonsus, which dates back to the frontier days of the 19 century, is the most crowded hospital in the state, yet it is so unsafe that Idaho authorities will extend its license only 90 days at a time.

"The place is a firetrap," said Carver.

St. Alphonsus asked for $2 million federal aid in 1964 to build a new 200-bed hospital. It was turned down that year, and the next, and the next. Not until last year did Boise get the aid—and then there were more problems.

The ground-breaking is finally set for tonight, but it will still be 1971 before the new facility is ready to replace the aging hospital.

OVERLOOKS LAKE

While St. Alphonsus waits, the small county seat of Soda Springs already has its new hospital, a modern, attractive building that overlooks a lake on the Bear River and pine covered mountains on the other side.

Soda Springs got $799,000 in federal aid in 1966 the first year it asked. The $1.7 million hospital opened this spring.

Soda Springs got the new hospital while Boise waited because of added rural bias in a second formula for passing out Hill-Burton aid at the state level.

On this scorecard, the old Soda Springs hospital was totally unacceptable. So was St. Alphonsus Hospital in Boise. But Boise has a second hospital with a small portion of beds meeting the standards. Therefore, according to the formula, Boise's percentage need was not as high as Soda Springs, and Caribou County got first priority.

When it finally got the aid, Boise still had to take a back seat.

An official recommendation put Boise in line for the $2 million last year. But two other towns, Malad City and Gooding, howled. When the swirl of politics finally settled, the recommendation had been revised to give both towns a slice of the money, too.

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., July 3, 1969.

Hon. RALPH W. YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I am pleased to forward this statement for the record which was requested during the course of hearings before your subcommittee on June 17. The request was for a response to the Associated Press article on hospitals which appeared in the Washington Evening Star on June 16, 1969.

The material for the article was developed by Mr. James R. Polk who had been given free access to the files of the Hill-Burton program. The statement in that article: "a total of 173 hospitals which have received $50 million in Hill-Burton aid over the past two decades are listed as half empty or worse in the latest available American Hospital Association's figures on occupancy rates" is in error. Using his methodology, we find the accurate figure to be 195 hospitals that received $60 million in Hill-Burton assistance. Mr. Polk also asked for and reviewed five state plans in some detail. They were Alabama, New York, West Virginia, Wisconsin, and Idaho. Mr. Polk obtained his data by going through the Hospital Guide issue of the American Hospital Association and then for each hospital with an average occupancy rate of less than 50%, ascertaining whether the hospital received Hill-Burton assistance for any portion of it.

It may be of interest to the Committee to know that the average occupancy rate for all facilities assisted under the Hill-Burton program in the aforementioned states is Alabama 76.8%, New York 81.7%, West Virginia 75.4%, Wisconsin 74.6% and Idaho 64.3%.

If the facilities aided are grouped by size, the average occupancy rate for hospitals of less than 50 beds is 70%, for those 50 to 99 beds is 75.7%, for those 100–199 beds is 79.1%, and those 200 beds or more 84%.

In discussing the article, we would propose to consider three questions.

1. What does average occupancy rate mean?

   The occupancy rate for a specific day is computed by dividing the bed census for that day by the licensed capacity of the hospital. The average occupancy rate is the average of daily occupancy rate. A hospital of 100 beds with an average occupancy rate of 75% may have had days of severe overcrowding during the year when the bed census reached 11%.

2. What is considered good?

   Qualified hospital administrators agree that, in order to be able to accommodate persons who are acutely ill and not have to defer elective surgery an inordinately long period of time, the average occupancy rate of a single large hospital in an area should not be in excess of 85%. Smaller hospitals usually operate at 70% to 75% and quite often at a lower figure. It should be mentioned that semi-private accommodations limit placement of patients by sex, that respiratory illnesses tend to be seasonable, that patients defer elective hospitalization prior to holidays, that bed census is in many hospitals intentionally low on weekends, and that a number of previously built hospitals have obstetrical beds that are relatively empty but cannot be otherwise utilized. For example, an empty 8-bed obstetrical unit in a 50-bed hospital has reduced its occupancy rate by 16%.

3. What is the interpretation of occupancy in relation to structure and how appropriate is it to use occupancy rate when discussing a recently completed project?

   Finally, Mr. Polk appeared to take issue with the fact that assistance was given by the State of Idaho in building a new hospital in Soda Springs. Its predecessor was two-thirds empty, and he makes the observation that the new hospital opened in March remains half empty. The former hospital in Soda Springs was both structurally and functionaly deficient and its low utilization was attributable to the inadequacy of the facility. Its replacement was appropriate. Communities are provided with a 5-year population projection by the state agency and are encouraged when building to plan for a facility which 5 years hence would be operating at an 80% occupancy rate. Furthermore, it is the usual experience for a new facility to operate in the first six months to a year at a substantially lower occupancy rate than in ensuing years.

We believe that this information places into correct perspective the performance of the existing program. On the other hand, we also are convinced, as we have stated on other occasions, that the program has substantially met the needs for which it was originally designed some 20 years ago. It is for this reason that our testimony emphasizes the necessity for a redirection of emphasis toward the end of encouraging a better balance among various types of health facilities, integrated in the functional sense, together with a revision of the formula under which Federal assistance is allotted among the states. Current studies reveal that 90% of the Nation's current requirements for general hospital beds have now been met. At the same time, less than 80% of the needed long-term care beds are available. We have therefore urged that the redirection of effort take the form of allotments to the states by a formula which reflects each state's relative need for construction or modernization and that the money so allotted be in the

form of a single bloc grant. Only then can we provide greater flexibility for use within the states for those types of health facilities described in S. 1733, including outpatient treatment centers, facilities for extended care, rehabilitation, and other supporting units. At the same time, we could distribute federal funds to the states on the basis of where the need now exists, just as the existing allotment formula did for the needs of 20 years ago when it was devised.

May we again express appreciation for the opportunity to submit comments. We shall be glad to provide any additional information.

Sincerely yours,

JOHN G. VENEMAN,
Under Secretary.

Senator JAVITS. I also request to have inserted in the record, Mr. Chairman, an editorial from the Washington Post, dated May 19, 1969, entitled "Updating Hospital Care."

The CHAIRMAN. Without objection, that article may also be printed in the record at this point.

(The document referred to follows:)

[From the Washington, D.C., Post, May 19, 1969]

UPDATING HOSPITAL CARE

There is an imperative need for an updating of the Hill-Burton Act, the Nation's basic hospital-assistance program. Unfortunately the House of Representatives missed an opportunity to take the lead in that updating a few days ago when it considered and rejected a collection of constructive amendments championed by Representatives Ottinger, Adams and Dingell. Hearings on these amendments will begin this week before the Senate Committee on Labor and Public Welfare where they should have a much more hospitable reception. The Senate has a chance to redeem the failure of the House.

When the Hill-Burton Act was adopted, the country suffered from a tragic shortage of rural hospital facilities. Many families living in rural areas had no facilities for lifesaving care available to them. Congress remedied that imbalance and inequity, largely through Hill-Burton funds, and did it so successfully that the Under Secretary of Health, Education and Welfare could testify recently that "today, despite rapid population growth, 90 per cent of the Nation's need for general hospital beds is fulfilled."

Indeed, the situation has been in a significant sense reversed. Today, as Senator Kennedy pointed out recently, "the most important single area in which new legislation is essential is the provision of greater Federal financial assistnace for the construction of hospital and other medical facilities in our major metropolitan areas." The priorities of the 1940s, in short, are not the same as the priorities of the 1970s.

Two vital developments are needed. The formula for allocation of Federal hospital aid ought to be based on population, per capita income and need. Such a formula, which the proposed amendments prescribe, would correct a long-standing inequity in the distribution of aid.

Almost equally important is a proposed amendment designed to expand other kinds of medical facilities that would reduce the pressure on hospitals and so help to cut skyrocketing medical costs. There is a crying need for community diagnostic and treatment facilities to meet the health needs of low-income city dwellers. These could do a great deal to forestall a subsequent need for hospitalization. Another proposed amendment which seems to make admirable sense would correct the allocation of funds between new construction and modernization programs to enlarge the latter and diminish the former.

Dr. Charles Mayo of the Mayo Clinic once observed that "sickness makes people poor, poverty makes people sick." The interaction is indisputable. Health facilities are needed wherever poverty is prevalent.

Senator JAVITS. Mr. Chairman, since my schedule does not permit me to stay for the rest of the hearing, I request permission to submit a list of questions to the witness the answers to which he may submit for the record.

Mr. VENEMAN. You would like written answers to all of the questions submitted, Senator Javits?

Senator JAVITS. Yes. I would prefer that you have time to research your answers.

Mr. VENEMAN. We will be very glad to do that, Senator.

The CHAIRMAN. All right. The staff is requested to contact the Department on this matter. Senator Javits' questions and the Department's answers will be inserted in the record at this point.

(The information requested appears on p. 371.)

The CHAIRMAN. Proceed, Mr. Secretary.

Mr. VENEMAN. One problem of national significance which we feel deserves special attention is the lack of health facilities primarily serving urban or rural poverty areas. S. 1733 would authorize the States, if they choose to do so, to increase the Federal share of funding projects to a maximum of 90 percent for projects for construction and modernization of facilities which are directed to poverty residents where there is an absence of local resources.

Such a program we feel is essential if we are to give maximum encouragement to local efforts designed to improve health services to the disadvantaged.

Recognizing the limitations of assisting health facilities through the grant mechanism, and recognizing also the growth of payments from or on behalf of hospital patients as a means of providing funds to meet expenses, we are recommending the authorization of the loan guarantee program which would guarantee annually for the next 3 years, commencing in 1970, $500 million worth of loans. The aggregate of loans to be guaranteed annually within each State would be determined in the same manner as the allotment of the grant funds specifically used in the same formula.

We believe that loan guarantees will assure that privately owned nonprofit health facilities have adequate access to the capital markets. But we do not feel at this time that interest subsidies should supplement these loan guarantees.

I think one significant change that has occurred in the past few years which relates to health facilities is that since the advent of title 18 and 19, medicaid and medicare, as well as private third-party payments, namely insurance companies, we have found a situation where many of these facilities are in fact reimbursed for depreciation and interest expenses.

As a matter of fact, I think last year it was estimated that we spent approximately $295 million of title 18 and 19 funds for reimbursement for depreciation and interest expenses for health facilities.

We feel that the Federal guarantee of payment in line with these other forms of reimbursement, enhance the marketability of and will reduce the market interest rate on these loans. We are strongly opposed to inclusion of guarantees for obligations of public agencies.

These agencies already enjoy unique advantages over privately owned health facilities in acquiring needed capital, because of their ability to tax as well as their ability to sell bonds that are exempt from Federal income taxation. This exemption involves such a substantial subsidy from the Federal treasury that it need not be supplemented with a second subsidy.

Further, the guarantee of tax-free public obligations creates a higher quality investment than the Federal Government's own securities and would, therefore, have an adverse impact on Federal obligations as well as on other tax-free bonds of local governments.

If it is the desire of the committee, we have in the audience today Mr. Bruce McLowery, Deputy Under Secretary for Monetary Affairs for the Treasury Department, who is available to speak to that particular point.

We are further recommending that the loan guarantee program include a premium charge to be paid by the health facility to the Federal Government at a rate not to exceed one-half of 1 percent of the amount to be guaranteed. We make this recommendation for two reasons.

First, it is consistent with the ongoing Federal programs of this nature. Secondly, although the risk of default is relatively low, funds should be readily available to cover such defaults, if and when they should occur, without necessitating recourse to the tax dollar.

Concern has been expressed, which is understandable, for giving special financial assistance in the form of direct Federal project grants to general hospitals to assist in the modernization of the existing emergency rooms. We feel that a Federal project grant program of this sort is inappropriate because it would create another unnecessary special grant category.

The emergency rooms are presently eligible for assistance under the existing diagnostic or treatment center category. They would continue to be eligible under S. 1733 and would be eligible under the extension of the regular grant program under S. 2182.

It is our view that the ongoing health facility planning bodies of the States are best able to determine where assistance is most imperative. Their judgment should not be subverted through a direct Federal assistance program which may or may not be compatible with a particular State's health facility planning effort.

Several bills are presently under consideration by the committee which provide for some kind of local planning involvement over and above the health facility planning efforts required by the Hill-Burton program proper. We support the provisions of S. 1733 which require that the State health facility plan must be approved by the comprehensive health planning agency of the State, and that the State Hill-Burton agency must consider recommendations of the areawide health planning agency assisted under section 314(b) of the Public Health Service Act with respect to individual project applications.

In those areas where a 314(b) agency has not been activated, such consideration would be given to the recommendations of the local areawide planning agency which is performing functions similar to those covered under 314(b).

At this point we would like to state that we agree with the primary objectives of S. 2037, as introduced by Senators Percy and Kennedy and several of their colleagues, to provide facilities for better medical care for the needy. However, we feel that those objectives can best be achieved under the provisions of S. 1733 which would authorize assistance for nonprofit private agencies in the construction of free standing diagnostic or treatment centers furnishing services primarily in rural or urban poverty areas.

This provision will permit the Nation to continue to exploit the early successes of neighborhood health centers in providing health care in poverty areas through free standing ambulatory care facilities.

Senator KENNEDY. Mr. Chairman?

The CHAIRMAN. Senator Kennedy.

Senator KENNEDY. Just on that point, the legislation that was introduced by myself and Senator Percy goes far beyond just construction of facilities. It applies as well for very close involvement of the people in the development of health service programs. It provides for the training of health service personnel, and it is an extremely broad kind of neighborhood health center concept.

Mr. Chairman, I would like to put into the record an article by Dr. Jack Geiger of the Tufts University School of Medicine. In his article, Dr. Geiger discribes the concept and operation of the extraordinarily successful neighborhood health center he directs in Mound Bayou, Mississippi.

(The material referred to follows:)

HEALTH CENTER IN MISSISSIPPI

(By H. Jack Geiger [1] Tufts University)

Comprehensive medical care through group practice, improvement of the physical and economic environment, and community organization—these are the fundamentals on which a pioneer health center bases its efforts to improve not only the health but the entire lives of its service population.

The Tufts-Delta Health Center recently moved into permanent quarters. Fresh and shiny in the Mississippi sun, the one-floor structure embodies advanced refinements of design to support family-centered group practice. It stands in a cotton field, a symbol of the future amid relics of the plantation economy. The location epitomizes our relationship to the 14,000 desperately poor people we serve in a 500 square mile area of northern Bolivar County: We are where they are—in the field. They know where to find us, and we them.

It might be easier for a stranger to locate Mount Everest than Mound Bayou, the town nearest us (population 1,500). But no matter. That's instructive, too. Believers in what we call the "Mount Everest fallacy" contend that the poor, both black and white, *can* get medical care of the best technical quality and that if they don't it must be their fault. But imagine a wonderful medical center, open to rich and poor, atop Mount Everest. If the only regular patients are Tenzing Norkay and Sir Edmund Hillary, obviously the rest of the world is apahtetic and uncooperative. Sounds absurd, doesn't it? Yet many of our nation's health services for the poor are divided from them by barriers—of time, distance, inadequate transportation, loss of a day's pay, lack of a baby-sitter, complex eligibility requirements, impersonality, fragmented service, and the stigma of "charity."

So—we work in the cotton fields. On a map, look for us 100 miles south of Memphis along U.S. 61 in the Mississippi Delta where the bolls fleck white through a persistent asthmagenic haze of dusted crops or the smoke of burning manure. The monotony of sky, smoke, dust, flat-lands, and cotton makes it hard for the visitor to discern the people from afar. Machines seem more indigenous. Field hands appear to be black specks either saddling the mechanical pickers or stuffing trailing white bags as they pluck cotton by hand for a few dollars a day. Weatherbeaten shacks cluster by dirt roads, their windows stuffed with paper, their tin chimneys askew. Some dwellings are vacant but many, also decaying, show a curl of smoke, an oldster bending into the light from a doorway or sitting, chin on cane, on a sagging porch, and children dodging in the yards among the outhouses.

You reach Mound Bayou on U.S. 61 through tiny towns called Alligator, Duncan, and Hushpuckena. Northern Bolivar is part of what "Dixie" recalls as the "land of cotton." Old times there are forgotten. For decades many natives have voted—with their feet—by migrating. The mechanical picker, deepening the ancient poverty with unemployment, drove many young people to the northern cities. In the last decade, one in seven Bolivar Negroes went, leaving behind high concentrations of the old, lame, blind, sick, young, and the bewildered. Every June you can see young people at the bus stops, saying goodbye, some with

[1] Dr. Geiger is professor of preventive medicine, Tufts University School of Medicine, and general director, Tufts-Delta Health Center, Mound Bayou, Miss.

high school diplomas in their bags, going North. Today, northern Bolivar's 12,000 Negroes are 75 percent unemployed, have an average annual family income of $900 per annum, an infant mortality rate of 60 per 1,000 live births (four times that of affluent Americans but less than the 100 per 1,000 in some urban tracts), hunger, bad housing, and other problems spawned in the social, political, economic, and racial climate of Mississippi.

In November 1967—after almost three years of planning, field work, struggling to create an adequate facility—the Tufts-Delta Health Center began clinical service in a remodeled church parsonage in Mound Bayou, an all-Negro community founded during Reconstruction. Operated by Tufts University School of Medicine under a $1.2 million grant from the U.S. Office of Economic Opportunity, the center is a "younger brother" to one Tufts operates in a Boston low-income housing project, Columbia Point. The two centers—first of what is now a nationwide network of OEO health centers—sit at terminals of one of America's great human migrations.

The Tufts-Delta center demonstrated from the outset a determination to learn from its environment and adapt to it. In the parsonage, a desperate improvisation because of delays in construction, bedrooms became examining rooms, the kitchen a laboratory, the living room a waiting room. A rundown movie theater became a school for training aides. A prenatal clinic was set up in a storefront. Space in a Sunday school building was turned into staff and nursing offices. Professional staff came from Tufts and other nonsouthern institutions, but many were recruited from among southern-born, northern-trained Negroes who wanted to return to the South. Today, 32 of 44 professional and technical positions are held by Negroes, many from Bolivar itself, as are almost all of the subprofessional posts. For instance. Bolivar women were trained as nurses' aides, receiving $65 a week, or triple what they earned at cotton picking when that work was available.

In May 1968 the center moved into an intermediate, prefabricated building in a cotton field about one-quarter mile from U.S. 61 in Mound Bayou. Last December it expanded into a 24,000 sq ft structure that expresses our basic medical strategy: comprehensive medical care through group practice, integrated with sanitation, environmental improvement, and community organization. The eastern half of the building has corridors along which are offices of the three family health care groups, each comprised of an internist, pediatrician, general practitioner, community health nurses, social worker, medical assistants, nurses' aides, and sanitarians. An obstetrician-gynecologist, a surgeon, and a psychologist serve all three groups. In the western half are an emergency room, a plaster room for fractures and trauma, facilities for performing normal deliveries and for training local midwives (43 percent of Bolivar births now are attended by relatively untrained midwives), x-ray facilities, record room, lab, and pharmacy.

The buildings in the cotton field represent only the visible skeleton of our relationship to the people. The center has helped organize community health associations in 10 Bolivar towns and rural districts in our service area. All our target population is represented through them on the North Bolivar County Health Council. The council and associations are avenues of popular expression about—and local participation in—health services and needs. Eventually, the council will share completely with Tufts in the planning, management, and direction of the entire program. For example, these organizations of the poor themselves are forming transportation and communication networks to assure that the sick get to the center and that center personnel know where to go to reach the sick.

Through community organizers, sanitarians, community health nurses, nurses' aides, social workers, environmental improvement workers, physicians, and others the center reaches out to the entire area. We have completed a full house-by-house demographic census. One third of the target population has answered a structured health interview. We have benchmarks on race, sex, age, employment, occupation, income, education, family structure, housing, sanitation, migration, health and illness, and health services utilization. The analytical work took two of the three years' preparation before clinical service began.

In reaching out, we found people with seemingly endless unmet medical needs. Some stark conditions had existed untreated or undiagnosed for decades. Some were straight out of 19th century textbooks of infectious disease. We found everything one would expect; infections, malignancies, heart disease, endocrine, disease, especially high rates of hypertension in adults and infectious diarrhea in children.

To meet the shortage of hospital beds, we often made people patients in their own homes. We put hospital beds in shacks, repaired the environment, and assigned physicians and nurses to make rounds. As an example of what we found

could be done (virtually hospital care outside the hospital) let me cite the case of elderly Mrs. Sally Jones. Injured in a shotgun accident, she had head wounds, brain damage, and one eye lost. She had been to one of the big Mississippi hospitals for neurosurgery, and after five weeks she was discharged. It's not clear to us or the family whether the hospital tried to make any provision for her continuing care. In any event, there are pitifully few chronic disease beds for Negroes in the state.

The family somehow brought her back 180 miles to their dilapilated shack on a plantation 10 miles out of Duncan, a small Bolivar town. She lay in an old, sagging bed in the four-room structure housing 11 people. On the first day, the family sent us frantic appeals for help. We found Mrs. Jones apparently hemiplegic, aphasic, with 102° temperature, pneumonia, a nasogastric tube and urinary catheter hanging out. The family, devoted and eager to care for her, neither understood nor had the equipment for tube feeding or bladder irrigation. There was no equipment for bed care. The Delta summer heat was unbearable.

From our stock of surplus beds at the center, we moved a railed hospital bed and equipment for tube feeding and bladder irrigation into the home. We instructed the family on using it.

We treated the pneumonia and bladder infection. Our environmental improvement unit helped the family screen the house, repair the floors, fill the holes in the walls and roof of Mrs. Jones's room, and make the water supply safe. As her condition stabilized, we removed the nasogastric tube. The family began spooning water and soft food to her, oh so slowly. Her swallowing was limited. She began to eat soft food, then regular food. Meanwhile, we took out the urinary catheter. She was continent. Testing showed that with intensive effort she could speak. We began working on that. It became clear she was not hemiplegic but hemiparetic. The family scrounged a wheelchair and we taught them to exercise her. Subsequently, she started walking with a three-point cane. All this was accomplished primarily by nurses and nurses' aides and the family.

That was in July. In October, Mrs. Jones walked into the center and said, "Good morning, doctor." She still has a long way to go. She needs tendon transplants, intensive physical therapy, and rehabilitation. But she has every prospect, if we can manage all this, of being restored to useful life despite deficits, particularly speech. I never would have believed such a patient could survive outside a hospital.

Unfortunately, Bolivar County Negroes are at the base of Mount Everest when it comes to basic as well as advanced hospital care. Among the prime barriers is segregation. When we arrived in 1965, Mound Bayou had two small, all-Negro hospitals put up by fraternal orders decades ago, when almost no hospital beds were available for nonwhites, out of the nickels and dimes of sharecroppers. Both were in desperate financial straits and both had major problems of examining facilities and equipment. Working together with Tufts and with Meharry Medical College, Nashville, Tenn., which had helped the area for 20 years, the two small private hospitals merged, formed a voluntary community hospital, and obtained a major grant from OEO to provide free hospitalization for the poverty population, create a new dental program, and upgrade its staff and facilities. Health center physicians double on the hospital staff, which is steadily growing with help from Meharry. Now there is hope for a new community hospital building, to be built with federal aid in association with the health center.

At present, however, we send complex cases 100 miles to Memphis or 140 miles to Jackson, even though 10 miles away is the 101-bed East Bolivar County Hospital, which has complete facilities including a pathology laboratory and premature nursery and JCAH accreditation. But it is not in Medicare because of segregation practices, and no federal money can be spent there except for emergency care.

Besides segregation, there is a money barrier: Many Mississippi hospitals require a $50 deposit before admission, effectively precluding use by a great majority of the Negro population and many poor whites.

Geography and other factors make big differences in the way a health center relates to hospitals. Our Columbia Point Health Center, serving 6,000 persons in Boston, is within a 15-minute drive of 18 teaching hospitals. It takes two hours of hard driving to reach a teaching hospital in Memphis from Mound Bayou. In either Mississippi or Massachusetts, the health center serves as the patient's protagonist, eager to continue or reassume responsibility from the teaching hospital for the patient's care.

In the urban setting, the center must coordinate the work of various hospital specialty clinics and that of physicians. The rural center has virtually no outside services—fragmented or not—to work with. Bolivar lacks physicians (34 per 100,000 in the county vis-a-vis 77 in Mississippi as a whole and 140 in the U.S. generally) ; it lacks third-party funding of services, transportation, and special hospital services. Thus the rural center by itself must constitute a big slice of a health care system. The Tufts-Delta center tries to do everything possible on an ambulatory or home basis.

In a significant way, the Tufts-Delta center's task is to generate hospitalizations, while that of the Columbia Point center is to reduce the use of hospitals. The Mississippi population has many untreated illnesses requiring hospital care. At Columbia Point, after the first two years of center activity, in-hospital use declined by 80 percent because the health care was available early, under a single roof, and within walking distance of the home. The 80 percent statistic derives from a study of 54 families in the year before the center opened and in the two years since. In 1965 these families used a total of 200 hospital days, with stays averaging 8.3 days. In 1966 they used 110 hospital days, averaging 5.5 days per stay. In 1967, the second year of center operation, they used 40 hospital days, averaging 5.0 days per stay.

These and other data suggest that by stressing comprehensive care, the family approach, group practice, and environmental responsibility, centers are providing better care for less expense and effort. To elaborate on the environmental aspect: In Bolivar, our environmental improvement unit (directed by Andrew James, who holds an M.S. degree and is the first Negro sanitarian in Mississippi) has helped whole communities to organize water corporations and obtain federal help for protected water supplies. In some communities people drink from drainage ditches. We improvised a machine to dig safe wells. We razed abandoned shacks, using the wood for new privies and for home repairs on occupied houses. The unit cleans up garbage dumps and kills rats.

The center's interest extends to other activities, since we believe that medical activity alone is not enough. We hope to help develop a pre-Head Start program in Bolivar; some rural Negro infants appear so deprived that they are afraid of toys they see for the first time. A work-study traineeship program in the center for Negro high school students gives them contact with Negro professionals and may influence the youngsters' further education. Two Mississippi Negroes and one from Alabama are now in the freshman class at Tufts University School of Medicine. Two of our Mississippi Negro staff are headed for social work training in Boston; others are being helped by the center to obtain training as practical nurses, sanitarians, and in other professional roles. In five years we hope the center will be staffed and directed primarily by Mississippians.

The philosophy behind these educational and environmental activities is that the health center is a community institution based on health services but oriented toward broader types of change, particularly by involving people in activities that change their attitudes, knowledge, and motivations. Center health associations give the communities a voice in management.

As a major example, the Tufts-Delta center stimulated the formation of the North Bolivar Cooperative Farm, a 120-acre farm on which the 800 poorest and hungriest families in the area pooled their efforts in one season to grow a million pounds of snap beans, Irish potatoes, sweet potatoes, collard greens, and other foods for Bolivar's hungry. This year we hope the farm will expand to 500 acres, and funding is sought for a cannery to process the surplus for marketing to northern Negroes who want southern "soul" foods. Thus Bolivar will have a new industry to take hundreds of people out of the starving cotton economy.

Another point of unity between the Tufts-Delta and Columbia Point centers is that they cover both ends—the rural source and the urban terminus—of one of this nation's great internal migrations, the flow of Negroes to the North. Columbia Point's Negro population came from places like Bolivar County. Knowledge gained at one center is applicable at the other. Columbia Point workers will benefit from a knowledge of family and institutional life in rural Mississippi and can better help migrant families adjust to the North. In return, so long as Delta people continue to leave for the North, the Mound Bayou center at least helps assure that they do not arrive in wretched health or totally devoid of marketable skills.

These are only some of the dimensions of what is not always regarded as the proper role for health professionals but which to me are basic if a comprehensive health care job is to be done. The centers carry out the idea that health services

are valuable not only in themselves but as a point of entry for other kinds of effort, such as economic development, education, job training, housing, and so on. Health professionals today need to rediscover the social commitments of their forebears of a century or more ago. They were leaders in the fight for sanitary reform, for an end to slum housing, for abolition of child labor. Today's crises—slums, hunger, rat bites, illiteracy, and discrimination—demand the same response.

My office in the intermediate building at Mound Bayou had an exit door to the outside. It was labeled "Emergency." In case of fire, you could run right out into the cotton field. Someone suggested it open into the building. The "emergency," after all, is outside.

Senator KENNEDY. I think that community involvement is one of the most valuable aspects of the neighborhood centers program. One of the dangers of your proposal is that the centers might become just a funding and a programing effort if we put them in S. 1733.

Mr. VENEMAN. Senator Kennedy, I agree your bill does contain all the elements in one specific piece of legislation. However, the objectives that you include in your bill are also objectives that we have in health, education, and welfare under separate programs.

The training of health aides for neighborhood health centers and this type of thing are programs that we have ongoing at the present time, also.

Mr. Chairman, we know that community-level health facility planning can best determine the specific site on which a hospital or other health facility should be constructed. However, under the existing program Federal funds cannot participate in the cost of site acquisition. Therefore, it is recommended that the costs related to the acquisition of a site be considered eligible for Federal participation.

This would be consistent with the authorization that is provided in most other grant programs where land acquisition is permitted to participate in the Federal assistance. In the same vein, the existing program permits Federal participation in the cost of needed equipment in a health facility only if there is construction associated with the project.

We would recommend that equipment projects, whether or not associated with construction, be considered eligible for assistance.

Mr. Chairman, we have learned much about the nation's changing health facility needs in recent years, and we now have both the opportunity and the responsibility to fulfill those needs. We feel that the circumstances are compelling enough that we should not delay in obtaining a better health return on the dollar. Accordingly, we are recommending that we not wait until the expiration of the current Hill-Burton authorization, but that Congress enact a redirected program along the foregoing lines effective with the fiscal year commencing July 1, 1969.

The program that I have recommended, Mr. Chairman, would move into new areas of support on a flexible basis, providing more flexibility and freedom to the States through the block grant concept. It recognizes some rather dramatic changes in health care needs, and recognizes some rather dramatic changes in the manner in which health care payments have been expedited in recent years, and it would redirect the Federal program to meet these changes in the best way.

At this point, Mr. Chairman, I would be pleased to answer any questions you may have and, if I can't, the expertise beside me would be most happy to respond.

The CHAIRMAN. Thank you, Secretary Veneman.

In your prepared statement you state that you are strongly opposed to inclusion of guarantees for obligations of public agencies when public hospital facilities are being built, and you indicated that there is someone here from the Treasury Department and that the Federal Treasury objects, too, to this Federal guarantee of those obligations.

We invite a statement from the Treasury Department setting out why they object.

Mr. VENEMAN. Senator, Mr. McClory is here and can testify, but whether he has a statement, I don't know.

The CHAIRMAN. We won't have time to have him come forward to testify, because we have a long list of witnesses who have come here from other States, to testify.

Mr. VENEMAN. Well, Senator, Secretary Kennedy had a letter that we submitted in the House transcript. We could probably submit that same letter.

The CHAIRMAN. He can testify later if you would like him to. I thought if he had a statement here we could print it following your statement. But if the Treasury desires to testify, we will arrange for them to testify later. But as I say, we have people here from three States who have come here to testify, and I feel that I shouldn't crowd them out.

Mr. VENEMAN. Fine. We will submit Secretary Kennedy's letter and the Treasury Department statement.

(The documents referred to follow:)

THE SECRETARY OF THE TREASURY,
Washington, June 4, 1969.

HON. ROBERT H. FINCH,
Secretary of Health, Education, and Welfare,
Washington, D.C.

DEAR BOB: I am deeply concerned with the proposal by the House Committee on Interstate and Foreign Commerce that the Federal Government guarantee the payment to private investors of interest on obligations of public bodies which is exempt from Federal income taxation. Such a provision appears in the proposed new section 621(a) of the Public Health Service Act, which is incorporated in the Medical Facilties Construction and Modernization Amendments of 1969 (H.R. 11102) reported by the Committee on May 20, 1969.

The report of the Committee recognized that the Treasury Department opposes such Federal guarantees of tax-exempt obligations, and the report cited the arguments made against such guarantees in the 1962 report of the President's Committee on Federal Credit Programs: (1) the cost in tax revenues to the Federal Government would generally exceed the benefits of tax exemption received by borrowers; (2) such Federally-guaranteed tax-exempt securities would be superior to direct Federal obligations themselves, and their increasing volume would adversely affect Treasury financing; and (3) the availability of increasing amounts of high-grade, tax-exempt issues would tend to attract funds from investors that should appropriately seek risk-bearing opportunities. The House Committee stated that it agrees with the substantial validity of these arguments but was of the opinion that competing considerations outweighed them. In light of the problems in the tax-exempt market and the undesirable precedent which would be set by acceptance of this legislation, I feel that I must recommend against this action.

Encouragement by the Federal Government of an additional volume of tax-exempt obligations will add to the present extreme pressures on the tax-exempt bond market and will tend to increase the interest rates which all State and local borrowers will be required to pay. The municipal bond market is especially vulnerable to such competition from Federal programs because of the limited nature of that market.

Moreover, as you know, there is currently a great deal of sentiment in the Congress and elsewhere for tax reform, including the problem of tax-exempt interest on municipal bonds. While it is a very complicated problem, which I will not attempt to discuss here, I am sure you would agree that the Federal Government should not be adding to the problem by encouraging an additional volume of tax-exempt bonds through the device of a Federal guarantee.

My concern with tax-exempt guarantees goes beyond the hospital financing program. There have been many recent proposals for Federal guarantees of municipal bonds for a wide variety of capital projects for health, education, transportation, housing, and other public facilities. The Treasury Department has successfully resisted this proposed method of financing new programs, and it would be extremely difficult to approve this financing device for one purpose and at the same time hold the line against its widespread use in other areas—which I am firmly convinced would not only be bad tax and debt management policy but would be a great disservice to the States and localities themselves.

As you know, we have under active consideration a number of proposals to assist States and localities, ranging from revenue sharing plans to specific assistance to high priority programs such as the financing of health facilities. Moreover, we are considering other means of alleviating pressures on State and local financing in the tax-exempt bond market, and I believe it would be counter to our efforts in this regard if new programs of guaranteed tax-exempts were authorized now.

Sincerely,

DAVID M. KENNEDY.

TREASURY OPPOSITION TO FEDERAL GUARANTEES OF TAX-EXEMPT OBLIGATIONS

The Department is opposed to Federal guarantees of tax-exempt obligations for four fundamental reasons: (1) such guarantees conflict with Federal debt management policy by creating a class of securities which the Federal Government is prohibited from issuing by the Public Debt Act of 1941; (2) such guaranteed obligations heighten competition for the limited funds available to state and local borrowers from high tax bracket investors and increase financing costs for other public projects for which Federal credit aid is not provided; (3) the tax exemption disproportionately benefits high income investors; and (4) tax exemption is an inefficient subsidy since the Federal tax revenue loss exceeds the interest savings of the borrower.

Federal guarantees of tax-exempt obligations create highly marketable debt issues substantially more attractive to many investors than Treasury bonds. The Federal guarantee would assure the investor against the risk of default, just as in the case of Treasury bonds. A very large amount of debt, with the credit risk largely or entirely underwritten by the Federal Government, is already outstanding, and the volume can be expected to grow. The diversion of the interest of many investors from direct Treasury issues to guaranteed issues has in itself created some serious new problems for debt management, even though the great bulk of this guaranteed debt is not so readily marketable as Treasury obligations and may entail significant servicing costs or other disadvantages. Moreover, guarantees for one purpose could lead to strong pressures to extend Federal guarantees to tax-exempt state or municipal bonds issued for other purposes, each perhap clearly desirable in itself. Over $130 billion of state and local government obligations are outstanding today, with the total having risen by an average of more than $7 billion per year over the past decade, and by an even larger amount in recent years. An end to that upward trend is not yet in sight. Should any significant fraction of that growing total eventually have the benefit of a Government guarantee, in addition to tax-exemption, the position of any Secretary of the Treasury charged with responsibility for the management of the Federal debt would quickly become—at the least—extremely difficult.

Encouragement by the Federal Government of an additional volume of tax-exempt obligations would also add to the heavy and growing pressures in the tax-exempt bond market. Assigning a Government guarantee to a portion of tax-exempt issues would assure them favored treatment in that market over the other obligations of state and local borrowers. The result would be to increase the interest costs of other such borrowers on non-guaranteed issues. The municipal bond market is especially vulnerable to such competition from Federal programs because of its limited nature.

There is currently a good deal of sentiment in Congress and elsewhere for tax reform, including the problems created by tax-exempt interest on municipal bonds. While this problem raises complicated issues which have not yet been resolved, it is not desirable that the Federal Government add to any inequities that may exist by encouraging an additional volume of tax-exempt bonds through the device of a Federal guarantee.

Exemption from Federal income taxation of interest on obligations issued by state and local governments involves a subsidy in the form of revenue loss to the Treasury. Not only is the amount of this subsidy not explicitly accounted for in any budgetary way, but it represents an inefficient subsidy in that the savings in borrowing costs for the state and local governments are less than the revenue loss to the Federal Government resulting from the tax exemption.

The CHAIRMAN. Senator Kennedy?

Senator KENNEDY. Thank you very much, Mr. Chairman.

Secretary Veneman, I am sorry I was not here for the earlier part of your testimony. I want to express a word of welcome to you.

Mr. VENEMAN. Thank you, Senator.

Senator KENNEDY. I was wondering if you could give the committee more exact information as to where the funds of the Hill-Burton Act have gone over recent years.

Mr. VENEMAN. The distribution?

Senator KENNEDY. Yes.

Mr. VENEMAN. Yes. Dr. Graning, I think, has that at his fingertips.

Dr. GRANING. Senator Kennedy, during the initial years of the Hill-Burton program practically 80 percent of the funds were going for the construction of completely new hospitals. In contrast with this, in 1968 only 4 percent of the funds made available under the Hill-Burton program were utilized for completely new hospitals, in contrast to this 96 percent which was utilized for additions, alterations, and modernizations, including replacement.

Senator KENNEDY. That gives me some helpful information on construction and modernization. I am also interested in the geographical distribution of funds between rural and urban areas.

Dr. GRANING. We have tables which identify, for the years 1965–68, assistance to communities of 250,000 or more and to communities under 250,000, further identified by rural and urban. With reference to general hospital projects of a total of 973 such projects, 222 have been allocated to metropolitan statistical service areas, and 613 to other urban areas.

As indicated earlier in the testimony of the Under Secretary, the needs in rural areas have been met in large part through the early impact of the program, and in recent years the national assistance has gone to an increasing degree to urban areas.

Each State currently allocates money, after they get it, on the basis of needs within that State. In other words, each State Hill-Burton agency has to develop a plan that shows, on a priority-need basis in terms of utilization of beds, where there is the greatest need, whether it be urban or rural.

Senator KENNEDY. How does a State like New York decide whether the needs are in urban or rural areas?

Dr. GRANING. All States, including New York, develop a State plan on the basis of service areas, which is to say, medical trade areas. The Public Health Service gives to the State from the Bureau of the Census a 5-year population projection. The State agency then obtains information in terms of days of care offered by each of the health care

facilities within a specific service area, and then on the basis of the utilization of that information for those service areas and the 5-year population projection, makes a computation in terms of how many beds would be needed 5 years hence, if those beds are going to be occupied at an 80-percent occupancy rate.

On the basis of such a computation, the State then sets up priorities within the State so each service area knows its relative standing.

Senator KENNEDY. Well now, in terms of, say, the funds which are available under Hill-Burton, what percent of those funds goes into what we call rural areas—communities, say, of less than 50,000?

Dr. GRANING. Can we provide this information? It is in two tables here for the record.

Mr. VENEMAN. Do you want to go on a 1-year basis, Senator? Just for the last year?

Senator KENNEDY. No. I would like you to give it to us in fairly general terms. But I think on this question of the distribution of funds between urban and rural areas. we ought to have some specific information.

(The information referred to follows:)

TABLE 14.—TOTAL PROJECTS BY TYPE OF CONSTRUCTION AND SIZE OF COMMUNITY, JULY 1, 1964–JUNE 30, 1968

Size of community	Projects		Inpatient beds		Outpatient facilities [1]		Cost (in thousands)		
								Federal share	
	Number	Percent	Number	Percent	Number	Percent	Total	Amount	Percent
TOTAL PROJECTS									
Total	2,743	100.0	122,978	100.0	818	100.0	$3,753,954	$1,098,993	100.0
Under 2,500	460	16.8	12,509	10.2	122	14.9	288,692	109,991	10.0
2,500 to 4,999	352	12.8	11,687	9.5	63	7.7	262,068	96,959	8.8
5,000 to 9,999	373	13.6	16,225	13.2	64	7.8	401,262	144,020	13.1
10,000 to 24,999	434	15.8	21,927	17.8	110	13.4	638,301	195,157	17.8
25,000 to 49,999	270	9.8	14,152	11.5	89	10.9	488,187	131,173	11.9
50,000 to 99,999	222	8.1	11,429	9.3	99	12.1	388,821	101,100	9.2
100,000 to 249,999	224	8.2	12,586	10.2	89	10.9	408,338	110,994	10.1
250,000 or more	408	14.9	22,463	18.3	182	22.3	878,285	209,689	19.1
NEW FACILITIES									
Total	480	100.0	17,166	100.0	230	100.0	524,108	176,885	100.0
Under 2,500	124	25.8	3,311	19.3	55	23.9	79,874	31,302	17.7
2,500 to 4,999	80	16.7	2,771	16.2	27	11.7	65,823	22,556	12.7
5,000 to 9,999	55	11.5	2,214	12.9	16	7.0	46,793	21,308	12.0
10,000 to 49,999	103	21.4	4,054	23.6	57	24.8	134,701	44,880	25.4
50,000 to 99,999	33	6.9	709	4.1	24	10.4	27,313	10,772	6.1
100,000 to 249,999	39	8.1	1,688	9.8	23	10.0	53,007	18,898	10.7
250,000 or more	46	9.6	2,419	14.1	28	12.2	116,597	27,169	15.4
ADDITIONS, ALTERATIONS AND REPLACEMENTS									
Total	2,263	100.0	105,812	100.0	588	100.0	3,229,846	922,108	100.0
Under 2,500	336	14.8	9,198	8.7	67	11.4	208,818	78,689	8.5
2,500 to 4,999	272	12.0	8,916	8.4	36	6.1	196,245	74,403	8.1
5,000 to 9,999	318	14.1	14,011	13.2	48	8.2	354,469	122,712	13.3
10,000 to 49,999	601	26.6	32,025	30.3	142	24.1	99,787	281,450	30.5
50,000 to 99,999	189	8.3	10,720	10.1	75	12.8	361,508	90,238	9.8
100,000 to 249,999	185	8.2	10,898	10.3	66	11.2	355,331	92,096	10.0
250,000 or more	362	16.0	20,044	19.0	154	26.2	761,688	182,520	19.8

[1] Includes diagnostic or treatment centers, rehabilitation facilities, and public health centers.

Senator KENNEDY. What percent of the funds that are available under Hill-Burton has gone to rural areas and what percent goes to urban areas, say, in the period of the last 10 years?

Dr. GRANING. For the period July 1, 1964, to June 30, 1968, the distribution by size of community of all projects is as follows: for communities under 2,500, 16.8 percent.

Senator KENNEDY. Go more slowly, please. 16.8 percent?

Dr. GRANING. 16.8 percent of the projects and 10 percent of the money.

Senator KENNEDY. All right.

Dr. GRANING. For communities 2,500 to 5,000, 12.8 percent of the projects and 8.8 percent of the money.

For communities 5,000 to 10,000, 13.6 percent of the projects and 13.1 percent of the money.

For communities 10,000 to 25,000, 15.8 percent of the projects and 17.8 percent of the money.

For communities 25,000 to 50,000, 9.8 percent of the projects and 11.9 percent of the money.

For communities 50,000 to 100,000, 8.1 percent of the projects and 9.2 percent of the money.

For communities 100,000 to 250,000, 8.2 percent of the projects and 10.1 percent of the money.

For communities of over 250,000, 14.9 percent of the projects and 19.1 percent of the money.

Senator KENNEDY. So communities lower than 50,000 population have received about 60 percent. In other words, taking 50,000 population as the dividing line, ratio going to rural and urban communities has been about 60–40. Is that correct?

Mr. LEWIS. In terms of money.

Senator KENNEDY. Let me ask another question. Has the distribution changed from 1964 to 1968? For example, in 1967 and 1968, has a higher percentage gone to the larger communities?

Dr. GRANING. It is getting more so in each passing year; yes, sir.

Senator KENNEDY. What is the ratio now? In 1964, say, was it approximately 70–30, and in 1968 is it 50–50? I am interested in whether or not more money in recent years has been going to the larger cities. I just want the general trend.

Dr. GRANING. I believe, sir, that the reason the trend has been increasing toward urban areas is that with the amendments the Congress made in 1964 they made provision for the modernization category. With this amendment it then became possible to be more helpful to urban areas.

Now, it might be useful to cite that the discussion that has taken place in many quarters with reference to the allocation of money to the States has nothing whatsoever to do with the utilization of the money by the States after they get it. The formula that is utilized in allocating money to the States simply controls how much money the State will have to work with.

Senator KENNEDY. Now, could you tell me how the funds would be distributed under the revised formula you have proposed?

Dr. GRANING. We will be happy to submit for the record a table that shows how the funds proposed under this piece of legislation, that is, the bill introduced by Senator Yarborough, would be allocated under the present formula and how it would be allocated if the recom-

mendations contained in the administration's proposal were to be followed; namely, population, per capita income, and need. This is a table that shows allocation State by State under the two systems.

(The table referred to follows:)

ESTIMATED STATE ALLOCATIONS FOR CONSTRUCTION AND MODERNIZATION ASSISTANCE UNDER THE PRESENT FORMULA AND NEED FORMULA, FISCAL YEAR 1971

State	Grant allocations under present formulas			Grant allocations under formulas using need		
	Total [1]	Modernization [2]	Construction	Total [1]	Modernization [2]	Construction
Total	$285,000,000	$50,000,000	$235,000,000	$285,000,000	$50,000,000	$235,000,000
Alabama	7,272,691	657,244	6,615,447	6,425,364	657,244	5,768,120
Alaska	1,100,000	200,000	900,000	1,100,000	200,000	900,000
Arizona	2,699,874	333,988	2,365,886	2,296,681	333,988	1,962,693
Arkansas	4,175,711	329,381	3,846,330	2,627,271	329,381	2,297,890
California	17,073,541	2,718,451	14,355,090	18,792,267	2,718,451	16,073,816
Colorado	2,926,045	609,076	2,316,969	2,814,026	609,076	2,204,950
Connecticut	2,816,286	935,714	1,880,572	3,313,538	935,714	2,377,824
Delaware	1,100,000	200,000	900,000	1,100,000	200,000	900,000
District of Columbia	1,100,000	200,000	900,000	1,101,062	200,000	901,062
Florida	9,429,042	1,264,017	8,165,025	13,915,667	1,264,017	12,651,650
Georgia	7,943,335	747,111	7,196,224	7,290,152	747,111	6,543,041
Hawaii	1,249,166	200,000	1,049,166	1,143,668	200,000	943,668
Idaho	1,422,930	200,000	1,222,930	1,204,015	200,000	1,004,015
Illinois	10,268,711	2,512,795	7,755,916	14,594,286	2,512,795	12,081,491
Indiana	6,720,005	1,493,242	5,225,763	7,959,951	1,493,242	6,466,709
Iowa	3,857,732	866,525	2,991,207	4,350,191	866,525	3,483,666
Kansas	3,456,471	805,617	2,650,854	3,760,889	805,617	2,955,272
Kentucky	6,051,959	841,613	5,410,346	3,915,594	641,613	3,273,981
Louisiana	6,977,809	832,666	6,145,143	4,899,705	832,666	4,067,039
Maine	1,873,108	308,164	1,564,944	1,757,328	308,164	1,449,164
Maryland	3,912,526	531,460	3,381,066	4,257,051	531,460	3,725,591
Massachusetts	6,676,749	2,044,056	4,632,693	8,442,143	2,044,056	6,398,087
Michigan	9,870,261	2,090,509	7,779,752	10,020,881	2,090,509	7,930,372
Minnesota	5,136,177	1,015,732	4,120,445	4,079,048	1,015 732	3,063,316
Mississippi	5,407,802	388,231	5,019,571	3,892,703	388,231	3,504,472
Missouri	6,864,675	1,357,608	5,507,067	7,536,949	1,357,608	6,179,341
Montana	1,437,576	291,210	1,146,366	1,366,190	291,210	1,074,980
Nebraska	2,124,373	377,157	1,747,216	1,729,513	377,157	1,352,356
Nevada	1,100,000	200,000	900,000	1,100,000	200,000	900,000
New Hampshire	1,288,960	200,000	1,088,960	1,498,681	200,000	1,298,681
New Jersey	7,391,128	2,087,128	5,304,000	9,097,985	2,087,128	7,010,857
New Mexico	1,909,868	200,000	1,709,868	1,561,816	200,000	1,361,816
New York	17,426,689	4,504,519	12,922,170	23,503,812	4,504,519	18,999,293
North Carolina	9,847,516	1,315,321	8,532,195	8,249,188	1,315,321	6,933,867
North Dakota	1,361,692	200,000	1,161,692	1,178,747	200,000	978,747
Ohio	12,859,403	2,041,459	10,817,944	13,202,124	2,041,459	11,160,665
Oklahoma	4,222,011	506,322	3,715,689	3,789,075	506,322	3,282,753
Oregon	2,749,116	466,044	2,283,072	2,268,431	466,044	1,802,387
Pennsylvania	16,491,849	3,930,429	12,561,420	16,136,015	3,930,429	12,205,586
Rhode Island	1,338,568	200,000	1,138,568	1,343,987	200,000	1,143,987
South Carolina	5,990,722	578,255	5,012,467	3,949,984	578,255	3,371,729
South Dakota	1,422,498	239,564	1,182,934	1,376,046	239,564	1,136,482
Tennessee	7,936,068	1,224,817	6,711,251	6,871,605	1,224,817	5,646,788
Texas	17,976,333	2,569,244	15,407,089	17,131,787	2,569,244	14,562,543
Utah	1,846,135	213,397	1,632,738	1,473,280	213,397	1,259,883
Vermont	1,134,488	200,000	934,488	1,187,754	200,000	987,754
Virginia	7,380,510	1,156,755	6,223,755	5,885,365	1,156,755	4,728,610
Washington	3,762,734	829,971	2,932,763	3,841,067	829,971	3,011,090
West Virginia	3,807,265	679,000	3,128,265	3,109,767	679,000	2,430,767
Wisconsin	5,541,533	961,096	4,580,437	5,133,198	961,096	4,172,102
Wyoming	1,100,000	200,000	900,000	1,100,000	200,000	900,000
American Samoa	375,000	100,000	275,000	375,000	100,000	275,000
Guam	409,306	100,000	309,306	375,000	100,000	275,000
Puerto Rico	7,411,053	845,112	6,565,941	4,199,153	845,112	3,354,041
Virgin Islands	375,000	100,000	275,000	375,000	100,000	275,000

[1] Excluding the $10,000,000 proposed direct Federal project program for modernization of emergency rooms which is not allotted to States.

[2] Modernization formula elements are: population, financial need, and need for modernization of health facilities. Need for modernization is a reflection of State surveys of health facilities in accordance with Federal standards.

[3] Includes hospitals and public health centers, long-term care facilities, outpatient facilities (DTC), and rehabilitation facilities. Allocation of construction grants under existing law and H.R. 11102, i.e., population and per capita income squared.

[4] Includes hospitals and public health centers, long-term care facilities, outpatient facilities (DTC), and rehabilitation facilities. Allocation of construction grants based on a formula comprising population, per capital income, and need for health facilities.

Senator KENNEDY. Just briefly, Mr. Secretary, how would you categorize the situation in our urban hospitals now? How would your own study and your own observations evaluate the need in our urban areas? Could you make a brief comment on that?

Mr. VENEMAN. I think we have two problems, Senator, in our urban centers. No. 1 is the problem of the facility being in the right place, and No. 2 is the problem of the facility being modernized to the extent that it is a good, usable facility under today's conditions.

I think that the whole direction we are suggesting in this revised approach to the distribution of Hill-Burton money takes these factors into consideration, particularly when we suggest, No. 1, changing the formula and, No. 2, suggesting that in poverty areas where I think the greatest needs for facilities are, could be funded up to 90 percent.

I think there is one other thing that we can't ignore, and that is the rising cost of health care. I think we are going to have to again place the emphasis where we are attempting to under this legislation, and this is to provide lower cost health care. This is the reason for placing the emphasis on the grants for the extended care facilities, neighborhood health centers, the types of care that are available at a lower cost than in the acute hospital bed care.

But in direct response to your question, I think in the urban centers of this country the most critical need is for acute bed care, primarily from the standpoint of modernization.

Senator KENNEDY. Perhaps you know that in some of these urban areas, there is the threat that these hospitals may be closed because of their decrepit condition and lack of modern facilities. For example, in Boston City Hospital last year, there was a doctors' revolt because of the conditions under which they are attempting to practice medicine. I understand they are almost to the point of closing the hospital up there. And recently in New York City, a man really was staged by doctors, churches, unions, and community groups to protest the budget cuts that nearly closed Harlem Hospital.

As I understand it, these situations are really not exceptional in our cities. They represent fairly accurately the kind of conditions which exist in our urban areas.

Mr. VENEMAN. I am aware of it. I have read the report, Senator, but let's lay the cards on the table. There are two areas of responsibility here. One is the Federal responsibility which we will attempt to meet. The other is a community responsibility which I hope they will also attempt to meet.

Senator KENNEDY. In that relationship, you are not suggesting that they have really met their responsibility?

Mr. VENEMAN. No. I am suggesting that in some communities the need for hospital facilities has not been as high a priority as it should have been when they were using their local resources.

Senator KENNEDY. Do you have a comparison between the patient occupancy rate of hospital beds in rural areas versus the rate in urban areas?

Mr. VENEMAN. We don't have that presently, Senator, but I think this information will be available as a result of the questions directed by Senator Javits before he left.

Senator KENNEDY. Mr. Chairman, I would like to place in the record a dispatch dated June 16, 1969, by Mr. James R. Polk of the Associated Press special assignment team. In the dispatch, Mr. Polk

cites a number of vivid examples in which rural hospitals built with Hill-Burton funds lie half empty, while urban hospitals are starved for funds.

I would also like to include a recent article from Medical World News, dated May 9, 1969, entitled "End of the Line for City Hospitals." The article makes the point that the lack of funds and decrepit equipment in our urban hospitals are causing a crisis in health care in many of our cities.

Finally, I would like to include an editorial from this morning's Washington Post, which emphasizes the need for increased funds for construction and modernization of urban hospitals, and for alternative kinds of medical facilities to reduce the pressure on hospitals and cut medical costs.

(The material referred to follows:)

By James R. Polk

(Associated Press Writer)

Washington (AP)—More than 160 hospitals built or expanded with federal aid are standing half-empty in the nation's rural areas while overcrowded urban hospitals plead for more money.

One large city hospital, built in 1894 and openly branded as a firetrap by officials, has had to wait five years for federal aid.

A small mountain town in the same state got a new hospital promptly even though its old one was two-thirds empty.

A fresh fight is boiling up in the Senate to try to chop the rural favoritism out of the Hill-Burton aid program and channel more cash into the outdated, overcrowded hospitals of America's major cities. But the House has already voted against such a shift.

Rep. Durward G. Hall, R–Mo., a doctor, has called many half-empty rural hospitals a waste. He said both politics and provincialism have played a role in passing out the federal aid.

An Associated Press examination of the hospital aid program found examples like these:

—Soda Springs, Idaho, got $800,000 to help build a new and bigger Caribou County Hospital to replace an old one that was only one-third full. The new hospital, which opened in March, remains half-empty.

—In Boise, Idaho, aging St. Alphonsus Hospital, the most crowded in the state, was turned down four times for federal aid even though the danger of a disastrous fire is so great that officials keep extending its license only a few weeks at a time.

—Bay Minette, Ala., has just received federal aid to pay for half of a $1.5 million hospital even though there are two other hospitals in the same rural county, the nearby city of Mobile has five major hospitals, and another million-dollar hospital was built with federal aid three years ago at Atmore, only 20 miles away.

—At Pineville, Ia., the federal government has just spent $1.1 million in a major remodeling of the half-empty Huey P. Long Charity Hospital. The facility exists for poor patients from nine parishes, or counties, in Louisiana where, the superintendent said, many hospitals refuse to admit needy patients who can't pay their bills.

—Scores of other rural hospitals built under the Hill-Burton program in towns like Romney, W. Va., Union Springs, Ala., and Durant, Miss., remain half-empty for an array of reasons. Even some doctors in the hospitals choose to go elsewhere when they get sick.

—No federal aid has been spent in the last 20 years to enlarge or improve New York's crowded Harlem Hospital in one of the poorest ghettos in the nation's largest city. Harlem is getting a new 777-bed hospital soon, but all the money is coming from state and local funds.

A total of 173 hospitals which have received $50 million in Hill-Burton aid over the past two decades are listed as half-empty or worse in the latest available American Hospital Association figures on occupancy rates. All but a handful are in rural areas.

The occupancy statistics had to be taken from the AMA's 1968 "Hospitals" guide because Hill-Burton officials in Washington don't keep track of whether the facilities they build are filled.

The Hill-Burton program feeds federal aid to the states which, in turn, pass out the money to hospitals to pay anywhere from one-third to more than half of construction or expansion costs.

The law favors the rural areas with an aid formula that squares the low-income level for a state. This means a rural state twice as poor as New York will get four times as much money per person.

The program was set up in the late 1940s to fill the critical needs of rural America for adequate hospitals. It has done the job well. But critics say the needs today have shifted to the cities and the program has not kept pace.

In the past 20 years, the nation's eight poorest states have made great gains in hospitals. But California, the nation's most populous state, has gone the opposite direction.

California has fallen behind all eight states with its average of 3.6 hospital beds per 1,000 persons, a rate that has slid so low it now matches what the national average was in 1950 when the program was just beginning.

The Senate health subcommittee will continue hearings Tuesday on proposals to pump more cash into the overcrowded and antiquated hospitals of the nation's cities. Nixon administration officials, who back more money for modernization, are scheduled to testify.

However, the House already has rejected 76–51 this month an effort to change the aid formula and distribute the funds evenly according to population and income. Opponents complained the change would mean 32 rural states would get less money.

"That just makes Hill-Burton another pork barrel project, doesn't it? Let's call a spade a spade," said Dr. Terrell Carver, Idaho's state health administrator.

Carver said at the state level the fight among rural towns is fierce for new hospitals—whether needed or not—to attract more doctors and, hopefully, to bring more industry. He suggested sarcastically the program perhaps should be turned over to the Department of Commerce to run.

From his window Carver looks out on Boise's aging St. Alphonsus Hospital, one of the victims of the way Hill-Burton works. He said he checks each morning to make sure the hospital is still standing.

St. Alphonsus, which dates back to the frontier days of the 19th Century, is the most crowded hospital in the state, yet it is so unsafe that Idaho authorities will extend its license only 90 days at a time.

"The place is a firetrap," said Carver.

St. Alphonsus asked for $2 million federal aid in 1964 to build a new 200-bed hospital. It was turned down that year, and the next, and the next. Not until last year did Boise get the aid—and then there were more problems.

The ground-breaking is finally set for tonight, but it will still be 1971 before the new facility is ready to replace the aging tinderbox hospital.

While St. Alphonsus waits, the small county seat of Soda Springs already has its new hospital, a modern, attractive building that overlooks a lake on the Bear River and pine-covered mountains on the other side.

Soda Springs got $799,000 in federal aid in 1966 the first year it asked. The $1.7 million hospital opened this spring.

The old Caribou County Hospital was more than two-thirds empty last year, according to AMA figures. Both the new 33-bed hospital and the slightly larger nursing home facility built into it were only half-full last week.

Dr. Carver called the new Soda Springs hospital "one tremendous white elephant" that taxpayers will have to support.

Mrs. Pearl S. Fryar, the hospital administrator, said Soda Springs had been losing patients to better facilities at Pocatelle. She said one reason the town needed a new hospital was to attract more doctors.

Rep. Hall has criticized spending federal money to build what he calls workshops just to recruit doctors. Told of the Soda Springs case, Hall said, "This is unforgivable."

Soda Springs got the new hospital while Boise waited because of added rural bias in a second formula for passing out Hill-Burton aid at the state level.

On this scorecard, the old Soda Springs hospital was totally unacceptable. So was St. Alphonsus Hospital in Boise. But Boise has a second hospital with a small portion of beds meeting the standards. Therefore, according to the formula, Boise's percentage need wasn't as high as Soda Springs, and Caribou County got first priority.

"The fact that only 50 per cent of their beds are occupied at any one time is beside the point under the formula," Carver said.

When it finally got the aid, Boise still had to take a back seat.

An official recommendation put Boise in line for the $2 million last year. But two other towns, Malad City and Gooding, howled. When the swirl of politics finally settled, the recommendation had been revised to give both towns a slice of the money, too.

Malad City, in the same corner of the state as Soda Springs, got $124,000 toward a new hospital and nursing home. Yet, in its present 19-bed hospital, when a check was made one day last week, there were only six patients.

On top of that, Carver says Malad City's only doctor may be moving out soon. And if that happens, the state won't be able to license the new hospital when it is built.

There are many times when I wish Hill-Burton would go away and die. The Malad City case is a perfect example," he said.

[From the Medical World News, May 9, 1969]

END OF THE LINE FOR CITY HOSPITALS?

"The vast majority of municipal and county general hospitals are badly run, impoverished, long-neglected fleabags!" This strong language comes from a man who ought to know. Dean Lewis Thomas of New York University School of Medicine, which staffs perhaps the most famous of those hospitals, Bellevue.

Dr. Thomas will find little disagreement from the medical staffs of the other 19 hospitals in New York City's municipal system, which last month was in the throes of convulsion. Medical boards of at least seven of the hospitals, threatened to close their institutions down rather than submit to budget cuts. The staff of one—Harlem—actually did severely curtail services for a month. Organizations representing 1,500 house staff and 3,700 RN's promised "whatever action may be necessary" to prevent fiscal cutbacks, while a new group composed of more than 100 chiefs of service contemplated hitting the city treasury by revoking their waivers of Medicare and Medicaid fees and using the money "exclusively for the upgrading of patient care."

This new organization, called the Society of Urban Physicians, is headed by Dr. Seymour M. Glick, chief of medicine at Coney Island Hospital. Says Dr. Glick: "You come to this hospital and we tell you somebody's going to take care of you. The fact is, you may lie in a pool of feces, develop an ulcer and septicemia, and perhaps ultimately die because of inadequate nursing care."

New York's city hospitals in recent years have been the target of at least eight investigations, all of which found appalling deficiencies. The Hospital Department's own annual report last year confessed that "none of our current facilities meet requirements of the federal Medicare law or the State Health Code." Yet Mayor John V. Lindsay's 1969–1970 annual budget proposes to lop $27 million off the amount the hospitals need just to keep running as is.

"At Coney Island, we're operating at a lower level than a year ago," says Dr. Glick. "Now there's little hope of restoring the cuts. The Mayor says he's giving priority to city services that affect life and health, but doesn't include hospitals! He'll hire sanitation men to clean the streets, but we can't hire housekeepers to scrub the OR or the baby nursery."

Most major cities could tell similar stories. Preoccupied with the difficulties of their local "fleabags," few people realize that the problem is national in scope.

And long-suffering medical staffs are now beginning to believe they have been too long silent. Two years ago, a Harlem Hospital doctor was disciplined for describing deficiencies there, but today, the physicians are leading the protests. A "doctors' revolt" at Boston City last summer is bringing a turn of the corner there. In New Orleans, a unanimous faculty council of Louisiana State University School of Medicine publicly predicted "a medical disaster of unimaginable proportions" unless support of Charity Hospital were increased. And in Chicago, the house staff of Cook County bought a full-page ad in the *Sun-Times* headed: "THE HOSPITAL IS DYING AND THE DOCTORS ARE HELPLESS."

The troubles of the city hospitals, of course, reflect the troubles of the cities themselves. Usually located in the rotting central core, the public hospitals have faced ever-increasing demand for services as their middle-class neighbors were replaced by poorer ones and as society has moved away from the

almshouse concept of "charity medicine" to the principle that health care is the right of everyone.

But income from public appropriations has not kept pace. Limited in authority and in taxing power, faced with zooming costs for everything from welfare, to garbage disposal, from education to civil service salaries, cities and counties are in a brutal squeeze that is felt by hospitals as well as by other arms of local government.

And the hospitals have felt it most because there is no one to speak for the patient, except where doctors have done so. Law-and-order groups march on City Hall on behalf of the police, homeowners and insurance companies fight for adequate fire protection, parents demand better schools. But until now, nobody has been lobbying for the poor patient—not even himself. "Even those who need the public hospitals most don't put them high on the list of priorities," says Dr. Glick, explaining why he founded the Society of Urban Physicians. "They can't see themselves as getting sick tomorrow, and there's always some other problem that's more pressing today."

Many hospital people had hoped that copious infusions of Medicare and Medicaid money would help to improve the public institutions, but more often than not those hopes have been dashed. Hard-pressed politicians have simply used the money to relieve the tightness of their general budgets rather than treat it as an extra for hospital improvements. In many instances—notable examples being Boston, Chicago, and New York—the money has gone into local treasuries and enabled the locality actually to *reduce* its own contribution to the hospitals.

So, while there are always local variations, public hospitals are plagued with many problems in common. Among the more frequent ones:

Antiquated plant, Kansas City General is 64 years old; Hennepin County (Minneapolis), 71; Cook County, 75. The age of such buildings not only militates against high-quality care, but also builds in costly inefficiency. Patchwork renovation helps, but it does not solve the problem. District of Columbia General has just completed a $1-million, three-year renovation. But because it was based on projections made in 1957, the new facilities were obsolescent before they were finished. And the hospital's OB unit is still housed in World War II "temporary" buildings.

Inadequate maintenance. Peeling paint, cracked plaster, broken windows, leaky plumbing—such things are frequent in public hospitals. "Hospitals like ours must meet tremendous needs," says Kansas City General's executive director, Dr. Richardson K. Noback. "For example, we get 40% of the ambulance calls in the city. So if we use our limited funds for painting, rather than for buying equipment, it's the wrong decision."

Substandard equipment, or none. Cook County just got its first in-hospital paging system last month, and its first ICU for medical patients opens only this month. A doctor there had to build his own home-made dialysis machine because the hospital had none. Several operating rooms are not air-conditioned, and "every one has a fly swatter," says orthopedic resident Robert L. Ghiz. Some ORs have no X-ray viewers, so surgeons tape the plates to the windowpanes for viewing. X-ray equipment at Houston's Ben Taub is worn out, and only one of the two radiology rooms is functional. New Orleans' Charity estimates that it needs $13 million for new equipment.

Overcrowded clinics and ERs and fragmented care. Charity sees 800,00 outpatients a year and "the crush is so great there's just no way to make things convenient for the patient," as one doctor puts it. At Atlanta's Grady Memorial, a University of Georgia professor with head injuries and multiple fractures from an automobile accident lay for seven hours in an ER corridor without medical attention. At Beu Taub, the *average* wait in the pediatric clinic is three hours.

Political interference and bureaucratic red tape. Until two years ago, all Cook County Hospital employees had to be hired through Chicago Mayor Richard J. Daley's patronage office. The hospital stil cannot employ its own nurses, who are supplied under contract by the county's schools of nursing. At Boston City, Dr. William V. McDermott, chief of Harvard's surgical service, said last summer: "The morass of chains of interlocking command between the hospital and the city makes it absolutely impossible to get anything done." Dr. Alonzo S. Yerby, former New York City commissioner of hospitals, counted 27 separate municipal agencies that had some kind of veto over the Department of Hospitals but no responsibility.

Yet for all their flaws and tribulations, the public hospitals remain essential for two reasons the first of which is pointed out by Dr. John E. Affeldt, medical director of Los Angeles County's department of charities: "There has to be a

hospital which will not shut its doors to a patient regardless of the circumstances. There has to be a hospital of last resort."

Second is their importance as training centers. The Los Angeles County system is currently training 800 interns and residents; Cook County, 450; Boston City, 381; Charity, 431. Hennepin County trained 45% of all county's specialists and 10% of all Minnesota doctors. And public hospital training has traditionally been of the best. "We went to one of these institutions because we wanted the best in medical training available, and we got it," says former Surgeon General Luther L. Terry, now vice president of the University of Pennsylvania.

Adds NYU's Dr. Thomas: "We even romanticize it when we're safe and away. We visualize the crash and explosion, the knotted crowd, and the firm, calm voice: "Stand aside, I am a Bellevue man.' "

Is the quality of training still so high? Much depends on whom you ask, and where. Quality has undoubtedly improved in many of New York's hospitals since the city began a few years ago to work out affiliation agreements for all of them with medical schools and major voluntaries. Institutions such as Harlem—now affiliated with Columbia—that were then desperately short of house staff now fill their quotas without difficulty. At Boston City, Harvard's Dr. McDermott gets 150 applications a year for eight residencies.

But Los Angeles County, despite its affiliation with UCLA, has detractors who say that its huge size militates against adequate supervision. "We get very good interns and residents and they can do a lot themselves," says one chief of service. "But without sufficient supervision, they learn a lot of shortcuts and bad medicine."

And a second-year resident at Ben Taub says flatly: "The teaching program here is not what it should be. The paid staff at Baylor who should be doing the teaching are too busy with their own practices." He says that Baylor lacks leadership and isn't going to get it under Dr. Michael DeBakey. "You can't run a medical school from an operating room." Dr. DeBakey has headed the school less than a year, and just four months ago Baylor changed from a denominational to an independent university, in the process acquiring a new board of trustees which the famed surgeon calls "one of the finest in the country." He adds: "I have always given everything my best effort, and I will give this my best."

But the most painful single ailment of the public hospitals has been what Dr. Terry calls "chronic underfinancing over a period of many years." His prescription: "A massive financial transfusion will be required to resurrect them from the shambles of their degeneracy." But under today's urban pressures, such medicine is easier to ask for than to come by.

Kansas City, for example, normally contributes about a third of the revenues of Kansas City General, some $6.9 million annually. But last year, with an unbalanced budget and every ounce of taxing power in use, the city had to *cut* the hospital's appropriation by $1 million.

"We had no fat," says executive director Noback. "We had already peeled back on maintenance. We had been buying only lifesaving equipment, not much for comfort. There was absolutely no alternative but to reduce services."

After much soul-searching, the hospital decided it just could not cut back on emergency services—28,000 patients a year, of whom a quarter are admitted—or on its outpatient clinics, visited 100,000 times a year. Poor patients would have to travel much farther to other hospitals, which didn't have ER and OP facilities to absorb the load anyway. "But all the other hospitals have beds, and when a patient requires admission, he has the clearest call on the community," says Dr. Noback.

So Kansas City General fired 100 employees, eliminated 50 more jobs by attrition, and closed 134 beds. At the end of November, the city was able to restore its contribution to the old rate, and Dr. Noback began to try to recruit personnel again. But Kansas City, like other places, is short of skilled help, and his former employees had found other jobs. To date, Kansas City General has been able to hire only enough people to reopen 24 of the closed beds.

Cutbacks in the number of beds at Charity Hospital, made beginning in 1957, have proved to be permanent—the number has fallen from more than 3,000 to 2,220. The occupancy rate in acute services is currently 100%, and in psychiatry, 113%. Every day the hospital turns away 25 to 35 patients who should be admitted, says associate director Charles Mary Jr.

Charity is unusual in that its financial support—such as it is—comes from the state, rather than city or county. Unless that support is substantially increased, the LSU Faculty Council warned last October, "Louisiana will suffer

the loss of medical services that will require decades to remedy." The council said that "Charity has enjoyed an international reputation for its many medical training programs," but that the accreditation of these programs is endangered by cuts in the hospital's services, and some are already on probation. "National reputation, like virtue, is easier to keep than to regain," the faculty statement observed. But when a member of the faculty was asked late last month what results the statement had produced, his answer was succinct and bleak: "None."

Results were spectacular in Chicago, however, after the Cook County house staff published its newspaper ad supporting a bill then pending in the legislature, and since enacted, to remove direct control of the hospital from the county board of commissioners and vest it in an independent board. The commissioners held a televised investigation of the ad's sponsors and allegations. "They thought they were the hunters and we the witches," Dr. Bruce A. Flashner, resident in general surgery and president of the house officers association, says drily. "Instead, we gave them unmerciful hell."

Dr. Flashner told the commissioners and the TV audience: "We as residents and interns have a moral commitment to human dignity and will no longer tolerate the patient care afforded by this hospital. We can only provide the best medical care. We are talking about what happens after we order medications, put in the last stitch, or attempt to save a human life. What we are talking about is pain in the middle of the night."

One commissioner demanded that Dr. Flashner "apologize" for the advertisement. Far from apologizing, the young surgeon said: "I am here to indict a political system and a group of elected officials who have allowed—in spite of repeated warnings from every type of professional group—these conditions to exist. You, as a governing body, are responsible for everything."

The militant house officers had beaten the commissioners before when they recently won salary increases to $9,000 for interns, plus $600 more for each year of residency. "One of them suggested that at those prices, they'd make us punch time clocks." Dr. Flashner recalls. "We said fine—and we'd start putting in for overtime after 40 hours. That was the last we heard of that." The increases also brought about a decrease in hated scut work. The doctor says: "When you're paying an intern $9,000, it becomes cheaper to hire a technician to draw blood."

House staff pressure also contributed to the replacement of the old hospital administration by a young and vigorous new medical superintendent, Dr. Robert J. Freeark, 41, who gave up a highly successful surgical practice to accept the challenge. And the interns and residents won a potent voice in the administration. "It's not just tokenism—we've got voting members on every committee," says Dr. Flashner. "And where the residents sit, they've been raising hell. For example, the OR committee hadn't met for a year. Now it meets every month. The residents bug the attendings, and they come out for fear of what might happen if they weren't there."

The hospital gained an important friend a couple of years ago when Republican Richard B. Ogilvie was elected president of the county board. Though he was in a political minority, "he accomplished ten years' progress in two," says Dr. Flashner. "But we were 50 years behind." Now governor of Illinois, Ogilvie pushed through the bill transferring control of the hospital to an independent board of governors. With full powers of administration, the board will collect and control the hospital's third-party payments but will still be dependent on the Cook County board to make up the institution's deficit.

How this will work out remains to be seen. The new president of the county board and a firm Daley ally, George W. Dunne, says the county will require the hospital to present an annual advance budget "in a form acceptable to us." He adds: "I assume and hope we'll be able to work with some of these doctors.

"You know, the only politics in the county hospital is by the doctors," he continues. "People think the place was a great patronage plum for the Democratic Party, but that's a falsification. We lose nothing by this change. And once I was talking to some of the doctors, and it came out that a certain summer job for medical students was always at the disposal of one fraternity. I said: 'Why, doctors, that's patronage.' They laughed, but they knew I was right."

Dunne is also unhappy that control over hospital staff appointments is passing to the local medical schools. "When a top job opens up you ought to promote an assistant to maintain staff morale, but these fellows bring in outsiders who have as much loyalty to the people of Cook County as a dead cat. If Houston wants to pay that man more, that's where he's going. And meanwhile he's ordered all kinds of equipment that the next guy dosen't like. It seems to me that things like this can escalate now."

Having an independent governing board does not guarantee a public hospital instant Paradise, as Houston is learning. In 1964, Jan de Hartog in his book *The Hospital* published a blistering exposé of medieval conditions at Jefferson Davis, one of the city's two municipal institutions. Shocked residents voted in November 1965 to create a special taxing district with a seven-man board to run the hospitals. A new administrator, William B. Forster, was brought in, and extensive renovation and reorganization was undertaken. Physical conditions have been much improved.

But today the politicians on the board are fighting each other, the hospital administration is fighting the board, and Baylor is fighting Baylor. Five chairmanships are vacant at the medical school that staffs the hospitals, and the unhappiness is seeping down to the working level. Two chiefs of service at Ben Taub resigned last month, and others are reportedly contemplating doing so.

Much of the hospital trouble revolves around labor problems. About half of the district's 2,000 employees are members of Local 1550 of the American Federation of State, County, and Municipal Workers. Don A. Horn, an official of the local AFL–CIO, is vice chairman of the hospital district board and, says Forster, "is out to get me." Forster say the board president, Dr. Mylie Durham, a past president of the Harris County Medical Society, "is one of Horn's stooges."

Bad feeling between labor and management runs high. "Some nurses hide behind the protection of the union and do and say things they otherwise might not," says Dr. Herbert Fred, who was director of medical inpatient services until last month. Forster says the grievance committee, of which Horn is a member, almost always reinstates anyone he tries to fire. The union has appointed shop stewards and told department heads that any but the most routine communications to employees must go through the stewards. Says an MWN correspondent: "I walked down the corridors with Forster and saw employees refuse to speak to him or even to look at him. You could feel the open hopsitality, almost a physical thing."

Under such conditions, patient care is bound to suffer. "I've never been impressed with Houston's heart," says Dr. Fred. "Some other large cities and some not so large seem to have a little better system for taking care of their indigent sick and a little more desire to do so."

One place that has both is Hennepin County. "We've got a bright young county board here, not the bunch of old fossils you find in some places," says Paul J. Vogt, the hospital administrator. "They've discovered that health can be a good thing, like schools and motherhood. They've been willing to let our staff show leadership, and they recognize what they have."

When control of the hospital was transferred from the city of Minneapolis to the county five years ago, the antiquated institution began catching up. The next big step comes in September when there will be a referendum on a $25-million bond issue to finance a complete new plant. The county commissioners are actively supporting the issue, so Vogt is reasonably confident of voter approval. But neither he nor the commissioners want to stop with a new building. They're aiming at a full medical center. "We are some way down the road towards comprehensive care now," says Vogt. "We want to offer the full range of services, and we'll be doing it in a few years."

Elsewhere, other approaches are being tried. In San Diego and Seattle, county institutions have been taken over by medical schools, services are being upgraded, and there is hope of attracting more paying patients by changing the image from "county hospital" to "university hospital."

Many California counties, encouraged by the state's Medicaid rules, are transforming their institutions into community hospitals. In Alabama, Mobile General shook off political control six years ago, went under the government of a citizens' board, and in 1967 moved into a spanking new plant. "The hospital has significantly advanced as a teaching hospital because of the more stable atmosphere," says the administrator, Winston C. Whitfield. New York City is seeking legislative approval for turning its entire system over to a board, which would consist of a minority of city officials ex officio and an outside majority to be appointed by the Mayor and City Council.

Not so in Boston. There the new Mayor, Kevin H. White, cut Boston City's budget last spring and triggered the "doctors' revolt" (MWN, June 16, '68). Shocked by the furor, he appointed five new trustees, including Dr. John H. Knowles, general director of Massachusetts General Hospital, and ordered the board to make a crash study of the situation. The trustees' report made sweeping recommendations, the board members said they would remain in office to see

them implemented, the Mayor threw his support behind them, and he restored the budget.

In the past few months, the pediatric service has been completely renovated, preparations have been made for an adolescent unit and for a South End clinic to be staffed by bilingual personnel. Spanish courses were set up for hospital employees, approval was obtained for a new biochemistry lab, and services for alcoholics have started. Representatives of both the medical staff and the community are on all committees of the trustees. And between January 1 and March 18, 12 Spanish-speaking persons and 91 black people were hired, two of them as assistant deputy commissioners.

Renovation has been completed or begun on the worst parts of the hospital. Construction will begin in June on a new combination staff residence and community center. Its completion will permit demolition of the old nurses' residence, clearing the site for the new main hospital. Occupancy of that building is thus five or six years away, "so we must continue to renovate," says Dr. Andrew P. Sackett, Boston's director of health and hospitals. "But we have the plans and the funds to correct all our remaining pest holes within the year."

Dr. Sackett adds: "The city is now doing its part—it's the federal government that's falling down. The federal formula for hospital construction has favored poorer states and rural areas. When it comes to construction funds, Boston is as poor as Arkansas and, in fact, has an even greater need."

Boston City still has plenty of other problems, There's a severe shortage of unskilled help because of the low civil service pay scale. Red tape is still being cut to enable the institution to collect all third-party payments due it, which it is hoped will increase collections to 70% of costs by next year. Red tape also hampers purchase of services because contractors are not paid promptly and either refuse to work or add on charges to compensate for the delay. And other problems remain.

"But the important things about the stand taken by the medical staff last year is that the Mayor responded responsibly, the trustees reported constructively, and everybody is following through," says Dr. James Harriman Jandl, chief of Harvard's medical services at the hospital. This has been a real morale booster. The staff now has confidence that our programs will be budgeted."

Dr. Jandl says the change in mutual attitudes between doctors and politicians has been great. He cites one politico who last summer denounced Boston's three medical schools for using the hospital for teaching purposes, but who last month boasted on TV about its great teaching program. He adds: "We've found that you can trust people in politics, if anything, more than you can philanthropists."

And, he says, "The hospital of the future will take shape here, at Boston City Hospital, not in the private institutions. We don't have the same sort of mossy, entrenched interests here that tend to develop elsewhere. We are confronted by the demand for change, and we ourselves don't like the old forms, old ways, old patterns. Change will take place here because we *want* to change."

[From the Washington Post, June 17, 1969]

UPDATING HOSPITAL CARE

There is an imperative need for an updating of the Hill-Burton Act, the Nation's basic hospital-assistance program. Unfortunately the House of Representatives missed an opportunity to take the lead in that updating a few days ago when it considered and rejected a collection of constructive amendments championed by Representatives Ottinger, Adams and Dingell. Hearings on these amendments will begin this week before the Senate Committee on Labor and Public Welfare where they should have a much more hospitable reception. The Senate has a chance to redeem the failure of the House.

When the Hill-Burton Act was adopted, the country suffered from a tragic shortage of rural hospital facilities. Many families living in rural areas had no facilities for lifesaving care available to them. Congress remedied that imbalance and inequity, largely through Hill-Burton funds, and did it so successfully that the Under Secretary of Health, Education and Welfare could testify recently that "today, despite rapid population growth 90 per cent of the Nation's need for general hospital beds is fulfilled."

Indeed, the situation has been in a significant sense reversed. Today, as Senator Kennedy pointed out recently, "the most important single area in which new legislation is essential is the provision of greater Federal financial assistance for the construction of hospitals and other medical facilities in our major metro-

politan areas." The priorities of the 1940s, in short, are not the same as the priorities of the 1970s.

Two vital developments are needed. The formula for allocation of Federal hospital aid ought to be based on population, per capita income and need. Such a formula, which the proposed amendments prescribe, would correct a long-standing inequity in the distribution of aid.

Almost equally important is a proposed amendment designed to expand other kinds of medical facilities that would reduce the pressure on hospitals and so help to cut skyrocketing medical costs. There is a crying need for community diagnostic and treatment facilities to meet the health needs of low-income city dwellers. These could do a great deal to forestall a subsequent need for hospitalization. Another proposed amendment which seems to make admirable sense would correct the allocation of funds between new construction and modernization programs to enlarge the latter and diminish the former.

Dr. Charles Mayo of the Mayo Clinic once observed that "sickness makes people poor, poverty makes people sick." The interaction is indisputable. Health facilities are needed wherever poverty is prevalent.

Senator KENNEDY. Just one additional area. How much overlap is there in the definitions of modernization and construction in the present statute? I saw last week that the AMA testified that 80 percent of the total Hill-Burton funds in recent years had been used to modernize or add to the capacity of existing facilities. In fiscal year 1968 only 8 percent of Hill-Burton funds went to new facilities; 92 percent went to addition, alteration, or replacement of existing facilities. Other evidence has suggested that the existing distribution between construction and modernization is grossly inequitable, and that far too little funds are available for modernization. What causes this difference of opinion?

Mr. VENEMAN. I think the answer to that is primarily the effectiveness of the Hill-Burton program as we have known it in the past. One of the major emphasis of Hill-Burton at its inception was to provide hospital and medical facilities in areas where they were not available. It appears we have done a relatively good job in doing that, and now the need is not for new facilities in areas where medical care facilities are not available, but in modernizing and increasing the capacity of those that are in existence. I think this is probably the basic answer.

Senator KENNEDY. Have you made any surveys as to the need for new kinds of facilities in these urban areas?

Mr. VENEMAN. There have probably been surveys made, but just off the cuff, we feel the primary new kinds of facilities needed would be for the lower cost facilities, extended care, neighborhood health centers, this type of thing.

Dr. CAVANAUGH. We have a national survey, Senator, on the need for modernization. This survey was carried out 3 years ago by the State Hill-Burton agencies according to criteria developed by the U.S. Public Health Service.

There were uniform criteria applied to each health facility in the Nation. That survey conducted by the States, showed a backlog of need for modernization valued at $11.8 billion.

However, when you begin to analyze those figures you find that somewhere in the neighborhood of 20 percent of that $11 billion represents facilities that need urgent replacement; that any modernization attempt in the current facility would not be productive.

The remaining modernization needs, generally speaking, can be taken care of in the existing facilities. They relate to safety standards, to better facilities for patient care, to certain safety factors and to hospital operating rooms and diagnostic and treatment rooms.

Senator KENNEDY. Would that include some of the rather innovative efforts that have been made? I know that at Massachusetts General Hospital, for example, there has been good progress in developing so-called adjacent facilities. The patient can move right out of the hospital rooms and into much lower cost, motel kinds of additions. The experimentations they are making are really reducing rather significantly and dramatically the costs to the patients, both in terms of the length of time the patient has to be in the hospital, and the kind of services he receives.

It is a very exciting undertaking. If you made your evaluation just on the question of the cost of the bricks and mortar to modernize the hospital, the cost would be a good deal higher than for the kind of alternative satellite facility toward which they have been working recently.

Many of these ideas, I suppose, would be incorporated into your own programs in terms of the cost estimates.

Dr. CAVANAUGH. Yes, they have, Senator, and that is why we are here this morning, to plead for enactment of the grant program, because it is specifically oriented toward meeting that kind of need. In fact, we have specifically asked that hospital construction be excluded from the grant program so that these types of innovative developments, designed to broaden the comprehensive care available, may be implemented.

Mr. VENEMAN. For example, if Massachusetts General wanted to increase their acute bed care in the downtown facility, they wouldn't be covered by the grant program. If they built one of these extended care facilities, they would be eligible for the grant. I think that is where the emphasis has to be.

Senator KENNEDY. I notice that the administration bill makes 20 percent of the grant appropriation available for direct grants by the Secretary. As I understand it, these grants will not be made through the State Hill-Burton agencies.

What is your view on that? I don't know whether Senator Yarborough has already asked that.

Dr. CAVANAUGH. The provision is in the administration bill, Senator.

Mr. VENEMAN. Those grants would be available only by approval of the State funding agency. In other words, the discretionary fund couldn't be used to build a facility without approval, although the Secretary would have some flexibility.

Senator KENNEDY. Does the State agency have a veto over grants made from the discretionary fund?

Dr. CAVANAUGH. The State agency would have 30 days to inform us of the fact that they did not concur with the need for a facility that would be financed under that 20 percent of the funds.

Senator KENNEDY. Does the State in effect have a veto over the discretionary power of the Secretary?

Dr. CAVANAUGH. The State notified us within 30 days of the announcement that they were opposed to the project, in effect, that would be a veto.

It is the type of proposal that I know certain components of OEO neighborhood health center program has used to develop programs in the State, and they have found by negotiations with Governors and State planning agencies that they have been able to move ahead with projects.

On the other hand, I don't think they would want to fund a specific project if all the agencies in the State were opposed to it.

Mr. VENEMAN. Rather than a veto power, I think it opens up the negotiation period.

Senator KENNEDY. Thank you, Mr. Chairman.

The CHAIRMAN. Am I correct in understanding your statement, Mr. Secretary, that you are opposed to any Federal grants for the building of hospitals?

Mr. VENEMAN. This measure that we are talking to does not include such grants.

The CHAIRMAN. And you recommend that city or county hospitals wouldn't have the Federal Government guarantee payment for that? All this administration is recommending in the building of hospitals is that they guarantee payment of the loan if it is a private hospital. That is all. In other words, you would have the Federal Government practically pull out of furnishing hospitalization through grants, helping furnish hospitalization to the American people?

Mr. VENEMAN. There are still grants available to public facilities for other than acute bed care. For example, where public hospitals have an extended care facility, they would be eligible for a grant.

But I think there is a factor here that perhaps was passed over a little rapidly. That is the reimbursement which is readily available to public hospitals which they did not have previously. This is over and above the other argument that when you guarantee a tax-exempt program you have some fiscal problems which will be described in Secretary Kennedy's letter. I don't think we can totally ignome the fact that last year we did pay some $295 million for depreciation and interest in our reimbursement schedule for hospitals, about one-third of which were public hospitals. So we are actually paying them back for those grants that we gave them.

They have another method now of accumulating funds, and this is in addition to guaranteeing a loan for tax-exempt bonds, which are available also.

The CHAIRMAN. What is their other method of accumulating funds?

Mr. VENEMAN. One of them, as I mention, through titles 18 and 19 they have this reimbursement. Of course, they have their own tax base, also.

The CHAIRMAN. You know, the American people are not voting for bond issues these days.

Mr. VENEMAN. Let me repeat: We spent as much in reimbursement in titles 18 and 19 as we used to have in Hill-Burton altogether.

The CHAIRMAN. According to your own statement, the Federal Government has put up less than a third of the cost.

Mr. VENEMAN. It was there for the purpose of fulfilling a need. There is no question about that. But, as I pointed out in the initial testimony, 90 percent of the acute bed facility requirements of this Nation have been met.

The CHAIRMAN. Well, the medicare payment you are talking about goes to all hospitals.

Mr. VENEMAN. That's right, and one-third of these were public hospitals.

The CHAIRMAN. Two formulas on this hospital bill have been administered over the years. One was the formula under which the money

was distributed to the States. We had a formula that depended on whether the State population was urban or rural; didn't we?

Mr. VENEMAN. The formula depended on population per capita income squared.

The CHAIRMAN. That's right. It depended on poverty, but not on urban-rural breakdown. Now that is your Federal distribution.

After it got to the State, there was provision in the Federal law which required the States to give a preference to rural communities. The law has read that after it ges consideraion on these applications that a State agency shall give a preference to both rural communities and areas with relatively small financial resources, so that relatively small financial resources could apply to a city that was impoverished but was surrounded by suburbs incorporated into different cities.

Now, this bill that I have introduced, and cosponsored by a number of the members of this committee—Senator Kennedy being one of the cosponsors—says the State would still give the rural communities preference, but it is not required to. Prior to this bill, the Federal laws required those rural communities to be given a preference; isn't that correct?

Mr. VENEMAN. I think that is correct. I think that is also true in the administration bill, Senator. We are also suggesting that this redirection take place away from the requirement to give preference to rural areas.

The CHAIRMAN. Now let me ask you, under the tables that have been read into the record, these grants of areas under 2,500, 2,500 to 5,000, 5,000 to 10,000, et cetera, isn't it true some of these hospitals were built in suburban areas which are really parts of the whole complex of a city and might show a population under this table of 10,000 to 25,000, but where they needed a hospital out in the suburbs it was really built in the city?

Mr. VENEMAN. I think it is possible, particularly when you look at a county like Los Angeles.

The CHAIRMAN. So this doesn't mean that all these in cities of 10,000 to 25,000 or 25,000 to 50,000 were off in a county surrounded by rice lands; does it?

Mr. VENEMAN. It is also not necessarily true that most of those rural areas described as being surrounded by farmlands have had their health care facilities needs met in the majority of cases. I am sure there are exceptions.

The CHAIRMAN. And of course, it wasn't only for this county seat town. Generally, you had a surrounding county of 10,000, 20,000, 30,000 or 40,000 population; did you not?

Mr. VENEMAN. You usually did. In fact, that was one of the purposes, was to make health care within a reasonable distance, not necessarily giving consideration to a county line.

The CHAIRMAN. I am thinking about my own State. I have traveled over those counties a good many times in campaigns. You have got the county hospital. I know county after county in a rural area will have a hospital, but there are 20,000 or 30,000 people in the county and so you don't have the hospital just for that one town in which it is located.

Mr. VENEMAN. No. I think all of us would assume logically that this would have a larger service area than the incorporated areas.

The CHAIRMAN. It is not just serving the people in that county seat town; isn't that the real fact of the matter?

Mr. VENEMAN. This is very true, Senator. As a matter of fact, we had several of them in unincorporated areas which don't even show in the incorporated population centers.

The CHAIRMAN. I believe you have already testified it would take $11 billion now to modernize these hospitals in cities, and you have recommended that a certain percentage be modernized, and certain others so obsolete in terms of modern architecture that you recommend that they be replaced rather than modernized. Did I hear your assistant say that?

Dr. CAVANAUGH. Senator, the national need of all health facilities, not only in the cities but in the country, was calculated to be somewhere in the neighborhood of $11 billion. About $7 billion of that was in general hospitals, about $2 billion in long-term care, and the remainder was spread out over other types of health facilities.

I would point out, however, the remark made earlier, and that is of that $11 billion need, somewhere in the neighborhood of 20 percent would require complete replacement of the facility to conform to construction standards. The remaining 80 percent could be accomplished with various changes in existing facilities.

The CHAIRMAN. Now this $11 billion you refer to is not new construction. This is replacement or modernization of existing facilities is it not?

Dr. CAVANAUGH. That is correct, except for the 20 percent.

The CHAIRMAN. Well, we will call that replacement.

Now, what is the need certified by the different States to your department for new hospitals entirely, not counting replacements here? Don't they certify they now need $5 billion more for new hospitals added to serve America in addition to modernization? That is the certification that you need, $5 billion for new hospitals. We need $11 billion to replace these obsolete hospitals. Is that a fair statement?

Dr. CAVANAUGH. I believe the $5 billion figure relates to all types of health facilities including hospitals.

The CHAIRMAN. Yes. I didn't mean to limit it to hospitals.

Dr. CRANING. That is correct, sir.

The CHAIRMAN. That is the need today. We need $5 billion for new health facilities?

Dr. GRANING. Yes, sir.

The CHAIRMAN. And $11 billion to rebuild, remodel, or replace the existing facilities that are obsolete? Is that correct? I notice you gentlemen have been making surveys for years. Is that correct?

Dr. CRANING. It is correct sir.

The CHAIRMAN. Out of the $5 billion new facilities needed, are they broken down through hospitals, nursing homes or outpatient centers?

Dr. CRANING. These needs are not developed by the Federal Government, but as are reported by the State agencies, and they are developed on the basis of utilization data provided by the States, as I indicated, the population projections for each area.

The total additional health facility needs, as reflected by State agencies, as expressed in dollars is $2.975 billion for general hospitals, $1.64 billion for long-term care facilities, $400 million for public health centers, $525 million for D. & T. centers, and $350 million for rehabilitation facilities.

The CHAIRMAN. Of course, we don't have real health care in this country. We have a medical business in this country and through medicare and medicaid the American people have finally found out that there could be health care in this country. Whether we sitting here furnish it or not, somebody is going to furnish it. People have found out there is no use for some people to lie there and die because they have no money.

We are 16th among the nations of the world in infant mortality. This condition can't go on.

With a certified need of $16 billion needed now—$5 billion for construction alone, not including the physicians and technicians and nurses and all the other things that go with health care—it seems to me, gentlemen, that the administration is recommending a massive retreat here, and I think we ought to have a massive advance.

I think you are moving in the wrong direction when you say the Federal Government will not give more grants to these hospitals and we won't even guarantee the loans for public hospitals.

Mr. VENEMAN. Senator, number one, those figures are based on Hill-Burton State figures under the Hill-Burton program. They may or may not be totally accurate. Now, there is no retreat, Senator. We presently provide $250 million a year under Hill-Burton——

The CHAIRMAN. Wait a minute. Didn't you cut that down?

Mr. VENEMAN. We are suggesting in this bill $500 million guaranteed loans——

The CHAIRMAN. Wait. Didn't the Budget cut that to $100 million this year?

Mr. VENEMAN. In this year's budget we have $150 million in grants and we are proposing $500 million——

The CHAIRMAN. Wait a minute. I am talking about the current year. Haven't you cut $250 million down? The Bureau of the Budget recommended only $100 million and recommended to freeze expenditures, didn't they?

Dr. CAVANAUGH. In the budget proposed for fiscal 1970, the amount proposed is $150 million. That decision was made after the administration had developed the proposal to ask authorization of the $150 million in grants, and then to seek at the same time authority to guarantee $500 million of loans.

Mr. VENEMAN. In the current fiscal year I am under the impression there is about $250 million in grants. We are recommending for the next fiscal year $150 million in grants for facilities other than acute beds. We are asking for authorization to guarantee $500 million in loans, and we do have ongoing compensation or depreciation and interest through the title 18 and 19 to the extent of another $19 million. I don't think that is retreating.

The CHAIRMAN. $16 billion is needed now. We will argue that later, but due to the lateness of the hour, I will yield. It is 11:20, and there are other Senators here who haven't had their opportunity to ask questions, but we may have to ask you gentlemen to come back after all of the witnesses have testified. I don't mean this morning, but all of the people interested in health care in America want to hear this.

Senator Hughes, you may inquire.

Senator HUGHES. Mr. Chairman, I would just like to ask a couple of questions that I think are germane to overall medical services.

Is there a relationship in your opinion, Mr. Secretary, between the availability of brick and mortar facilities and the availability of practitioners themselves? Is a doctor going to locate, in other words, in a nonurban facility even if it is of the most modern kind?

Mr. VENEMAN. You have two problems there, Senator, and that is why I am hesitating.

I think a good medical facility would lend itself to attracting good health manpower. But one of the real problems we have now is not only the facility itself. It is the economic condition that may exist within an area in which there is the greatest health need, and this is one we have to wrestle with every day. How do you get the doctor from Beverly Hills to Watts even if you have the finest health facility in the world in Watts?

You know, you bulid a nice neighborhood health center. How do you get the manpower there?

These are things I think we are all going to have to face up to and wrestle with. I am suggesting that one of the problems that we have is distribution of health manpower, be it the doctors, the nurses, or other professionals.

I think that what Senator Hughes has indicated is actually time, that an attractive facility such as Massachusetts General attracts good talent. However, this is not necessarily where we need the manpower.

I think the point that I made is that a good facility and good income in the lower income areas, in the urban center for instance, does not necessarily attract the manpower, number one.

Number two, I think when we place emphasis on the neighborhood health center and other types of outpatient centers, one of the biggest problems we are going to have to face is how to get the doctor there. I suggest that this is one that we in Government, the professions, and the academic community, have to work together on.

Senator HUGHES. Doesn't this also relate to rural America? Can you tell me what you consider to be rural America?

Mr. VENEMAN. Well, I think that would depend upon who you talk to.

Senator HUGHES. You are talking to an Iowan right now.

Mr. VENEMAN. Your response is coming from a San Joaquin farmer from California now.

I think that "rural" probably relates to distance from the metropolitan center where perhaps economic conditions are more attractive. I think this is what we are really talking about, where there is less financial incentive to practice, be it a community of 10,000 people or out in a "rural area" where there is just agricultural land, both of those could be considered rural.

What I think a professional looks at is the relative benefits that he can gain by practicing in one area or another.

Senator HUGHES. I doubt that that is true for a number of reasons, but one reason is that I know a couple of practitioners in their middle thirties who are making $40,000 and $50,000 a year. I know other general practitioners who wouldn't live there no matter what you paid them.

The problems that we are generally talking about are not only brick and mortar institutions, but medical services that I think the chairman was relating to, and I think that we have failed. I am not

sure that the solution lies entirely in the facilities. If you build a fine facility in Watts, I am not sure you are going to have the manpower to make it effective. I agree with building the facility there, but we have to take other steps. We are not touching upon them yet. That is the reason I question the germaneness of what I am saying. But this still applies in providing health services to the people of America.

You are relying on State plans provided by State health agencies. Now, we have some people who are going to testify about that following you. But it has only been about 3 years that there have been any funds available in the States for State planning and the State health agencies—perhaps some of you gentlemen came out of State health agencies—but planning and programing in State government is a recent development as you know, and I question the authenticity of the plans that are being provided in many instances by State agencies.

I think the next logical question is: What is the alternative?

Dr. CAVANAUGH. I do think your point is well taken. We know of the general practitioner in his midthirties who is making $40,000 a year in Iowa, but generally speaking, a number of those individuals, when they reach their late thirties go back to a teaching hospital for specialty training to get away from the 15- and 16-hour days.

Senator HUGHES. Or the grave. It is just too tiring. They can't even get someone in so that they can take a vacation.

Well, I will leave that problem. I know you are aware of the problem and I know you will probably share my concern about legislation that might provide some sort of incentive to get practitioners into rural America as well as in urban America. I know that you are also aware that many of these fine facilities are many, many miles in distance from families who wish to go to a good modern hospital facility.

I am sure you are also aware of the fact that there isn't ambulance service to get anyone to those facilities in many parts of rural America.

The problem of providing good overall health service to rural America is not solved, and I don't want to leave that impression here today. Let's not leave the impression that we have solved the health problems of rural America at all. Although we have been building over the years and Hill-Burton has served excellently in meeting the needs of rural America—you have a survey indicating how many hospital facilities you have financed or guaranteed—but there are not enough practitioners to meet the needs.

Mr. VENEMAN. I think that perhaps would be in response to Senator Javits' question, too. If there are vacant beds, for example, in rural areas, a good reason for it may be the lack of health manpower.

Senator HUGHES. That is my point. I think in many instances it is a fact that you do not have enough people there to make up a surgical team, aside from one man operating.

Well, I will drop that and say that I believe I agree with Chairman Yarborough. I am not convinced that this is a withdrawal from meeting our needs. But I am convinced that no matter what we call it, we are not meeting those needs, and that we need to do more and as rapidly as we possibly can.

Doctor, when you mentioned priorities, you tempted me to go at length into the priorities of the Nation. I will refrain from that. I think you know my views without my expressing them here this morning.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

I will stand by my terminology, "withdrawal from." The history of the Hill-Burton shows that out of all the money spent, the Federal Government has put up less than a third. It has encouraged the States and cities to put up money; and now to say, "We are going to stop the grant program," I think is a withdrawal from reality.

Senator Kennedy?

Senator KENNEDY. Thank you, Mr. Chairman. I have just one final area, which I think you spoke to, Mr. Chairman. I would just like to ask the Secretary about it.

As I see from your testimony, you are strongly opposed to loan guarantees to the public hospitals. Your proposal offers guarantees only for loans to nonprofit private institutions. As I understand it, you feel that public hospitals have a special advantage, in that they receive financial assistance through tax-free State and local bonds.

As Chairman Yarborough mentioned earlier, municipalities often have a great deal of difficulty in going ahead and floating such bonds. Faced with that reality, how firm is your own position of opposition to guarantees to public agencies?

Mr. VENEMAN. I think that I am somewhat flexible. I think the administration is. I think the guaranteed loan would not be the approach to go. There might be other methods of providing some resources for those facilities.

Senator KENNEDY. Would you be kind enough to submit them to the committee, or would you care to talk about them now?

Mr. VENEMAN. Based on the conversations I have had, the objections that have been raised by some of the more astute economic advisers to the administration, I feel the guaranteed loan in a situation like this does erode some basic fiscal policy.

I think that a direct loan would be more desirable than a guaranteed loan.

Senator KENNEDY. Therefore, it is a balance between fiscal considerations and the needs of the public hospitals in our cities.

Mr. VENEMAN. Yes, Senator. I don't think any of us are suggesting there is not a need for public facilities as well as private.

Senator KENNEDY. That is right. But you take a position in opposition to loan guarantees for public facilities. I think if you have some alternative ways of approaching that problem, it would be helpful to us to receive them. I would certainly appreciate it if you could provide us with some additional alternatives for assisting public hospitals. I think it would be helpful to us, at least in the consideration of the pending legislation.

Mr. VENEMAN. I am sure that we could, Senator.

The CHAIRMAN. Mr. Secretary, I might point out that my bill, S. 2182, also has direct loans in addition to direct grants.

Mr. VENEMAN. Do you have a guaranteed loan for the public hospitals in yours, too?

The CHAIRMAN. We have all three.

Thank you very much, Mr. Secretary and gentleman.

Mr. VENEMAN. Thank you, Mr. Chairman.

(The following information was subsequently supplied for the record:)

SELECTED DATA, HILL-BURTON PROJECTS, BY SIZE OF COMMUNITY, AND CATEGORY OF FACILITY, FISCAL YEARS 1965-68

Category and size of community	Number of projects	Number of beds	Total cost	Federal share
All categories	2,187	98,898	$3,100,622,227	$904,938,437
Within SMSA [1]	521	29,602	1,140,592,745	265,010,126
Communities of 250,000 or more	320	17,350	717,803,738	166,401,994
Communities under 250,000	201	12,252	422,789,007	98,608,132
Other Urban	1,294	59,599	1,722,174,016	548,729,447
Rural	372	9,697	237,855,466	91,198,864
General hospital	973	65,067	2,111,206,948	578,275,743
Within SMSA [1]	222	21,912	781,726,092	165,904,406
Communities of 250,000 or more	125	12,250	465,688,807	98,687,798
Communities under 250,000	97	9,662	316,037,285	67,216,608
Other urban	613	39,218	1,216,140,489	357,170,091
Rural	138	3,937	113,340,367	45,201,246
Long-term care	556	32,230	529,382,099	186,667,509
Within SMSA [1]	78	7,286	125,520,667	36,550,051
Communities of 250,000 or more	46	4,827	75,489,091	21,384,096
Communities under 250,000	32	2,459	50,031,576	15,165,955
Other urban	347	19,440	319,708,922	117,368,421
Rural	131	5,504	84,152,510	32,749,037
Outpatients	632	----	424,996,277	132,169,005
(D. & T., Rehabilitation PHC State Laboratory) within SMSA [1]	210	----	222,268,598	59,778,711
Communities of 250,000 or more	141	----	169,009,661	44,375,833
Communities under 250,000	69	----	53,258,937	15,402,878
Other Urban	324	----	174,775,864	61,119,322
Rural	98	----	27,951,815	11,270,972
TB and mental	26	1,601	35,036,903	7,826,180
Within SMSA [1]	11	404	11,077,388	2,776,958
Communities of 250,000 or more	8	273	7,616,179	1,954,267
Communities under 250,000	3	131	3,461,209	822,691
Other urban	10	941	11,548,741	3,071,613
Rural	5	256	12,410,774	1,977,609

[1] Standard metropolitan statistical area.

The CHAIRMAN. Our next witness is Mr. Allen Jensen, special assistant, National Governors' Conference.

Come around, Mr. Jensen.

Mr. Jensen, we will be very glad to hear from you, but first I want to call on Senator Hughes.

Senator HUGHES. Thank you very much, Mr. Chairman.

I simply wanted to address myself to the fact that Mr. Jensen is a former administrative assistant in my office when I served as Governor of Iowa prior to the time that I left the State of Iowa to assume my seat here in the U.S. Senate.

I wanted to comment that I recommended Mr. Jensen highly for the position he presently holds. I feel that he has displayed a great deal of capability and understanding in these areas.

I want to apologize to the chairman and to these gentlemen for the fact that I have to leave. But I know that Mr. Jensen is particularly well versed in all of the areas that have been brought up here this

morning, so I extend my apologies to you, Mr. Chairman, and to the men here, but I have to be on the floor in order to present a matter over there that is extremely important.

The CHAIRMAN. Senator Hughes, you have the reputation all over this Nation of having had one of the most forward-looking State governments while you were Governor of Iowa. If Mr. Jensen can claim any credit for any part of that, or if any of it rubbed off on him, I know he will be most helpful to us today.

You may proceed, Mr. Jensen.

STATEMENT OF ALLEN JENSEN, SPECIAL ASSISTANT, NATIONAL GOVERNORS' CONFERENCE; ACCOMPANIED BY DR. ALFRED C. KRAFT, J. MILO ANDERSON, EUGENE H. GUTHRIE, AND DR. IAN T. LOUDON

Mr. JENSEN. Mr. Chairman, members of the committee, I appreciate very much this opportunity to present to you the views of the National Governors' Conference on the very important subject of hospital and health facilities construction and modernization. I am a special assistant on the staff of the Washington office of the National Governors' Conference and the Council of State Governments. Accompanying me here today is Dr. Alfred Kraft, commissioner of the Office of Medical Services and Facilities of the State of Pennsylvania, Mr. Henry Walkowiak, director of the Pennsylvania State Comprehensive Health Planning Agency, and Mr. J. Milo Anderson, executive vice president and director of the Episcopal Hospital in Philadelphia, Pa.

PRIMARY CONCERNS OF GOVERNORS

The following three points summarize at least part of the expressed concerns of Governors as related to the legislation being considered by this committee.

1. They support the continuation of the grant programs, support the proposed guaranteed loan-interest subsidy program and low-interest-loan program for both construction and modernization.

2. They support increased reliance on State comprehensive health planning and ask that State Hill-Burton plans be in conformance with plans developed by the State comprehensive health planning effort.

3. They request that the allocation of funds for specific uses or categories of health facilities be based on State needs and priorities, not national estimates to fit all States.

1. SUPPORT FOR THE CONTINUATION OF THE GRANT PROGRAMS AND LOAN-GUARANTEE-INTEREST SUBSIDY PROGRAM AND THE LOW-INTEREST LOANS FOR BOTH CONSTRUCTION AND AMORTIZATION

Governors have expressed their support for the continuation of the grant program and support the guaranteed loan-interest subsidy program and low-interest loan programs which are included in legislation being considered by this committee.

The State of New York has a low-interest loan program through which more than $1.2 billion in low-interest loans have been made available for municipal hospital and nursing some construction and modernization.

2. INCREASED RELIANCE ON STATE COMPREHENSIVE HEALTH PLANNING AND REQUIRING STATE HILL-BURTON PLAN TO BE IN ACCORDANCE WITH PLANS DEVELOPED THROUGH STATE COMPREHENSIVE HEALTH PLANNING

As a result of the partnership for health legislation of 1966, each Governor designated the unit in his State government to conduct State comprehensive health planning. In about half the States, the responsibility was given to a unit within the Governor's office, such as a State planning agency, and in the others primarily to State health departments. Variations in State government structure and personnel involved were factors in the designation of an agency to be most effective in coordinating the planning activities of State agencies concerned with health services.

Governors have expressed the desire that State Hill-Burton plans be in accordance with plans that result from the State comprehensive health planning efforts. It has been said that, "action without planning is fatal and planning without action is futile." Unless the extension of the Hill-Burton program includes this provision it may be said that futility is being legislated and progressive and essential planning efforts by Governors and State government are being ignored and partially negated by act of Congress.

In May, I requested from the Governors examples of specific activities of State comprehensive health planning agencies in the following areas:

(1) Determining and developing plans to meet health manpower needs.

(2) Interrrelating Hill-Burton hospital and health facilities construction and modernization plans to State and area comprehensive health delivery system plans.

(3) Utilizing comprehensive health planning activities to develop specific plans to combat rising health care costs.

(4) Involving consumers, the poor and the disadvantaged in the State comprehensive planning process.

I have made available to the members of this committee some of the responses received to date.

By the first part of July a more complete record of these activities related to specific concerns of the Congress will be ready and a summary of these responses will be made available to you.

I respectfully urge this committee before final action is taken on this or any other of the major pieces of health legislation which will have to be extended before July 1, 1970, to hold hearings which can utilize the experiences and the findings of the State comprehensive health planning agencies. Especially important will be the need to hear the representatives of consumers and the poor which are part of the State comprehensive health planning team.

I would like to give you just three examples of activities by State comprehensive health planning agencies.

Governor John Burns of Hawaii wrote that the State comprehensive health planning agency in his State played the leadership role in planning for the improvement of the services provided by the leprosy treatment center located on one of the islands of his State.

Governor Ellington of Tennessee reports that the efforts of the environmental health committee of the State health planning council was a major force in the passage of State legislation which provides for

ultimately systematizing and regulating solid waste disposal in the State.

Governor Smith of Texas wrote that he has made the State health planning office part of his office and that one of its activities is a cooperative effort with the Texas office of economic opportunity in taking an indepth look at alternative methods of supplying or creating a reservoir of subprofessionals in the health manpower field.

3. REQUEST THAT THE ALLOCATION OF FUNDS FOR SPECIFIC USES OR CATEGORIES OF HEALTH FACILITIES BE BASED ON STATE NEEDS AND PRIORITIES, NOT NATIONAL ESTIMATES TO FIT ALL STATES

The legislation which is being considered by this committee makes some changes in the priorities from the legislation in effect at the present time. However, it must be pointed out that the actual setting of priorities at the national level ignores the fact that the ratio of needs between the types of facilities differs considerably from State to State. The ratio of needs between modernization and construction or the optimum relative location of various types of facilities such as extended care facilities and acute care hospitals is also a matter for State comprehensive planning, not Federal legislation.

Governor Nelson Rockefeller of New York has stated that the greatest need in his State is for the modernization of the hospitals in the urban areas. At almost the other extreme, Governor Keith Miller of Alaska has written that the primary need is for the modernization and replacement of many of the small hospitals in the sparsely populated rural areas of his State. These and other statements from other States indicate that the priority of needs varies considerably from State to State.

It is apparent there is a variation in the types of needs between States and a necessity to coordinate health facilities plans with comprehensive health plans. These facts make very clear the need for the legislation to allow States to submit Hill-Burton plans which utilize comprehensive health planning to divide the States allocated funds by uses or categories based on the needs of the State and priorities which best contribute to effective and efficient delivery of health services in that particular State.

As to the contention that the present legislation provides for liberal provision for the transfer of funds between categories of health facilities, I will let Dr. Kraft explain the actual situation which will indicate that such an arrangement is less than satisfactory.

In closing I have asked Dr. Kraft, Mr. Walkowiak, and Mr. Anderson to relate more specifically their experience and present their suggestions on the improvement of the Hill-Burton program from the standpoint of their experiences in administering and using Hill-Burton funds.

Mr. Anderson, an administrator of a hospital in the inner city area of Philadelphia, can relate how Federal priorities, not State regulations, have prevented certain improvement of the services to the disadvantaged.

There are also instances where efficiency in the provision of health services had been frustrated in rural areas because of Federal requirements unresponsive to unique local situations.

Later today Dr. Eugene Guthrie, representing Gov. Marvin Mandel of Maryland, will also present testimony concerned with some of the same issues that I have discussed.

Again, Mr. Chairman, we are pleased to have this opportunity to appear before this committee.

I am not asking that the attached examples be made part of the record, but I am just saying that it could be made available to the Senators on the committee so they can evaluate for themselves the progress being made.

If there are any questions, I would be glad to answer them, or we can go directly to the testimony of the other people.

The CHAIRMAN. I have been very much interested here as I have read your statement, Mr. Jensen, in what you say on this allocation of funds and in the weaknesses that you feel in the present law that there should be more latitude for the States in deciding. For instance, New York State wants to spend most of it in the urban areas, while in Alaska they specifically state they need it for rural areas.

If your organization on further study has proposals for proposed amendments to this S. 218, I will welcome those recommendations and have the staff study them over to see how we can do the essential job of getting Federal participation in these projects, and I regard getting the needed facilities as essential because many times people will vote against a tax if they have got to bear all of the burden, but they might be inclined to vote for some local participation if they know that they can get a portion of Federal funds or that they will lose that Federal grant if they don't participate.

I think that is a very strong weapon in helping people get their own State's needed facilities. So if the National Governors Conference has additional amendments they would like to suggest, they are welcome.

Next we will hear from Dr. Alfred C. Kraft, commissioner, Office of Medical Services and Facilities, Department of Public Welfare, Harrisburg, Pa.

STATEMENT OF ALFRED C. KRAFT, M.D., COMMISSIONER, OFFICE OF MEDICAL SERVICES AND FACILITIES, DEPARTMENT OF PUBLIC WELFARE, HARRISBURG, PA.

Dr. KRAFT. Pennsylvania Gov. Raymond P. Shafer and Secretary of Health and Public Welfare, Thomas W. Georges, Jr., M.D., extend their greeting to the Senate subcommittee and wish to thank the members for the opportunity to appear at the hearings on proposed amendments to the Public Health Service Act.

The Commonwealth of Pennsylvania vigorously supports the continuation of the Hill-Burton program. Since the act is now being reviewed by Congress, we urge consideration for a number of improvements in its provisions. Some of our concerns are as follows:

1. While the history of the program has made a very substantial improvement in the hospital system, the record of recent years indicates rapidly dwindling effectiveness. Since the allocation of funds has not been adjusted to rising costs, less and less project requirements have been fulfilled.

In 1969, Pennsylvania medical facilities entered applications for 216 approvable projects which would have required a total of $252 million in Hill-Burton grants at 33⅓ percent funding. The allocation to the Commonwealth was sufficient to make only 14 grants, limited to facilities with critical priority, thus satisfying only 6.3 percent of the total need.

Approximately 50 percent of our beds in hospitals and related facilities are regarded nonconforming and in need of considerable updating and expansion. This $1 billion backlog seriously impairs our capacity to move forward in the development of vitally necessary new generation facilities of all kinds.

If the Hill-Burton program expects to realistically address itself to the development of an adequate system for the delivery of high quality medical services, it is imperative that it extend its usefulness beyond the funding of antiquated and obsolete facilities, many of which should be abandoned entirely and replaced by modern structures consistent with areawide planning requirements.

2. The Commonwealth has already made considerable progress toward the development of a statewide comprehensive health care planning agency. As you will note from the appended graphical operational prospectus, there is an intent to utilize this new program as the single State agency for the coordination of all grant services, including those emanating directly from the Federal Government. The State has identified six human service regions based upon demographic characteristics and is prepared to decentralize its State capital resources by establishing regional offices.

Consistent with this, the comprehensive health care planning agency is developing regional planning councils, some of which will cooperate with similar councils in adjacent States. Thus, the present condition of relying upon three hospital planning councils limited to the Pittsburgh, Philadelphia, and Lehigh Valley areas will be supplemented by six coordinated agencies reflecting the planning requirements of the entire State.

3. The characteristics of the State plan, required as an annual submission under the Hill-Burton program, limit the funding responsibilities to areas of highest priority based upon formulary evaluations of critical needs for medical care beds. The simplistic nature of the formula does not lend itself well to areawide planning services, which might indicate a need for another kind of facility in another location, or to the consideration of medical manpower problems which might deprive the people of service despite facility improvements. Further, the plan fails to adjust, in rural communities, to the impact of projections based upon new highways, new industries, and population growth and, in urban areas, the acutely critical problems of the ghetto.

More important, perhaps, is the fact that facilities operating in high degrees of competence and manpower capability are often deprived of their desire to develop new generation programs because of the special priority placed upon nonconforming institutions.

4. Everyone recognizes the need for providing high-quality medical services within the limitation of the national as well as the personal pocketbook. The current Hill-Burton program does not include cost control incentives and the State agency has no influence in the planning of facilities other than by persuasion. In simple terms, if a facil-

ity in a high-priority hospital planning area enters a letter of intent, it enjoys a right to funding for programs which may be contrary to economical and realistic areawide planning. The State agency is limited to reviewing plans for conformity with existing codes and statutes, but has a weak control over the applicant agency's program content or cost.

Vital to cost control are measures to counter the competitive solo entrepreneurship and grantsman capabilities of facilities which, acting in airs of mimicry and oneupmanship, install costly and often grossly underutilized programs where institutional sharing agreements would better suffice.

5. When the Federal Government makes its annual allocation to the States, it designates predetermined amounts of money to be granted in specific categories, based upon a national percentile formula. The States, in turn, are required to adhere to categorical grants until all priority applications within the category are fulfilled.

Clever grantsmen who have a propensity for beating the system find this a useful loophole for misutilizing the purpose of the categorical formula by entering letters of intent in whatever category they think they may have a chance for funding.

Notable in this area are the number of beds created in the vital long-term category which from the very beginning are utilized for acute services. The structure of the enforcement of the law offers little or no compensation for this kind of activity.

Pennsylvania, therefore, recommends as follows—

1. That the Hill-Burton program be continued for a minimum of 10 years to permit the States to develop high-quality medical care delivery systems consistent with the needs of the people.

2. That all the allocation of funds be substantially increased not only for modernizing nonconforming facilities, but for permitting the orderly development of new generation services in the areas of highly sophisticated acute treatment, emergency care, pre-admission testing programs, multiphasic screening, ambulatory and partial hospitalization programs, hospital related extended and long-term care, community health services and facilities for the mentally impaired.

3. That grant services be supplemented by liberal low-cost loan provisions.

4. That the role of the comprehensive health planning agency be clearly defined as the single State agency through which all areawide planning is decided and all State and Federal funding is approved.

5. That the Hill-Burton State plan be elaborated to include categorical percentile requirements based upon areawide planning studies, evaluations of available medical manpower, PPBS interpretations of 5-year projections and realistic definitions of actual needs, all subject to consideration by the Federal agency.

6. That rigid conditions for cost control incentives be included in all funding.

7. That privileges now available to undergraduate teaching institutions be extended to regional medical centers specializing in graduate education.

8. That institutions participating in the program be required to adopt uniform cost accounting systems incorporating factors which exclude the cost of services not approved by areawide planning agencies.

9. That Hill-Burton grant participation in all projects be established at a minimum of 33⅓ percent, supplemented by loan provisions for selected projects.

10. That the cost of land acquisition be limited to the loan provision of the program.

11. That provisions be made to guarantee Federal right of recovery when a completed project is not utilized for the purpose under which it was funded.

12. That moneys allocated during a fiscal year be made available for 3 years instead of the 2 years under the present program, thus allowing appropriate time for proper planning and the preparation of architectural drawings and specifications.

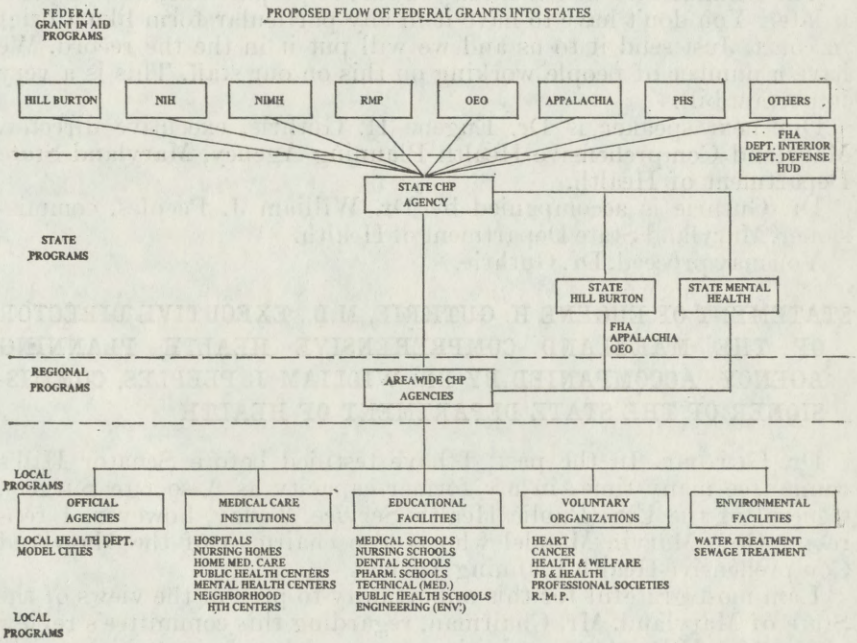
13. That building specification standards be revised with new Federal guidelines to reduce the cost of construction, taking advantage of architectural innovations and the use of newer materials to provide greater versatility and renovation capability.

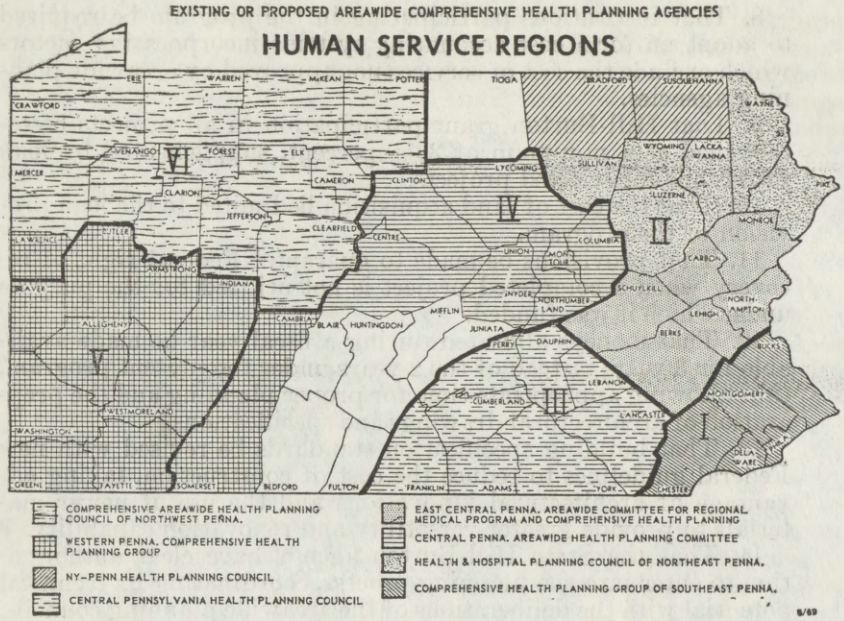
14. That the State Hill-Burton agency have clear authorization to enter into the planning process, coordinating its technical potential with the deliberations of the areawide planning councils.

The CHAIRMAN. Thank you, Dr. Kraft.

I am ordering this chart and this map to be printed as part of the record.

(The documents referred to follow:)





The CHAIRMAN. Mr. Anderson, did you have a prepared statement?

Mr. ANDERSON. Mr. Chairman, I do not. I was invited rather recently to testify.

The CHAIRMAN. Fine. Well, if you care to prepare one, we will print it later. You don't have to have it in any particular form like a brief in court. Just send it to us and we will put it in the the record. We have a number of people working on this on our staff. This is a very important bill.

Our next speaker is Dr. Eugene H. Guthrie, executive director, Maryland Comprehensive Health Planning Agency, Maryland State Department of Health.

Dr. Guthrie is accompanied by Dr. William J. Peeples, commissioner, Maryland State Department of Health.

You may proceed, Dr. Guthrie.

STATEMENT OF EUGENE H. GUTHRIE, M.D., EXECUTIVE DIRECTOR OF THE MARYLAND COMPREHENSIVE HEALTH PLANNING AGENCY; ACCOMPANIED BY DR. WILLIAM J. PEEPLES, COMMISSIONER OF THE STATE DEPARTMENT OF HEALTH

Dr. GUTHRIE. In the past, I have testified before Senator Hill's committee many times in my former capacity as Associate Surgeon General of the U.S. Public Health Service. Today, however, I represent Gov. Marvin Mandel who is also chairman of the Maryland Comprehensive Health Planning Agency.

I am most grateful for this opportunity to present the views of the State of Maryland, Mr. Chairman, regarding this committee's review of S. 2182, H.R. 11102, and other proposed legislation which would extend the Federal health facilities construction and modernization

program. As you know, Mr. Chairman, we are on record on the House side of hearings on H.R. 11102 favoring the continuation of such a program, administered by a single State agency, charged with the responsibility to devise a State health facilities construction plan which is in accord with the State comprehensive health plan.

It is our understanding that Congress wants the State comprehensive health planning agencies to be responsible for the coordination of all State health program planning. I respectfully point out, Mr. Chairman, that not one of the bills introduced or passed by Congress thus far, which would extend the Federal health facilities construction and modernization program provide the support needed by State comprehensive health planning agencies to effectively discharge this responsibility.

We ask you to provide the support we need by including in any legislation proposed by this committee, provisions which will involve the State's 314(a) and 314(b) areawide comprehensive health planning agencies in a working relationship with the State's health facilities construction and modernization agency.

More specifically, S. 2182 now provides under section III for the review of project applications by the 314(b) agency covering the area in which such project is to be located. We believe that approval of project applications by this agency would be preferable and more in keeping with the principles under which the comprehensive health planning program was established. However, if there are circumstances which, in the wisdom of this committee, lead it to conclude that review of projects rather than approval of projects is more appropriate at this time, we would accept this as a step in the right direction and be supportive of it.

We note, however, that there is no provision for a review of project applications by a comprehensive health planning agency where there is no 314(b) agency. In order to provide for consistent treatment of project applications originating from other parts of the State which have no 314(b) agency, we respectfully suggest that you add to section III—"If there is no such agency or organization, by the State agency administering or supervising the administration of the State plan approved under section 314(a)."

We are convinced that there is a major omission in the proposed legislation in regard to the relationship between comprehensive health planning and categorical health planning as far as facility construction and modernization are concerned. That omission is a provision whereby the State plan for health facility construction and modernization, as provided under section 604 of the Public Health Service Act must be in accord with the State's comprehensive health plan, as provided under section 314(a) of Public Law 89–749. We respectfully request that this provision be made a part of any legislation recommended by this committee.

These kinds of involvement of the comprehensive health planning program with the facilities construction and modernization program, we believe, embody those elements that are absolutely essential to insure effective State and local coordination of health facilities construction and modernization and constitute a logical next step in the evolvement of comprehensive health planning as it was envisioned by a perceptive Congress. Without them, we will only perpetuate a frag-

mentary and potentially costly and wasteful method of providing needed health facilities for all our people.

You may be interested to know that recently the State formed a new organization known as the "American Academy of Comprehensive Health Planning." One of its missions is to collectively respond to all matters relating to comprehensive health planning. As chairman of the board of directors of the academy, I have recently received numerous calls from the States informing me of their concern. Those States are assuming a position similar to that taken by Maryland as presented to you today.

The comprehensive health planning program offers the assurance to the Congress, and to other bodies which have broad decisionmaking responsibilities and accountability, that through the linkages requested in this testimony between the planning of the Nation's comprehensive health planning agencies, at the State and local level, with categorically planned programs such as Hill-Burton, mental health, solid waste and others, the State's total health problems will be carefully considered before final judgments are made with due consideration to available resources for manpower, financing, services, and facilities.

Mr. Chairman, again I thank you for this opportunity to testify before this committee.

Dr. Peeples would like to submit a letter setting forth his comments for the record.

The CHAIRMAN. Without objection, so ordered.

(The letter subsequently submitted follows:)

DEPARTMENT OF HEALTH,
STATE OF MARYLAND,
Baltimore, Md., June 18, 1969.

Hon. RALPH W. YARBOROUGH,
Chairman, Senate Subcommittee on Health,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I am very sorry that the press of Senate business did not allow my testimony before your Subcommittee on June 17, 1969. I am grateful, though, for the opportunity to comment in writing on S. 2182, to express a need to include in any new medical facility legislation, funds for construction of comprehensive health care and treatment centers.

If I may, I would like to provide a bit of background information regarding the reasons for the inclusion of such centers in the array of medical facilities. As the State Department of Health, we are responsible for administering the Hill-Burton program and, more recently, have been designated as the single agency for administration of Title XIX, the Medical Assistance Program. There are approximately 275,000 persons in Maryland eligible for the Medical Assistance Program with about 150,000–170,000 eligibles in Baltimore City. Most of the physicians in the areas of the City where these eligibles live have moved to more affluent parts of the City or Baltimore County, so that hospitals in the City have for many years been the providers of most of the primary medical care for low income population segments. Out-patient clinics and emergency rooms are usually crowded, and the latter are improperly utilized, being used for general medical care rather than for emergencies only. In this setting, it is impossible to emphasize preventive services. Outpatient clinic care is becoming expensive and is limited because of staff. It has now become a secondary medical function rather than a primary one as was its concept in the past.

This Department has had meetings with seven major Baltimore hospitals, including the two University Hospitals, who wish to establish satellite clinical and health care operations *off* the hospital campus for a population within a defined geographic area of the Inner City (low income-high poverty-health risk areas). These areas in Baltimore contain 25,000–40,000 persons, 50% of which are on Medical Assistance. The Centers would provide a comprehensive array of services

to include primary care, which would serve well the more common elemental illnesses, specialized out-patient clinic care by referral, hospital inpatient care and the necessary follow-up in any of these situations. Preventive care for both children and adults would be built in principally at the primary care level. I might add that this is an area of serious neglect in present medical assistance programs throughout the country.

This background leads to a pressing need for funds to lease or buy and renovate existing structures or construct low cost centers to house primary care facilities. Only one of the seven hospitals mentioned above can visualize adequate funding to proceed. Medical facility legislation should provide such funds to States and metropolitan areas who have developed plans for area-wide comprehensive medical coverage. Preferably, as we see it, the facilities should be away from the present hospital campus or, at least, be a separate physical entity.

I might add that in addition to the needs expressed here for urban areas, there are entirely urgent reasons for establishing such centers in rural areas of the State. Local health officers in agricultural areas of the State document serious gaps in medical services to patients, mostly due to scarcity of practitioners, clinics and hospitals in these locales, distance to be traveled and lack of transportation.

Funds should be in the form of loans or grants, possibly both, and should be relatively easy to obtain, contrary to present procedures for acquisition of Hill-Burton funds, which are cumbersome and involve complex detail from beginning to end. Low interest loans have appeal since the charges for service could cover and repay facility costs. It is interesting to note that the only present source of such funds is through the Housing and Urban Development agency, rather than an agency with interest in health and medical care.

In our present situation, this Department can pay for the cost of care to Medical Assistance recipients, but we have no means to finance construction or renovation of such centers. The principal economic benefit of such comprehensive care is to prevent or shorten hospital stays, the most expensive part of medical care. It is documented in comprehensive health plans such as Kaiser, Health Insurance Program of New York and Group Health of Washington, D.C., that 35–40% reductions of hospital day useage results when compared to similar groups with only hospital insurance coverage. A comprehensive care project for children at Johns Hopkins has reduced hospital care almost to nothing for these age groups in the past two years. Preventive care is enhanced by being built-in through contractual arrangements for prepayment.

Therefore, I strongly urge that provisions such as have been described above and are advocated by the Department of Health, Education and Welfare and others, be included in new medical facility legislation to make it possible for communities to expand their medical care horizons, not only for those with low incomes but for all Americans.

Thank you again for the opportunity to submit these views.

Sincerely yours,

WILLIAM J. PEEPLES, M.D.,
Commissioner.

The CHAIRMAN. Our final speaker this morning is Dr. Ian T. Loudon, assistant commissioner for hospital review and planning, New York State Department of Health.

You may proceed, Dr. Loudon.

STATEMENT OF IAN T. LOUDON, M.D., ASSISTANT COMMISSIONER OF HEALTH IN CHARGE OF THE DIVISION OF HOSPITAL REVIEW AND PLANNING, NEW YORK STATE DEPARTMENT OF HEALTH

I am Dr. Ian T. Loudon, assistant commissioner of health in charge of the division of hospital review and planning of the New York State Department of Health. I am here today as the representative of Dr. Hollis S. Ingraham, commissioner of health for the State of New York. The New York State Department of Health has, as one of its responsibilities, the management of the existing Hill-Burton grant

program in New York State. This program has made a great contribution to the development of health facility resources in New York State, and for that reason I am grateful to have this opportunity to appear before this committee today to bear witness to that contribution, and to attempt to describe our continuing need for a program such as this. To date, the Hill-Burton program in New York State has aided health facility construction totaling approximately $830 million in 366 construction projects. This aid has consisted of a Federal contribution of approximately $179 million. While this assistance has been of tremendous importance in helping to provide health care facilities for communities in our State, we would certainly agree that a great deal remains to be done.

MAGNITUDE OF THE PROBLEM

Our current estimates are that New York State requires now $1 billion to modernize needed nonprofit hospitals. With the escalation trend of construction costs, this estimate is by no means unduly generous and in fact may require an upward adjustment. The 1969 "New York State plan for construction of hospitals and related facilities" identifies a need to create an additional 240 health facilities in the State and to modernize 505 facilities by 1972. Using a more specific unit of measurement, New York State requires an additional 26,000 hospital and nursing home beds and requires in addition the modernization of 50,000 beds in these same categories. When we consider that the cost of construction of the hospital and nursing home bed, or the cost of modernization, is ranging at the present time between approximately $20,000 and $50,000 per bed, we can see readily the magnitude of the capital improvement requirements in New York State.

STATE PROGRAMS

New York State has in effect legislation called article 28 which is a form of "franchising" of health facilities, and in recent years has attempted, through several other innovative legislative programs, to find some resolution of this specific challenge. Presently, more than $1.2 billion has been made available; $750 million has been provided for low-interest loans to modernize and replace municipal health facilities; $500 million has been made available in low interest mortgage loans to construct nonprofit nursing homes and health related facilities; in addition to the above loan mechanisms, New York State has made available $4 million in a State grant-in-aid program to cover up to one-third of the cost of public nursing home construction, usually in conjunction with a Hill-Burton grant; and to further augment the above programs, a constitutional amendment will be placed before the voters of New York State, this fall, that would allow our State to make low interest loans to modernize and replace needed nonprofit hospitals. In anticipation of the passage of this amendment, enabling legislation has been passed and signed by the Governor which would provide an initial investment of $350 million for this purpose. It is intended, wherever possible, to couple the Hill-Burton grant mechanism with this lower interest loan mechanism so that the portion of the per diem service cost which reflects construction repayment may be kept at a minimum.

FEDERAL ROLE

A valid and essential contribution toward resolution of our need can be provided by Federal programs even with the ambitious programs identified above, the magnitude of the challenge precludes our do ng the job alone. Although the State programs could.

At the end of this calendar year, provide a total investment of $1.6 billion, additional sources of funding are required. As mentioned earlier, the current capital requirements to add and modernize needed facilities and beds in the State of New York carries a price tag of from $2.3 to $3.8 billion.

Any funds made available which do not require repayment by a facility have a beneficial effect on the eventual cost of service by that facility to the community. Because the traditional Hill-Burton grant-in-aid mechanism provides this benefit, its true value has exceeded the actual dollar amount provided. The State of New York must con t nue to look to the Federal mechanism and to private philanthropy to complement and support the State loan methods because of the magnitude of the dollar need and the effect on cost of care arising from a high percentage of loan financing. A third essential Federal contribution lies with the necessity for objective planning and for the production of a State plan document to guide the investment of these funds into the areas of greatest need. The incentive to plan engendered by the past Hill-Burton program must be considered one of the great contributions of that program.

SPECIFIC IMPROVEMENTS DESIRED

The major requirement facing New York State is the need to replace obsolete health facilities. We are concerned, therefore, that any Federal program developed to assist in constructing or modernizing health facilities place appropriate priority and emphasis on modernization. We all recognize that most of this modernization need is in the urban areas and in most instances these areas are the very sites of greatest need for modern health care. Many of our urban residents are served by obsolete or unsafe hospital facilities. Our main concern then is a human concern—to replace these facilities for reasons of helping to deliver quality medical care, human safety, and comfort. Our second concern is economic—to limit the upward spiralling cost of providing quality care by the construction of efficient physical plants.

We, therefore, urge that this committee recognize that to achieve maximum effect on improving patient care and maximum effect on controlling the cost of that care, our first priority lies with hospital modernization in densely populated urban areas. Once having assured the provision of what must be our highest order of medical need—hospital care for the acutely ill in an optimal physical environment—our second major concern must be the provision of the appropriate types and levels of care. To insure the creation of the full range of service and facility types necessary to provide services from housing or home care of the well aged to intensive health care, our planning and our funding mechanisms must have flexibility so that we may respond appropriately to the real needs generated by our population. Accordingly, we recommend strongly that the Federal legislation permit the States first to plan, and second to fund, service programs with

a minimum of restrictive guidelines or fragmentary categories of funds. The States must be free to write a plan for development which can address itself to the most critical areas for capital improvement and service expansion for that State. Funds made available to the State by the Federal Government should be in a block or uncategorized form so that the State can direct their use into meeting its highest priority needs.

In keeping with the desire to see the final legislation reflect the relative magnitude of urban modernization, we recommend that the allocation formula as now applied be revised so that the grant, loan, or loan guarantee funds are made available to the States solely on the basis of the State's relative population size modified by a factor such as the need for construction and modernization. We recognize that the original use of the "squaring factor" in determining the State's allocation and use of the allotment percentage were designed to achieve maximum impact of the original Hill-Burton funds on the rural areas of the country which had previously lacked services. Twenty years of successful operation of the Hill-Burton program has had a major impact in helping to meet a top-priority need. It would appear that the time is now right to delete the "squaring factor" from the program and to direct funds into today's area of greatest need—modernization in urban areas. In addition, we would recommend that the Federal grant-in-aid share of a project's cost be set at 50 percent, which will eliminate the present sliding scale and minimal grant assistance.

CONCLUSION

The Hill-Burton grant-in-aid mechanism has made a significant contribution in New York State by providing nonreimbursable funds for construction and by stimulating planning in both the facility planning and statewide developmental planning context. The magnitude of the actual capital improvement requirements in New York State are such that the availability of $1.6 billion in State low-interest-loan programs cannot, in and of themselves, sufficiently meet the need. We continue to need a Federal program which provides more funding alternatives, grant-in-aid funds, and planning incentives. The program selected, to be of greatest benefit in New York State, must place appropriate emphasis on the modernization needs of urban areas and allow sufficient flexibility in the allocation of funds.

Gentlemen, I thank you most sincerely for the opportunity to appear before you today. It was a privilege to be permitted to share our interest and concern with you regarding the improvement of health facilities.

The CHAIRMAN. Thank you, Dr. Loudon.

It is now 12 o'clock and I must leave. We have eight witnesses listed for the day after tomorrow when we will continue hearings.

I have one question I will throw out to you and the other gentlemen. This is a general question of hospital management.

Not too long ago I was discussing this problem with a man who sells equipment to hospitals, and he said, "You can't use my name. I couldn't sell any more equipment. My company would fire me. I do quite well, but," he said, "I visit these hospitals. I go in as a salesman. I look at them. I see what they are doing."

He said, "Most hospitals are in the red. As I see the problem, it is that hospitals generally are poorly managed from a business standpoint because they are generally managed by medical doctors who are trained in health care and are not trained as business managers."

He said, "I believe if all of the hospitals had good business managers, that 90 percent of the hospitals in the United States would be in the black at this time without more charges."

That was his opinion as a business salesman who was selling equipment. He said, "If they knew I said this, I would be through," so I just throw that out for you gentlemen's consideration.

Thank you very much for your patience. I regret we couldn't reach the questions by the Senators. This took more time than we had anticipated, but we will work out a future schedule. Thank you.

I would come back this afternoon, but we are in session on an appropriation bill for some very crucial points. It is not just a pro forma discussion today. We expect to vote on very crucial issues and I am required to be there.

Thank you very much.

(Whereupon, at 12 noon the committee was recessed, to be reconvened at 10 a.m., Thursday, June 19, 1969.)

MEDICAL CARE FACILITIES CONSTRUCTION AND MODERNIZATION

THURSDAY, JUNE 19, 1969

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

The subcommittee met, pursuant to recess, at 10:25 o'clock a.m., in room 4232, New Senate Office Building, Senator Ralph Yarborough (chairman of the subcommittee) presiding.

Present: Senator Yarborough (presiding).

Committee staff present: John S. Forsythe, general counsel; James Babin, professional staff member; Roy H. Millenson, minority staff director; and Jay Cutler, minority counsel.

The CHAIRMAN. The Subcommittee on Health of the Committee on Labor and Public Welfare will come to order.

The hearing will be resumed on S. 2182 and H.R. 11102 and other related bills, to amend the Public Health Service Act, and to extend and improve the programs for hospital and medical facilities, construction and modernization.

STATEMENT OF HON. CHARLES H. PERCY, A U.S. SENATOR FROM THE STATE OF ILLINOIS

The CHAIRMAN. Senator Percy, we welcome you to this committee. We note you have displayed quite an active role in the Congress.

Senator PERCY. Thank you very much.

The CHAIRMAN. We will put this committee up against any in the Senate for having dynamic members of both parties. There are a good many new members in both parties that are very active in these fields.

We regret the unavoidable incident that happened to delay our coming here for hearing you. You are our first witness, and we regret the delay. We have other witnesses waiting, so you may proceed in your own way.

Senator PERCY. Thank you very much.

I would like to indicate that there has been a Republican caucus called for 10 o'clock this morning. I did not know about it until last night, but I felt that it might inconvenience the committee to try to reschedule my testimony. I will be able to relate to those members, later, on what my testimony was here this morning.

There are five members of the committee who are cosponsors of the legislation that I would like to review with you, the Neighborhood Health Center Act.

31-435—69——19

It is rather unusual that I should be proposing health legislation and medical legislation, my being, perhaps, the first Christian Scientist that ever appeared before you on behalf of the medical services. I am very deeply grateful for the services of Dr. Howard Fields, who has assisted me and has updated me now for some time as to the health needs of the country. I have had help from my own legislative staff, headed by Mrs. Carol Khosrovi, who has long been deeply devoted to the health needs of the country. She is mainly responsible for the fact that I have gone into this field and tried to become familiar with it and with the health needs of the country. I have been overwhelmed by the great need that does exist, and I also have been gratified with the fine work that this committee has been doing.

I think we are all aware of the widening gap between the demand for medical services and the ability of the health care industry to provide these services. During these hearings this medical gap has been studied and the legislation which you recommend to the Senate will, I hope, provide the mechanisms which will begin to narrow this gap.

However, because this widening gap does exist, it is especially important at this time that we make full use of the legislative tools at our disposal. The Hill-Burton program has served the Nation well, but it is clear that major changes must be made in order to keep abreast of the great strides made by American medical science in the past two decades. I believe that, with appropriate changes, the Hill-Burton program can be very important in helping to shape a more effective overall approach to the provision of health services in this country.

One can consolidate the many problems confronting the medical care system today into three major, interrelated areas:

1. The shortage of medical manpower.

I was very much interested, Mr. Chairman, in the testimony that was given before the committee which indicated the changes needed under Hill-Burton. Originally, the need was for the construction of hospitals to provide more beds and to get more physical facilities constructed. There has been a magnificent job done through the years in that area.

AMA has now indicated that the greatest need is not just in providing additional facilities, but the greatest priority should be given to updating, modernizing, existing facilities so that they can be more effective and efficient. Our medical needs are in need of this service. I, therefore, have introduced this legislation to provide neighborhood comprehensive centers, both in rural and urban areas because of the changing needs that exist today. There is a tremendous gap between those who can afford to pay for medical attention and those who cannot.

We are short of doctors, we are short of nurses, and short of volunteer assistants and help. I trust that Mr. Biemiller will emphasize that the country is in quite a bit of trouble with a shortage of trained medical technicians. There are sick people in urgent need of help, and we simply do not have the trained manpower available to assist them.

The following are the next two problem areas in our medical care system:

2. The lack of a comprehensive approach to the provision of health services; and

3. The inaccessibility of medical care for a large segment of our population.

By properly amending the existing legislation we can make a major contribution toward the solution to these problems.

The Neighborhood Health Center Act which was introduced in the 90th Congress and again in the 91st Congress with 24 cosponsors (including five from this committee) contains amendments to the Hill-Burton program which, I believe, offer the opportunity to begin a new program of health facility construction. I would like to discuss with you just the major ideas in this legislation.

I will leave with you a complete and full text of my analysis of the problem, and a section-by-section analysis of S. 2537.

The Neighborhood Health Center Act amends the Hill-Burton Act to authorize the funding of comprehensive ambulatory care centers. The bill defines a "comprehensive ambulatory care center" as a facility providing a full range of medical services for patients not requiring hospitalization." The priority area for this type of facility would be one having low physician accessibility; that is, an area where it is difficult to obtain medical care.

I know that you are familiar indeed with problems in the urban areas. The largest black ghetto area in America exists in the south side of Chicago. This is an area that I know well. I went to school there, and I go back frequently. I will be going back Saturday morning. This is an area where you can walk some 10 miles without ever passing a white family. It is a low-income area. Probably some 30 square miles is what may be considered low-income ghetto area.

Many people in that area live in sections that do not even have a doctor working or residing any place near.

A low-income person must take several hours to get out by public transportation to the only facility available—the Cook County Hospital. The people that I have talked to indicate that they may have to wait 5 to 6 hours to be attended then chances are one out of four that they will be admitted to that hospital. Seventy-five percent of the patients are turned away because they are not bed cases.

However, in contrast there is an area on the west side that has a neighborhood health clinic and in this area the resident simply walks to that facility with less cost to themselves and to their own health. They are inclined to go before their condition gets critical, when it is easier to go.

The same situation exists in Los Angeles. The same condition exists for the Los Angeles County Hospital. I have been there in Watts, to the neighborhood health center that OEO now provides, It has made it possible for a person to walk to get care and attention. I stood for hours watching patients come in time after time. A patient would say that this was the first time that he had ever had dental or medical care in his life. Many times it was the first time that the children had ever seen a dentist. They simply did not know how to get health care for them before.

These new facilities would provide a wide range of health services under one roof. Present Federal programs have tended to fragment medical care by providing one type of care in one place, another type in another place. It makes little sense to build a clinic for children, another for their mothers, and none at all for anyone else in the family. Comprehensive centers should be built rather than categorical centers.

We have learned from the experimental comprehensive ambulatory clincis, funded by the OEO, that they are an extremly effective mechanism for getting health services to the people who need them. These clincis are an extremely worthwhile investment. Not only can preventive medicine and family planning services be made available with consequent reduction in hospital usage but, with proper use of ancillary personnel, the need for professional manpower can be dramatically reduced. For example, for the population served by the Columbia Point Neighborhood Health Center in Boston, the number of hospital admissions was cut by more than 50 percent in the first year of operation. Dr. Harold Wise of the Montifiore Hospital Neighborhood Health Center has informed me that he is able to serve a population of 45,000 with only 25 physicians, whereas normally this would require about 600 physicians.

It is clear that such centers offer the most efficient way to use our limited pool of professional people. I know that the committee agrees that something must be done now to lower medical costs without curtailing services. I believe there is one proven method of accomplishing this now available to us. It can be done by increasing our capacity to provide services on an outpatient basis through the establishment of a system of neighborhood clinics.

Another important change that I would propose is the removal of the earmarking of funds for certain types of projects. This earmarking tells the States how their allotment is to be divided. It is true that certain transfers of funds are allowable under present legislation, but I see no value in having the Federal Government dictate to the States what is best for them. Each State has different needs. Take Texas, as compared with the needs of South Dakota or New York. Texas should have the right to determine its own needs taking into account their own existing facilities and the needs of its own population. I think that by establishing priorities for certain types of projects, the legislation has gone as far as necessary in spelling out what Congress expects of the States.

I have also proposed a change in the allotment formula from one based on per capital income and population to one based on absolute number of medically indigent. This is only fair and right. Title XIX eligiblity would be used to determine the number of medically indigent to each State. This change is important because it is the poor who have the greatest difficulty in getting medical care and who now generally receive inadequate care in the most overtaxed facilities. I feel that this allotment proposal is more workable than a formula based on need, because need is a nebulous and relative term. Also, a formula based on need tends to penalize those States that have done the best job in the past.

In order to reduce the cost of services to the health consumer, I have proposed the following steps to avoid duplication and inefficiency in new and modernized facilities. First, the State Hill-Burton plan must be consistent with the plan of the newly created State comprehensive planning agencies. Thus my proposal would spell out the role of these planning agencies in determining the funding of facilities and would bring the facilities construction into line with overall requirements for health services. Secondly, the project applicants must submit cost estimates and information on other health facilities that they may be operating. The Secretary of the Depart-

ment of Health, Education, and Welfare is instructed to give preference to the most efficient and effective projects.

Present medical care for the poor is fragmented, uncoordinated, and unresponsive to the total patient needs. It is hard to believe that, although we spend $50 billion a year for health care, a recent report of the National Advisory Commission on Health Manpower stated flatly: "There is a crisis in American health care."

Before putting this legislation in, I went with Dr. Joe English of OEO, now of HEW, who had set up these OEO clinics across the country. We visited a number of different States. We spent several days doing this. I have also consulted with a great many other people, since the legislation, from the medical profession, and I have attached to my own testimony voluntary comments that have come in from experts in this field. In concluding my own comments, I would not do any better than to repeat a few of the statements made by the National Advisory Commission on Health Manpower.

The report states:

> Unless we improve the system through which health care is provided, care will continue to become less satisfactory even though there are massive increases in cost and in numbers of health personnel.

The National Advisory Commission on Health Facilities made its report to the President in December of 1968. This report is an excellent one and should be read by all. Its recommendations are summarized in the letter of transmittal when Boisfeuillet Jones, the Chairman, said:

> The Commission believes that development of systems for delivery of comprehensive health care to all our people where they live is a community responsibility. The existing fragmented delivery systems must be made whole through full coordination of resources and services at the local level. Emphasis must be given to the organization of ambulatory care for the individual and his family, with coordinated professional direction through the full spectrum of comprehensive health services.

The legislation that I respectfully suggest for your consideration is designed to accomplish just this. It is my conviction that we must and that we can get more from the health care dollar.

Instead of pouring more dollars into a system in order to try to cover up the problems in the system, we should come to recognize that only a reorganization of the system itself will produce the level of care of which we are capable. We must remember that the individual physician is the primary distributor of health care. From the standpoint of cost, the tendency for more and more services to be delivered in the hospital is one major factor for the spectacular rise in health expenditures.

The Congress is presently at an important crossroads in the area of health legislation. New health legislation of the past several years has been addressed to important problems and certain demonstration programs have beamed a ray of hope into some hard core areas of need. However, these can only be looked upon as tentative first steps. And, as in so many other areas, once the path is first tread, we have only begun to realize the truly massive problems of personnel, organization, and financing that must be attended to. The time has now come to correct the inadequacies of the present system.

I could not be more pleased as a Member of the Senate to see that the direction of the future is in your own competent hands, and in your own concern, which has been longer standing than mine.

I know it is such that we can now chart a course, and I stand ready to serve in any way that I can to help the committee, although I am not a member of the committee, to perform the responsibility that it has.

The CHAIRMAN. Senator Percy, you made a very valuable contribution to this committee and to the Congress and to the country in your research and your statement.

Your legislation falls into what S. 2182 does, which includes these centers. We have been working on this under the list of bills, as you know, for several years; but our knowledge has increased my personal belief that the greatest unit of the American people in the field of domestic matters is that of health care. You have dramatically shown, from your own research, how inadequate these programs are in many areas of the country. Your work and your statement will be very helpful to this committee.

At this time, I will have placed in the record all of the attachments to your statement, along with your statement.

(The documents referred to follow:)

PREPARED STATEMENT OF HON. CHARLES H. PERCY, A U.S. SENATOR FROM THE STATE OF ILLINOIS

I am grateful for the opportunity to appear before this committee during its consideration of such important legislation. The members of this committee and members of the entire medical community have become increasingly aware of the widening gap between the demand for medical services and the ability of the health care industry to provide these services. During these hearings this medical gap will be studied and the legislation which you recommend to the Senate will, I hope, provide the mechanisms which will begin to narrow this gap.

However, because this widening gap does exist, it is especially important at this time that we make full use of the legislative tools at our disposal. The Hill-Burton program has served the Nation well, but it is clear that major changes must be made in order to keep abreast of the great strides made by American medical science in the past two decades. I believe, that with appropriate changes, the Hill-Burton program can be very important in helping to shape a more effective overall approach to the provision of health services in this country.

One can consolidate the many problems confronting the medical care system today into three major interrelated areas: 1. the shortage of medical manpower, 2. the lack of a comprehensive approach to the provision of health services, and 3. the inaccessibility of medical care for a large segment of our population. By properly amending the existing legislation we can make a major contribution toward the solution to these problems.

The Neighborhood Health Center Act which was introduced in the 90th Congress and again in the 91st Congress with twenty-four co-sponsors (including five from this committee) contains amendments to the Hill-Burton program which, I believe offer the opportunity to begin a new program of health facility construction. I would like to discuss with you just the major ideas in this legislation. A more detailed statement and a section-by-section analysis are also available.

The Neighborhood Health Center Act amends the Hill-Burton Act to authorize the funding of comprehensive ambulatory care centers. The bill defines a "comprehensive ambulatory care center" as a facility providing a full range of medical services for patients not requiring hospitalization. The priority area for this type of facility would be one having low physician accessibility; that is, an area where it is difficult to obtain medical care.

These new facilities would provide a wide range of health services under one roof. Present Federal programs have tended to fragment medical care by providing one type of care in one place, another type in another place. It makes little sense to build a clinic for children, another for their mothers, and none at all for anyone else in the family. Comprehensive centers should be built rather than categorical ones.

We have learned from the experimental comprehensive ambulatory clinics, funded by the O.E.O., that they are an extremely effective mechanism for getting health services to the people who need them. These clinics are an extremely worthwhile investment. Not only can preventive medicine and family planning services be made available with consequent reduction in hospital usage but, with proper use of ancillary personnel, the need for professional manpower can be dramatically reduced. For example, for the population served by the Columbia Point Neighborhood Health Center in Boston, the number of hospital admissions was cut by more than 50% in the first year of operation. Dr. Harold Wise of the Montifiore Hospital Neighborhood Health Center has informed me that he is able to serve a population of 45,000 with only 25 physicians, whereas normally this would require about 60 physicians. It is clear that such centers offer the most efficient way to use our limited pool of professional manpower. I know that the committee agrees that something must be done now to lower medical costs without curtailing services. I believe there is one proven method of accomplishing this now available to us. It can be done by increasing our capacity to provide services on an outpatient basis through the establishment of a system of neighborhood clinics.

Another important change that I propose is the removal of the earmarking of funds for certain types of projects. This earmarking tells the States how their allotment is to be divided. It is true that certain transfers of funds are allowable under present legislation, but I see no value in having the Federal government dictate to the States what is best for them. Each State has different needs. I think that by establishing priorities for certain types of projects, the legislation has gone as far as necessary in spelling out what Congress expects of the States.

I have also proposed a change in the allotment formula from one based on per capita income and population to one based on absolute number of medically indigent. This is only fair and right. Title XIX eligibility would be used to determine the number of medically indigent to each State. This change is important because it is the poor who have the greatest difficulty in getting medical care and who now generally receive inadequate care in the most overtaxed facilities. I feel that this allotment proposal is more workable than a formula based on need, because need is a nebulous and relative term. Also, a formula based on need tends to penalize those States that have done the best job in the past.

In order to reduce the cost of services to the health consumer, I have proposed the following steps to avoid duplication and inefficiency in new and newly modernized facilities. First, the State Hill-Burton plan must be consistent with the plan of the newly-created State comprehensive planning agencies. Thus my proposal would spell out the role of these planning agencies in determining the funding of facilities construction into line with over-all requirements for health services. Secondly, the project applicants must submit cost estimates and information on other health facilities than they may be operating. The Secretary of the Department of Health, Education, and Welfare is instructed to give preference to the most efficient and effective projects.

Present medical care for the poor is fragmented, uncoordinated, and unresponsive to the total patient needs. It is hard to believe that, although we spend $50 billion a year for health care, a recent report of the National Advisory Commission on Health Manpower stated flatly:

"There is a crisis in American health care."

The report further stated:

"Unless we improve the system through which health care is provided, care will continue to become less satisfactory even though there are massive increases in cost and in numbers of health personnel."

The National Advisory Commission on Health Facilities made its report to the President in December of 1968. This report is an excellent one and should be read by all. Its recommendations are summarized in the letter of transmittal when Boisfeuillet Jones, the Chairman, said:

"The Commission believes that development of systems for delivery of comprehensive health care to all our people where they live is a community responsibility. The existing fragmented delivery systems must be made whole through full coordination of resources and services at the local level. Emphasis must be given to the organization of ambulatory care for the individual and his family, with coordinated professional direction through the full spectrum of comprehensive health services."

The legislation that I respectfully suggest for your consideration is designed to accomplish just this. It is my conviction that we must and that we can get more from the health care dollar. Instead of pouring more dollars into a system in order to try to cover up the problems in the system, we should come to recognize that only a reorganization of the system itself will produce the level of care of which we are capable. We must remember that the individual physician is the primary distributor of health care. From the standpoint of cost, the tendency for more and more services to be delivered in the hospital is one major factor for the spectacular rise in health expenditures.

The Congress is presently at an important crossroads in the area of health legislation. New health legislation of the past several years has been addressed to important problems and certain demonstration programs have beamed a ray of hope into some hard core areas of need. However, these can only be looked upon as tentative first steps. And, as in so many other areas, once the path is first tread, we have only begun to realize the truly massive problems of personnel, organization and financing that must be attended to. The time has now come to correct the inadequacies of the present system.

Section-by-Section Summary of the Neighborhood Health Center Act

(a) Amends the purpose section of title VI of the Public Health Service Act to include comprehensive ambulatory care centers among the categories of facilities to be assisted.

(b) Eliminates the earmarking of funds for specific categories of projects. The type of projects to be funded in each state is left to the discretion of the State planning agency.

Changes the present state allotment formula which is based upon average per capita income and population to one based upon the number of medically indigent in each state.

(c) Requires the approval of the appropriate areawide health planning agency for a state to share its allotment with another state.

(d) Requires that the surgeon general, in prescribing regulations under the comprehensive ambulatory care center program, give priority to areas of low physician accessibility.

(e) Requires that the state plan include information on the number of comprehensive ambulatory care centers needed to provide adequate health services for the state.

Requires that information be submitted with each application detailing the cost of health services to be provided by the proposed facility.

(f) Requires projects to be consistent with comprehensive health plans provided for under the Comprehensive Health Planning and Public Health Services Amendments of 1966. Applications must provide date concerning efficiency of operation of health facilities presently operated by the applicant and requires the surgeon general to give priority to the most efficient project applicants.

(g) Technical amendment.

(h) Technical amendment. Defines "Comprehensive Ambulatory Care Center" and "medically indigent family population".

Statement of Senator Percy When He Introduced S. 2037 on May 1, 1969

THE NEIGHBORHOOD HEALTH CENTER ACT

Last year I introduced legislation intended to form the basis of a new approach to the delivery of health care for those now unable to afford it. The urgent problems to which that legislation was addressed are still very much with us. Although illness is distributed indiscriminately among our population, proper treatment is still a privilege reserved only for those who can afford it. The United States, acknowledged to be the wealthiest nation in the history of this planet, has not yet committed itself to assuring the availabiliy of health care to all its citizens. Although billions have been spent on medical research, we have dealt inadequately when it has come to extending the benefits of that research to our own people.

The poor in the United States receive a disproportionately low share of the health services. Like in so many other areas, Federal health programs have tended to provide help to middle-income Americans, while virtually ignoring the health problems of the poor. And the result is that the health of the poor in this country is a national disgrace.

Poor people seek and receive much less medical attention than the affluent, but they need more. And the health gap between the rich and the poor is growing. In 1940, the infant mortality rate for nonwhites was 70 percent higher than for whites. But in 1962, the rate was 90 percent greater. George James, former New York City Commissioner of Health, noted that if the death rate in a middle-class white neighborhood were projected for New York City as a whole, 12,000 lives a year would be saved. He stated that poverty is the third leading cause of death in New York City.

The changing social and medical order is creating, with increasingly compelling urgency, new challenges in health care. Contemporary patterns of disease and disability call for primary emphasis to be given to health maintenance measures; and the growing complexity of medical resources requires the integrated function of the health team. Effective health maintenance implies, in today's setting, a unified, personalized, and continuous service system.

Present medical care for the poor is fragmented, uncoordinated, and completely unresponsive to the total patient needs. It is hard to believe that, although we spend $50 billion a year for health care, a recent report of the National Advisory Commission on Health Manpower stated flatly:

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Health problems are certainly complex. We are faced with a shortage of physicians in the face of an expanding demand. The expansion of medical knowledge in recent years has made it difficult for the solo medical practitioner to provide a complete range of top quality service. This has resulted in increasing specialization and a relative decrease in primary care physicians. Although we are now able to do more for the sick person, it is more difficult for him to gain access to a physician. Nowhere is the problem more acute than in the low-income neighborhoods of our inner cities and rural communities. With the emigration of middle-income population to the suburbs, the physicians and new facilities have followed. Furthermore with the decline of the municipal tax base, hospitals and clinics in the central city were left to deteriorate, along with schools and housing.

The arrival of large numbers of immigrants from rural areas into our cities has placed an increased load on the charity hospitals. This problem is multiplied by the poor health of low-income populations. For example, the percentage of persons with family incomes under $2,000 having some chronic illness is *triple* that of persons with family incomes greater than $7,000. A recent Harris survey, sponsored by the Blue Cross Association, showed that serious illness has struck one in four poverty level families compared with a national average of one in ten. A significantly larger proportion of poor people suffer from eye disease, heart disease, high blood pressure, arthritis, tuberculosis, and mental illness. Especially disturbing is that the infant mortality rate is double and the proportion of mothers dying in childbirth is four times greater among the poor. There is no need to belabor the fact that the poor are the sickest segment in our society; in fact, poverty itself may be thought of as a disease rather than an economic condition.

In the face of these overwhelming health problems a person of limited income has few alternatives in seeking help. Some physicians donate their services but, in general, the poor are referred to the large county or city hospitals. In these institutions large numbers of people are crowded into unpleasant, impersonal, inadequate facilities where they must sit for hours. Before they can see a physician, they are subjected to the indignity of establishing that the degree of their destitution entitles them to free care.

The United States is one of the few modern Western nations with separate medical systems for the poor and the non-poor. Although the medical profession has been aware of this dual system of health care for many years, only recently has the Congress, with the passage of Medicaid and Medicare, recognized that the good health of all its citizens is a goal worthy of America.

With the need for services so clearly defined, one may ask what is preventing the poor from receiving adequate medical care. Obviously, inability to pay is important. Unfortunately, Medicaid has not solved this problem. Some states have not implemented it and others have had to cut back due to insufficient funds. However, even had Medicaid not run into financial difficulty it would have been inadequate. There is growing evidence, that Medicare and Medicaid have not succeeded in increasing the availability of health care. A recent study of the effects of these programs by the Tax Foundation concluded that, "To date the major demonstrable effect of the 1965 Federal legislation creating Medicare and Medicaid has been a shift in financing medical care from the private to the public sector. Although public spending for medical care increased by nearly three-fifths in the first full year of these two programs, the resulting improvement in per capita medical care for the population at large was only 5%, no greater than had been experienced in some previous years in the 1960's."

One major problem with the present health care system is that it is inaccessible to many low-income families. Figures from Chicago, Cleveland, and Los Angeles show that in spite of the staggering health problems of the poor less than half as many physicians practice in low-income neighborhoods as in the other areas of the cities. Very few of this limited number of ghetto physicians are specialists. It is not surprising that more than 50% of inner-city children examined under the Head-Start programs had never before been seen by a physician. It was either too expensive or physically difficult for their mothers to get them to a clinic.

In addition to problems of distance and lack of transportation, the operation of tax-supported clinics often seems planned to discourage all but the most diligent. Short daytime-only hours and long waiting periods result in time lost from work, there is no provision for daycare for children whose mothers need care and facilities are decrepit, understaffed, ill-equipped, and generally unpleasant; worst of all is the impersonality of the service. These complaints are not new. They have been voiced repeatedly by community leaders from low-income neighborhoods.

Besides the staffing and facilities problems I have just discussed, there are fundamental organizational barriers which constitute the most serious obstacles to the provision of good health care. These organizational barriers are lack of continuity of services and fragmentation.

Lack of continuity refers to the situation in which no one physician has responsibility for the total care of an individual patient. Thus, a patient may see a different physician each week, and, if hospitalization is required, several more physicians may take charge. With each change irretrievable information is lost and confidence must be rebuilt. The patient has no concept of who his physician is. Although consultation is a necessity there can be no substitute for a one to one doctor-patient relationship—for the poor this situation rarely exists and, as a result, the quality of care they receive suffers.

Fragmentation is the division of responsibility for treatment of different diseases among different facilities and personnel. Nowhere is this tendency more evident than in the provision of tax-supported health services. Until recently, Federal and state programs for health care have focused on specific disease categories. Thus, funds may be available for diagnosis and treatment of tuberculosis, mental illness, venereal disease, rheumatic fever, cancer screening, and prenatal care, but not for pneumonia, leukemia, or emphysema, or any other disease. In this situation, a person may be refused care not because he isn't sick, but because he has the wrong disease.

Specialization within the medical profession has resulted in still further fragmentation of care. One New York inner-city hospital has over 100 different specialty clinics, each one restricted to certain types of illnesses. If a patient comes on the wrong day or at the wrong hour, he must come again some other time. Often the various services are provided in physically separate facilities. This fragmentation is encouraged by the categorical funding of health care through numerous separately administered Federal, State, and local agencies, although it seems obvious that a single primary care physician with responsibility for the health of the patient would be best able to cope with the variety of threats to the health of the patient.

In order to hasten the provision of good health care for all Americans while maintaining a strong orientation toward efficiency and economy, I am today introducing the Neighborhood Health Center Act. It is designed to deal with some of the problems I have just outlined in both rural and urban areas. This bill amends the Hill-Burton Act with the intent of building a system of neighborhood comprehensive ambulatory care centers similar to those established in the experimental O.E.O. program. By bringing multispecialty resources into the areas of low physician accessibility the problems of fragmentation and inaccessibility can be overcome.

After introduction of the Neighborhood Health Center last July, I sent copies of it to approximately four hundred individuals and organizations interested in the health field. Their response to the bill was helpful and generally favorable. Some sample comments were:

"I am pleased to see the thrust toward moving away from categorical programs and increasing our comprehensive services—and also fully agree that broad community planning is necessary so that each hospital does not duplicate expensive equipment which may be present close at hand.

"We will continue to relay our ideas to you—we are much in your debt for projecting this important new legislation."—DAVID E. ROGERS, M.D., Dean of the Medical Faculty, The Johns Hopkins University, Baltimore, Maryland.

"It seems quite clear that there is urgent need for better ambulatory medical care facilities in the ghettos. It is equally apparent that new techniques are needed for providing service through such centers. Therefore, it would seem an appropriate step on the part of Congress to provide funds for ambulatory health centers."—J. G. HARRAR, President, The Rockefeller Foundation, New York, New York.

"The need for more and better health facilities accessible to people so that they can receive care without the necessity of hospitalization or long expensive trips to crowded hospital outpatient department and emergency rooms is incontestable.

"Your Neighborhood Health Center Act constitutes an imaginative approach. Your lucid analysis of the chaotic medical care situation in the country is an excellent documentation of the need for action."—JERRY VOORHIS, Secretary, Group Health Association, Washington, D.C.

"If implemented, I sincerely believe this legislation would be a large contribution toward the solution of the health care problem of the poor and the rural area and small towns of America."—LAWRENCE J. ROSSI, M.D., Medical Director of The Hopedale Medical Complex, Hopedale, Illinois.

"I commend you for introducing and sponsoring legislation to provide funds for the establishment of neighborhood health centers. Throughout my years in the College of Nursing, I have followed the progress of the Mile Square Health Center. The faculty of our college has repeatly stated that centers such as Mile Square are needed throughout the city and the entire nation."—PAT SCHUPRACH, Co-moderator, Medical Center Y.M.C.A., Student Board, Chicago, Illinois.

"The bill, which would provide funds for construction of health centers, would help to solve one of the problems we have encountered in implementing our program. In the inner city of Rochester, as undoubtedly in the slums of many cities, decent buildings for use as health centers are simply not available, and, as we have found, capital funds to build these centers are hard to come by. Consequently, in our opinion, your bill is very much needed."—MARION B. FOLSOM (Former Secretary of H.E.W.), Eastman Kodak Company, Rochester, New York.

"With respect to the Neighborhood Health Center Act, I think it would provide federal financial assistance to the states for the benefit of our neediest people. Preventive medicine would certainly contribute to a reduction in the number of hospital admissions and well-staffed clinics by properly qualified medical and paramedical personnel would go a long way toward providing it."—HAROLD GRIMM, Buffalo, New York.

"As an Engineer, I have had the opportunity of working with people establishing the Clinic in Watts, as well as the Tufts University project at Mound Bayou, Massachusetts, and other similar applications, including the Kaiser Pediatric Eye Clinic in Bellflower, California. As a citizen, I have come to recognize the great potential of this type of operation, and feel that it is extremely important to the maintenance of the health and welfare of our people in every walk of life."—EDWARD F. WEHLAGE, Professional Engineer, Whittier, California.

"I am writing in support of your position urging Congress to pass legislation which will extend the Neighborhood Health Center program. The centers estab-

lished by the Office of Economic Opportunity have demonstrated their effectiveness in meeting the health needs of the medically indigent.

"Comprehensive health services delivered in this type of organization structure can be best geared to the needs of individual communities. It also provides for better utilization of medical personnel as well as to give the consumer an opportunity to participate in the planning, maintenance, and promotion of his own health."—JOSEPH PATTERSON, Ph. D., College of Physical Education, University of Illinois.

"As you know, the Department has not yet taken an official position on this proposed legislation but, speaking personally, I concur wholeheartedly with the general objectives of the proposal. Certainly the problem of accessibility to physicians and to care facilities must be major considerations in any meaningful program of planning for health services."—JAMES H. CAVANAUGH, Ph.D., Director, Office of Planning and Program Coordination, Department of H.E.W., Washington, D.C.

"I believe that (we have) definitely proved the value of the neighborhood health center. I believe that instead of the 40 centers that (we have) now, we ought to have 400 in the United States within the next couple years. I believe they are effective because they create a new mechanism for more efficiently utilizing the resources that we have and putting them in a place where people can have access to them."—WILBUR COHEN (former Secretary of H.E.W.).

The main provisions of this bill are as follows:

First. Federal funds are committed to the establishment of outpatient clinics in areas of low physician accessibility. Public Law 88–443, the Hospital and Medical Facilities Act of 1964, is amended to include comprehensive ambulatory care centers among the facilities eligible to be constructed with Federal funds. These centers will be staffed by a group of physicians with different specialty training in order to provide a wide range of services.

Second. No additional funds are authorized. However, the present restrictions under Public Law 88–443 are removed, and the type of project to be funded is left to the discretion of the State planning agency. It is felt that each State can best determine its own needs and priorities.

Third. In order to focus Federal expenditures on the health needs of the poor, State allotments will be calculated on the basis of the number of medically indigent families within each State rather than on the basis of the present complicated formula involving average per-capita income and population. The industrialized States are discriminated against by the present formula because of their higher per-capita income. However, for a two-year period no State will receive less money under the new formula than it did under the old.

Fourth. To make better use of Federal funds spent for research and planning, the bill provides for the consideration of recommendations of the areawide planning agencies established under Public Law 89–749.

Fifth. The major goal of the bill is provision of the best possible medical care for all. Therefore, the bill provides for the Surgeon General to give priority to areas with low physician accessibility, because these are the areas of greatest need due to the fact that most present legislation ignores these areas.

Sixth. In order to avoid funding inefficient operations, the bill requires priority in granting funds be given to the most efficient and effective facilities. This will, therefore, circumvent the pitfalls of medicare and medicaid which tend to reward the most inefficient operations by reimbursing on a cost basis.

It is anticipated that applicants will include groups of private physicians, medical schools and their affiliated hospitals, voluntary hospital centers, nonprofit organizations, and local medical societies.

The Nation's health is its most valuable possession, and soundest investment. A program of neighborhood health centers would clear the most difficult obstacles between many of our citizens and a productive life.

The time has arrived when Federal support for health services should be directed away from the categorical approaches of the past and our resources focused on the provision of comprehensive services. Comprehensive implies a one-step entry into an all-inclusive, continuous system. Medically, the term "comprehensive" means a complete approach to the individual no matter what his disease or disability.

Preliminary steps toward a comprehensive approach were taken with the passage of The Comprehensive Health Planning and Public Health Service Amendments of 1966 and the Partnership for Health Amendments of 1967. Under sections 314(d) and 314(e) of these laws money is made available for comprehensive health services. Unfortunately, of the more than $120 million spent, less

than $10 million was actually spent on comprehensive health services. The remainder was consumed by the same old categorical programs previously funded from other sources.

I don't say that the categorical programs are unworthy of support . . . the prevention and treatment of any disease is a worthy undertaking and should be supported. However, the evidence suggests that this categorical approach to the health problems of the poor has not and cannot succeed. To quote Dr. John DeHoff, director of local health services, Baltimore City Health Department, "The Neighborhood Health Center Act will help hospitals, other medical centers and groups of physicians to move into neighborhoods which have the greatest need, with funding based on needs as measured by indigent and medically indigent populations. Although hospitals give excellent inpatient care for complicated and interesting cases, they cannot easily prevent disease from happening . . . or follow patients closely after they leave a hospital phase of care. Federal money for construction will help greatly."

Professionals with experience in community medicine realize the futility of the present fragmented and discontinuous approach. Professor Robert Daniels of the University of Chicago Department of Social and Community Medicine wrote, "The State of Illinois makes a large financial contribution through public aid and welfare programs. However, these are administered in such a way that they respond to episodes of illness rather than providing continuity of health care over periods of time. . . . Many episodes of illness occur in individuals not registered and the medical and hospital community in such situations are uncertain about whether they will be reimbursed by public programs or not."

Comprehensive services must be brought together in easily accessible facilities. It is wrong that in the face of preventable and treatable diseases afflicting large numbers of our citizens most government programs have ignored the special problems of the poor. The billions spent on medical research have greatly expanded the ability of the modern physician to cure or prevent many previously incurable diseases. Yet in the very shadow of the great medical centers where hearts are being transplanted and cardiograms are being read by computers thousands of individuals are dying from preventable diseases. No one can deny that the very best medical care in the world is available in American cities, but it is obvious that unless one can get to a physician these advances are meaningless. The nine billion dollars thus far spent for hospital construction and modernization under Hill-Burton legislation have had far too little impact on improving the health care of the poor. In fact, it is the more affluent citizen, with his greater demand for and utilization of medical personnel and facilities, who has benefitted the most from this program.

Comprehensive clinics pay their own way. All evidence indicates that providing comprehensive outpatient care reduces hospital utilization dramatically. In a Massachusetts comprehensive health center, a spot check after 2 years of operation indicated that the health level of local residents was raised to the point where the number of hospitalization days had been cut by 80 percent. Not only are many diseases prevented or diagnosed earlier, but hospitalization for diagnostic purposes can be avoided by providing such services in the clinic. Most important, the tendency to fragment medical services—fostered by most Federal programs—can be avoided. Perhaps many of the categorical programs will be found unnecessary, which will save more Federal dollars.

Diseases, such as measles, mumps, diptheria, polio, and rheumatic fever can be prevented and others, such as tuberculosis, pneumonia, and cervical cancer can be cured if treated early. But immunizations and early diagnosis can only be accomplished only if comprehensive care is available. The orientation of our programs must be shifted from disease to health. The economic loss to the nation caused by preventable or curable diseases is incalculable. The lack of ambulatory care centers at convenient locations means that large numbers of people wait too long before seeking help and thereby finally require hospital care. This is neither an efficient nor an effective way to provide health services. To quote Mr. Leonard Procita of the Albany Medical College . . . ". . . we are considering persons here who, because of their marginal income, hesitate too long in obtaining necessary health care. These neglected health problems become more prominent in later years . . . many health problems can be traced to neglect in childhood. In this regard a neighborhood health center would be a great step forward in establishing preventive medicine for these people on a sound basis."

The limited program of comprehensive clinics funded under O.E.O. has demonstrated that the neighborhood health center approach is the most effective strategic approach to the delivery of health care in areas of low physician acces-

sibility. It is also the most efficient and probably least costly method of providing top quality services. Comprehensive care implies, though does not necessitate, a multispecialty group practice approach providing a full range of diagnostic services. Where this system has been coupled with prepayment of a monthly set fee, hospital utilization has been cut in half and overall costs average 25% less than for the same range of services provided under the traditional fee-for-service system.

The National Advisory Commission on Health Facilities states: "One approach that has decreased hospital utilization is prepaid practice. A study of Federal employees' health program benefits over a 5-year period shows that employees in prepaid group practice plans had consistently the lowest rates for nonmaternity utilization of in-hospital services. In 1965, according to this study, the number of hospital days per 1,000 covered persons in prepaid group practice was approximately half of that for those in the indemnity benefit plan of Blue Cross-Blue Shield."

I cannot emphasize too strongly that if we are to get the most from our health dollar we must take into consideration alternative approaches to funding. Experience with health insurance programs based on the fee-for-service approach has shown that they are usually associated with increased hospital utilization. Many services are not reimbursable unless delivered in the hospital and there is therefore no economic incentive for preventive medicine again, diseases are being treated, not people. Medicaid and Medicare are basically forms of health insurance and have thus encouraged greater hospital utilization. They have also placed a greater demand on the limited supply of practicing physicians. In fact, I am frequently asked where I expect to find the physicians to staff these clinics.

In answer to this question I can point out that the group practice approach, with the employment of sufficient paramedical personnel is itself a partial solution to the physician manpower shortage. In this regard, I received the following letter from Dr. Harold Wise, Program Director of the O.E.O. Montefiore Neighborhood Medical Care Demonstration, "The use of paramedical personnel to increase physician productivity has been well documented. We plan to serve a communuity of 45,000 people. With the more intelligent utilization of nursing and family health worker personnel, we are able to reduce the number of physicians necessary to 25."

Of course, this approach will not, in itself, solve the shortage of physicians. We must push for greater Federal support for the expansion of medical school class size. This can be done by increasing the amount of money authorized for medical student loans and scholarships, for medical school improvement and for schools for the allied health professions. Direct support of teaching programs must be instituted instead of funding them through the back door with moneys appropriated for research. We must ask why the United States needs to recruit a large percentage of its practicing physicians from foreign medical schools when qualified college graduates in this country are denied entrance for lack of space. This problem is one of the utmost priority and urgency. However, it must be kept in mind that even if enough medical school places were made available today there would still be a lag of eight to ten years before these prospective doctors would enter practice.

The evidence shows that we have the resources to provide comprehensive health care and that vast new expenditures will not be required. What seems to be needed is a focus to bring together the various government and private programs trying to provide health care. At this point the neighborhood health center seems to be the most logical method. Edgar Kaiser wrote to me, saying: "Such facilities can function on a sound operating basis through more effective application of existing public and private funds already available for purchasing health care services."

I am confident that with the proper administration of this proposed legislation we can go a long way toward realizing the goal of top quality health care for all our citizens.

It has been estimated that the cost of living will rise by 20 percent by 1975, but medical costs are expected to jump 140 percent. As medical care costs continue to skyrocket, fewer and fewer Americans can afford necessary medical attention.

It is my position that we can get more from the health care dollar. Instead of pouring more dollars into a system in order to try to cover up the problems in the system, we should come to recognize that only a reorganization of the system itself will produce the level of care of which we are capable.

The Congress is presently at an important crossroad in the area of health legislation. New health legislation of the past several years has been addressed to

important problems and certain demonstration programs have beamed a ray of hope into some hard core areas of need. However, these can only be looked upon as tentative first steps. And, as in so many other areas, once the path is first tread, we have only begun to realize the truly massive problems of personnel, organization, and financing that must be attended to. The time has now come to correct the inadequacies of the present system. The bill I offer today represents a step in this direction.

The CHAIRMAN. I will ask three brief questions.

We know, as you pointed out in your last sentence, that it is going to take more money, and we have difficulty there. The information that was ascertained last week on the Appropriations Committee, in the subcommittee that deals with the Bureau of the Budget, was astounding. I have learned that there are 500-some-odd employees, 178 of whom are specialists who review the Federal budget. Of that 178, 32 review the budget of the Defense Department. The other 146 are the ones that reduce a budget like this. There are some 30 assigned to work on education and health and related fields for the welfare and they come back and cut, cut, cut all the time. This is a part of the Government that your influence in this certain area could, obviously, be helpful. I will not be so bold to say that any Senator has great influence with the Bureau of the Budget. Take the educational program. There is not a single professional educator in the whole bureau. So there is no sanctity, in my mind, about figures because the Budget Director recommended it. Quite the contrary.

After I questioned them, I was astounded to find out how little they knew about the work. I just think that it means that there are some very strong blocks to overcome. They cut to pieces the health and education appropriations that we first authorized; then, you know, there was great difficulty getting only a portion of that in the Appropriations Committee.

The Bureau of the Budget has been, in the past, sitting there and having the Cabinet officer come over and tell them not to cut specific programs. Up until a week ago the Defense Department turned to the Bureau of the Budget and asked the Bureau of the Budget to let them have some of those cut funds. I mean, we have got to do something to balance this. We have got to restore the balance.

There are three questions that I would like to ask.

How many clinics would be needed across the country, what would be their expenses and what would they cost to carry out? What do you have in mind about the legislation?

Senator PERCY. I can give you a very quick answer to your questions and I would like to comment on your brief statement which I think is so very important.

First, according to the HEW figures 620 clinics would be necessary for rural and urban areas of need.

There are now around 40 experimental clinics, so that no program could go into being that has had more experimentation than that.

We are simply asking for authority under the Hill-Burton Act for States to be able to provide for centers in their State plans. This is, in their judgment, they feel that they need them.

As you know, the formula in every bill is based on the number of medically indigent in each State. No additional funds are authorized except whatever might be necessary to assure that no State would suffer under the new formula; that is, for a 2-year period, no State would receive less than they did under the old formula.

Each clinic would cost about $2 million to construct, but I would like to point out that some of the best clinics that I have been to have been in rehabilitated quarters. The Alviso clinic in California has been operated at a very low cost from a reconverted model. The San Francisco Mission Street clinic consists of a group of trailers in the center of the low-income, Spanish-speaking community. The Mile Square clinic in Chicago is in an old building. These are better clinics in many respects than even the very expensive clinic built in Watts. The others grew up within the community. They have taken existing facilities that the neighborhood was familiar with, and they adapted them to their need and made fine facilities out of them. The other one which I know of is in Louisville. It is in a public housing project. They converted units and made excellent facilities at much less cost than new construction would require.

The cost would be on the average of three-quarters of a million dollars if you adapted existing facilities. It takes $150,000 to equip a clinic and it would probably cost around $1.5 million a year to operate one. And, of course, funds that are now available through programs such as medicare and medicaid, as well as individual fees where they could be afforded, would be available to cover the operating expenses.

Your comments, Mr. Chairman, on priority in the military interest me. The former Director of the Budget Bureau, when he testified before a meeting of the Joint Economic Committee on the very point that you made, said that the Bureau of the Budget has been derelict in not looking at the military budget. "It is too complicated." "We do not understand it." "We should not interfere with defense." This is the impression that everybody has been under. The Congress has certainly thought in this way. Whatever has been handed down to us from the Armed Services Committee, was considered sacrosanct. That is not true of any program that comes out of this committee. Everyone feels the right to take a look at it.

I am very happy to state that there is a change in this policy that Robert Mayo, the present Director of the Bureau of the Budget, a fine fellow Chicagoan, is heading now. He is hardheaded with a soft heart. He works together with his colleague from the banking profession, David Kennedy, the Secretary of the Treasury. They have probably done more to help build facilities for medical care in Chicago than any two men that I know of. These are the kind of men who now say that we should begin these other programs and reevaluate the priorities. We should scrutinize the military programs and give them the agonizing reappraisal that we give others. I think we are—I think we can stand up and say that health care is just as important, and might be even more so, than the ABM missile system. We have got to build homes. It is a matter of urgency in this country. Health care in this country is a matter of extreme urgency. We have to give all Americans the feeling that they have a right to medical attention. This legislation is aimed to accomplish that. And I think this can be done at a relatively low cost.

The CHAIRMAN. I think that the Bureau of the Budget confessed that they could not understand the military budget and they admitted that they determined policy in the field of education without these different programs; they recommended, for example, that the libraries be cut out of the elementary and secondary school system that is

covered by that act. They wanted that to be reduced to $1 out of $6. They determine priority and they recommended no appropriation for certain ones and there was not a professional educator on there.

I think that, after having been on the Education Subcommittee for 12 years and listening to great educators for 12 years, that I know a little bit about education, and probably a lot more than what the people from the Bureau of the Budget do.

I am not a professional educator, but I spent 3 years teaching at a university law school and was counsel for the Texas State Teachers Association for 4 years. Any member of the Senate, I think, is better able to answer some of those questions than are a bunch of men in the Bureau of the Budget. They said they determine policy when they appropriate money for this educational program. They did not appropriate any money for the educational program. I think the Bureau of the Budget needs overhauling about as bad as anything else in this Government does.

Senator PERCY. I think you have performed a great service. I think it is reflected by your amendment to exempt education from the budget restriction.

The CHAIRMAN. Thank you very much. I'm glad we won that battle. It was a proposal that was so badly needed.

I want to thank you again for this information. As you know, the comprehensive bill that we have introduced covers the ideas that you have put forward to us today for the health centers and the ideas of a number of other bills.

I have another question here. This is the hard facts about the number of clinics that you saw and the cost. We have just indicated that we have got to put more money into health care to get health care to the people of the country. Next, I would like to know who will run these neighborhood health clinics. Who do you have in mind?

Senator PERCY. Groups of physicians, medical schools, hospitals, and I think there would be a great number of responding applications to it. I think that there would be adequate management for it.

I would like to point out in that respect that the need is great, Mr. Chairman, that, from talking to the members of the existing student health programs, these medical students are searching to find equipment and space. They try to take medical care into their hands and draw the attention to the low-income person in the city of Chicago who simply does not have health facilities available. The need is great. They are taking time out of their studies to provide that service that is needed there. They cannot wait until they get out of medical school. They are doing it now. That is the urgency that is needed.

The CHAIRMAN. I think that we are seeing a new dedication, dedication to the welfare of all people. We are going to be able to get staff more easily in the future than the past as new graduates come from the colleges.

One other question. Do you, in this respect, have any documentation here to show the source of the expenses in the hospital and offices, and if so, what is the difference in cost between them?

Senator PERCY. Well, as a former businessman who had to look at return investment and acknowledge whether this investment was better than some other investment, I give the legislation that kind of fiscal scrutiny before I suggested it.

The CHAIRMAN. I think that is valuable because there are so many tax dollars going around that there is not enough for some crucial needs.

Senator PERCY. And if there is anything that people are enraged about now, it is the high cost of hospitalization and medical bills. Medical bills, today, going up higher than they ever were before.

Here is a list that we can quickly look at and we quickly can get those answers. This is from the AMA News, February 24, 1969. It indicated that when a function is performed in a hospital as against performance in a radiologist's office (or the counterpart might be a comprehensive health center), the cost goes down dramatically for chest X-rays. The cost in a hopsital is $15 and in the radiologist's office is $11.

For gallbladder it was $30 in the hospital. It is $22 in the radiologist's office.

For the skull, it is $37. It can be reduced to $27. Now that is a large percentage reduction in an individual bill.

Now, they also examined patient cost records. They took 10 patients. I would like to introduce this chart into the record.

The CHAIRMAN. It will be received and ordered printed in the record.

(The document referred to follows:)

X-RAY SAVINGS

Of interest and relevance was the letter by Edward Stevens dealing with unnecessary expense and wastefulness in medical care resulting from the in-hospital performance of many tests which may be performed equally well in private offices at a considerable saving in medical costs (*The AMA News*, Feb. 24, 1969).

The fact that insurers show little interest in such savings indicates an existence of a credibility gap when one hears the cant regarding the careful use of the public's insurance dollars. I recently made a few calculations relating to certain commonly performed diagnostic X-ray procedures in one community hospital. These procedures can be performed equally well in a private X-ray office as in a hospital. The difference in cost when done in the hospital as compared to their performance in a private office is evidence from the following figures:

Procedure	Cost when performed in hospital (includes radiologist's professional fee)	Cost when perfomed in radiologist's office
PA chest	$15	$11
PA and lateral chest	22	16
GI series	53	38
Gallbladder	30	22
Barium enema	47	33
Skull	37	27
IV pyelogram	52	38
Cervical spine	37	27

Evaluation of the charts of a few patients who had in-hospital X-ray procedures of the type that could have been performed in an office, showed the following results:

Patient No.	Cost of diagnostic X-ray procedures during hospital admission (includes radiologist's professional fee)	What cost would have been in private office
1	$154	$104
2	75	55
3	91	66
4	68	49
5	131	93
6	83	60
7	82	60
8	100	71
9	175	126
10	356	258

Senator PERCY. The cost of diagnostic and X-ray procedure, when performed in a hospital, which included the radiologist's professional fee, was, in the actual billing, $154. What it would have cost had it been in a private office would have been $104. Now, that is a tremendous saving.

We must get to people's medical problems early in life, especially those of malnutrition. A single visit to a doctor, in a comprehensive clinic, can result in not putting a person on welfare for the rest of his life. We cannot make these corrections in the ailments of children early unless there is a medical investigation and an investment in the child's future.

The CHAIRMAN. Senator Percy, in our hearings last fall and early winter when the plight of the Mexican-American was developed, there was testimony, from some doctors in Los Angeles that the $50 deductible aid under medicare was hurting these people because they did not have the money to be paying $5 or $7 or $8 for a call. This was causing failure to provide for prescriptions under medicare. It was failure to pay for the first call and was costing the taxpayer more money than they would pay out if they paid for that call to the doctor or paid for the prescription. I have introduced a bill to pay for those prescriptions and pay for those costs under medicare.

I wanted to mention something on the matter that you raised, being a former businessman in the country. As that former businessman, you know what things cost and the value of them. We know this, because you are a very valuable Member of this Senate.

The following has been stated in the past week, not in these hearings: people feel that the cost of this medical care and the insurance in America is adding to the astronomical cost of medical care overall because of policies which provide for payments only under hospitalization. There are many policies that pay only according to hospitalization, and so there is a large push to get in the hospital so that the insurance will cover it. It furthermore was said that the people are influenced by policies by what they paid for and will not pay for under the policy. So here is a broad field to deal with. People came to me about this and they did not want their names on the record. This raises an intriguing question.

This is the first time in my 11 years on the Health Subcommittee I have ever had it raised by some men with knowledge in the field. What extent does insurance play a role in this? The way policies are written

they influence medical treatment. This is one of the tasks that has been assigned to the staff. My staff is preparing work for research in this very broad economic health field.

We thank you, Senator Percy, for the work you have done in this field. We thank you for the work that you have done outside of this field and the studies that you have brought before us and we thank you for your presentation here.

Senator PERCY. I mentioned at the outset that Carol Khosrovi is my legislative assistant, and she has great and deep interest in this field. I thank her for getting me as deeply involved as I have been now for 2 years. I think I should also mention that she has reported to me everything that she has found out about this health problem.

There is extreme dedication on my staff, and I know that there is a tremendous amount of dedication on the staff of this committee. We have received excellent assistance and help from them, and I think we can be very grateful for the fine caliber and quality of expertise that each member of the staff of this committee has.

The CHAIRMAN. We are very thankful to Senator Hill, when he was chairman of the committee, for leaving us such a fine staff. There have been few changes made. We had to just about beg most of them into staying here on the staff. Some of them did leave, but we were able to have some of them stay.

I join with you in what you said about the dedication and knowledge of the staff.

Before we go on to our next witness here, we have a statement from Senator Hugh Scott. He wants this in the record, and I think the logical place to put this would be in the record right after Senator Percy's statement.

(The statement referred to follows:)

STATEMENT OF HON. HUGH SCOTT, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

I am pleased to express my support of S. 2037, the Neighborhood Health Center Act of 1969, of which I am cosponsor. This measure would permit Hill-Burton construction funds to be used for neighborhood ambulatory care centers, primarily in poverty neighborhoods.

The centers would be patterned after the successful experimental program of comprehensive medical care in neighborhood health centers now conducted by the Office of Economic Opportunity. Their experience accentuates the extreme lack of medical facilities, of preventative medical examinations, and of medical treatment for those in poverty neighborhoods. The results are a higher rate of disease, disability, and premature death within these areas than for the rest of the United States.

Neighborhood health centers would make health care available—for many, for the first time in their lives—to persons whose efforts to get treatment would otherwise be frustrated because of the inaccessibility, impersonality, and fragmentation of traditional medical services for the poor. This bill would help establish outpatient clinics with first priority to areas where physicians are scarce.

These health clinics would operate under the sponsorship of a medical institution of recognized competence, such as a hospital, medical

school, or a public health department. The Pittsburgh Hospital Center and Temple University Hospital, with OEO neighborhood health center grants, are already sponsoring such centers in the Homewood-Brushton area of Pittsburgh, and Hartranft and Nicetown-Tioga areas of Philadelphia in my Commonwealth of Pennsylvania. S. 2037 would guarantee a continuation of successful programs like these and, more importantly, would provide the necessary framework to encourage others.

Poverty is a many faceted condition of life. Without good physical and mental health, the poor cannot be expected to rally behind the efforts to end their own deprivation and want. Ill health retards initiative and performance in school and on the job and lessens the will to live for those of advanced years of age. It affects relationships within the family and ultimately the entire community.

Increasing the number of neighborhood health centers, the purpose of S. 2037, will multiply the chances of the poor to emerge from lives of regressive poverty.

The CHAIRMAN. The next witness is Andrew J. Biemiller, director, Department of Legislation, AFL–CIO. Would you introduce your staff to us please?

Welcome to this committee.

STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS; ACCOMPANIED BY RICHARD SHOEMAKER, ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT; AND CLINTON FAIR, LEGISLATIVE REPRESENTATIVE

Mr. BIEMILLER. Thank you very much.

The CHAIRMAN. I remind you that Mr. Biemiller is a former Member of Congress. We are glad to have him before us today and to tell us how people feel about this.

Mr. BIEMILLER. Thank you for your kind words, Senator Yarborough.

I am appearing today in my role as legislative director of the AFL–CIO with regard to the legislation pending before your committee.

I am accompanied by Mr. Richard Shoemaker, who is the assistant director of our department of social security, and by Mr. Clinton Fair, who is one of our legislative representatives.

What I would like to do, Mr. Chairman, if it is agreeable to you, is to consider our statement as read and comment on certain parts of our statement in the interest of time. I recognize that you have a full schedule here this morning.

The CHAIRMAN. Your statement will be printed in full at this point in the record. That is Mr. Biemiller's statement. Do you request that the statement of policy by the Executive Council of the AFL–CIO, dated February 17, 1969, be printed in full at this point also?

Mr. BIEMILLER. Yes.

The CHAIRMAN. All right. Your statement will be printed in the record at this point.

(The prepared statement of Mr. Biemiller follows:)

PREPARED STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. Chairman, Gentlemen of the Committee. My name is Andrew J. Biemiller. I am the Director of the Department of Legislation of the American Federation of Labor and Congress of Industrial Organizations.

We appreciate the opportunity to appear today on the extension of the Hill-Burton program. And for the reasons we will develop later we hope you will look with favor on an expansion of its horizons.

The Executive Council of the AFL–CIO recently reviewed health care needs. They adopted in part a statement calling upon the Congress "to update Hill-Burton to provide grants in aid for the development of complete health services and not just health facilities." They urged that Hill-Burton "expand the horizons of the program as a means of stimulating the organization of comprehensive health systems." They pointed out that the "equality and productivity gains of such comprehensive health care systems would be massive."

Mr. Chairman, we have attached a copy of the Executive Council's statement to our testimony and we respectfully request that it be included in the record of this hearing.

Since the Congress enacted Hill-Burton in 1946, the program has significantly contributed to fulfilling the health needs of the American people. Throughout the years the program has placed its major emphasis on the construction of hospitals and related facilities in outlying and rural areas. Since hospitals and related facilities were few and far between in rural areas, the Congress justifiably and reasonably developed a program to fill the tremendous health care gap for the people of our agricultural and rural areas.

In the almost quarter of a century during which the program has been in operation, Hill-Burton financing has made it possible for 3,700 communities in every part of our nation to build hopsitals and nursing homes with more than 400,000 beds, 7,200 public health centers, more than 900 diagnostic and treatment centers, and over 400 rehabilitation facilities. And for each dollar the Congress has appropriated, private and local public sources have added an additional two dollars. The aggregate expenditures have reached some $10 billion. It has been a tremendous achievement and if we may pat ourselves on the back, we in the AFL–CIO are proud that we have been in the forefront of its staunchest supporters.

The changing American scene, however, does not permit us to stand on our laurels. Many of the distinguished members of this Committee and of the Congress have spoken out for an updating of thee Hill-Burton program. We believe, Mr. Chairman, that S. 2182 does update the program. We believe that, if enacted, it will stand with Hill-Burton as a milestone in improving the health care of our Nation.

Mr. Chairman, we propose in our presentation to follow substantially the order of topics as they appear in S. 2182.

GRANTS FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

We believe Hill-Burton has been one of the most rewarding investments of the taxpayers' dollars. We shall not itemize the amounts of the funds authorized for grants for construction and modernization by S. 2182 in detail, since you have them before you. They represent only modest increases which are fully justified by the urgency of the needs they would fulfill. Therefore we recommend the full amount in S. 2182, but with an increased authorization for grants for outpatient facilities.

Mr. Chairman, there is no question that the construction of outpatient facilities and neighborhood health centers will reduce the need for hospital beds by making treatment available on an ambulatory basis. We need cite only the experience of Kaiser Foundation or the neighborhood health center at Columbia Point.

We believe the Hill-Burton program can make a significant contribution by increasing the development of outpatient facilities providing comprehensive services for all citizens, poor and wealthy alike, by substantially increasing the grants for construction. Neighborhood health centers alone will require $30 million in construction funds this fiscal year. The authorization for outpatient facilities under S. 2182 is $40 million and under H.R. 1102, $20 million. We think the authorization under this section should be increased to $100,000,000.

Priority No. 4 extends the priority list to include projects for construction or modernization of general hospitals which will or in the case of modernization do provide the services of a long-term care facility. We support this effort to lessen the demand for acute hospital beds.

Priority No. 5 extends the priority list to include the health needs of our inner-city.

As we have already mentioned and as the members of this Committee know, the Hill-Burton program has traditionally had a predominantly rural emphasis. In its early years this was certainly understandable. Hospitals in rural areas were few. Financial resources for hospital construction in rural communities were extremely meager. Therefore, it was quite sensible to develop a program immediately after World War II which would try to fill the tremendous health care gap for the people of our agricultural and rural areas.

But now the Hill-Burton program must also meet other health care needs, particularly in the low-income areas of our metropolitan communities where there is a great lack of adequate health care facilities and services. S. 2182 recognizes the urgent needs of the poor in the inner-cities for medical care by establishing a new Priority 5 for the construction and modernization of outpatient facilities in metropolitan areas with low per capita income. We are pleased to note that Priority 4 of S. 2182 accomplishes the same objective, and that H.R. 11102 alters the rural priority in the same direction.

Existing health care services simply do not reach many of the urban poor. When care is available, it tends to be provided in over-crowded under-staffed clinics at inconvenient hours. It is episodic, focused on emergencies rather than continuous and comprehensive care. Too little if any attention is given to preventive services. In many such communities there are no hospital facilities and where there are hospital facilities, they are too often poor, over-crowded and outmoded.

Take the Watts area in Los Angeles, for example. With the exception of the ambulatory care provided by an OEO clinic, most of the quarter of a million people living in that area must rely on the Los Angeles County General Hospital for both inpatient and outpatient care. It requires an eight or ten mile automobile or ambulance trip from Watts to County General. The travel barrier makes it difficult both for patients and doctors in the Watts community to utilize its services. For low-income poor people who are sick, it means hours spent in going to and from the hospital in addition to the long delays in crowded clinic waiting rooms.

Providing health services to the poor through the development of outpatient facilities in low-income areas not only improves their health, which should be the most important consideration, but in the long run it is less costly. This has been dramatically illustrated at the Columbia Point Neighborhood Health Center in Boston.

Dr. H. J. Geiger, Professor of Preventive Medicine at the Tufts University School of Medicine, reported in the February 1969 issue of *Hospital Practice* that at the Columbia Point Health Center serving 6000 poor in Boston *in-hospital use declined by 80 percent because the health care was available early, under a single roof and within walking distance of the home.* The new priority for outpatient facilities in the inner-city should help the development of such neighborhood health centers in urban communities throughout the country. We, therefore, strongly support this new priority in S. 2182 and S. 2037.

However, as important as expansion of outpatient facilities is in providing for the health needs of the poor in our metropolitan areas, we must not neglect the urgent need to modernize existing hospitals and construct new ones to provide inpatient hospital care for low-income patients. This becomes all the more important with the recognition that all Americans are entitled to high quality health care, whether in or out of the hospital. The days of crowded, dreary ward treatment for poor patients should be behind us. This goal calls for modernizing old hospitals and constructing new ones in center-city areas. Therefore, we urge that the priority for outpatient care for low-income areas in metropolitan communities included in S. 2182 be extended to cover the development of inpatient facilities as well. There is still much need for outpatient facilities in rural areas as S. 2037 recognizes.

Priority 6 extends the priority list to include projects for facilities which, alone or in conjunction with other facilities, will provide comprehensive health

care, including outpatient and preventive care as well as hospitalization, particularly projects for facilities which will serve a defined population.

Implicit in the new comprehensive health care priority is that just building facilities is not enough. A community may have a greater need for a home health service, for example, which requires no facility. In its recent report, the National Advisory Commission on Health Facilities said that its comments and recommendations "lead to one major conclusion: The Nation must now concentrate upon organizing health facilities and other health resources into effective, efficient, and economical community systems of comprehensive health care available to all."

Many authorities who have studied the problem of organizing and delivering health care have maintained that "ideally," the community hospital should be the major community resource and that the hospital should be surrounded by satellite outpatient facilities so located as to be readily accessible to the people in local areas. Our teaching hospitals can reach this "ideal" because they have permanent salaried medical staffs. Until the Coggeshall Report, the medical schools however, limited their function to teaching and medical research. Since the Coggeshall Report, the medical schools are beginning to implement one of the Report's recommendations: namely, to become involved with the provision of medical care in the community. Our prestigious medical schools at Harvard, Yale and Johns Hopkins are involved in the development of a comprehensive health delivery system on a capitation basis in Boston, New Haven and in the new city of Columbia, Maryland.

Intermediate between the teaching hospital and the more typical community hospital are those which are approved for internship and residency training. Many of these have some part time or full time permanent staff but over 5000 of the 7160 short term acute hospitals in this country are the voluntary nonprofit and proprietary hospitals which have no permanent medical staff at all! These hospitals, many of which were constructed with Federal Hill-Burton funds are utilized by the physicians in the community as a resource for their acutely ill patients.

The importance and economy of having the same medical staff assume responsibility for both outpatient or ambulatory service and inpatient services cannot be underestimated. On this point, we would like to quote Dr. Ernest Saward, Medical Director of the Kaiser Portland medical group. Appearing before the Subcommittee on Executive Reorganization of the Senate Committee on Government Operations, Dr. Saward, in discussing those aspects of the Kaiser plan which made it so much more efficient, stated:

"The medical group is hospital based. It has satellite clinics serving other neighborhoods of the area, but has an organized central system with a single medical record, both for inpatient and outpatient. The laboratory services, purchasing department, accounting department and administration are unified. *This produces massive economies*" (emphasis supplied).

The relevance of these facts is that the priority for comprehensive care in S. 2182 is interrelated with the modification proposed by S. 2182 to change section 605(e) of the existing Public Health Service Act. Unless this modification is enacted, the comprehensive care priority will not mean too much since section 605(e) of the present law requires the applicant to be a hospital or public agency where the application is for the construction of an outpatient facility.

Priority 7 concludes the new priorities proposed to Hill-Burton. It extends the priority list to projects for construction or modernization of facilities to facilities which provide training in health professions. Numerous studes have clearly indicated the need for additional personnel in the health profession. While we might debate which came first: the chicken or the egg, no discussion is necessary on Priority 7—no facilities—no training.

ROLE OF HEALTH PLANNING AGENCIES

S. 2182 and H.R. 11102 require a review of grant applications by a local area comprehensive health planning body. S. 2037 requires, as a condition for approval of any project, that it be consistent with any comprehensive health plan carried out by the State 314(a) agency. In the present stage of comprehensive health planning at the state level we favor the provisions of S. 2182. Significantly, H.R. 11102 requires each 314(b) agency to provide for appropriate representation of the interests of the hospitals, other health care facilities, practicing physicians and the general public! Requirements of present law with regard to the advisory councils to the State 314(a) agencies require a majority of consumer

representatives. We recommend the law should stipulate that there should be majority representation of consumers on the local area planning bodies.

DEFINITION OF HOSPITALS

S. 2182 and H.R. 11102 extends the definition of hospitals to include home health services and self-care units. We strongly support this revised definition, but suggest that transportation at least on an experimental basis be included. The time is fast coming when, not only ambulances but also helicopters, will be needed to transport the critically ill person to the medical center where the services of highly specialized physicians and sophisticated equipment can be utilized for saving the life of the patient. This is being done in Viet Nam. It certainly should be desirable in many rural areas.

GRANTS FOR EQUIPMENT

S. 2182 permits grants to be made for equipment of any hospital or other medical facility, whether or not it is in connection with construction or modernization, if it will help to provide a new service in the community. In view of the amount and variety of diagnostic and therapeutic equipment needed by a modern well-equipped hospital and the rate of obsolescence of such equipment resulting from new technical advances in medicine, financial assistance to provide such equipment is certainly desirable. Rules and regulations should be authorized to avoid costly duplication.

RESEARCH AND DEMONSTRATIONS

S. 2182 extends and increases the authorizations for research and demonstrations relating to health facilities and services. The other bills do not include this provision. The National Center for Health Services Research and Development can play an important role in improving the quality of health care and in reducing the cost of health services available to the American people. We, therefore, strongly favor the extension of this program at the level provided in the bill.

LOAN GUARANTEES FOR MODERNIZATION AND CONSTRUCTION OF HOSPITALS AND OTHER MEDICAL FACILITIES

S. 2182 and H.R. 11102 establish a new program of loan guarantees with an interest subsidy for the construction and modernization of health facilities. S. 1733 does the same thing, but without subsidy. H.R. 11102 limits the applicant to being a hospital or public agency. Therefore, we favor S. 2182 which provides that the Secretary shall pay to each holder of a loan guaranteed under this program an amount equal to one-half of so much of the interest on the portion of the loan so guaranteed as does not exceed the amount of the interest payable on such portion at a rate of 6 per centum per annum, plus one-third of the remainder (if any) of interest payable on such portion.

S. 2182 also has a direct loan program for public hospitals and facilities; and the need for modernization of our public hospitals is urgent. We urge inclusion of this provision, which is not in the other bills, be included by the Senate.

Regarding the Federal share of the costs of construction, we support the provisions of S. 2182 except that the maximum Federal share might be raised to 90 percent in areas where financial need is shown. S. 1733 makes such provision.

MISCELLANEOUS

The proposed amendments to Section 605 of S. 2037 of the present law which introduces a criterion of efficiency in approving applications for neighborhood health centers. A single criterion of need is not enough, our standard of "need" is approximately 4 beds per 1000 of population. The comprehensive group practice prepayment plans "need" 1.7 beds per 1000. In Canada, they "need" 6 beds per 1000.

The report of the Panel on Hospital Care of the National Advisory Commission on Health Manpower noted large variations in both the quality of health care provided and in the costs of operation of a sample of two groups of hospitals. The first group consisted of medium size hospitals with from 100 to 300 beds. The second group consisted of distinguished hospitals of from 300 to 400 beds, recognized for the high quality of their services. The range in cost between hos-

pitals in the first group was from $43 per day for the lowest cost hospital to $65 per day for the highest cost hospital. Yet the high cost hospital provided fewer services.

Among the prestigious hospitals, the cost per day varied from $45 to $110. The panel concluded: "The large variations in cost per patient day are not attributable to differences in the scope or quality of services rendered, or in salaries and wages paid hospital personnel. The strong inference of these results is that there are widely varying degrees of efficiency among individual hospitals."

There has been much discussion of incentive reimbursement. We submit that the Congress should put the hospitals on notice that they may no longer expect public funds in support of inefficient operations. We see no reason why inefficient hospitals should expand. We believe the whole matter of hospital costs merits surveillance.

We have not commented on S. 1589 introduced by a distinguished list of Senators. We have not commented on the bill because it amended the Comprehensive Health Planning Act (P.L. 89–749) rather than the Hill-Burton program. However, it does appear to us that the purposes of S. 1589 could well be incorporated into the Hill-Burton program. We think there is need for emergency grants and loans. Certainly, there is a major crisis in New York City with respect to the city hospitals and S. 1589 could provide needed relief. We urge this Committee to incorporate the main features of S. 1589 in any bill reported out by this Committee.

CONCLUSION

Because we believe the principal facility deficiency has shifted from the country to the city, we support the elimination of the squaring formula which diverts Federal funds away from the states which presently have the greatest need.

We urge the Committee to recognize the importance of not only continuing the present programs but expanding the horizons in order that the health service needs of our population be fulfilled.

I would be remiss if in closing I did not pay tribute to the members of this Committee for their continued deep interest and support of improved medical programs for the people of the United States. Our appreciation and thanks.

Mr. BIEMILLER. You will recognize from our statement that our organization has a tremendous interest in extending the programs that are possible under the Hill-Burton Act.

Like yourself, and like Senator Percy who testified just a few moments ago, we feel that there has been tremendous progress made under the Hill-Burton Act, but that it is quite necessary to expand the scope of Hill-Burton and to recognize the type of programs which can be made available through S. 2182.

We know also that you have all the Democratic members as cosponsors of this bill. We think this bill——

The CHAIRMAN. We offered to all members of the committee to cosponsor it, and none of our Republican colleagues were part of it. We offered the opportunity to each one of them separately. They declined to do so. We did not discriminate. This was equal opportunity. We invited them as cosponsors.

Of course, Senator Percy is not on this committee. We hope that their declining does not indicate a lack of interest in this legislation.

Mr. BIEMILLER. We think that, if this bill is enacted into law, it will go down in history as being just as important a step as the Hill-Burton Act has been in fulfilling health needs.

The CHAIRMAN. You know, Mr. Biemiller, this includes as one phase of this comprehensive plan of S. 2182, a matter that Senator Percy was talking about. It leaves all of this up to the option of the State. The bill that I have introduced leaves it up to each State as to whether or not they want to give priority to rural areas.

Mr. BIEMILLER. We feel that approach is a forward step, and, as we say, we are happy that Senator Percy and a score of other Senators have put in a bill for ambulatory health services which are also included in S. 2182.

Now, in the short time that we have here this morning, I would like to go over your priority 6. Priority 6, which extends the priority list to include projects for facilities which alone are in conjunction with other facilities will provide comprehensive facility care including outpatient and comprehensive care as well as hospitalization, particularly projects or facilities which will serve a defined population.

Implicit in the new comprehensive health care priority is that just building facilities is not enough. The community may have a greater need for a hospital service, for example, which requires no facility.

In its recent report the National Advisory Commission on Health Facilities said that its comments and recommendations lead to one major conclusion: The Nation must now concentrate upon organizing health facilities and other health resources into effective, efficient, and economical community systems of comprehensive health care available to all.

Many authorities who have studied the problem of organizing and delivering health care have maintained that ideally the community hospital should be the major community resource and that the hospital should be surrounded by satellite, out-patient facilities so located as to be readily accessible to the people in local areas.

Our teaching hospitals can reach this ideal because they have permanent salaried medical staffs. Until the Coggeshall report, the medical schools, however, limited their function to teaching and medical research. Since the Coggeshall report, the medical schools are beginning to implement one of the report's recommendations, namely, becoming involved with the provision of medical care in the community. Our prestigious medical schools at Harvard, Yale, and Johns Hopkins are involved in development of a comprehensive health delivery system on a capitation basis in Boston, New Haven, and in the new city of Columbia, Md.

Intermediate between the teaching hospital and the more typical community hospital are those which are approved for internship and residency training. Many of these have some part-time or full-time permanent staff, but over 5,000 of the 7,160 short term acute hospitals in this country are the voluntary nonprofit and proprietary hospitals which have no permanent medical staff at all. These hospitals, many of which were constructed with Federal Hill-Burton funds are utilized by the physicians in the community as a resource for their acutely ill patients.

The importance and economy of having the same medical staff assume responsibility for both outpatient or ambulatory service and inpatienit services cannot be underestimated. On this point, we would like to quote Dr. Ernest Saward, medical director of the Kaiser-Portland medical group. Appearing before the subcommittee on Executive Reorganization of the Senate Committee on Government Operations, Dr. Saward, in discussing those aspects of the Kaiser plan, which made it so much more efficient, stated:

The medical group is hospital based. It has satellite clinics serving other neighborhoods of the area, but has an organized central system with a single medical record, both for inpatient and outpatient. The laboratory services, purchasing department, accounting department and administration are unified. This produces massive economies.

The relevance of these facts is that the priority for comprehensive care in S. 2182 is interrelated with the modification proposed by S. 2182 to change section 605(e) of the existing Public Health Service Act. Unless this modification is enacted, the comprehensive care priority will not mean too much since section 605(e) of the present law requires the applicant to be a hospital or public agency where the application is for the construction of an outpatient facility.

I want to, Senator, commend you and your committee particularly for that section of your bill. This would make it possible for extending the type of operation that we have under the Kaiser and similar plans which would make it possible for many of our unions who want to establish prepaid clinics on a basis similar to the Kaiser plan to do so, and it would make it possible for them to qualify under the provisions of your bill which they cannot do at the present time.

I think there is no more important part of your fine bill than that section, and that is what I have gone out of my way to call your attention to.

The CHAIRMAN. You think that is of vast importance. Let them build this outpatient facility without its being a satellite or adjunct of existing hospitals? So that it also would be done by a prepaid group and not just by an existing hospital or public agency?

Mr. BIEMILLER. Yes, we think that the added value of this bill by providing aid to the delivery of medical services through outpatient centers has proved itself over and over again, and we see no reason why it should not now be recognized by the Government.

The CHAIRMAN. This type of medical practice has its heaviest percentage uses probably in California, doesn't it?

Mr. BIEMILLER. Yes, sir.

The CHAIRMAN. It comes there first?

Mr. BIEMILLER. I believe that is true. The Kaiser program is the largest.

The CHAIRMAN. What other areas have tried this?

Mr. FAIR. They are from California.

The CHAIRMAN. California.

Mr. BIEMILLER. Those are the two larger.

The CHAIRMAN. How many States are in this type?

Mr. SHOEMAKER. There are programs in Washington on the west coast, Washington, D.C., and Portland, Oreg. There will be one in Denver very shortly. Cleveland, Ohio. There are quite a number of others.

The CHAIRMAN. You have had some resistance in the past from the organized medical groups, have you not?

Mr. SHOEMAKER. Yes, sir. I am glad you asked that question. Yes, there have been.

The CHAIRMAN. Is that opposition just as it was or has it declined?

Mr. BIEMILLER. I regret to say, Senator, that it has not declined.

Being a former member of the Wisconsin Legislature, a member of Congress and as a lobbyist for the AFL–CIO for 31 years, I have not seen any diminution of this. This has been their attitude toward it.

They have a very poor attitude on medical economics. I have great respect for American medicine for the progress that it has made in research and so on, but when it comes to the question of medical economics, they're in the 18th century let alone the 20th.

The CHAIRMAN. From studies that have been made since I have been on the committee for 11 years, I think our medical science is the greatest in the world. The great failure is in the health care of people.

Mr. BIEMILLER. Precisely.

The CHAIRMAN. I believe their medical economics is atrocious. The system of medical science is superior. It is superior in all things. We especially need change in the medical economics.

Is that your presentation?

Mr. BIEMILLER. Yes, it is.

The CHAIRMAN. Well, thank you very much for your strong support to S. 2182. We did not introduce it the first month of the year. As you know, we did quite a bit of work by very able staff and others on this. We received recommendations from the Government, private groups and from medical groups. We directed the staff to contact them and work on them. We tried to get it introduced earlier, but we have been waiting and waiting for last minute recommendations, and doubtlessly there will be some others. As we find flaws in it, we will correct them for hope to get as good a bill as possible.

I think the most important domestic need of the American people is health care of all the people in America.

Mr. BIEMILLER. We could not agree with you more.

May I also offer to the committee an analysis of the various bills pending before your committee which our staff has prepared.

I would also want to volunteer the services of our very able people in this field at any time to assist your staff in any future work that has to be done.

The CHAIRMAN. Thank you. I will ask my staff to make a note of that. I know that they have consulted with your staff and they have offered aid.

Did you identify both of your associates?

Mr. BIEMILLER. Yes; their names are in the record.

The CHAIRMAN. Thank you, Mr. Biemiller. There are other witnesses waiting to be heard so we will not go into any more questions at this time. We thank you for your very fine presentation. I have been reading through the statement as you condensed it. There are a number of fine points that were in here, but you have very beautifully broken it down by subheadings so that we will be able to pinpoint your statement and your argument of the recommendations on any particular point that we will want to know about in the bill.

Thank you.

Mr. BIEMILLER. Thank you.

The CHAIRMAN. Our next witness is Dr. Martin R. Steinberg, member, board of trustees, American Hospital Association.

STATEMENT OF DR. MARTIN R. STEINBERG, MEMBER, BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION; ACCOMPANIED BY KENNETH WILLIAMSON, DEPUTY DIRECTOR

Dr. STEINBERG. Thank you. I have with me Mr. Kenneth Williamson, who is the deputy director of the American Hospital Association.

I would like to, first, ask that my entire testimony be entered as a part of the record, but in the interest of conserving time, I am going to comment on it instead of reading the whole statement. I will read certain portions of the text.

The CHAIRMAN. Thank you. The entire statement will be printed in the record.

(The prepared statement of Dr. Steinberg follows:)

PREPARED STATEMENT OF DR. MARTIN R. STEINBERG, MEMBER, BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Doctor Martin R. Steinberg. I am Executive Consultant of the Mount Sinai Medical Center in New York City. I am a member of the Board of Trustees of the American Hospital Association, and I appear here today in behalf of that Association. I am accompanied by Mr. Kenneth Williamson, Deputy Director of the American Hospital Association and Director of its Washington Service Bureau.

The American Hospital Association represents over 7,000 of the nation's hospitals, comprising 90 percent of the total hospital beds in the country. For the most part, these hospitals are private, nonprofit organizations, and they serve the health needs of communities throughout the United States.

I first wish to express the deep appreciation of the American Hospital Association and of the hospitals of the country for the strong support which this Committee has always given to legislation designed to meet the health needs of our people. Through the years the Hill-Burton Program has been a primary means of providing the health facilities needed without which it would have been impossible to provide the benefits of modern medical care. This Program has been a strong testimony to the wisdom of the Congress in structuring it so as to strengthen federal, state and local relationships—to provide a fruitful partnership between government and voluntarism in health affairs and to facilitate the expenditure of funds on the basis of priorities established within the states and in keeping with plans developed by the states. The Program has fulfilled its purpose of generating substantial amounts of private capital. This Program also initiated health facility planning in this country. We strongly believe that the Congress, the public and the health field continue to find reassurance in the orderly expenditure of public funds which has been provided through this Program.

Under the Hill-Burton Program from its inception in 1946 through December 31, 1968, 9,780 projects have been approved involving 424,879 inpatient beds of all categories and 2,780 outpatient facilities. This involves a total expenditure of $10.4 billion of which $3.2 billion came from federal sources. The remainder amounting to $7.2 billion came from non-federal sources.

Under the program assistance has been provided for construction of general hospitals, long-term care facilities, mental hospitals, tuberculosis hospitals, diagnostic or treatment centers, rehabilitation facilities, public health centers and state health laboratories. In spite of the tremendous accomplishments of the Hill-Burton Program and the efforts which have been made throughout the country, the needs have far out-stripped the capacity to provide the facilities needed. As we have delayed in meeting the needs, the costs of doing so are continuing to increase. The latest figures on unmet needs of health facilities indicate an existing shortage of 85,007 new general medical and surgical beds with an estimated cost of $2.9 billion and 165,430 long-term beds at an estimated cost of $1.6 billion. There are 240,624 general medical and surgical beds in need of modernization at an estimated cost of $7.2 billion and 214,506 long-term beds needing modernization at an estimated cost of $2.1 billion. The above figures are a compilation of estimates developed by the individual states and includes long-term and extended care facilities.

Recognizing the vast changes taking place in the delivery of health care and, consequently, the need for new and innovative types of facilities, the American Hospital Association in 1967 sought the advice of several of the most widely experienced and knowledgeable individuals responsible for administering the Hill-Burton Programs within the states. As a result of these discussions and of conferences with a number of people in the hospital field itself, a series of recommended guidelines were promulgated. The Board of Trustees of the Association in August, 1967, officially endorsed the following guiding principles which it was felt

would provide a basis for extending the Hill-Burton Program and making it more responsive to present day needs:

1. *Modernization*

Modernization is the first great need in terms of health facility programming for the future. It is most essential that replacement of facilities be coupled to the fullest possible extent with modernization, when such modernization is clearly indicated in response to community needs, and that additional beds, if good planning shows them to be needed, be considered as a part of the modernization project, but funded from new construction monies.

2. *Rehabilitation Facilities*

The language of the Hill-Burton legislation should continue to provide for participation of other than completely comprehensive rehabilitation centers, and should be amended so as to provide that only those rehabilitation facilities that are health related should be included in the program.

3. *Diagnostic and Treatment Facilities*

The language of the Hill-Burton legislation should be amended so that the concept of the law is broadened. The definition of facilities should be changed to "ambulatory care facilities," so that other methods and facilities for the care of ambulatory patients by members of the medical staff in carrying out the program of the hospital, including such systems as group practice, may be included. The use of the facilities should be specifically permitted to inpatients as well as outpatients.

4. *General Hospitals*

The definition of "general hospitals" should be amended so as to include the following:

A. Acute psychiatric inpatient facilities in general hospitals;
B. Regional hospital service centers when part of the general hospital; and
C. Hospital-based home care facilities.

5. *Long-Term Care Facilities*

The language of the Hill-Burton legislation should be amended so as to specifically include extended care facilities developed as a part of general hospitals.

6. *Hospital Educational Facilities*

It is recommended that the Hill-Burton legislation be amended so as to establish a special category for educational facilities developed in, or in connection with, general hospitals. The sum of $20 million would be suggested as an appropriate amount in this category.

7. *State Allotments*

A. It is recommended that the Hill-Burton legislation provide for allocation of funds for new construction on the basis of per capita income and need.

B. It is recommended that the squaring factor in the present formula be eliminated.

C. It is recommended that funds be allotted for modernization on the basis of per capita income and need.

8. *Priorities*

A. It is recommended that the Hill-Burton legislation be amended to remove the required first priority for rural areas. The need for facilitiies should be determined by the states.

B. In order to assist both new construction and modernization in an orderly manner, two separate priority systems are required.

9. *Coordination with Regional Planning*

It is recommended, in accordance with long-standing Association policy, that the federal government require that the development of health care programs under the Office of Economic Opportunity, the Department of Housing and Urban Development, and any other agencies be coordinated with regional planning activities.

10. *Loans*

It is recommended that the present 25-year loan provision for modernization be lengthened to 40 years.

We deeply appreciate the opportunity of commenting on legislation which is so directly related to meeting the future health facility needs facing the country.

I shall address my remarks primarily to S. 2182 introduced by Senator Yarborough and co-sponsored by several members of this Subcommittee. We strongly support the over-all purposes of this bill which continues the basic Hill-Burton Program as a means of meeting health facility needs and proposes amendments to relate the program more directly to changes that have occurred in the rendering of health services. The bill recognizes the most urgent problem—the need for modernization of old and out-moded health facilities. It also provides for needed new facilities. The bill gives encouragement to the development of emergency services; it evidences concern for urgently needed extended care services developed by hospitals; it provides special incentives for development of health services for low income areas; it gives special encouragement to the development of shared facilities designed to reduce the cost of hospital care; and it gives special recognition to facilities which provide comprehensive programs of care and projects which provide training for health care personnel.

TITLE I—GRANTS FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

The increased amounts provided for in the bill appear to us to be fully justified in light of the unmet needs which we have set forth and in light of the annual increased costs of construction.

The bill retains the squaring factor in the formula for allocation of funds to the states for new construction. At the time the Hill-Burton Program was started in 1946, it was evident that the unmet needs for health facilities were in direct relationship to the financial needs of the states. Thus, the allotment formula provided for a squaring factor which resulted in allocating proportionately more to the states with the least financial resources. This purpose has now been largely served.

We recommend that the bill be amended so as to eliminate the squaring factor and to provide for allocation of funds to the states on the basis of population, extent of need for such facilities, and financial need of the states.

Part B—Operation of grant program

Section 110—Priority of Projects

This section establishes a system of various priorities for the grant program. We believe as a matter of principle that special priorities directed by the federal government are undesirable. The whole theory of health facilities and services planning is based upon areas within the states determining their needs. The states then establish the priorities which should be followed in meeting these needs.

We are very pleased that the bill would remove the mandatory rural priority provision. This amendment is in keeping with the expressed desires of the states that they should not be compelled by federal law to allocate funds to rural areas irrespective of their determination of their most pressing need.

Paragraph (4) of Section 110 would establish a priority for projects for construction and modernization of general hospitals which give reasonable assurance that services of a long-term care facility will be available.

We understand the intent of this section is to encourage development of extended care services by hospitals. We believe, however, that the language of this section is confusing in its use of the term "long-term care" instead of "extended care" which is a part of acute hospital care. A more effective means of accomplishing the objective would be to establish the provision of extended care services as a condition for a grant to any general hospital rather than as a priority.

We Recommend the following language be substituted for Paragraph (4) of Section 110 of the bill:

"Effective July 1, 1971, provided, that before any project for construction and modernization of any general hospital is approved by the state agency, there will be reasonable assurance of adequate provision for extended care services (as determined in accordance with regulations) to patients of such hospitals when such services are medically appropriate for them, with such services being provided in facilities which are structurally part of, physically connected with, or in the immediate proximity to such hospital, and are under the supervision of the professional staff of such hospital. If the state agency determines that it would be inadvisable to require that such extended care services be provided in facilities that are structurally part of, physically connected with, or in immediate proximity to such hospital, the Secretary may waive the requirement that such services be provided in such facilities."

Extended care facilities have been specifically identified under the Medicare law. Such facilities are intended to be an extension of the general hospital so that once the acute period of care is completed patients can receive continued medical supervision and nursing care but to a lesser degree than would be required in the facilities of the general hospital. Such care is likely to be provided only in the hospital complex or in close proximity thereto and under the same medical supervision. The object of the Medicare provision was to provide the care needed at the least possible cost. This permits a more effective use of the hospital's acute care facilities.

The result of such a provision is important to the federal government as it contributes to the development of general hospital facilities and as it pays for the cost of care in such facilities.

Paragraph (5) of Section 110 provides priority to projects for the construction and modernization of outpatient facilities in low income areas. This paragraph would provide for the development of such outpatient facilities either as a part of general hospitals which are in low income areas or for the development of free standing facilities independent of general hospitals. We strongly support the need for the development of ambulatory health care services for low income areas. We believe it is of utmost importance, however, that such facilities be developed in a manner which will provide real assurance that medical care will be available, that quality standards will be maintained, and so that the most effective and efficient use of health manpower, which is in short supply, will be assured. We feel that such essential objectives can only be accomplished where the ambulatory care facility is developed by a general hospital or as a satellite of such a hospital.

It is our belief that the experience with the neighborhood health centers developed by the Office of Economic Opportunity has demonstrated that essential services of a high quality are only likely to be provided where such care is planned in relationship to a general hospital so that the hospital's medical staff will be responsible for standards of care. This will provide medical intern and resident participation and the ease of transfer of patients from the ambulatory care facilities to the hospitals for additional diagnosis and treatment.

We Recommend, therefore, that the bill be amended so as to require free standing ambulatory care facilities be affiliated with a general hospital.

We Also Recommend that the words "a metropolitan area with low per capita income" contained in Paragraph (5) be revised to read "an area with low per capita income."

Paragraph (6) of Section 110 would provide a priority for the development of hospitals and other facilities sponsored by group medical practice organizations. No limits are specified as to the portion of the funds authorized in the bill which can be assigned for this purpose.

We support the concept of comprehensive care and group practice.

We believe, however, that it is not in the public interest to provide tax payers' funds for the development of facilities intended to serve "a defined population". We construe this to mean only limited sections of the population. We believe that public funds expended under this legislation should assist the development of facilities which will be available to the entire population.

We Recommend that the last clause of this paragraph, "particularly projects for facilities which will serve a defined population," be deleted.

Paragraph (7) of Section 110—We believe the term "health professions" as used in this paragraph is subject to misinterpretation.

We recommend that the language be amended to read as follows:

"In the case of projects for construction or modernization of facilities, to facilities which provide training of health personnel."

Section 111—Areawide Health Planning Agencies

As stated earlier in our testimony, the Hill-Burton Program initiated health facility planning in the United States. Such planning has provided fundamental guidance for the expenditure of public funds in the development of health care facilities.

The American Hospital Association is committed to the proposition that health facilities must be constructed on the basis of need evidenced by orderly planning in the area. Good planning basically comes from thorough study, evaluation and projections made on the part of individual institutions. It requires that facilities and services be developed in relationship to the over-all needs of the community and the area with the realization that such determinations go beyond the desires and projections of the individual institution.

The association's House of Delegates in February of 1969 developed a Statement on the Financial Requirements of Health Care Institutions and Services. This statement clearly ties the provision of capital funds to needs developed as a result of orderly planning. Copies of this statement have been made available to the Committee. The Association's official Statement on Planning begins on page 34.

This section of the bill provides that in addition to the state agency planning and recommendation that is required under present law, further planning requirements must be met. An opportunity must be given prior to state agency approval for consideration of projects by the areawide planning agency as defined in Section 314(b) of Title 6, U.S. Public Health Service Act. This language, however, does not provide for planning undertaken by an independent voluntary planning agency representative of the community's interest.

We recommend that this section be amended by inserting on page 7, line 2, after the word "located" the following, "or if there is not such agency or organization, by such nonprofit private agency or organization (if any) which performs, as determined in accordance with criteria included in regulations, similar functions."

Section 113—Federal Share

This section provides the federal share for any project shall be computed as under present law with the states being given a new option of increasing the federal share for projects offering potential for reducing health care costs through shared services, interfacility cooperation, or dispersed ambulatory care centers. The increase may not exceed 20 percent. We are heartily in agreement that this incentive be provided for such projects but we urge that the language of the Committee's report make it clear that dispersed "ambulatory care centers" be a part of hospitals.

We firmly believe that cooperative facilities developed to serve groups of hospitals offer a most important potential for increased economy in providing health services. The Association has long urged such developments.

Section 114—Definition of Hospitals

We Recommend that in line 24 of paragraph 2 of page 8, the word "professions" be deleted and that the word "care" be substituted and that the word "professions" on line 7, page 9, be replaced by the word "care."

Section 115—Change in Name and Clarification of Functions of Diagnostic or Treatment Center

Subsection (e)—This subsection of the bill attempts to assume that a relationship will be established between a free standing outpatient facility and a general hospital. We feel that the language of the bill is uncertain of accomplishing this purpose.

We Recommend the language be amended to read as follows:

"In the case of public or other nonprofit outpatient facilities which are not a part of a general hospital, a contractual relationship be established with a general hospital which will assure that inpatient and other facilities of a general hospital shall be made available."

Section 117—Inclusion of Cost of Acquisition of Land

This section makes the cost of acquisition of land an item eligible for federal participation. We feel this is a needed improvement in the program and support the provision.

Section 118—Grants for Equipment

We understand the purpose of this provision is to provide equipment which will help provide services not previously available in the community and that the provision of such equipment is not contingent upon new construction. We approve the purposes of the provision; but, we believe the language is unclear.

We Recommend the language on page 11, line 17, be amended to read as follows:

> "and, in any case in which it will help to provide the equipment needed to provide a service not previously available in the community."

TITLE II—LOAN GUARANTEES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

This title of the bill establishes a loan guarantee and interest subsidy program for construction and modernization of private nonprofit hospitals and other medical facilities. A five-year program is provided and the loan guarantee for any project could not exceed 90 percent. This maximum applies to any federal grant or loan guarantee or combination thereof received by the facility.

Under this program the government would pay one-half of the interest on guaranteed loans up to 3 percent plus ⅓ of any interest above 6 percent. The total of loans which could be guaranteed is $400 million for each of the five years on a cumulative basis.

The loan authorizations would be allocated to states by the Secretary on the basis of population, financial need, and need for construction and modernization of such facilities.

This section recognizes what we believe to be the most critical need in the health field today—modernization of existing facilities. While the need is most pressing in metropolitan centers, there is a great need also in smaller communities and rural areas for the modernization of obsolete and out-moded facilities. In the aggregate, the need for modernization applies to more than ⅓ of the hospital facilities of the country. The total estimates projected for this need approximate $10 billion. Many of these facilities in the older metropolitan centers serve the largest segments of the population and are our primary teaching and research centers. They are the basic source for the education and training of phyiscians, nurses, and paramedical personnel. It is in these facilities that the results of the great advances emanating from medical research are tested and translated into programs of patient care. We strongly endorse this title of the bill.

TITLE III—LOANS FOR CONSTRUCTION AND MODERNIZATION OF PUBLIC HOSPITALS AND OTHER PUBLIC MEDICAL FACILITIES

This title would establish a new five-year program of direct government loans to be made by the Secretary to public agencies for construction or modernization of public hospitals and other public medical facilities. It is our understanding that direct federal loans are proposed in this instance primarily because of the ability of the publicly owned institutions to issue tax exempt bonds. We believe it is unfortunate that a similar program can not be provided for private, nonprofit institutions as well. We understand, however, that budgetary considerations argue against such treatment. It does appear that because of increasingly high interest rates—for example, just this week we understand one large private, nonprofit, community hospital in seeking funds for capital improvements is having to pay interest rates of 9½ percent—that the provision results in more favorable treatment of the public institution than the private, nonprofit institutions. We note that Section 302 relating to the Federal National Mortgage Association Charter Act applies only for the servicing of loans for *modernization* of hospitals and other health facilities. We believe it was intended that both *construction and modernization* loans be included.

TITLE IV—GRANTS FOR MODERNIZATION OF EMERGENCY ROOMS OF GENERAL HOSPITALS

This title would establish a program of special project grants for modernization of emergency rooms of public or other nonprofit general hospitals. These grants would be made by the Secretary and the grants would be limited to 50 percent of the cost. Ten million dollars is authorized for each of the five fiscal years of the program.

This program gives recognition to the fact that accidents are a major cause of death and disability. In many cases the victims are children. There is widespread need for modernization of emergency care facilities in hospitals, and the incentive provided by this section should result in added emphasis by the hospitals on such facilities and consequent increased protection to the public.

We recommend that these funds be allocated to the states on the same basis as is provided in other categories.

Mr. Chairman, when you introduced S. 2182 and again when you announced these hearings, you spoke of the urgent need for increased funds to modernize obsolete hospitals and other medical facilities and to construct new facilities where needed. You also pointed to the necessity of innovations to encourage a better utilization of our health resources including health manpower, to im-

prove the delivery of health care, and to attack the problem of increasing health care costs. Enactment of this legislation will help meet these needs and will be a major step toward the goal of better health care for all Americans. The American Hospital Association wholeheartedly supports the bill.

We will be glad to answer any questions the members may have and to furnish any additional information requested by the committee.

The CHAIRMAN. I would just like to point out that Dr. Steinberg has helped us in this bill. It does not mean that you are responsible for this bill. What we have here is a composite worked out at different recommendations. I doubt that if one recommendation will be the entire bill. What we are trying to do is to get the best legislation that we can for health care to the American people in using the great knowledge of the different organizations that work in this field and have been working in it for so many years.

Thank you for the help you have given us on the bill.

Mr. STEINBERG. Thank you for the opportunity to help.

Mr. Chairman, I am Dr. Martin R. Steinberg. I am executive consultant of the Mount Sinai Medical Center in New York City.

The American Hospital Association represents over 7,000 of the Nation's hospitals, comprising 90 percent of the total hospital beds in the country.

I first wish to express the deep appreciation of the American Hospital Association and of the hospitals of the country for the strong support which this committee has always given to legislation designed to meet the health needs of our people. Through the years the Hill-Burton program has been a primary means of providing the health facilities needed without which it would have been impossible to provide the benefits of modern medical care.

My statement contains a history of the Hill-Burton bill, and I am going to skip that because it is in the record before you, and I will move on to page 3.

The latest figures on unmet needs of health facilities indicate an existing shortage of 85,007 new general medical and surgical beds with an estimated cost of $2.9 billion and 165,430 long-term beds at an estimated cost of $1.6 billion. That has been testified to by several of the previous witnesses and I am not going to go into that.

I will move on to the last paragraph on page 3.

Recognizing the vast changes taking place in the delivery of health care and, consequently, the need for new and innovative types of facilities, the American Hospital Association in 1967 sought the advice of several of the most widely experienced and knowledgeable individuals responsible for administering the Hill-Burton programs within the States. As a result of these discussions and of conferences with a number of people in the hospital field itself, a series of recommended guidelines were promulgated. The board of trustees of the association in August 1967, officially endorsed a set of guiding principles which it was felt would provide a basis for extending the Hill-Burton program and making it more responsive to present day needs. These principles are set forth in my statement.

I will not comment on the next two pages because they have been adequately covered. I hope that the committee will have an opportunity to read these 10 principles here. I will go down to the last paragraph on page 6.

We deeply appreciate the opportunity of commenting on legislation which is so directly related to meeting the future health facility needs facing the country. I shall address my remarks primarily to S. 2182 introduced by Senator Yarborough and cosponsored by several members of this subcommittee. We strongly support the overall purposes of this bill which continues the basic Hill-Burton program as a means of meeting health facility needs and proposes amendments to relate the program more directly to changes that have occurred in the rendering of health services. The bill recognizes the most urgent problem—the need for modernization of old and outmoded health facilities. It also provides for needed new facilities. The bill gives encouragement to the development of emergency services; it evidences concern for urgently needed extended care services developed by hospitals; it provides special incentives for development of health services for low income areas; it gives special encouragement to the development of shared facilities designed to reduce the cost of hospital care; and it gives special recognition to facilities which provide comprehensive programs of care and projects which provide training for health care personnel.

The increased amounts provided for in the bill appear to us to be fully justified in light of the unmet needs which we have set forth and in light of the annual increased costs of construction. The bill retains the squaring factor in the formula for allocation of funds to the States for new construction. At the time the Hill-Burton program was started in 1946, it was evident that the unmet needs for health facilities were in direct relationship to the financial needs of the States. Thus, the allotment formula provided for a squaring factor which resulted in allocating proportionately more to the States with the least financial resources. This purpose has now been largely served.

We recommend that the bill be amended so as to eliminate the squaring factor and to provide for allocation of funds to the States on the basis of population, extent of need for such facilities, and financial need of the States.

Section 110 of the bill establishes a system of various priorities for the grant program. We believe as a matter of principle that special priorities directed by the Federal Government are undesirable. The whole theory of health facilities and services planning is based upon areas within the States determining their needs. The States then establish the priorities which should be followed in meeting these needs.

We are very pleased that the bill would remove the mandatory rural priority provision. This amendment is in keeping with the expressed desires of the States that they should not be compelled by Federal law to allocate funds to rural areas irrespective of their determination of their most pressing need.

We recommend the following language be substituted for paragraph (4) of section 110 of the bill:

Effective July 1, 1971, provided, that before any project for construction and modernization of any general hospital is approved by the State agency, there will be reasonable assurance of adequate provision for extended care services (as determined in accordance with regulations) to patients of such hospitals when such services are medically appropriate for them, with such services being provided in facilities which are structurally part of, physically connected with, or in the immediate proximity to such hospital, and are under the supervision of the professional staff of such hospital. If the State agency determines that it

would be inadvisable to require that such extended care services be provided in facilities that are structurally part of, physically connected with, or in immediate proximity to such hospital, the Secretary may waive the requirement that such services be provided in such facilities.

Extended care facilities have been specifically identified under the medicare law. Such facilities are intended to be an extension of the general hospital so that once the acute period of care is completed patients can receive continued medical supervision and nursing care but to a lesser degree than would be required in the facilities of the general hospital. Such care is likely to be provided only in the hospital complex or in close proximity thereto and under the same medical supervision. The object of the medicare provision was to provide the care needed at the least possible cost. This permits a more effective use of the hospital's acute care facilities.

The result of such a provision is important to the Federal Government as it contributes to the development of general hospital facilities and as it pays for the cost of care in such facilities.

The CHAIRMAN. Dr. Steinberg, I have instructed the staff to extract a particular paragraph that you made in one of your statements there. It is just prior to your statement, Dr. Steinberg, in your discussion with respect to priorities. You pointed out that the bill does have mandatory, rural priorities provisions, but it does not still contain a mandatory provision for an urban or rural area. Now, this would be the type of area that Senator Percy was describing in Chicago, and others, but your provision gives the State an option to give priority to rural States. In other words, they may keep the priority system for rural areas if they desire. It leaves it up to that State to determine what is the most urgent need to get hospitalizaion.

Dr. STEINBERG. We are very happy to see it left to the States as provided in the bill, Senator.

Paragraph (3) of section 110 provides priority to projects for the construction and modernization of outpatient facilities in low-income areas. This paragraph would provide for the development of such outpatient facilities either as a part of general hospitals which are in low-income areas or for the development of such outpatient facilities either as a part of general hospitals which are in low-income areas or for the development of free standing facilities independent of general hospitals. We strongly support the need for the development of ambulatory health care services for low-income areas. We believe it is of utmost importance, however, that such facilities be developed in a manner which will provide real assurance that medical care will be available, that quality standards will be maintained, and so that the most effective and efficient use of health manpower, which is in short supply, will be assured. We feel that such essential objectives can only be accomplished where the ambulatory care facility is developed by a general hospital or as a satellite of such a hospital.

It is our belief that the experience with the neighborhood health centers developed by the Office of Economic Opportunity has demonstrated that essential services of a high quality are only likely to be provided where such care is planned in relationship to a general hospital so that the hospital's medical staff will be responsible for standards of care. This will provide medical intern and resident participa-

tion and the ease of transfer of patients from the ambulatory care facilities to the hospitals for additional diagnosis and treatment.

We recommend, therefore, that the bill be amended so as to require free standing ambulatory care facilities be affiliated with a general hospital.

We also recommend that the words "a metropolitan area with low per capita income" contained in paragraph (3) be revised to read "an area with low per capita income."

Paragraph (6) of section 110 would provide a priority for the development of hospitals and other facilities sponsored by group medical practice organizations. No limits are specified as to the portion of the funds authorized in the bill which can be assigned for this purpose.

We support the concept of comprehensive care and group practice. We believe, however, that it is not in the public interest to provide taxpayers' funds for the development of facilities intended to serve "a defined population." We construe this to mean only limited sections of the population. We believe that public funds expended under this legislation should assist the development of facilities which will be available to the entire population.

We recommend that the last clause of this paragraph "particularly projects for facilities which will serve a defined population," be deleted.

I want to go on to the second part of the last paragraph on page 13 that is labeled areawide health planning agencies. That has been covered earlier, but I just wanted to draw your attention to it.

The American Hospital Association is committed to the proposition that health facilities must be constructed on the basis of need evidenced by orderly planning in the area. Good planning basically comes from thorough study, evaluation and projections made on the part of individual institutions. It requires that facilities and services be developed in relationship to the overall needs of the community and the area with the realization that such determinations go beyond desires and projections of the individual institution.

The association's house of delegates in February of 1969 developed a statement on the financial requirements of health care institutions and services. This statement clearly ties the provision of capital funds to needs developed as a result of orderly planning. Copies of this statement have been made available to the committee. The association's official statement on planning begins on page 34.

This does not need to be made a part of the record, sir, but it is here and it can be made available.

I am going to skip now to page 15, and I will cite the recommendations that are set out in the second paragraph there on page 15.

We recommend that section 111 of the bill be amended by inserting on page 7, line 2, after the word "located" the following:

Or if there is no such agency or organization, by such nonprofit private agency or organization (if any) which performs, as determined in accordance with criteria included in regulations, similar functions.

The CHAIRMAN. I have instructed the staff as to your first recommendation in the amendment that you made that is on page 13 of your statement. Also, the staff will draft these up and make them into a formula.

Dr. STEINBERG. Thank you very much.

I am going to skip my comment on the Federal share, which is the last paragraph on page 15, and continue on page 16. I am going to skip the definition of hospitals. That is section 114 of the bill. Our complete statement is before you, and I do not think that any clarification is needed now. I will refer to the bottom of page 16 where we recommend the language of section 115(e) of the bill be amended to read as follows:

> In the case of public or other nonprofit outpatient facilities which are not a part of a general hospital, a contractual relationship be established with a general hospital which will assure that inpatient and other facilities of a general hospital shall be made available.

This recommendation in essence repeats our earlier recommendation that free standing ambulatory care facilities for treating outpatients should be affiliated with general hospitals.

I am going to skip all of page 17. I would like to go to our discussion of title II, which starts on the bottom of page 17 of the statement.

This title of the bill establishes a loan guarantee and interest subsidy program for construction and modernization of private nonprofit hospitals and other medical faclities. A 5-year program is provided and the loan guarantee for any project could not exceed 90 percent. This maximum applies to any Federal grant or loan guarantee or combination thereof received by the facility.

Under this program the Government would pay one-half of the interest on guaranteed loans up to 3 percent plus one-third of any interest above 6 percent. The total of loans which could be guaranteed is $400 million for each of the 5 years on a cumulative basis.

The loan authorizations would be allocated to States by the Secretary on the basis of population, financial need, and need for construction and modernization of such facilities.

This section recognizes what we believe to be the most critical need in the health field today—modernization of existing facilities. While the need is most pressing in metropolitan centers, there is a great need also in smaller communities and rural areas for the modernization of obsolete and outmoded facilities. In the aggregate, the need for modernization applies to more than one-third of the hospital facilities of the country. The total estimates projected for this need approximate $10 billion. Many of these facilities in the older metropolitan centers serve the largest segments of the population and are our primary teaching and research centers. They are the basic source for the education and training of physicians, nurses, and paramedical personnel. It is in these facilities that the results of the great advances emanating from medical research are tested and translated in top programs of patient care. We strongly endorse this title of the bill.

I am going to skip the rest of page 19 and also page 20 and go to the top of page 21.

Mr. Chairman, when you introduced S. 2182 and again when you announced these hearings, you spoke of the urgent need for increased funds to modernize obsolete hospitals and other medical facilities and to construct new facilities where needed. You also pointed to the necessity of innovations to encourage a better utilization of our health resources including health manpower, to improve the delivery of health care, and to attack the problem of increasing health care costs. Enactment of this legislation will help meet these needs and will be a major step toward the goal of better health care for all Americans.

The American Hospital Association wholeheartedly supports the bill.

We will be glad to answer any questions the members may have and to furnish any additional information requested by the committee.

The CHAIRMAN. Any questions of Dr. Steinberg by counsel for the majority or the minority?

If not, thank you, Dr. Steinberg, for your presentation. We have also in addition to your statement this book on the Financial Requirements of Health Care, Institutions and Services, and we will order this not to be reproduced in its entirety, but filed for reference for the staff and all members of the committee.

Mr. STEINBERG. Thank you, sir, for the opportunity.

The CHAIRMAN. The next witness is Mr. James Brindle, president of the Group Health Association of America, Inc., who has an associate with him, Mr. Brindle, please come around and introduce to the committee your associate.

STATEMENT OF JAMES BRINDLE, PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, INC.; ACCOMPANIED BY LOUIS J. SEGADELLI, ASSOCIATE EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Mr. BRINDLE. Mr. Chairman, I have with me Mr. Louis J. Segadelli, associate executive director of the Group Health Association of America.

Senator, we appreciate very much the opportunity to come and testify on this particular piece of legislation, and I would like to file the formal statement and comment briefly on some sections of it and answer any questions that you may have.

The CHAIRMAN. Your statement will be received, filed, and ordered printed in full in the record so that it is available for all members of the committee.

You know, Mr. Brindle, its being printed in the record is very important when we go into executive session. Under our rules, we must have a physical quorum present, and the members can do a good bit of their homework here. Representing a professional group, you do not overlook the importance of having it printed, because that is not only the basis of the work of this subcommittee and the staff and the full committee, but also on the floor.

Mr. BRINDLE. I am the president of the Group Health Association of America and also president of the Health Insurance Plan of Greater New York.

I am also speaking on behalf of the Kaiser Foundation health plan, which is the largest prepaid group practice plan in the country.

We appear here to support the provisions of S. 2182, the Hospital and Medical Facilities Construction and Modernization Amendments of 1969, which was introduced by you and your distinguished colleagues of the committee. We favor its enactment as an essential step toward improving the health care of the American people and further developing adequate health programs.

GHAA is a professional trade association of more than 100 health plans, representing prepaid group practice health programs which serve more than 6 million persons throughout the United States. The Kaiser plan on the west coast and in Hawaii has actually nearly 2

million members, and all these plans cover about 6 million people. The Kaiser plans are located all up and down the west coast and in Hawaii.

HIP, the health plan of which I have the honor to be president, has 31 affiliated medical groups throughout the Greater New York area, and we have just acquired our first hospital in the Forest Hills section of Queens.

Other community plans—and I think this question was asked of Mr. Biemiller—I would like to name a few of the other plans so that you could see the extent and nature of them.

The other group health associations are in Washington, which is one of the pioneer plans, the Group Health Cooperative of Puget Sound, in Seattle; the Community Health Association in Detroit; the group health plan in St. Paul, Minn.; and also a new emerging plan of the Rhode Island Group Health Association, which is getting ready to start up in Providence. And we are working on programs to be developed in Nashville, Tenn., and Cincinnati, Ohio. There is a whole other series of programs related and represented by the Group Health Association.

The health plans established in Appalachia from western Pennsylvania to northern Alabama serve beneficiaries of the United Mine Workers welfare and retirement fund and the populations of the communities in which they live. The St. Louis Labor Health Institute and the union family medical fund of the hotel industry of New York City are the two largest among a number of union-sponsored plans which are members of our association. There are 30 railroad hospital associations distributed widely across the United States that are yet another segment of GHAA's membership. We have widely varying sponsorships from cooperative to government agencies to industry and labor. And while there are great differences between these plans, actually, they are fundamentally interested in the more efficient and effective organization of health-care services rather than merely the providing of facilities or paying for medical care.

Actually, we believe that with some 25 years' experience in this area, we have demonstrated a validity of a medical care delivery system that gives the physician both the means and incentive for optimum use of all elements of medical care.

Typical in the plans are well-equipped and staffed facilities for ambulatory care; hospitalization for diagnostic workups is reduced; balanced teams of family physicians and specialists work together as a medical group with professional consultation freely available; the formality, the time and expense of specialty referrals is minimized; the medical group is compensated for comprehensive care of the enrolled population on a capitulation or other non-fee-for-service basis.

Referrals to outside agencies can be kept at a minimum and a patient can get a one-stop place for medical care. This is the ideal that I think was laid out today.

I heard Senator Percy mention the great necessity for this. I know the committee has this in mind.

As a matter of fact, these amendments are probably the key items to producing better medical care in the United States. I understand that Congressman Ottinger has also testified before this committee and reinforced the same general idea that the reorganization of medical services is a key item.

Now, the economies of group practice prepayment, I think, are most strikingly illustrated in some of the tabulations that are attached to this statement and which I would also like to see appear in the record, if this is possible.

The experience of the Federal employees health benefits program, which covered over 7 million persons during 1966, was a dramatic example of the 300,000 persons who elected coverage in group practice plans. Forty-six individuals per thousand were hospitalized at some time during the year, compared to 85 to 90 per thousand of those enrolled in various insured plans. The days of hospitalization in group practice were 408, as contrasted with 808 and 884 per thousand for the insured population.

You raised the question, when Senator Percy was testifying, about the effectiveness of providing ambulatory care rather than putting people in a hospital and about the deficiency of America's traditional health insurance programs which stressed hospitalization.

I think the group practice prepayment plan has given the most convincing demonstration that it can provide a comprehensive range of benefits furnished on an ambulatory basis, that you can cut back on the most expensive component of medical care, which is hospitalization, and many of our programs have hospitalization rates just half that of the persons who were covered by the traditional types of health insurance.

Because of this, we are very strongly in favor of the provisions of section 110 of S. 2182 which would extend the priority provision of the Hill-Burton Act projects for facilities which will provide comprehensive health care. We strongly support the principle of priorities for facilities conducive to comprehensive health care which would be added to subsection 603(a)(6) by subsection 110 of S. 2182. Adding the weight of subsection 603(a)(6) to the priorities in the present Hill-Burton Act would constitute a declaration of policy by the Congress which would provide needed impetus to the Federal, State, and community administrators of health services and health services planning.

Adoption of this additional priority would also reaffirm the action of the 90th Congress, which enacted this principle as section 242(f) of the National Housing Act, as follows:

> (f) The activities and functions provided for in this section shall be carried out by the agencies involved so as to encourage programs that undertake responsibility to provide comprehensive health care, including outpatient and preventive care, as well as hospitalization, to a defined population.

I notice that Dr. Steinberg in his testimony from his American Hospital Association, indicated resistance to this and I would strongly urge that this item on defined population be retained.

The group practice prepayment plans under Dr. Steinberg's suggested amendment would actually be ruled out for the benefits of this act, which we look on as one of the strongest reinforcements to the development of group practice prepayment which need no longer be proven as effective. We have adequate experience, so I would strongly urge that the recommendation of the American Hospital Association on this point not be accepted.

In regard to the modernization of the priorities, we invite the attention of the committee to the concepts embodied in S. 2037, introduced

by Senator Percy and Senator Kennedy and colleagues, including other members of this subcommittee who also joined with the distinguished chairman in introducing S. 2182, of requiring the Secretary to consider the efficiency and effectiveness of operation of health facilities in arriving at decisions whether to support specific projects.

Again, this idea of defined population related to specific outpatient and hospital facilities is extremely important.

The most important aspect of S. 2182 for prepaid group practice organizations such as ours would be the recognition given to the efficiencies of comprehensive health care systems by the addition of subparagraph 603(a)(6).

We favor the extension of the Federal construction-grant program in view of the continuing rising demand for medical services and the necessity for modernization of existing hospital facilites.

We support the provisions of the bill creating a new loan guarantee program under which the Federal Government guarantees private lenders against the risk of loss on loans extended by them for hospital construction or modernization.

We also agree that rehabilitation of existing facilities is very important because many of these are in such a dilapidated state that they need priority consideration.

The addition of a new interest subsidized loan program, which I mentioned as provided in S. 2182 and S. 269, introduced by Senator Javits, would give us another option to the range of financing mechanisms embodied in the Public Health Service Act and the Housing Act.

Section 115(3) of S. 2182 is of particular importance to the fostering of new prepaid group practice organizations. Hospital-based practice is the most efficient and effective form of medical care, and present law requires that the sponsor of an outpatient facility project own or operate a hospital. This would cut off the development of a lot of the OEO projects that the committee has spoken of, and it would also make it impossible, first, to develop the kind of plan that is being developed in Providence.

The Health Insurance Plan—HIP—for a long time in New York was seriously discriminated against in term of hospital facilities, and if the hospitals had generally moved into prepaid group practice and to the attention of outpatient care, this might have been excusable, but to do as Dr. Steinberg suggests and to have these new facilities only sponsored by hospitals or operated by hospitals would really slow down the whole development of the neighborhood health center program. I would agree that the ideal organization is one where the hospital is a center and the outreach are the medical centers. But to make this mandatory would really stop the development of a good many exciting programs that are coming along. I do think it is necessary for these centers to have a backup hospital and in some instances several backup hospitals, but to make their existence contingent on or officially tied to a hospital, I think, would be devastating.

I think I would like to point out in conclusion that the prepaid group practice program represents a fundamentally different form of health care organization, and this is the problem that medical care has been struggling with for a long time. It may involve different planning considerations and, therefore, the planning agencies, which we very greatly favor, and which must be operated to assure the

reasonable development of the whole health system, really ought to pay special attention to comprehensive prepaid group health plans based on defined population, which is very different from that of a normal community hospital.

Too often the planning agencies are overly wedded to the status quo, to the rigidities of the present hospital system, and it is important that the governmental policies at the highest levels be assured of a form of organization which has proven to be one of the most efficient and which promises not just high-quality medical care and carefully supervised medical care, but seems to be one of the methods by which the ballooning cost of health care can be arrested.

With these comments, Mr. Chairman, we would urge the committee to act favorably on S. 2182, to extend and expand the Federal program of assistance for the construction of hospitals and other health-care facilities.

I might say that I have testified a number of times here and been concerned with the development of Federal programs for health care for a long time, and this bill represents one of the most progressive steps that the group health organizations have seen in the Hill-Burton legislation since its inception.

The CHAIRMAN. Thank you, Mr. Brindle, for this statement. Thank you for the support of the bill and the data that you have given.

Your prepared statement was most intriguing and one part of it calls for intensified study of comprehensive health care and hospitalization by this committee. Comprehensive health care requires fewer hospital beds than are required when payment under the policy for medical work depends on the patient's going to the hospital. The doctor does his work in the office under some health plans. Under many, many insured medical treatment plans it isn't reimbursable or compensable under the insurance policy if the work is done by the medical doctor who is to be paid by the insurance policy, if the patient doesn't go to the hospital.

Of course, the patient wants to go to the hospital. He has paid his premium and he wants the insurance policy to cover him. So even though it might be minor surgery, he goes to the hospital or he loses his premium's coverage.

Mr. BRINDLE. When you have the whole range of medical services covered, as we do, typically, in these programs, the doctors can select not the coverage in which the man happens to hold a limited health insurance policy, but you can consider what is medically and economically best for the person and treat him in the best way.

The CHAIRMAN. You can restore to the medical doctor the option which he thinks is best.

Mr. BRINDLE. That is right.

The CHAIRMAN. Not to make it dependent upon where his patient would be reimbursed.

Mr. BRINDLE. That is very important.

The CHAIRMAN. And it seems to me it would give the doctor more autonomy, restore the old autonomy he used to have.

Mr. BRINDLE. I think it is quite important. Many medical decisions have to be made on an economic basis out of consideration for the patient because he doesn't have insurance and so he trots him in the hospital.

The CHAIRMAN. I agree with you and I am not criticizing the medical profession.

Mr. BRINDLE. They have no alternative.

The CHAIRMAN. The family has no money and the doctor feels some obligation to help the family out of the dilemma.

Mr. BRINDLE. This decision is often made in relation to the needs of the family and it is a good health judgment, but it is lousy insurance.

I would call your attention to the attachment which gives in very great detail the statistics for 6 years of the Federal employees health benefits program and highlights this lower hospital utilization; and on the back of it are some other interesting statistics—the great difference in the pattern of some surgical procedures. These are quite important aspects of the differences between group prepayment and the traditional.

The CHAIRMAN. I will order this Group Health & Welfare News special supplement of October 1968, the Federal employees health benefits program, sixth term coverage and utilization, printed in full in the record.

Our next witness is Mr. Fred J. Hughes, a member of the board of regents of the University of Minnesota, representing the Association of American Medical Colleges, accompanied by Dr. Robert B. Howard, dean, University of Minnesota Medical School, chairman-elect of the Association of American Medical Colleges, and Mr. Ted Bowen, the administrator of the Methodist Hospital, Houston, Tex.

Gentlemen, we are glad to welcome the University of Minnesota Medical School because the name of that medical school is known all over America.

Mr. Hughes, you may proceed in your own way. We welcome you here and we appreciate the opportunity of hearing you.

STATEMENT OF FRED J. HUGHES, MEMBER, BOARD OF REGENTS, UNIVERSITY OF MINNESOTA; ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ACCOMPANIED BY DR. ROBERT B. HOWARD, DEAN, UNIVERSITY OF MINNESOTA MEDICAL SCHOOL AND CHAIRMAN-ELECT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; AND TED BOWEN, ADMINISTRATOR, METHODIST HOSPITAL, HOUSTON, TEX.

Mr. HUGHES. Thank you, sir.

We will try to be appropriately brief and we believe if the three of us have a total of 12 minutes we may complete our presentation.

It is indeed a privilege for me to appear before you and to support the concept and the form of this legislation.

In addition to serving on the board of regents of one of the Nation's largest health science centers, I have served for many years as legal counsel to the St. Cloud Community Hospital, the community from which I come. Therefore, my perspective as to the desirability of this legislation encompasses my experience in both a community and a teaching hospital.

The needs for such legislation have been well documented. I recognize the tendency of some leaders of the health field to solve the problems by word rather than by deed. For years we have heard about the

problem relating to shortages, accessibility, lack of personal physicians, lack of "out-of-bed" services and inadequate financing, particularly of medical education.

I believe the time has come when we can say that there is truly a new direction in the health field and this proposed legislation will give impetus to certain desirable trends that will accelerate our ability to meet the Nation's health problems. I would like to give some example of what I mean when I suggest that slogans have been replaced by programs and new concepts have overcome the dead lethargy of the status quo. St. Cloud, a community serving an area in excess of 70,000, is fortunate to have but one large community hospital—St. Cloud Hospital. I say fortunate because it has allowed our hospital to develop to a size of over 300 beds and provide an economy of scale that provides the citizens of St. Cloud with a full range of services.

I have been fully aware of the Hill-Burton Act from our program and I fully support the need to develop other programs at this stage of our hospital history. The condition of the health care in our part of Minnesota, Senator, is no longer comparable in 1969 to what it was a decade ago. And this is due, and I would be derelict if I did not say it to you today, in a large measure, to the influx of Hill-Burton funds which have made possible the development of this facility. This, I suspect, is rather typical of what has happened throughout what we think of as rural America.

The CHAIRMAN. We have been impressed by the statement of an earlier witness about the percentage of public hospitalization, of publicly owned facilities in Minnesota, the proprietary hospitals.

Mr. HUGHES. Are you asking me a question, Senator?

The CHAIRMAN. I was leaving it open for you to comment, if you cared to. I wasn't going to ask point blank do you know what it is and what it isn't.

Mr. HUGHES. Let me answer this for you. I think I may be helpful. That sounds like a former law professor. As a lawyer, I can say that, Senator.

Senator, St. Cloud Community Hospital was and still is under the control of the Benedictine Sisters, but we are in the process of moving this into a board of directors, largely as a result of the developments of the last decade.

I have just been saying to some of these men today that we have just put on our board the gentlemen whom I consider to be probably the most outstanding businessman in our central Minnesota area and we are bringing to this whole concept a quite different concept than the proprietary, narrow, parochial area which, I think, traditionally has been true of our institution.

In addition to the standard acute in-patient unit, we have an extensive care unit under construction, made possible by Hill-Burton funds, and have recently finished a complete rehabilitation service including physical therapy, occupational therapy, and vocational counseling. Part of the strength of the Hill-Burton program has been a recognition of a coordinated approach to the entire program. Federal assistance has played a vital role in fulfilling the public obligation to encourage the best possible vehicle for meeting the needs of our people.

In my own community of St. Cloud, we have developed a facilities and service planning commission. This commission has wide-scale

community involvement and includes planning for home health service, emergency visits, mental health, and dental services. Having a community base, it has developed its own bylaws and operation procedure, functions as a program planning commission and operates with the support of all parties concerned. At the present, the mental health center accepts outpatients only, with acute inpatient care rendered by the St. Cloud Community Hospital.

From the two experiences as the hospital attorney and my involvement with the facilities and services planning commission, I recognize the merit in the need for nonbed services, for the emphasis of modernization as well as new construction and the introduction of the concept of guaranteed loans.

As a member of the Board of Regents of the University of Minnesota, I am acutely aware of the importance of facilities to our teaching obligation. This has been a time of ferment in education and emerging educational patterns require new and different facilities.

In turn, the curriculum developments and the facilities changes allow us to grapple with the problem of delivery of care in a more effective manner. For example, increased emphasis on delivery of care to the ambulatory patient and the teaching of principles of medicine from other than the acute inpatient model have been severely limited. Our University of Minnesota Hospital was designed in 1928 to accommodate a maximum of 60,000 visits a year. This year there will be about 120,000 visits in the same available space. This example of the University of Minnesota Hospital is not unusual among the major teaching hospitals in America.

It is important to recommend priorities for manpower development, for instance: the University of Minnesota has currently enrolled about 600 medical students, but a total of 3,200 are enrolled in the entire health manpower field. That is, doctors, dentists, nurses, technicians, public health workers, therapists, and pharmacists. In the administration of these funds I have seen very tangible evidence of the advantage of a linkage of the university-trained graduate in the rendition of the health services to our own St. Cloud Hospital.

In conclusion, a word about the guaranteed loan program.

As a regent, as a lawyer, and as a taxpaying citizen, I suggest, that it makes good sense that those units which can generate revenue be allowed to move ahead on this basis. This retains the private enterprise concept and yet assures community participation through the loan process. I firmly believe that the concept of Hill-Burton funds represents a singular social response to the directly felt needs of our people. It is, I submit, a magnificent manifestation of the concern and compassion of a responsible government meeting the needs of its people.

In response to the question you put to Senator Percy, "Who is going to staff these community centers?" he said, "groups of physicians, medical schools and hospitals," but the group of physicians, Senator Yarborough, are not going to be available in American unless our teaching hospitals are able to produce these men. Therefore, we feel that the priorities in manpower development is a sinequanon of the end results you intend to achieve and rightfully so in this legislation.

The CHAIRMAN. You have won your argument with me right there. I agree with you.

We had in my State this past year 1,300 young men who applied for admission to medical schools, who were approved by the administration authorities, who on qualifications met every standard of the American and Texas Medical Associations, but they admitted only 400. That is all the places they had. Out of the 1,300 who prepared themselves by premedical training, there were only 400 admitted, despite the great shortage of medical doctors in America—and our shortage in Texas is more acute than the national. We have pulled down the national figures, having such a great shortage.

Now, by contrast, a Mexican university admitted 1,500 medical students to its first-year medical class, and some 600 of those were from the United States.

I had a letter of thanks from one student admitted there, for my help in getting documentation so he could be admitted. I saw his father at a meeting recently in Texas and he came by to thank me for helping, and he said, "You know, it took a lot of work to get him admitted. They are so careful. They are afraid the people will come down there and they have had some come with forged documents from American universities. We had to get affidavits from American public officials."

Actually, he had graduated from one of our larger universities in Texas. So it indicates they are not just registering anybody for a field. We know they can't train 1,500 in the first-year class comparable to the American education, but when these students came back up to the United States they will be welcomed because we don't have enough doctors. One of the greatest failures in America, the failure to build enough medical schools and teaching hospitals to train these doctors. You know that 10 more could be added.

I believe it was the preceding witness who talked about something of the rigidity of the medical authority; that is, too rigid. If they would give enough instructions, if they could train 1,500 the first year, surely our medical schools could increase from 100 to 110 and to 125 the first year, if they wanted to.

To use an old slang expression, put your money where your mouth is. If they wanted to really educate more medical doctors, they could do it, even though they are a little crowded.

Mr. HUGHES. Senator, as you spoke it brought to mind the situation in Minnesota. We feel a concern for our sister States, for instance, North and South Dakota are not economically equipped for full medical schools.

The CHAIRMAN. Do they have medical schools?

Mr. HUGHES. They have students to the junior year and we take some of them. We feel some sense of responsibility, I guess, to our neighbors and friends of adjoining States. These are expensive facilities. At our University of Minnesota, we have just had funded from the legislature which just adjourned $14 million for additional health facilities to expand our medical college. With this thought in mind, more people, but again we don't want to be committed to so many from South and North Dakota. But this is the authority that is behind us, to assume some sense of area responsibility, if you will, as hopefully the Congress is and has done in terms of national responsibility.

The CHAIRMAN. We have an even greater shortage in the dental schools in our State. There were two schools in my State when I was an undergraduate, one at the University of Texas which admits no one out of the State, but the Baylor University Dental School does admit out-of-State students not that it is larger. It sets a certain quota for they have far more students applying for admission to the Baylor medical school, although the fees are three or four times as high because they come from other States.

Our sister State of New Mexico had no medical school until the recent act authorizing 20 more medical schools. New Mexico got one of those, and their population was over 1 million, roughly equivalent to the population of North and South Dakota combined. But we don't have enough facilities to train or to educate enough medical personnel for the more thinly settled States farther west.

I want to commend you on the sense of responsibility that Minnesota has toward those States to the west. Reflected in the political influence of Minnesota and the Nation is the fact that all three of the Democratic candidates for the Presidency whose names were before the Democratic National Convention last year came from those three States, two of them from your State of Minnesota.

So that is politically a viable region, I would say, when all three of our nominees who went before the convention were from South Dakota or Minnesota.

Mr. HUGHES. As an aside, I don't know whether you know it or not, but former Vice President Humphrey was elected to a teaching position at the University of Minnesota by a bunch of us who are generally considered to be William McKinley Republicans.

The CHAIRMAN. I commend you. He is a very articulate person.

Mr. HUGHES. He is that.

The CHAIRMAN. And in the field of political science, I think he could stimulate a class.

Mr. HUGHES. Senator, we feel, for instance, at the University of Minnesota, that while we have only 600 medical students currently enrolled, we do have a total of approximately 3,200 in the entire health manpower field; namely, doctors, dentists, nurses, technicians, public health workers, therapists, and pharmacists, and in the administration of these Federal funds I have seen very tangible evidence of the advantage of a close linkage of these university-trained graduates in peripheral areas as well as the central areas, who are in our own immediate area in St. Cloud.

In conclusion, if I may, a word about the guaranteed loan program.

As a regent of our university and as a lawyer and as a taxpaying citizen, I suggest that it just makes good sense that those universities which can generate revenue be allowed to move ahead on this guaranteed loan basis. This retains the private enterprise concept, which I happen to agree with, and yet assures community participation through the loan process.

I firmly believe the concept of Hill-Burton funds represents a singular social response to the directly felt needs of our citizens. It is, I submit, a magnificent manifestation of the concern and compassion of a responsible Government to meet the needs of its people.

I thank you for your courtesy and, if we may, Dr. Howard and Mr. Bowen will speak.

The CHAIRMAN. Thank you very much. This is a very interesting and stimulating statement and I want to congratulate you for it. I want to congratulate you for having some 3,200 enrolled in the entire health manpower field, 600 enrolled as medical students. That would leave 2,600 in other health manpower fields.

I wonder how that compares with the national average on a population basis, in comparison with other universities.

I want to direct the staff to get the data and find out how many people are enrolled in the universities of America.

I believe you are going to have a much higher percentage than the Nation as a whole.

Mr. HUGHES. I think that is true, Senator. But you mentioned your dentist situation. We have the Hill Family Foundation. The Jim Hill Foundation gave a grant to the university to study this whole health complex in our area, including the two Dakotas, western Wisconsin and Montana, and we find, Senator, interestingly enough that a decade hence, our acute problem will be dentists, not doctors.

We are moving, I think, we are making a bona fide effort in the peripheral paramedical areas to make available to our people quasi—not quasi-professional, not doctors and not dentists, but people who can make contributions such as those to which Senator Percy so eloquently alluded in his testimony this morning. In other words, assistants to doctors and dentists.

The CHAIRMAN. The studies of this committee indicate there are 92,000 dentists in the country right now. The shortage is about 9,000, according to the best estimates we can obtain. It indicates it will be necessary to fill the need for dentists under existing methods of financing and by 1975 that shortage will have increased where this country will have a shortage of 28,000 dentists, and that contemplates an increase in the use of technicians in the meantime. There will still be a shortage of 28,000, though by 1975 it is anticipated that the technicians will be doing part of the work which the dental doctor himself does.

Dr. HOWARD. Senator Yarborough, I am Dr. Robert Howard and, as I have been introduced, Dean of the University of Minnesota College of Medical Sciences, which includes responsibility for the medical school and some of the other health units.

I am also chairman-elect of the Association of American Medical Colleges, and it is in this role that I appear before you.

I am greatly appreciative of the opportunity to present the views of the association concerning the hospital and medical facilities construction and modernization amendments of 1969.

As I think you know, sir, the association is composed of all the medical schools in the United States, 358 of the major teaching hospitals and 29 of the distinguished academic societies in medicine, and I am pleased indeed to record and testify to the fact that this association strongly supports the objectives and the provisions of this bill.

I have prepared and filed with you a written statement which I should like to request be introduced into the record, and I would like with your permission to speak very briefly to certain of the points.

The CHAIRMAN. The statement will be printed in full in the record.

Dr. HOWARD. Thank you, sir.

We are confident that other spokesman will present the needs of the community hospitals for modernization and construction, and we are sympathetic in support of those needs, but at this point we wish to focus our remarks and our support in particular on a situation with respect to that group of hospitals that we call the urban and teaching hospitals, because their needs for construction and modernization are very great, because they do have a special relationship to health care and to health manpower development in this Nation.

These are hospitals which we can identify as having the following characteristics and roles and functions:

In the first place, they are terribly important from the standpoint of rendering care to patients. They are found customarily and characteristically in the inner city where they often constitute the primary and sometimes virtually the only source of medical service for people who live and work in the inner-city areas. They are of great importance because they are often a hospital of last resort, the hospital that takes care of the highly complex or serious problem, and they render important emergency services.

A second function which they serve is that they are the area in which the fruits of medical research are introduced to patient care. There are close relationships with the medical schools which means that new techniques, new concepts of theories are worked out within the medical schools and put into practice in hospitals of this type.

The third and related point relates to their importance as clinical teaching laboratories in this business of training the manpower that is necessary to meet the growing needs and demands that we find in this Nation. These hospitals, these teaching hospitals, perform a vital role, one that cannot be substituted by anything else. They really are the teaching laboratories for the instruction in clinical medicine and indeed in the other health professions as well. There simply is no substitute for them.

It is a place in which young men and young women learn their professional roles and where they put into effect the things they have learned in theory in their earlier years.

I would like to emphasize what has already been referred to, that we are not just dealing with the education of physicians, we are also dealing with the education of a host of other health professionals in the allied health fields, and these teaching hospitals to which we are referring have this role of providing the clinical instruction laboratory over the wide span of the education of health professionals. We have in our Twin Cities, Minneapolis and St. Paul, excellent examples of this need. We have the Hennepin County and the university hospital, both of which are very important as far as supplying personnel for meeting the health-care needs of the upper Midwest. They play this very important role in both instances, their facilities are outdated and both need modernization and expansion.

As Senator Percy testified earlier, and as you yourself have testified, too, in your statement and some of your earlier actions, we are dealing with an increased public demand for medical and health services, one which we are going to be hard pressed to meet. These demands are going to focus in many instances on these large public hospitals, these urban and teaching hospitals, and we in the Association of American Medical Colleges feel strongly that anything that could

be done to update them, to strengthen them, will be in the best interests of the health of the American people.

Thank you.

The CHAIRMAN. Again, we congratulate you upon the great status of the University of Minnesota Medical School, and I want to note that you are the dean of the University of Minnesota College of Medical Sciences, which includes the medical school, the school of public health, the school of nursing, and the university hospital. I think Minnesota is to be congratulated for its leadership in this field and for the great health facilities in your State. It is not the richest State in the Union, but it is second to none in medical leadership and political leadership, I would say.

Mr. HUGHES. Be careful or he will be asking the regents for a raise.

Mr. HOWARD. I am glad you said that in the presence of one of my bosses.

The CHAIRMAN. Since I live in Austin, Tex., the site of the main branch of the University of Texas, I have some knowledge of how these things arise with faculties and regents.

Thank you.

Do you have a statement?

Mr. BOWEN. Yes; I do, Mr. Chairman.

First, I would say I am sorry we can't get equal time for Texas here, but being on the same panel with two people from Minnesota, we will have to make it up in another appearance.

The CHAIRMAN. I think if you make this full statement you are going to have it.

Mr. BOWEN. Mr. Chairman, I come here as a representative of the Council of Teaching Hospitals to the assembly of the Association of Medical Colleges, and in the interest of time, I will briefly summarize my remarks and we would, as usual, appreciate that a copy of the testimony together with the statement for excellence in service and education be inserted in the record of these hearings.

The CHAIRMAN. We will order the entire statement printed in full, and we will order printed as a part of the record also the publication "Meeting Society's Expectations for Excellence in Service and Education," prepared and adopted by the Institutional Membership Council of Teaching Hospitals and the Association of American Medical Colleges, November 4, 1968.

Mr. BOWEN. Thank you, sir.

We would like to say that we of the Council of Teaching Hospitals are pleased to say to you, Mr. Chairman, that we fully support your most progressive and innovative bill, S. 2182. We vigorously endorse section 102 of this legislation which provides a specific and identifiably separate category for authorization grants, and we are also particularly pleased to note the loan guarantee and interest subsidy provision for private, nonprofit hospitals contained in this bill. We think the concept of providing the loan guarantees with interest subsidy to nonprofit hospitals represents a very constructive and beneficial innovation in the relationship of the public and private sectors.

With particular regard to the provision of direct Federal loans to publicly owned health facilities, we should point out that of the 358 teaching hospitals that are institutional members, 74 are publicly owned, 49 of which are State-owned university teaching hospitals.

It is with a great deal of enthusiasm, in addition, that we support the provision contained in S. 2182, which provides for grants for modernization of emergency room service in general hospitals.

Additionally, Mr. Chairman, we endorse title 1, part B, section 110, which allows for priority allocations to States on the basis of areas with relatively small financial resources at the option of the State. This is a most brief statement, as we have said before, for your committee to consider.

We do specifically call attention to our support of part C, section B, which extends the authorization of $405 million over a 5-year period for research and demonstrations relating to the health facilities and services.

Thank you very much for this opportunity to appear on behalf of the Council of Teaching Hospitals.

The CHAIRMAN. Thank you for the comprehensive statement.

You have your points and your recommendations numbered and it is easy to pick them out and I appreciate it.

Thank you gentlemen very much.

Our next witness is Mr. John K. Pickens, general counsel, American Nursing Home Association.

STATEMENT OF JOHN K. PICKENS, GENERAL COUNSEL, AMERICAN NURSING HOME ASSOCIATION; ACCOMPANIED BY NORMAN BURCH

Mr. PICKENS. Mr. Chairman, I have Mr. Norman Burch, who is the assistant executive director of the American Nursing Home Association, with me.

I will follow, generally, the order that I have in my prepared statement, but I do not intend to read it. We support S. 2182.

Our association represents over 7,000 nursing homes with over 350,000 nursing home beds. Over 10 percent of our membership are nonprofit homes.

Although, as you know, Mr. Chairman, the nursing home field is almost diametrically opposed to the hospital field, whereas there are 95 percent of all hospitals are nonprofit or voluntary hospitals, approximately 87 percent of the nursing homes are proprietary nursing homes.

The CHAIRMAN. In getting into the nursing home business, the public regards the illness of people of all ages as an acute priority but they built other types of facilities first. It took the proprietary interest to get the nursing homes.

Mr. PICKENS. That is correct.

The CHAIRMAN. Funds weren't advanced by the taxing authorities.

Mr. PICKENS. That is correct. The nursing home field started in the 1940's and I suppose primarily for the need to take care of welfare patients. And it was the welfare programs in the various States that really started the nursing home field out.

We have three amendments which we believe will improve the bill and we would like to have the committee consider.

A survey by the association showed that some 300,000 new beds were built between mid-1960 and mid-1966. An estimated additional 130,000 beds were constructed in 1966 and 1967.

A recent survey, in 1967, by the Department of Labor and Manpower shows that by 1975, the forecast of 1,200,000 nursing home beds, and some 900,000 hospital beds, and I think this shows that in your bill you have provided for priority on manpower because in 8 short years the number of nursing home beds are going to be double. And when you consider you will have 1,200,000 beds by 1975, it is going to cause a real problem of personnel in America in the paramedical field.

Three hundred thousand new beds were added during the 5-year period 1961 to 1966, which represented a capital expenditure conservatively estimated at $1.5 billion, most of which came from the private sector of the economy. By "the private sector," of course, I also include the church-affiliated, nonprofit homes, most of which have been built through private capital rather than through Government funds.

During this same period, of the $291.9 million spent to provide 22,700 beds in nonprofit Hill-Burton homes, Federal Hill-Burton funds amount to $102.3 million.

Now, the first amendment that we would suggest is on page 5 of S. 2182.

Under section 10, we would strike out lines 21 through 23 and substitute in lieu thereof "or a facility with which the applicant has a transfer agreement in accordance with Title 18 or Title 19 of the Social Security Act, to patients of such hospitals who no longer," and so forth, so that subparagraph (4) could read as follows:

> In the case of projects for construction or modernization of general hospitals, to any general hospital with respect to which there is reasonable assurance that services of a long-term care facility will be available, either through a facility of the applicant for the project or a facility with which the applicant has a transfer agreement in accordance with title 18 or title 19 of the Social Security Act as amended, the patients of such hospital who no longer need care in such hospital but require the services of a long-term care facility.

Title 18 of the Social Security Act, which is medicare, and title 19, which is medicaid, require that an extended care facility and a skilled nursing home must have a transfer agreement with one or more hospitals.

The title 18 conditions of participation for extended-care facilities spell out in detail regulations concerning such transfer agreements.

Of course, originally, H.R. 1, the so-called King Anderson bill, which eventually became title 18, required affiliation of extended-care facilities with hospitals. However, this was changed by the House Ways and Means Committee to require the transfer agreement instead And later, the so-called Moss amendments to title 19 adopted by the Congress in 1967, require a transfer agreement between a skilled nursing home and a hospital.

So it would seem to us that the Hill-Burton program should be in accord with the language of title 18 and title 19 and, of course, you bill is very close to that at the present time.

However, the term "affiliation," has a somewhat different meaning in the health-care field. We are unalterably opposed to the language contained in the House-passed bill, and also the language now suggested by the American Hospital Association. We don't believe that hospitals should be required to be structurally connected, or physically located adjacent, to a nursing home, nor should a nursing home be

under the direction of the medical staff of the hospital or be required to have a hospital-type medical staff.

Whenever this has occurred, the nursing home has no longer remained a nursing home long-term-care facility but became, instead, a part of the hospital.

One of the principal reasons for nursing home or extended care is to cut the high cost of hospital care. When a nursing home comes under the direction of a hospital, many of the hospital costs, directly and indirectly, are passed on to the nursing facility.

However, it is well to require a transfer agreement to insure cooperation between the hospital and the nursing home. This cuts costs and eliminates duplication and allows use of X-rays, laboratory, and other services where volume and continued use cuts the costs of such services.

Now, I might add here that we also disagree with the hospital association in saying that the term "long-term care," that you have used in your bill should be stricken and the term "extended care" used, because "extended care" is a term of the art under the Medicare Act and we feel that if you use only the term "extended-care services," or "extended care," you are putting the emphasis on medicare patients and you are leaving out the public assistance or public-welfare patients. If you wanted to say long-term care, extended care, and skilled nursing care, this would cover the field. But I believe the language that you have in your bill now covers welfare patients or public-assistance patients; whereas, I don't believe the language of the hospital association does. It directs the emphasis to medicare and I don't believe that was the intention of your bill, to direct it solely to medicare and not to welfare patients.

Now, in many States the regulations for skilled nursing care are even higher than the regulations of the Federal Government for medicare.

The CHAIRMAN. Let me raise a point right there.

I have complaints from the Association of Practical Nurses. Many of them have been trained in hospitals. In my State, in California and in two or three other States they are called vocational nurses, practical nurses, being a degree of nursing below that of a registered nurse. But I believe they require 15 months of schooling.

Mr. PICKENS. Twelve to fifteen; plus they have to pass a State examination.

The CHAIRMAN. They have certain professional standards that they have to meet.

Now, the shortage is so great in my own State that they have run out of registered nurses, run out of vocational nurses, and now have what they call sitters with no training to sit and look at the patient to see if there is a change in his condition.

But the practical nurse is complaining that the payments under medicare and under social security require that they have registered nurses in the hospitals or they won't approve the hospitals for medicare payments.

Mr. PICKENS. That is correct. And then I think you have the further problem that approximately half of our nurses in many of our States, your licensed practical nurses or licensed vocational nurses, are

licensed by waiver, which means that they might have had to drop out of a registered nurses program because of financial reasons or because they got married, and so then they obtain the waiver from the State and took the State examination for the licensed practical or licensed vocational nurse, but because they didn't graduate from a State-approved school, they are not considered under medicare a fully licensed vocational nurse. They are still considered a nurse by waiver. And especially in the nursing-home field they have tried to eliminate this licensed vocational nurse by waiver from being in charge of a shift, from being a shift nurse or charge nurse, and in many of these instances these licensed vocational nurses, in Texas and California, especially, are as well qualified or better qualified than some of your practical nurses that have graduated from State-approved schools. But the Department refuses to classify them in accordance with their education and background and training. And this, I think, is greatly depleting the supply of licensed practical and licensed vocational nurses.

The CHAIRMAN. And to the detriment of these young ladies who have gone and studied. The ones I know in my own State have been generally educated in hospitals or colleges.

They have a graduation. I know they are not registered nurses, but they learn enough and study and apply themselves and they learn certain basic rules to be of great value in the hospital.

Mr. PICKENS. My recollection, sir, is that there are over 9,000 licensed vocational nurses in Texas alone that were licensed by waiver.

The CHAIRMAN. Is that the problem, the licensing by waiver?

Mr. PICKENS. That is one.

The CHAIRMAN. That the HEW and social security officers are protesting about?

Mr. PICKENS. That is correct. But there are two problems. The first one that you mentioned——

The CHAIRMAN. And they are objecting also to vocational nurses, even though they do go to school and take the examination and are licensed?

Mr. PICKENS. That is correct. If they haven't graduated from the State-approved schools, then they license them by waiver.

Now, many States, for several years, didn't have approved programs for schools of vocational or practical nursing, and you could have an individual graduate, say, last year from the same school with the same identical course and the State hadn't approved the school because they didn't have an approved program and she is licensed by waiver, whereas the nurse that graduates this year, after the approved program, comes from the same school, with the same education, and she is a full-fledged licensed vocational nurse and they have had the same course and the same instructors, but because the State had no approved program—so the requirements of the regulations of title 18 are very stiff in this field because they require that a licensed vocational or licensed practical nurse be a shift supervisor in a nursing home on the evening and night shifts and frequently the only nurse you have, you will just have one nurse, if you have a 50- or 60- or 70-bed nursing home, and so that if the licensed vocational nurse by waiver can't be

a shift nurse or a change nurse, this means a nursing home is not going to have them because they would rather go out and employ a nurse that is not licensed by waiver.

So there are two aspects to the problem. The first one that you mentioned and the second one that I have just discussed.

The CHAIRMAN. And the nursing home has an economic problem that the hospital doesn't have. Your payments are not mainly from insurance policies. Aren't your payments mainly from social security or welfare payments?

What percentage of the people in the nursing homes are paying for their upkeep there through social security and/or welfare payments that they receive?

Mr. PICKENS. Well, the composition of nursing homes throughout the country is in excess of 50 percent or welfare of patients. Perhaps between 15 and 20 percent are medicare patients. You brought this point up, there are very few insurance policies that cover nursing home care, just as though very few insurance policies cover home health care.

The CHAIRMAN. So your nursing homes have to be built and managed in a way to subsist on the much smaller income?

Mr. PICKENS. That is correct, principally because under title 19 the nursing homes are not guaranteed reasonable costs for welfare payments, as hospitals are.

I think, however, you discussed this had a real point that probably some of these insurance policies by various carriers that have not provided for nursing home care and home and health care have directed the attitude of the people solely toward hospital care.

The CHAIRMAN. What percentage of your patients are social security patients as distinguished from welfare patients? They have earned the social security. They have aged and they are in nursing homes. That is their only income. I don't count a social security person living on social security as a welfare case, if they pay for it, if that is all the income they have. They have earned that social security by working in life.

Mr. PICKENS. We could supply the figures.

The CHAIRMAN. Proceed with your statement.

Mr. PICKENS. I have some appendixes, A, B, and C, which are Hill-Burton-constructed homes, and D, E, and F, which are Federal Housing Administration, and in making comparisons we have found by and large that Hill-Burton homes built to the same standards as FHA homes cost roughly twice as much and sometimes a little bit more than comparable FHA homes or homes built entirely by private financing.

Now, I realize in these appendixes that I can't tell you which homes were built to the same standards. Some were built to the same standards as Hill-Burton homes and some were not. But that information isn't available to me.

But the only point that I wish to make is that nursing homes built under the Hill-Burton program by and large have cost approximately twice as much, built to the same standards, and that the tax dollar can only go so far and the medical dollar can be spread only so thin. And we feel that the private sector in the past has shown that in most areas they can build nursing homes to the standards required and

provide adequate beds. And we say that where they can they should be allowed to do so. On the other hand, we see a real need for Hill-Burton programs where private financing has failed to take up this slack and because the Hill-Burton homes do cost substantially more than the other type of home, we feel that this other money should be put into a more comprehensive health care program and should not be spent on construction where it is not needed.

Now, we have another amendment that we would add a new section on page 6, after line 13, as follows. It would be a new section 110(a), which would provide as follows:

Amend section 604(a)(4)(A) by striking out the semicolon at the end thereof and adding the following:

Provided, however, in making an inventory of existing facilities for long-term care needed to provide adequate facilities for inpatient care of people residing in the State, the State agency shall be required to count and recognize as existing and acceptable beds, those beds in a facility constructed since 1960 under the mortgage insurance programs of the Federal Housing Administration and the Small Business Administration.

Although, for the greater part of the last 8 years, there have been three Federal programs for the construction of nonprofit and proprietary nursing homes; namely, the Federal Housing Act program for proprietary and nonprofit, the Small Business Administration program for both types of facilities, and the Hill-Burton program for nonprofit facilities, there is no uniformity of construction or other standards.

Now, this has been true up to the last year or so. However, I believe until recently the Federal nursing home program under the Federal Housing Act still only requires a 7-foot corridor, whereas if you built under the Hill-Burton program, you are required to have an 8-foot corridor.

In many of these instances the State agencies have gone into areas where you had brandnew nursing homes built under the FHA program, and because they had a 7-foot corridor, rather than an 8-foot corridor, the State agency would not count these beds in the new nursing home as being existing beds. They would say these beds are unacceptable because they weren't built to Hill-Burton standards.

We feel that the standards on the three programs should be the same and they have had a number of years to make them the same, and we feel that in considering the number of beds available in any State that the State agency should be required to count the beds built under the Federal Housing Act program or the program of the Small Business Administration. So this is the reason that we have asked for this amendment.

And then the third amendment, at the end of section 110(a), as provided in amendment No. 2, we have just added, we would add section 110(b), which would read as follows:

After the effective date of the hospital and medical facilities construction and modernization amendments of 1969, section 604(a) of the Act is amended by adding at the end thereof a new subparagraph section 604(a)(13) to read as follows:

"Provide that the State plan contain satisfactory assurances that no facility built under the provisions of this Act will discriminate against beneficiaries or recipients of benefits under title 19 of the Social Security Act."

Now, we have had reports from New Jersey, New York, and many other States that some Hill-Burton nursing homes have refused to take welfare patients and will only take private paying patients. And we have checked enough of these reports to know that this situation exists in some of these nursing homes built by Federal funds in some States. We believe it wrong for a facility to receive Federal funds whether in loans or under a grant program and discriminate against public assistance or welfare patients under title 19.

Some have suggested that it would be proper to require Hill-Burton nursing homes to make available one-third of its beds for welfare patients.

We do not know how the committee feels about this but we do believe that there should be a requirement in the State plan stating that a nursing home built with Federal funds or with Hill-Burton funds cannot discriminate against welfare patients.

Now, I don't mean to mislead the committee, because I believe a public health survey of 1964 shows that proprietary nursing homes were caring for 54 percent of their patients who were on public assistance, where the nonprofit voluntary homes had a 40.4 percent composition of welfare patients, and the Government-owned nursing homes were providing 61.5 percent or 61.5 percent of their patients were welfare patients. We believe that there should be a provision in the State plan which provides that the facility cannot discriminate against beneficiaries under title 19 and that they be required to take title 19 patients.

The other sections of the bill, we feel that the bill is a much better balanced bill. We agree that in some cases the need is in all areas and that in other cases it is in the metropolitan area, and we agree with the treatment that the bill has made in this connection.

We also agree that one of the crying needs today is modernization, probably as much as, if not more so, than new construction in many areas.

If you have any questions, Mr. Chairman, I will be glad to answer them.

I thank the committee for their time and if there is any way that we can help the committee or the staff, we will be glad to do so.

The CHAIRMAN. Thank you very much.

We now receive the statement of Senator Stevens of Alaska for the record.

STATEMENT OF HON. TED STEVENS, A U.S. SENATOR FROM THE STATE OF ALASKA

Mr. STEVENS. Mr. Chairman, as a cosponsor of Senator Percy's Neighborhood Health Center Act of 1969, I am pleased to add my support to the many others who realize the urgency and need for such legislation.

As an Alaskan Senator, I am particularly mindful of the importance of this bill for providing comprehensive medical treatment in rural areas for the poorer people of our land. The establishment of such outpatient clinics in areas of low physician accessibility, staffed by physicians with different specialty training so that a wide range of medical services may be provided to these people is critical to equalizing the

quality of medical treatment received in our country today. To aid these physicians, it is suggested that maximum use of paramedical personnel, such as nurses and family health workers, be undertaken. I believe this is an excellent plan for such neighborhood health centers and should substantially increase physician productivity.

This bill has key provisions which I believe are especially paramount for effective implementation. For instance, the provision that State allotment be calculated on the basis of the number of medically indigent families within each State instead of the current formula involving average per capita income and population is extremely important. I believe this approach allows us to develop the allotments on a base that is much more closely akin to the real need for such health care in a State.

Because we are addressing areas which now lack adequate medical care, the bill's provision that the Surgeon General give priority to areas with low physician accessibility is especially critical. Also, the approach of granting funds to such operators which are judged to be "the most efficient and effective facilities" versus a cost reimbursement formula as in medicare is, I believe, an important component of this program.

In correspondence from our Alaska Department of Health and Welfare, Office of the Commissioner, it is stated that:

> This bill is a much-needed addition to the Hill-Burton program and will help our small communities to provide badly needed preventative medical services.

I fully agree with this feeling expressed by our Alaska Department of Health and Welfare and am pleased to be a cosponsor of this extremely important amendment to the Hill-Burton Act. I believe such neighborhood health centers in areas where now the neediest of our people often receive minimal health services is a critically needed piece of legislation, and I urge its early passage by the Congress.

The CHAIRMAN. We now receive for the record the statement of Senator Goldwater of Arizona.

STATEMENT OF HON. BARRY GOLDWATER, A U.S. SENATOR FROM THE STATE OF ARIZONA

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present these remarks in support of S. 2037, the Neighborhood Health Center Act, which I have sponsored with Senator Percy. I am most hopeful that this proposal will be adopted, either as a separate act or as a part of omnibus legislation to amend the Public Health Service Act.

In short, our bill is designed to offer a new departure in meeting the health needs of all citizens, whatever their income and wherever they live. To do this, in a sound and effective way, our measure goes right to the heart of the most pressing, current problem—the fact that comprehensive health services are simply not available or accessible to all our people at the local level. In order to meet this challenge squarely, our bill seeks to improve the system through which health care is provided by giving to local communities and local groups the funding they need to construct or modernize comprehensive health care centers in the neighborhoods and areas where physician accessibility is lowest.

It is this approach—toward a program of community health centers

in the areas where people live—that holds the best promise of providing the connecting fibers to bind together a new coordinated and personalized medical service system.

There are several advantages to the type of program we are recommending, and for the sake of conciseness I would like to itemize the major benefits as I see them.

1. Comprehensive neighborhood health clinics, staffed by physicians who can treat a wide range of diseases, can provide residents of low-income areas and rural communities with the primary care that is now unavailable to them.

2. This concept will provide a continuity of services by the same doctors to the same individuals in their own neighborhood—a situation that rarely exists at present for those who live in our rural and low-income areas.

3. Our plan will concentrate the responsibility for the treatment of a wide range of illnesses at the same facility and by the same personnel, thus overcoming the present tendency for fragmentation of care among specialized clinics. We would hope to reverse the situation, which now occurs too often, in which a person who is sick is refused care because he has the wrong disease.

4. The provision of comprehensive outpatient care at neighborhood centers will result in a dramatic reduction of hospital utilization. Through immunizations, early diagnosis, and preventive medicine, many diseases will be prevented outright or diagnosed before the need for hospitalization arises. In addition, hospital admissions for diagnostic purposes will be avoided since such services will be given at the clinic.

5. The possibility for increasing comprehensive facilities as part of a coordinated county or urban delivery system will enable hospitals to reduce costs by eliminating the duplication of expensive equipment which can be present close at hand.

6. The establishment of neighborhood clinics on a large scale will certainly encourage and make it possible for insurance carriers to offer low-cost health programs because so many kinds of medical services can then be provided in lower cost areas, with the accompanying factor of a decrease in the number of hospital days per number of covered persons.

7. The development of comprehensive health care clinics will help county and city governments get the most from their health dollar. It it more economical by far to contract for care to be handled by clinics than by hospitals. This point is especially pertinent to our situation in Arizona where almost all of the counties lack a public county hospital and are required to contract for the provision of services with existing private hospitals.

8. The program of neighborhood health centers promoted by our legislation is sound. It has been proven to be effective where tested in the form of pilot projects and is probably the least costly Federal approach to bringing more and better health services to people in every walk of life. And, I would like to emphasize that our proposal does not require any added specific authorization of Federal funds. The measure would achieve its ends by eliminating the earmarking of existing authorizations for specific programs and moving to a block grant system. Thus, the plan will not add to the pressures on the Federal budget.

9. The bill incorporates built-in safeguards to assure that projects

for which funds are granted will be operated in the most efficient manner possible. Unless the applicant can show that its project is or can be the most efficient and effective project in the neighborhood, the measure requires that the application shall be denied. As a further step to avoid wasteful funding, the applicant must also show that any other health facilities which are operated by it are likewise efficient and effective.

10. The bill increases the ability of the States to control the resources used for their health needs. The States can certainly adapt their powers and programs far more quickly and wisely to meet the varied needs of their people than it is possible for some administrator to do who sits in Washington, D.C. It is particularly significant to me that our legislation takes account of this fact by permitting the States to determine for themselves their own needs and priorities as to the type of projects to be funded under their allotments for Hill-Burton purposes.

Mr. Chairman, this completes my presentation of the general reasons why I am so strongly convinced that the approach set out in this proposal is worthwhile. But before closing, I would like to add a few thoughts concerning the intent of the sponsors of the legislation so that a clear history will be made to answer possible questions that may arise in the day-to-day operations under this law.

First, I want the record to be entirely clear that the benefits of the bill are equally intended for our rural areas and small towns as well as for the low-income urban communities. The State of Arizona is interested in this measure from both standpoints as are several other States.

As I see it, the act will definitely be useful in Arizona by helping to bring health services closer to the indigent senior citizen, or Mexican-American, or American-Indian, or black citizen who resides in one of our urban centers. But it also will be of immense assistance to the citizens of Arizona because it will make comprehensive health care available in the sparsely built-up areas of the State which are remote from any major medical facilities. I would like to remind members of the subcommittee that several counties in Arizona are larger in territorial size than many entire States and yet have a population too small to support more than one public hospital—if that.

In my State, trips of 25 and 30 miles to reach high-quality health centers are common. And it is not unusual to find the situation where even longer journeys are needed. For example, there is Mohave County which has one major facility located in Kingman, the county seat. Now this means that citizens of Wikieup in the same county must travel a distance of more than 50 road miles before they reach a hospital. Or, take the case of Yuma County where residents of Mohawk live over 40 miles from the closest hospital. And, in the northern half of this county, we have another typical situation in that the people of Hope have to go 50 miles in one direction to an Indian hospital at Parker or 50 miles in the other direction to get to the community hospital at Blythe, Calif.

Mr. Chairman, I could fill the record with similar instances but these are sufficient to make the point. Our legislation must be and is intended to be interpreted broadly to enable the establishment under the act of neighborhood centers far from the hospital with which they are associated. And, by "far", I want the record to show that I am talking about distances of 50 and 60, or even more, road miles. If

this measure is to fulfill the purpose which we want, it is absolutely essential that an expanded construction be given its provisions in the manner which I am describing.

Next, Mr. Chairman, I want to indicate some other areas where the bill must be interpreted so as to give the broadest meaning to its terms. I hope the explanations set forth about the definition of a comprehensive ambulatory care center" establish that (a) a center can qualify for construction grants even if it is to be staffed by only two or three physicians, so long as these individuals alone or together can treat a wide range of diseases, (b) a center need not be capable of caring for all or almost all the diseases to which individuals are succeptible in an area, but should merely be able to show that in fact it truly is not a specialty clinic restricted to one or a very few types of illnesses, and (c) the clinic is not expected to provide formal health education, but rather is intended only to attempt to offer preventive-type education, such as health hints given at community gatherings or food-preparation advice stated in pamphlets distributed in the area.

And, of course, I have already discussed the requirement that the clinic be associated with an accredited hospital by stating that it is our purpose to allow the establishment of neighborhood clinics in communities which are up to 60 miles or so away from the associated hospitals. This feature is not so unusual as it sounds at first hearing, which I hope I have demonstrated by the previous examples; and I would like to add for your consideration the fact that several locations in Arizona are already serviced by helicopters in medical emergencies, which makes it entirely practical for these centers to be constructed at great distances from the affiliate hospital. Also, such a broad interpretation will help existing hospitals to develop a network of clinics which will expand the existing good services to areas that lack it but need it. This will contribute to expanded and better services both in counties where towns are remote, and in places such at Pinal County where the present hospitals are small and might well wish to supplement their facilities by contracting with associated clinics that will relieve the demands on the hospitals.

And, in this connection, I wish to make certain that the guidelines which are set up under the statute are not so strict that most Arizona hospitals will be found ineligible to participate in the new program. I refer to the fact that almost one-half of the hospitals in Arizona have been adjudged to be nonconforming by the Arizona State Department of Health on the basis of their physical structures. I want it plainly understood, however, that this survey evaluation specifically was not based upon the quality of the services being rendered at the nonconforming facilities. These hospitals are still providing adequate care and services and should be considered eligible to participate in projects under our bill to the same full extent as the other hospitals. And, as the final point I wish to raise concerning the hospitals which may participate in the program, the record should show that the term "hospital center" when used in section 625(m) is not intended to signify anything more than what is ordinarily understood to be a hospital. The language "hospital center" merely conforms to normal parlance used in the medical profession in describing what we laymen refer to simply as a "hospital."

In summary, Mr. Chairman, I urge that any report on the proposal endorsed in our bill make it unmistakable that Arizona and the several other States with similar situations are to not be written out of the bill by administrative decision. The guidelines which are promulgated under the law must be amed at fostering and encouraging the creation of these vitally needed health care centers. It must never be overlooked that the preeminent purpose of our measure is to provide the delivery of high-quality health services to all citizens regardless of what they earn or where they live. In my opinion, the approach presented by the measure represents a real opportunity for the Nation to deal with one of the most deeply felt human needs—the good health of all our citizens. This goal is certainly basic to the enjoyment of each individual's personal freedom and I respectfully request that the subcommittee act favorably on the measure or incorporate the concept and approach recommended by us into any general legislation that it approves in this field.

The CHAIRMAN. We now receive the statement of Senator Hansen for the record.

STATEMENT OF HON. CLIFFORD P. HANSEN, A U.S. SENATOR FROM THE STATE OF WYOMING

Senator HANSEN. Over the years, the Hill-Burton hospital and medical facilities construction program has been a vital one in Wyoming and has been the reason for marked progress in the State's towns and cities toward meeting hospital-medical facilities needs and toward allowing long-range planning to meet the needs of the future.

I would like to take this means of stressing the importance to my State of continued aid under this program for hospital construction and modernization, and I would respectfully request that this statement be included in the record of the hearings on H.R. 11102 as evidence of my support for this legislation, as approved by the House of Representatives.

Federal allocations to Wyoming under the Hill-Burton program over the years have accounted in no small way for the fact that the State is currently in the position of having nearly met present need for new hospital beds.

But construction is proceeding at an increased pace because of the urgent need for more and better long-term-care facilities for the aged of Wyoming, and the equally urgent need for replacement or modernization of a number of older hospitals in the more populous areas which are obsolete and, in some cases, unsafe for continued use.

The State currently has nine small general hospitals that operate long-term-care wings, two of which will be closed or have already been closed. There are only eight adequate nursing homes in the State. The balance of 12 nursing homes are of such condition that they will have to be replaced.

An analysis of the minimum need in Wyoming in the months ahead for assistance under the Hill-Burton program indicates that at least $2,204,400 would be necessary to supplement State and local funds for new construction and modernization that can be put off no longer.

This assistance is urgently needed to help in financing modernization of four hospitals involving some 259 beds; new construction of one hospital involving 11 beds; and construction of three long-term-care

units involving 62 beds. Applications for Hill-Burton assistance have already been submitted for most of these projects, but only $650,000 is available to be allocated by the State to fill a need for more than $2 million.

It is my earnest hope that H.R. 11102 will be approved by the committee and the Senate substantially as it was passed by the House of Representatives.

Thank you for your consideration.

The CHAIRMAN. You have raised a number of intriguing questions and I am going to put the staff to work on these. I didn't realize there was such a jungle of the Federal laws of one department under Hill-Burton and one under FHA and one under SBA and the different standards.

Thank you very much. We will have questions later. We will have research by the staff on this.

This concludes the oral hearing on this bill. We will hold this record open for a week and anyone who desires to file an additional statement or additional information may do so and it will be considered as fully as if offered here orally.

(The material referred to follows:)

PREPARED STATEMENT OF W. JUDD CHAPMAN, O. D., CHAIRMAN, COMMITTEE ON LEGISLATION, AMERICAN OPTOMETRIC ASSOCIATION

Mr. Chairman and distinguished members of the Committee: the American Optometric Association, representing 15,500 professional optometrists in the United States, shares your concern for the need to extend and modify the Hill-Burton hospital construction legislation. This Act has unquestionably improved the health care system and benefited American citizens, and surely merits continuation.

The Hill-Burton legislation, first enacted in 1946, provided an excellent method of meeting the pressing problems of that day and age. With construction of some 3700 hospitals accommodating over 400,000 beds, the basic need for financing additional hospital facilities in communities of all sizes has been completed. Today's hospital facilities are more nearly adequate than they were when the Hill-Burton legislation was enacted.

Many new but related problems of health care delivery have become apparent during the last quarter of a century. Problems which we face today are largely attributable to our rapid growth of population. Another major factor is the constant shifting of population from rural areas to cities and from cities to the suburbs.

Congress has attempted to keep pace by passing effective legislative programs. These programs were designed to lead up to the ultimate goal of comprehensive health care for all Americans. It has been gratifying to witness bold new programs of extended health care services. These programs were authorized by such legislation as Partnerships for Health, the Model Cities legislation, and amendments to the National Housing Act which allowed for FHA-insured loans to health care practitioners willing to establish group practice facilities. There is little doubt that the Hill-Burton legislation was a real pace-setter in pointing our health care delivery system in new directions and toward wider horizons.

The profession of optometry and its institutions have played an important role in this twenty-three year era of expansion, too. During this period of new challenges to the health care system, optometrists throughout the nation engaged in attempts to devise new mean and methods of making their valuable services more readily available to individuals in every segment of the socio-economic spectrum. Their answer to this recognized challenge was the "optometric center."

Optometrists at the local level faced almost insurmountable obstacles in establishing these centers. Funds were unavailable from any source except their own personal contributions and the meager amounts which could be extracted from the local professional societies. Occasionally a generous supplier of ophthalmic materials would donate some new or used equipment. Professional time was donated by the optometrists. Establishment of optometric centers represented

optometry's attempt to meet the vision care needs of the nation's indigent, medically indigent, and others who for various reasons were unable to obtain professional optometric care in the private practice setting. These centers were established in key cities throughout the Nation.

There are twenty eight such optometric centers in the country today. Two more are proposed or in the final planning stages. These centers accommodated something over 60,000 patient visits last year, an impressive record of service when one considers their severely limited operating budgets and relative lack of access to outside financial assistance.

In addition to the optometric centers, all ten schools and colleges of optometry operate public clinics as a part of their clinical teaching curricula, and these clinics took care of well over 300,000 patient visits last year.

The Optometric Center of New York, located in mid-town New York City, is one of the oldest of optometric centers. It is constituted as a non-profit teaching institution, recognized by and subject to the standards of the New York State Board of Regents. This center has been highly successful, and has served as the basic pattern for many of the other centers operating today.

Alden N. Haffner, O.D., Ph. D., who also holds the Masters in Public Health degree, is Director of the Optometric Center of New York. Dr. Haffner states that approximately 50% of the Center's income is derived from patient fees which are paid by the patient himself or by a third party. Other activities resulting in professional fee income include a contractual arrangement with the National Maritime Union Medical Center, which maintains an optometric clinic staffed and supervised by Optometric Center personnel.

The next largest source of income for the Optometric Center of New York, approximately 25% of its total budget, comes from tuition fees levied for post graduate educational courses and symposia formulated and conducted by the Center. These courses have gained wide acceptance within the profession and among many members of the medical profession. They are based on material that only a broad-based clinical teaching institution can provide. The type of material presented is available to the Optometric Center because of its extensive research activity. This research activity has made the Center eligible for some Federal research grants which today account for approximately 15% of the Center's total budget.

The remaining amounts necessary to operate the Center (10% to 15%) are obtained through special individual gifts and philanthropy.

These figures are cited as typical of the kinds of financial "tightrope-walking" necessary to maintain an optometric center operation today. In terms of the type of operation and sources of income, the New York situation is comparable to centers in other major cities such as the East Bay area of Oakland, California; in Denver, Colorado; St. Louis, Missouri; and a number of other metropolitan areas including Washington, D.C.

Rising costs, combined with the increasingly difficult problems associated with utilization of volunteer professional services, are but two factors in a highly complex financial and operational situation which cries for attention and immediate solutions. The optometric centers which are providing such excellent care to so many individuals sorely need financial assistance. If such assistance were available at the outset, when a Center is being established, the Center would be in a much more favorable position to carry on its work without the disruptively erratic ups and downs so common to new Centers.

It is clearly demonstrable that a good many of the problems in America's inner-city areas today can be traced to visual deficiencies. There are children who fail to learn because they have undetected visual problems. These same children are frequently the drop-outs from school who turn to anti-social behaviour and become a factor in the crime rates in our cities. Perhaps their visual problems could be discovered and corrected if adequately staffed and equipped optometric centers were more readily available.

No health care plan can be considered complete and comprehensive unless visual care is included. Means must be found to make optometric services available in as many health care facilities as possible, to assure that the Nation's 4,500 highly specialized medical eye practitioners, the ophthalmologists, are available to perform the medical and surgical procedures which are their specialties.

Ideally, each hospital, nursing home, neighborhood health center, and public health clinic would incorporate the equipment and skills of modern optometric practice within its structure . . . physically as well as philosophically. In this way, full utilization could be made of the optometrist's skills in detecting the

presence of ocular and systemic disease. It is hoped that optometrists providing this service would have ready access to ophthalmologists and other medical specialists for purposes of referral of those 4% to 6% of all patients who require medical attention.

Unfortunately, efforts to make optometric care available as a routine part of services provided in hospitals and extended care facilities have consistently been thwarted. Slow development in this area results from reluctance on the part of policy-making medical practitioners to permit the participation of optometrists in medically-oriented institutions. Conversely, optometrists are understandably reluctant to enter into arrangements which require abdication of the principle of peer review.

The American Optometric Association believes it is a completely logical proposition that Hill-Burton legislation, when modified, should allow for grants, direct loans or Federally-insured loans to optometric centers. These grants or loans should be authorized for free-standing clinical institutions as well as those which are fully integrated into other health care institutions.

Americans need the assurance that modern, professional visual care is made available in the growing comprehensive health care system. The benefits of optometric research and development conducted at these optometric centers should be put to optimum use for the visual health of all our citizens.

The American Optometric Association urges your approval of the following amendments to the legislation you have under consideration today:

1. "Effective with respect to projects approved under title VI of the Public Health Service Act after June 30, 1969, section 605(e) of such Act (42 U.S.C. 291e) is amended by inserting before the period at the end thereof ", (3) a nonprofit private agency which provides or will, on completion of the project for which such application has been filed, provide services primarily for persons in urban or rural poverty areas, as determined in accordance with criteria in regulations.

(NOTE.—An alternative to the above would be the repeal of section 605(e) of the Public Health Service Act.)

2. Amend section 625(f)(2) of the Public Health Service Act to read:

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

Both amendments No. 1 and No. 2 above are needed to effect the desired change in the law.

Enactment of the above amendments as part of the Hill-Burton extension before you would clearly indicate the awareness of this Congress that professional visual care is equally as important to the health and well-being of the general population as dentistry and other types of professional health care.

These amendments would allow for Hill-Burton support to the free-standing optometric centers operating today, and would provide impetus for inclusion of visual care facilities in neighborhood and comprehensive health centers authorized by other Federal programs as well as those which could be established in conjunction with unions and other third-party health care plans with third-party backing.

Renewal and modernization of the Hill-Burton Act is urgently needed. The American Optometric Association asks your support for inclusion of visual care as a vital element in updating the law to encourage health care centers which are truly comprehensive in nature.

Thank you for your consideration of our proposal.

PREPARED STATEMENT OF JOHN B. DE HOFF, M.D., M.P.H.,[1] ASSISTANT COMMISSONER OF HEALTH, BALTIMORE CITY HEALTH DEPARTMENT

The Baltimore City Health Department has had a major interest in the delivery of comprehensive medical care to its indigent and medically indigent

[1] Experience upon which the following testimony is based includes four years as Assistant Commissioner for Local Health Services in the Baltimore City Health Department; chief participant in the planning, development and operation of Baltimore's Provident Hospital Comprehensive Neighborhood Health Center; chairman of a planning committee for a large health manpower consortium in Baltimore; executive secretary for an association of metropolitan Baltimore emergency department chiefs.

residents since 1946, when its Medical Care Program was begun. Twenty years before Title XIX medical assistance programs went into effect, my Health Department financed and supervised a comprehensive sort of care involving selected hospitals and private physicians. Within the past three years, we have become increasingly involved in the medical care service field, helping to initiate new programs in hospitals and carrying on original evaluation studies of medical care delivery effectiveness.

We are pleased to see funds proposed for the construction of ambulatory care centers not necessarily a part of the physical plant or administrative structure of a general hospital. Although hospitals give excellent inpatient care for complicated or special cases, they cannot easily prevent disease from developing, or furnish home care to acutely or chronically ill persons, or follow closely their patients after discharge. Newly developing configurations of health professionals for other types of group practices can give a wide range of diagnostic and treatment services for patients who are primarily ambulatory, can provide personal preventive services and health education, and can provide some home care. In fact, modern health departments have highly developed preventive services and health education programs, and my Department has offered to provide these to any formally constituted comprehensive medical care group.

The construction of comprehensive ambulatory care *simplexes*, at some distance from a major hospital *complex*, will help free up this primary care from the strictures of hospital administrative structure, from confines of hospital buildings erected for a different type of care, and will go far to lessening hospital admissions for essentially diagnostic procedures. Money should be available for new buildings to meet the requirements of new forms of health care delivery. In Baltimore, at least, few existing buildings can be found which meet the criteria for new health centers. We have found that proposed alterations of warehouses, garages, or theaters leave much to be desired and result in many unsatisfactory architectural and professional compromises. Few large buildings exist in the old or deprived areas, and many of these are relatively inaccessible to patients. Special requirements of medical buildings for these new forms of ambulatory care are best and most efficiently met by new construction.

As regulating and licensing officials for Baltimore's ordinance governing commercial ambulances, and as the public health agency member of an informal group of twenty metropolitan Baltimore emergency department chiefs, we regularly see the need to modernize emergency medical systems and hospital emergency departments. Therefore, we strongly support any provision which would grant or loan monies for the modernization of general hospital emergency departments.

We approve new funding formulas based upon populations of indigent or medically indigent persons. Baltimore and other large cities have seen physicians who render personal or primary care move out to suburbs and counties, as their churches and businesses and allied professionals have done before them. Health centers must be easily accessible, not only to patients but also to physicians, in order to encourage competent primary or managing physicians to return to areas of need. Suitable incentives, such as excellent salaries and some firm career pattern, must be offered if one expects to attract good personnel. Ambulatory care centers, now located in poverty areas, represent a high risk endeavor to physicians, and plunge all professional personnel into a career of hard work with patients from the culture of poverty and at salaries and under conditions which often duplicate existing crowded public clinics.

In summary, the Baltimore City Health Department approves the inclusion of construction for comprehensive ambulatory care centers not necessarily a part of general hospitals, additional funds for modernization of hospital emergency departments, the provision of some latitude for the state agency to favor the construction of these ambulatory care simplexes, and a formula which bases federal allotment on the number of indigent or medically indigent persons residing within a given area.

We believe that there are several unmet needs. *First*, physicians do not possess skills in management, supervision or administration which ambulatory centers will require. Therefore, we suggest that some requirements or provisions for such training be established. *Second*, small hospitals and small physician groups lack the staff and experience to apply easily for grants or loans. These small groups may require either funds for planning or assistance, or the procedures for application may be simplified. *Third*, accounting procedures for small groups should be made simple. Perhaps the tedious and time consuming process of refunding could be permitted without undue redocumentation. We believe

that as small groups gain experience, the degrees of accountability and bookkeeping could be increased according to a predicted scale. *Fourth*, manpower training programs must parallel building construction for centers delivering health services in a new manner. Just as the military schedules their recruitment and training to meet activation or replacement manpower needs, so must medical administrators prepare personnel to fill roles now being planned. Otherwise, these new centers will draw their staffs from existing and undermanned valuable health resources.

My Health Department is also engaged in manpower programs and studies, understanding that these health *simplexes* will require trained and skillful staffs. It is currently involved in planning a series of neighborhood health centers, possibly numbering as many as twenty, to be operated by private, public or voluntary groups.

The Baltimore City Health Department is vitally interested in these amendments.

PREPARED STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

The 2,500,000-member National Council of Senior Citizens sees an urgent need for the reorganization of today's fragmented health care services so adequate health care is made available to all Americans efficiently and economically.

The National Council, largest organization of older Americans, asks that the Hill-Burton program be used to encourage development of health services to meet the health care requirements of all our people.

Especially, the National Council seeks greater emphasis on keeping people well so there is less need for hospitalization.

The 20,000,000 Americans age 65 or over have much to gain by an expansion of the Hill-Burton program to assure easily accessible health services in every U.S. community.

Four out of five men and women age 65 or over have chronic ailments or disabilities requiring medical care.

A third of those 65 or over live at or below the poverty line in areas where getting adequate health care is difficult—sometimes impossible.

The National Council of Senior Citizens strongly supports extension of the Hill-Burton program on an expanded basis with the emphasis placed on development of comprehensive coordinated health services.

In particular, the National Council of Senior Citizens asks that Section 605(e) of the Hill-Burton Act be broadened to encourage non-profit community groups to sponsor health centers. The present section 605(e) unfortunately restricts sponsors of health centers to hospitals or public agencies.

In brief, the National Council asks that the Hill-Burton Act be extended and expanded to spur development of comprehensive, coordinated health care services, such as home health services provided by local health centers, as well as health care facilities including much needed facilities for long term care.

PREPARED STATEMENT OF THOMAS J. KENNEY, PRESIDENT, B. C. ZIEGLER & CO., WEST BEND, WIS.

While our presentation could have been much more involved, I would like to present to you herewith three thoughts our Company has concerning the legislation, namely:

1. That the loan guaranty program be set up in such a manner which will provide that said loans may be evidenced not only by straight mortgages but also by bond issues such as are underwritten by B. C. Ziegler and Company and other companies in the field. This is not permitted under FHA loan procedures. However, FHA requires that we sell the bonds only to approved FHA mortgagees. The effect of this is to eliminate the sale of these bonds to any individual.

To eliminate the individual and to prevent him from buying these bonds forecloses the opportunity of tapping important sources of money which is available to loan to hospitals for construction purposes. Our Company's annual rate of bond sales for hospital loans this year is $120 million, in and of itself almost one-third of the amount authorized under the loan guarantee program included in your bill. *At least 90% of these bond sales are to individuals.*

As you can see, if the bill does not make individuals eligible to purchase these guaranteed bonds which could be issued under your proposed legislation then you eliminate automatically for our Company alone about $108 million of funds available for this purpose.

In effect, you require the hospitals to go to banks and other saving institutions and insurance companies for their financing. Today this segment of the money market has hardly any funds available for hospital loans, and so even the guaranty program can not help to solve the situation.

2. We have talked with many institutional lenders who purchase our bonds. They constantly criticize loan guaranty programs which provide that the payment of principal and interest through operation of the guaranty is in debentures bearing a low rate of interest. Today these sources of money have absolutely no interest in guaranties which do not provide for payment in cash under the guaranty.

It is also very important that payment through the guaranty not be dependent upon an appropriation by Congress. The secretary of HEW must be given the authority to borrow the money from the federal government in case funds are not available for this purpose through Congressional appropriation.

Currently FHA loans under Section 235 provide for interest subsidies for home loans. There is no market for this type of loan because too frequently FHA will not make the interest subsidy payments on time and when due. Delays as long as six or nine months have absolutely killed the market for these loans.

3. There should be some safeguard whereby the secretary of HEW, or some subordinate, does not determine "a reasonable interest rate" which is way below the market. This is what has created such great difficulty with FHA loans. Today the maximum interest rate on such loans is 7½%. Consequently, there is hardly any market for the large FHA loans. When a market is found, the borrower is required to pay a very deep discount, often as much as six to ten points. We in the hospital finance field know that one of the troubles the hospitals have is a shortage of cash, and so when they have to pay six to ten points off the top of the loan they do not have enough money remainiing to complete construction and equipment costs.

Senator Nelson has suggested that we send a copy of this letter to the Senate Health Subcommittee, and we are doing just that. No doubt this letter will also end up in your office, but we do want to be sure. I am also sending copies of this letter to Senators Nelson and Proxmire and also to Representative William Steiger.

Any consideration which you can give to our suggestions will be very much appreciated. Also, I sincerely believe that they will do much to make the loan guaranty program a workable and practical program which is very valuable.

STATEMENT OF WALTER J. MCNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION

Mr. Chairman and distinguished Members of the subcommittee:

I am grateful for this opportunity to submit for your consideration my views on S. 2182—the extension and modification of the Hill-Burton hospital construction program. This renewal comes at a critical juncture in the evoluation of the American health care system and presents an unparalleled opportunity to the Congress, the Executive Branch, and the health establishment to participate in the redesign of this vital program which in its first 23 years allocated over 3 billion dollars in grants to the states for hospital and allied health facilities construction.

The Blue Cross Association, speaking in behalf of its 75 Member Plans (who collectively provide hospital benefits to more than 68 million American citizens of all ages, and provide administration of federal government programs to an additional 24 million persons), supports the general provisions of S. 2182 concerning the extension of the present grant authority and the establishment of new loan programs for hospital construction and modernization. In expressing our support for this bill, I should like to offer a few observations on future needs in the hospital facilities field as they relate to provisions in the bill.

Senator Yarborough and the other members of the Committee are to be commended for introducing language into S. 2182 which would permit nonprofit outpatient facilities to be eligible for Hill-Burton funds. This change is much needed and will allow health professionals to evaluate more accurately the advantages and disadvantages of this particular medical care format in terms of its impact on costs and quality.

The present Hill-Burton legislation provides priority to rural areas through the allotment provisions relating to the distribution of federal funds to the States and the distribution of these funds within the States. When the program was first proposed in 1946 there was a crying need for the construction of hospital facilities in rural areas. Over the years, however, with the rapid urbanization of our population and the exponential growth in medical technology, it has become clear to many people in the health field that major needs have arisen in urban areas as well. What is needed is a balanced allotment formula which will recognize the needs of both areas. A correction in the present allotment formula should not shift the imbalance in another direction.

Because this legislation calls for a 5 year renewal of the Hill-Burton program and has potentially such a broad impact on the capital structure of the health field, it should be designed to provide not only badly needed funds, but to improve the access and productivity components of the field.

PLANNING

Further expenditure of capital funds, either through grants or loans should be related more symptomatically to the process of planning. I applaud the action taken by Senator Yarborough and the members of this Committee in writing planning provisions into the bill which provide the local areawide planning groups with an important input into decisons concerg health faclites costructon and modernization. These local agencies have been underutilized in the past and will never develop an acceptable level of planning expertise unless they are utilized more fully.

At the state and local levels there is a vital need to pull together all of our present disparate planning efforts such as comprehensive health planning, regional medical programs, Hill-Burton and other federal health programs. Presently they leave important gaps, often fail to be mutually reinforcing and at times are contradictory.

The Blue Cross Association in a recent policy statement [1] pointed out that the heart of planning lies in the individual institution where the process serves management in clearly focusing on community needs and the development of efficient means for meeting them. As mentioned, a properly designed capital structure can have a favorable influence on cost, use and accessibility of health facilities and services. However, none of these things can happen unless the hospital itself makes plans for the future. It would be valuable to tie Federal monies for hospital construction and modernization to a requirement that the hospital promulgate a short and long term plan for physical structure and program. This would not be designed to influence the way in which a hospital would operate, but rather to provide an incentive for the hospital to project its needs in such a way that planning bodies at the community level, the regional level and state level can make realistic decisions taking into account institutional input.

INNOVATION

I should again like to commend the Committee for the language in Section 113 of the bill which provides that "the federal share shall, at the option of the state agency, be equal to the percentum provided plus an incentive per centum (which shall not exceed 20 per centum) specified by the State agency in the case of projects that offer potential for reducing health care costs through shared services among health care facilities, interfacility cooperation, or dispersed ambulatory care centers." This language represents well the principle of the selective use of federal monies to promote innovation in the health field. Further in this vein, grants should be used as much as possible to encourage innovation and to promote greater productivity while loans with grants should be used to sustain the basic capacity of the system.

PRIORITIES

S. 2182 outlines in Section 110 seven priorities with respect to applications approved under Title VI for construction and modernization. BCA supports these priorities particularly priority No. 4 dealing with the relationship of long term care facilities to general hospitals and priorty No. 6 dealing with comprehensive health care.

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[1] BCA, Statement of Policy on Planning of Health Facilities and Services, 1968. (Attached.)

Priority No. 5 which deals with projects for construction and modernization that will be located in, and provide services for the residents of, areas determined by the Secretary to be metropolitan areas with low per capita income is extremely important. Recognizing that the need for ambulatory care in poverty areas exceeds the need for such care in wealthy communities, some concern should be expressed about tying ambulatory care only to low income areas when, in fact, ambulatory care is a major problem in both rich and poor and urban and rural settings. There is a need to rationalize ambulatory services in all income neighborhoods. This is one technique which holds a great deal of promise for reducing costs and lessening fragmentation.

There is need not only to redress the balance between bed care and ambulatory care, but to provide for broader opportunities for doctors working in groups to develop broader benefit programs. The design of Hill-Burton assistance should encourage close working relations of groups with general hospitals and rule out eligibility for assistance where such regrettable impediments as staff privilege based on other than qualitative factors are involved.

RESEARCH AND DEMONSTRATION

Health services research and demonstration activities should be an integral part of any comprehensive facilities construction program. To date there has been a severe lack of funds. It is almost inconceivable that a $50–60 billion industry such as the health industry would spend less than 1% of its income on research and demonstrations leading to improved care and greater productivity. I urge the committee to make every effort possible to ensure adequate funding in this area.

CONSTRUCTION AND MODERNIZATION

The subject bill provides for the extension of the existing authority for construction and modernization grants as well as new programs for loan guarantees for construction and modernization and direct loans for the construction and modernization of public hospitals and other public medical facilities. There has been a great deal of discussion of late about the relative needs for hospital construction and modernization. Little has been said however about the varying needs of the states for both types of monies. While it is true that modernization requirements in urban areas out distance new construction needs, the difference between new construction and modernization is sometimes a semantical one. If we are serious about developing planning expertise in the health field at all levels of government, we may want to explore the possibility of giving the states the authority to determine their own modernization and construction needs and priorities.

LOAN GUARANTEES

It is important that guaranteed loans for the construction and modernization of hospitals and other medical facilities be geared to the planning process. As a major prepayment agency Blue Cross knows fully well the effect of interest rates on hospital bed charges and the relationship of inefficiencies in the development of capital structure to increased costs at the bed side.

Section 623B (5) of the present bill states that the secretary shall "determine that the terms, conditions, maturity, security (if any), and schedule and amounts of repayments with respect to the loan are sufficient to protect the financial interest of the United States and are otherwise reasonable and in accord with regulations, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States." I think that it might be helpful here to insert a clause which would prevent a hospital from borrowing money while it is collecting income on its own unencumbered funds. There is little reason for the Federal government to reimburse the hospitals for the expenses incurred in borrowing money when they have unemcumbered funds in the form of endowments, etc. which could be used for the same purposes. At present, Blue Cross Plans try to place some limitations on this sort of activity and I think that it would be beneficial for the Federal government to do the same.

DIRECT LOANS FOR PUBLIC HOSPITALS

The need for such loans is, of course, subject to many exceedingly complex financial considerations. The advantages that public facilities have in raising

funds through tax exempt bonds is often offset by the financial straits of our cities and the increasing reluctance of tax payers to assume additional tax burdens. The financial bind that exists in the cities often places public medical facilities at a disadvantage in obtaining capital funds.

Also, it would be well for federal money to be made available under the program to assist selective communities on a direct basis without local or state matching funds where poverty is pervasive and there is an urgent need to solve access problems. Such projects would necessarily be coordinated with Neighborhood Health Center, Model City, and Community Mental Health Facilities programs.

Blue Cross has recognized the need to relate its payments for capital purposes to the planning process and its corollary obligation to strengthen that process. Blue Cross Plans have been instrumental in the organization and support of many areawide planning agencies through participation in their boards and committees, provision of support services, ranging from personnel, housing, data collection and processing and direct financial support which has now reached an annual level of more than one half million dollars. We are now exploring incentive payment methods to promote greater productivity in the health field and prevent health expenditure increases from being absorbed by price changes as opposed to service increases. It makes little sense to pour large additional monies into a system that lacks adequate built-in safeguards such as planning and research and development which would serve to translate these additional monies into increased productivity.

The American Hospital Association has also recognized this fact and published relevant policy statements.[1] If the federal government were to join such efforts by coordinating the control programs it sponsors and spending its monies to reinforce the general patterns and objectives set forth, we could hope for some moderation in the costs of services and an improvement in the quality of such services for the poor and rich alike.

[1] American Hospital Association, Statement on the Financial Requirements of Health Care Institutions and Services, 1969. American Hospital Association, Statement on Planning, 1969.

PREPARED STATEMENT OF JOHN W. SCOTT, MASTER, NATIONAL GRANGE

The National Grange, a rural-urban family organization, composed of 7,000 community Granges located in 40 of our 50 states, has a long history of interest in matters pertaining to public health and welfare of our citizens, with a special interest in the health problems of rural America.

It is basic Grange policy that it is a proper function of the Federal government to assist State and local governments in the construction of hospitals and other medical facilities. The legislation before this committee is the continuation and improvement of that function. Therefore, the National Grange is in support of S. 2182, a bill to amend the Public Health Service Act to revise, extend, and improve the program established by title VI of such Act.

As early as 1944 the Grange policy on Health stated:

"Consideration be given to support of expanding federal and state aid for the erection of hospitals, supplying of medical equipment, and training of personnel for medical care, so that the cost of these may be reduced as well as making more of them available."

In 1945, our policy was restated as follows:

"Since many rural families and rural areas are too poor to support doctors and hospital services even with any form of health insurance, public or private funds should be combined with insurance funds to equalize the ability of these families and these areas to secure and maintain needed health services.

"The people and doctors in every rural area should have access to modern diagnostic facilities and a hospital of good standing.

"Since many rural areas cannot provide these facilities and services through their own efforts alone, state and federal funds should be made available for the construction of new hospitals and the improvement of some existing hospitals serving rural areas, but with the management of these institutions remaining in the hands of local people."

Adequate diagnostic and hospital facilities and stabilization of paying power through private as well as public insurance are not only important for enabling rural people to secure modern medical services, but they are vital prerequisites

for attracting and holding physicians, dentists, nurses, and other health personnel in rural areas and assuring them of stable incomes.

While the rural community may no longer be bound together by the mutual interest of farming, there is still most definitely a rural community, tied closely to agriculture, with problems differing somewhat from those of the urban community.

Rural America has one-half as many physicians and one-third one many dentists, in proportion to population as does urban America.

Rural America, with one-third of the population, has one-half of the nation's poverty. While the national rate of unemployment averages 3.5%, the rate in rural areas is 18%, and among farm workers runs seasonal highs of 37%.

Infant mortality is far higher among the rural poor than the least privileged group in urban areas.

These statements may not apply to each rural community, but they are averages according to a recent report of a Presidential Commission entitled "The People Left Behind."

Accidental deaths are startingly high in rural areas. Farming is rated as the third most dangerous occupation, exceeded only by mining and construction.

Accidental deaths on the rural highway, likewise, are unusually high. This high rate may be due, in part, to three things: (1) a longer delay in locating the person who needs help; (2) a longer time span between the emergency treatment and expert medical attention; and (3) inadequate emergency room equipment and hospital facilities of many rural communities.

We fully realize that urban areas are in need of new hospital facilities as well as modernization of present facilities; therefore, we are strongly in favor of permitting each state to decide, through its own health facility plan, how the funds allocated to the state should be disbursed between rural and urban areas. However, we hasten to point out that we still are of the strong opinion that the health needs of rural America are far from being adequately met, in proportion to our urban counterpart, and we therefore urgently request that the main thrust of additional amending legislation to the Public Health Service Act should be to alleviate the poor health facilities of rural Americans, truly the people left behind.

At the present time, this Congress is considering several bills to, *First:* Increase employment opportunities in rural America; and *Second:* Stem the flow of rural people to our already overcrowded urban areas. The primary method being advanced is to encourage industry to locate new plants in rural America, thereby meeting both needs, providing gainful employment in rural communities, which in turn will slow down, if not reverse, the migration from rural areas to urban centers.

All of private industry's efforts and the Federal government's efforts to reverse this trend by providing increased job opportunities in rural areas will fail if such communities do not have the local facilities that industrial management looks for before locating new manufacturing facilities. High on this list of requirements for plant sites is adequate medical facilities, including, but not limited to, accredited hospitals and emergency room facilities. Doctors, nurses and other medical attendants will not normally be available in rural areas without modern hospital facilities.

We also hear a lot about the need in the near future of 100 new towns of 500,000 population to meet the needs of our growing population. We submit that it will be far less costly to American taxpayers to utilize the county seat towns and other small-to-medium rural communities as a nucleus for such expansion than to start from the bare ground to build a town. This may not be true in all cases, but it would be in the great majority of situations. In addition to being more economical, it would, at the same time, help revitalize rural America.

First and foremost, before present small town and rural communities can be so utilized, they need financial help in constructing, among other things, adequate and modern hospital and medical facilities.

It is for these reasons that the National Grange is in support of legislation like S. 2182, but we want to strongly emphasize that, *One:* Medical needs of rural America have not been adequately met; and *Two:* If rural development is to become a reality, increased funds are needed to provide our rural communities, the cities of tomorrow, with adequate and modern hospital and medical facilities. In our judgment, it would not be in the best interest of America to re-direct the thrust of Federal grants and assistance for such facilities from rural areas to urban centers.

PREPARED STATEMENT OF JERRY VOORHIS, FORMER MEMBER OF CONGRESS AND VICE PRESIDENT OF CONSUMER FEDERATION OF AMERICA

Among the bills under consideration by the Senate to amend the Hill-Burton Act are the bills introduced by Senator Percy of Illinois and Senator Yarborough of Texas.

Both these bills lay emphasis on the Neighborhood Health Center or Outpatient Clinic as a basic factor in improvement of community health and, particularly, in meeting the needs of the most disadvantaged and deprived people from a healthcare standpoint.

It is altogether evident from experience thus far gained in programs carried on in many fields that services and opportunities must be brought *to* the people of the core cities—the poor people especially—if they are to benefit or their poverty to be overcome.

This is the central concept of the Neighborhood Health Center. Experience with O.E.O. sponsored health centers has been almost universally good. The health of the neighborhoods served has been improved, participation by the people has steadily increased, and even in some cases a sense of ownership has begun to emerge. Another gain has been to overcome the low priority placed on health by many low-income families simply because of the cost and inaccessibility of decent care.

Our low-income people simply will not travel long distances to fancy facilities to obtain the health care they need. But they will come to Neighborhood Health Centers or Outpatient Clinics in their own neighborhoods for the day-to-day care they so desperately need.

The formula contained in Senator Percy's bill which would allocate available funds on the basis of the number of medically indigent people in an area also recommends itself if Hill-Burton is to reach the population groups whose need is most acute.

It is to be assumed that Neighborhood Health Centers will develop the closest practicable relationship with central teaching hospitals—wherever possible becoming, in effect, outpatient clinics of such hospitals. Better yet, that where group practice-prepayment health plans exist, efforts will be made to relate the populations served as Neighborhood Health Centers with such plans, as has been done so successfully by Health Insurance Plan of Greater New York, Bellaire Clinic at Bellaire, Ohio, and the Kaiser Health Plan of Portland, Oregon.

But the core emphasis and the beginning of the task of upgrading the health of our neediest people must and should be focused on the Neighborhood Health Center as the unit best calculated to meet outstanding need *where it exists.* And under circumstances where over time, true constructive participation by the poor in solution of their own health problems can be developed.

U.S. SENATE, COMMITTEE ON COMMERCE,
June 3, 1969.

Hon. RALPH YARBOROUGH,
Chairman, Labor and Public Welfare Committee,
New Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN. It was recently brought to my attention that S. 1589 does not mention its application to some of the holdings of the United States, particularly the Virgin Islands. I would hope that under Section 9, Subsection a, Page 9, the bill would be expanded to mention all the territories.

This was an oversight on my part, and I certainly hope that your Committee will recognize that I did not intend for this bill to have a limited application.

Best regards.

Sincerely yours,

WARREN G. MAGNUSON,
U.S. Senator.

KAISER FOUNDATION HEALTH PLAN, INC.,
Oakland, Calif., June 13, 1969.

HON. RALPH W. YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: The Kaiser Foundation Medical Care Program conducts the largest prepaid comprehensive group practice health care program in the United States. At present, our program provides most of the hospital and medical care services for more than 1,800,000 persons through 19 hospital-based health centers and 47 outpatient facilities. These facilities are located in the metropolitan areas of San Francisco, Sacramento, Los Angeles and San Diego, California; Portland, Oregon and on the island of Oahu, Hawaii. We have recently added a new service area in Cleveland, Ohio and we will begin operations in Denver, Colorado on July 1, 1969. Professional services to health plan members in each of the operating regions are provided by independent groups of physicians.

The Committee has scheduled hearings on S. 2182, cosponsored by yourself and other members of the Committee, which would extend and modify the federal program of financial assistance for the construction of hospitals and other health care facilities. We would like to take the opportunity to give our support to the passage of S. 2182 and to comment on certain issues raised by your bill and H.R. 11102, as passed by the House of Representatives.

1. The existing Federal program has done much to assist communities in meeting the need for hospital construction in many areas of the United States. As population increases, and as demand for medical services continues to rise, there is a continuing need for programs of Federal assistance, particularly in poorer communities. S. 2182 would extend the existing construction grant programs and recognize the need for increased emphasis on the modernization of existing hospital facilities. We believe that the extension of the Federal grant program at this time is sound.

2. The bill provides for the creation of a new loan guarantee program, under which the federal government would guarantee private lenders against the risk of loss on loans extended by them for hospital construction or modernization. The Kaiser Foundation Medical Care Program has in the past supported the development of new methods of financing for hospital construction and modernization. Thus, in the 89th and 90th Congresses, we supported the new program of mortgage insurance for the construction of group practice medical, dental, and optometric facilities; and the new program of mortgage insurance for hospital construction and modernization. The need for up-to-date hospital facilities and outpatient facilities in this country continues to be so great that we believe all of these forms of financing are necessary and desirable, and it is our hope that the entire range of financing programs will, to the maximum feasible extent, be coordinated administratively and in the law. The addition of a new interest-subsidized loan program, proposed in S. 2182 and in S. 269, introduced by Senator Javits, would in our view be desirable, adding yet another option to the range of financing mechanisms embodied in the Public Health Service Act and the Housing Act.

3. We wish particularly to give our strong support to the provisions of Section 110 of S. 2182. Those provisions would add new considerations to the assessment of project priority. The new subparagraphs 603(a)(4), (5), (6), and (7) would require the state agency to determine project priority under a revised set of standards which would, more nearly than the existing standards, reflect the strong need to improve the quality of health care and to change the pattern of the delivery of health services. All of the new requirements seem to us to move in a desirable direction, and we give them our wholehearted support. *The most important aspect of S. 2182 for prepaid group practice organizations such as ours would be the recognition given to the efficiencies of comprehensive health care systems by the addition of subparagraph 603(a)(6).*

This amendment would stimulate planners to recognize that the lower inpatient utilization experienced by comprehensive health care programs means that fewer hospital beds are needed to provide medical care to the portion of a community served by such programs.

4. We also support the provisions in Section 623 of S. 2182 which would permit the Secretary to determine the responsible maximum rate of interest on loans based upon current market factors. The further provision included in H.R. 11102 as passed by the House, which would require the Secretary to determine

that a loan applicant cannot otherwise secure the loan on reasonable terms and conditions, is not necessary and might delay applications and reduce the effectiveness of the proposed legislation.

5. Section 111 of S. 2182 contains provisions which would alter the process of planning for health care facilities by requiring that areawide health planning agencies be given the opportunity to consider a project prior to approval by the state agency. Planning is desirable, and the Kaiser Foundation Medical Care Program has been among its foremost practitioners. However, prepaid comprehensive group practice programs represent a fundamentally different method of organizing health care services. They represent a systematic approach with definite, demonstrable efficiencies in the provision of health care services. Because they represent a fundamentally different form of organization, the considerations in planning for facilities and services are not necessarily the same as they are in the case of other health care facilities or organizations. There may be quite different considerations in determining whether a hospital or outpatient facility is required in the case of a comprehensive prepaid group health plan than in the case of the ordinary nonprofit community hospital. We have no easy answer to this problem. We do not advocate prepared comprehensive group health care as a universal system. We do, however, strongly suggest that government policy should insure that this form of organizing care is one of the choices available to consumers in a competitive pluralistic health care system, regardless of the method of financing health care services or facilities. We suggest that a small step toward assuring such competitive pluralism might be achieved by modifying the language contained in Section 111 of S. 2182 to add language which would, in effect, bring Section 314(b) into line with Section 605(a)(3) by requiring that area-wide health planning agencies include at least "an equal number of representatives of consumers familiar with the need for the services provided by such facilities." It should also be noted that Secttion 314(a)(2)(B) presently requires that, for state-wide comprehensive health planning agencies "a majority of the membership of such council shall consist of representatives of consumers of health services." It seems even more important that consumer representation be provided at the local level so that those who reside in the area where the proposed facilities will be constructed can participate in the decision to approve or reject a particular application. As passed by the House, H.R. 11102 requires that the membership of an area-wide health planning agency include "appropriate representation of the interests of the hospitals, other health care facilities, and practicing physicians serving such area, and the general public." We believe that the language of the House-passed bill does not adequately carry forward the principle of consumer representation already embodied in related sections of the Public Health Service Act.

6. Section 115(3) of S. 2182 is of particular importance to the fostering of new prepaid group practice organizations. Hospital-based practice is the most efficient and effective form of medical care, and present law requires that the sponsor of an outpatient facility project own or operate a hospital. However, as applied to prepaid group practice organizations, this requirement is unduly restrictive. The whole concept of such organizations is premised upon providing *comprehensive* care. But new group practice organizations may not be able to justify direct operation of a hospital on the basis of their initial enrollments. In such a situation, the "reasonable assurance" arrangement which S. 2182 would incorporate into Section 605(e) would provide a workable solution which both allows the development of new prepaid group practice organizations and also assures the quality of care provided.

With those comments, Mr. Chairman, we urge that your Committee act favorably on S. 2182, to extend and expand the Federal program of assistance for the construction of hospitals and other health care facilities.

Sincerely,

ROBERT J. ERICKSON, *Counsel.*

KAISER FOUNDATION HEALTH PLAN, INC.,
Oakland, Calif., May 19, 1967.

JAMES H. CAVANAUGH, Ph. D.,
Director of Comprehensive Health Planning,
Office of the Surgeon General,
Bethesda, Md.

DEAR DR. CAVANAUGH: In a letter dated April 24, 1967 you asked Dr. Morris F. Collen of The Permanente Medical Group for his reactions and comments to pro-

posed draft regulations and policies governing Sections 314(a) and 314(b). Dr. Collen has asked me to reply on behalf of the Kaiser-Permanente Medical Care Program.

Our comments on the draft regulations relating to Section 314(a) are as follows:

1. Page 4. The following statement appears in the last paragraph on page 4 with reference to the state planning agency "in fullfilling its planning responsibilities, the Agency will necessarily work closely with other planning and operating government and nongovernmental agencies at state, regional and local levels. It is not expected to exercise administrative authority over such agencies."

If the state agencies will exercise no administrative authority over other planning agencies in the state, it appears to us that a substantial amount of confusion including inconsistent policies and actions is likely to result. The state agency should give overall direction to all the planning agencies in the state.

2. Page 13, paragraph 4. This section provides that "no person whose major occupation is the administration of health activities or performance of health services can be considered as a consumer representative." The examples indicate that a member of a voluntary health agency's board who is not in a health related occupation would qualify as a consumer representative.

We interpret this to mean that a trustee of a nonprofit hospital whose major occupation is not health related would qualify as a consumer representative. We believe that the term "consumer representative" not only excludes health professionals and others whose major occupation is the administration of health activities or the performance of health services but should also exclude persons who are in a policy making relationship with health facilities and health organizations. Trustees of boards of voluntary health agencies such as hospitals are likely to represent the interest of the hospital or other agency to which they owe a fiduciary obligation, rather than bona fide consumer interests.

3. Page 16. The last paragraph under the heading "Administrative Methods" provides that "in addition to seeking the advice of the Advisory Council, the Agency may wish to submit the comprehensive plan or major portions of it to public hearing, prior to adoption."

In view of the importance of such plans to many different elements of the community and to all consumers of hospital and medical care services in each state, it would be appropriate to require the Agency to submit the comprehensive plan for public hearing prior to adoption.

Section 314(b), page 4, Section III–2, creates the same problems with regard to consumer representatives that are discussed in comment Two on Section 314(a).

Part 51, Section 51.4(b), also creates a problem with regard to consumer representatives. The language "a majority of the council members must be consumer representatives whose major occupation is neither the administration of health activities nor the performance of health services" should be amended to read as follows: "A majority of the council members must be bona fide consumer representatives whose major occupation is neither the administration of health activities nor the performance of health services and who do not have a policy making relationship with any voluntary health care organization or agency."

We find the great bulk of your draft proposals to be consistent with the provisions of Public Law 89–749 and believe that, with the exception of the changes suggested above, you have formulated a framework that will enable the program to develop in a satisfactory manner.

Very truly yours,

ROBERT J. ERICKSON,
Counsel.

KAISER FOUNDATION HEALTH PLAN, INC.,
Oakland, Calif., August 4, 1967.

PHILIP R. LEE, M.D.,
Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, Washington, D.C.

DEAR PHIL: Scott Fleming asked me to get in touch with you regarding our *suggested amendment to regulations for P.L. 89–749* (health facility planning) as published in the FEDERAL REGISTER dated July 22. However, you have been

out of town so I am attaching a copy of the suggested amendment and making a few comments on what I have learned about this matter in the last day or two.

The suggested amendment, intended to limit consumer membership for the health facility planning bodies to true representatives of the public with no vested interest in existing health institutions or the traditional ways of providing health care, is supported by the AFL–CIO. Dr. Harold Herman, of the Planning Office in the Office of the Surgeon General, thinks this is too rigid and believes that people who have some connection with the "power structure" should be considered as public members for the purposes of the Health Facilities Planning program. Dr. Herman also told me that he did not think that a change in the regulations on this point was contemplated at this time.

I shall be returning to Washington in two to three weeks and at that time I hope to be able to see you for a few minutes.

Sincerely,

GIBSON KINGREN.

KAISER FOUNDATION HEALTH PLAN, INC.,
Oakland, Calif., August 9, 1967.

Mr. JOHN GRUPENHOFF,
North Building,
Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. GRUPENHOFF: Gibson Kingren has asked me to send you the enclosed material relating to the Kaiser Foundation Medical Care Program and several legislative or administrative matters in the health care field. The following material is enclosed:

1. A set of the Annual Reports, 1960–1966, of the Kaiser Foundation Medical Care Program.

2. A copy of comments on Senate Bill No. 283 that were submitted by Kaiser Foundation Health Plan. This bill relates to health facility planning and was introduced by Senator Anderson.

3. A copy of the statement of Kaiser Foundation Health Plan which was submitted to the House Committee on Interstate and Foreign Commerce on H.R. 6418. A proposed amendment to H.R. 6418 is attached to the statement as Exhibit A.

4. A copy of a proposed amendment to Section 51.4(b) of the Regulations adopted pursuant to Public Law 89–749, Part 51, Chapter 1, Title 42, Code of Federal Regulations. The third sentence of subsection (b) would be amended to read as follows:

"The majority of the council members must be bona fide representatives of the consumer public whose occupations are neither the administration of health activities nor the performance of health services, who have no fiduciary obligation to a hospital or other health agency and who have no material financial interest in the rendition of health services."

The purpose of this amendment would be to go as far as possible to assure that a majority of the members of state health planning councils would be primarily interested in the consumer (the patient or potential patient) and would not be representatives of vested interests in the health services field. For example, the president of an industrial corporation who is also the trustee of a large community hospital would be an eligible consumer representative under the regulations as written even though as a trustee of the community hospital he would owe a fiduciary duty to that hospital to act in its best interest. Our proposed amendment would also exclude wives of physicians or hospital administrators who have a material financial interest in the rendition of health services. If planning councils are going to have the power to determine who gets construction grants, Medicare payments for depreciation, Blue Cross payments and other matters vital to the survival of hospitals, then the tribunal should be as fair and impartial as possible.

Very truly yours,

ROBERT J. ERICKSON, *Counsel.*

ENCLOSURE A

REGULATIONS FOR P.L. 89–749 AS THEY APPEAR IN THE FEDERAL REGISTER OF JULY 22

"The majority of the public members must be consumer representatives whose *major occupation* is neither the administration of health activities nor the performance of health services."

The Proposed Language reads as follows:

"The majority of the council members must be bona fide public representatives of the consumer public whose occupations are neither the administration of health activities nor the performance of health services, who have no fiduciary obligation to a hospital or other health agency and who have no material financial interest in the rendition of health services."

COLORADO MEDICAL SOCIETY,
Denver, Colo., June 23, 1969.

Senator PETER H. DOMINICK,
U.S. Senate,
Washington, D.C.

DEAR SENATOR DOMINICK: We appreciate the opportunity to present some of our views on the legislation being considered to extend and expand the program of federal aid for the construction and modernization of hospitals and other medical facilities.

We would, of necessity, hope to make our comments brief. First, we believe that the emphasis for the continuance of construction and modernization through the Hill-Burton program should be continued. Certainly we feel that the priority for modernization and up-grading existing facilities is of primary importance. Therefore, we support the continuation of the grant program for the construction and modernization.

In reviewing HB 11102 and HB 2182, we feel that both bills seek the same objective. We wish to state however that we support the provisions which would permit the transfer of certain funds upon request of any state from one allocation to another. We feel that this provision is most important and this flexibility would merit support.

Since Colorado, for all intents and purposes, is a rural state that has a large number of public supported hospitals, we feel that the provisions for loan guarantees to both public and non-profit facilities is desirable. An exclusion of the public hospitals could seriously affect as many as 16 counties in Colorado in which the only hospital in the community is a public supported hospital.

While the Medical Society is not fully conversant with the squaring factors now used, and while we are cognizant of problems large industrial centers may have relative to the use of this factor in allocating funds, our major concern would be that should the squaring factor be deleted we would not want any diminution of support than we are now experiencing. We understand that Colorado could possibly lose as much as $112,000 annually out of a 2.8 million dollar allocation, therefore we would urge the rentention of the squaring factor.

HB 11102 amends priority provisions of the law by allowing priority to rural communities at the option of the state. We believe this flexibility is desirable.

Both bills contain provisions for extended care facilities to be affiliated with hospitals and we believe that adding a priority for grants with affiliated extended care facilities is appropriate.

Both bills have the provision calling for consideration by a 314(b) agency, the local areawide planning agency. We support this provision of local planning effort. However, we feel that such local consideration should relate to the Hill-Burton Advisory Committee rather than the 314(a) agency.

The legislation indicates a special need for the improvement of emergency room facilities. We recognize the increase in use of such facilities and that there may be a special need for their modernization. Our position, however, would be that the granting of such funds be channeled through the state Hill-Burton agency.

Sincerely yours,

DONALD G. DERRY,
Executive Secretary.

U.S. SENATE, COMMITTEE ON COMMERCE,
Washington, D.C., June 17, 1969.

Hon. PETER DOMINICK,
U.S. Senate,
Washington, D.C.

DEAR SENATOR: Enclosed is correspondence from William Wilson, Administrator of the Mary Hitchcock Memorial Hospital in Hanover, New Hampshire, as well

as an exchange of remarks in the House of Representatives between Congressman James Cleveland of New Hampshire and Congressman Harley Staggers during the debate on H.R. 11102. I shall appreciate it if you will have this material included in the record of hearings on S. 2182.

You will note from this correspondence that the Hospital is in a unique situation and would be much interested in having language included in the bill to assure that it be given consideration by the State Agency in obtaining interest assistance in connection with the loan on construction already underway.

Should your thinking coincide with mine on this point, I would be grateful for your assistance in obtaining such language or in making a record in the Committee and in the Senate which would not preclude a State Agency from giving assistance to hospitals where construction has already begun.

Regards.

Sincerely,

NORRIS COTTON,
U.S. Senator.

MARY HITCHCOCK MEMORIAL HOSPITAL,
Hanover, N.H., June 10, 1969.

Senator NORRIS COTTON,
Senate Office Building,
Washington, D.C.

DEAR NORRIS: As you are probably aware, the House unanimously passed the Hill-Burton Extension Bill, HR–11102. The vote was unanimous and the bill referred to the Senate Labor Committee's sub-committee on health, which has scheduled hearings on June 12, 17 and 19.

You may remember our correspondence in the early days of the consideration of this legislation, which referred specifically to the Mary Hitchcock concern over our present construction project and its qualification for eligibility under the interest subsidy provisions of the Bill. We worked on that actively with the help of Jim Cleveland, who along with others in the process of the Bill's progress through the Committee, proposed specific language which would permit eligibility for projects begun prior to passage of the legislation, but not completed until after; and more specifically, projects on which final long-term financing was not to be committed until after the effective date of the proposed legislation. It was not possible to make the suggested changes, and obviously the unanimity of the House in passage of the Bill as written would indicate to this unsophisticated observer of the legislative process that further efforts to amend would probably not be appropriate.

However, Jim Cleveland did engage in floor conversation with Mr. Staggers, who I believe was the sub-committee chairman in the House responsible for the final development of HR–11102. In this exchange, Jim got into the Congressional Record for June 4, 1969, pages H–4458 and 4459, comments which quite likely might be successfully used in pursuing the Mary Hitchcock case with the state agency charged with activating terms of the proposed legislation.

I wonder if someone in your office could check this matter to determine the wisdom or not of some similar strategy as HR–11102 proceeds through the Senate sub-committee hearings and later action.

We will be terribly appreciative of any appropriate stand you may have occasion to take in connection with HR–11102 as it can hopefully assist in the establishment of eligibility for projects such as the one being undertaken here in Hanover where Trustee wisdom and courage results in an early undertaking saving hundreds of thousands of dollars in terms of simple timing, and without any Governmental support whatever; but with the distinct hope that appropriate Government might be forthcoming to permit minimizing the burden placed on New Hampshire residents and others who will be purchasing service from Mary Hitchcock in the future, and therefore carrying a major portion of the financing costs involved.

Please call on me or anyone in our organization for such further information as may be useful to you. Meantime, thanks immensely for your consideration of this matter, about which we have had some preliminary correspondence from time to time in the last few months.

Best personal regards.

Sincerely,

WILLIAM L. WILSON,
Administrator.

MARY HITCHCOCK MEMORIAL HOSPITAL,
Hanover, N.H., March 14, 1969.

Hon. NORRIS COTTON,
Senate Office Building,
Washington, D.C.

DEAR NORRIS: Since writing you last month in connection with S. 269, dealing with aspects of assistance to hospitals for modernization by means of guaranteed loans and interest assistance, the terms of this bill seem to have been incorporated into two House bills which have a broader impact than S. 269. These bills are H.R. 6797, introduced by Mr. Staggers, and H.R. 7059, introduced by Mr. Rogers. Both of these provide for a continuation of the Hill-Burton principle of grant assistance to hospitals via the various states, and specifically include the aspect of guaranteed loans with interest assistance.

Since the concern of the hospital field has, among other things, to do with extension of Hill-Burton in some appropriately modified form, and since the two House bills mentioned above both do include the guaranteed loan and interest assistance provisions, probably our attention is properly directed toward these; and I do know that our American Hospital Association office and its staff in Washington are following all of these matters with distinct interest and concern.

Most accurate information of a nature requested by you in the fourth paragraph of your letter to me of March 7th, can be obtained from the American Hospital Association, One Farragut Square South, Washington, D.C. There has been careful calculation of estimated requirements made by AHA in this and related connections.

So much for the broad concerns of the hospital field. Now, of course, comes a restatement of our Mary Hitchcock concern with the hopeful retrospective eligibility for qualifying under interest assistance terms of any one of the acts in question should one of them eventually become law, of our current construction project. This is scheduled for completion next summer at which time the hospital will fulfill terms for activating the long-term borrowing on which interest assistance would provide a vital saving to the New Hampshire people and others who use Mary Hitchcock.

All of the Congressional activity in this connection is heartening. Jim Cleveland is following the House activity closely and all of us here will be very grateful for such attention as you and your colleagues can give the matter as the Senate may be involved.

Best personal regards.

Sincerely,

WILLIAM L. WILSON,
Administrator.

MARY HITCHCOCK MEMORIAL HOSPITAL,
Hanover, N.H., February 12, 1969.

Hon. NORRIS COTTON,
Room 5109, Senate Office Building, Washington, D.C.

DEAR NORRIS: The attached copy of a letter written recently to Senator Javits is self-explanatory, I believe, and simply makes current our position with respect to legislation of the type involved. I am tremendously hopeful that there may be some way in this session of Congress to recognize the fantastic needs of the teaching hospitals. Certainly the possible application to the Mary Hitchcock program is one which is of essential importance locally. The important thing, however, is the total need.

Whatever support you may find it possible to give the legislation in question as it may proceed through the legislative process, will certainly be tremendously appreciated.

It was with delight that we learned of Mrs. Cotton's discharge from the hospital there in Washington. I am so glad that we got squared away on the availability of her medical information from here in the interest of her progress down there. I hope all proceeds well for her.

With kind regards.

Cordially,

WILLIAM L. WILSON,
Administrator.

MARY HITCHCOCK MEMORIAL HOSPITAL,
Hanover, N.H., January 31, 1969.

Hon. JACOB K. JAVITS,
Senate Office Building,
Washington, D.C.

DEAR SENATOR JAVITS: Let me document with you the hearty support of this institution and undoubtedly the hospital field in general of your recently introduced Bill S269 to provide Federal loan guarantees and interest subsidies to assist in modernization of hospitals. I am confident that there will be very general support from the health field in this connection in particular as it applies to the many efforts currently being undertaken to relate modernization and renovation in the hospital field to total health field facility planning.

Your similar efforts in the last session of Congress were followed with tremendous interest from the point of view of this institution; and you may recall that Dr. Mack Lipkin wrote you with particular reference to the plans of Mary Hitchcock Memorial Hospital as they related to the direct teaching relationship of Dartmouth Medical School of which he was at that time visiting Professor of Medicine. Our growing teaching relationship in medicine, professional nursing, technology and other health fields make us particularly responsive to your remarks with reference to S269 contained in the January 16, 1969 Senate Congressional Record.

In connection with this institution's specific interest, it is desirable that I make inquiry regarding eligibility under terms of your Bill for a modernization project already underway with construction financed in large measure by temporary construction borrowing from commercial banks to be replaced at the completion of the project by a mortgage loan. It is anticipated that the mortgage financing will replace the construction financing in mid-1970. The question becomes one, therefore, of whether or not we would be eligible for Federal interest assistance on a project already underway. It should be stated that the project was undertaken on authorization of the Hospital's Board of Trustees in some substantial measure because of the growing teaching relationship mentioned above, and completely without Federal assistance all in the interest of the most expeditious possible pursuit of the project to make the facilities available as soon as possible and to avoid further escalation of construction costs.

A copy of your Bill might provide the information requested in the previous paragraph, but any additional interpretation which you would be willing to give would be extremely helpful.

This communication will be shared with Senators Norris Cotton and Thomas J. McIntyre along with Congressman James C. Cleveland, all of New Hampshire and very definitely interested in the legislation in question.

Please be assured of the unqualified support of S269 and, of course, from the vested interest point of view with the hope that there may be eligibility for very desperately needed assistance in Federal payment of interest charges for the obligation undertaken by this particular teaching Hospital.

With best regards.

Sincerely,

WILLIAM L. WILSON,
Administrator.

[From the Congressional Record, June 4, 1969]

MEDICAL FACILITIES CONSTRUCTION AND MODERNIZATION AMENDMENTS OF 1969

* * * * * * *

Mr. CLEVELAND. Mr. Chairman, I move to strike the requisite number of words.

(Mr. Cleveland asked and was given permission to revise and extend his remarks.)

Mr. CLEVELAND. Mr. Chairman, I take this time to inquire of the chairman of the committee concerning certain aspects of this legislation. My question, Mr. Chairman, is whether or not the committee by this legislation has made it explicitly clear, and has made it mandatory that under no circumstances could a project that might have been started but which is not yet completed and has not yet completed all the arrangements for a loan, receive benefits under the modernization program where there will be some subsidy of interest.

As I read the bill it does not make it clear that this type of situation could not be covered. Nor does it make it clear that a State agency could not certify to the Secretary such a project if indeed the State agency wished to do so. And I

wondered if it was the intention of the committee that under no circumstances would any pending project be barred from relief under this legislation?

Mr. STAGGERS. Mr. Chairman, if the gentleman from New Hampshire will yield, the bill is not specific on this issue of the loan going back and being covered retroactively. Is that the part that the gentleman is talking about?

Mr. CLEVELAND. Yes and I am talking too about situations which we have a project that may have already been started, but is not as yet completed, and has not completed all arrangements for its final loan. This would not be something that could go back 10 or 15 years, or even 3 or 4 years. The situation I have in mind would be where a project is caught right in the middle of this legislation.

Mr. STAGGERS. That would be an unusual situation. I doubt whether we are going to find many situations such as the gentleman refers to where construction has started and is going on today, with final completion of the loan to be made later.

I would say that my interpretation is that this would be entirely left up to the State agency as to what should be done in this case, but they would have to abide by the law.

Mr. CLEVELAND. It would be the understanding of the gentleman, then, that there would be some discretion in the State agency in regard to that type situation?

Mr. STAGGERS. They would have to obey what the law is. I hate to exactly interpret that right now, but I would say this: I just cannot conceive of any situation such as the gentleman refers to arising where you would have started a facility and you have not made final arrangements for funding, but I would say if there was such a situation it would have to come up before the State agency, and then the State agency would determine it according to the law.

Mr. CLEVELAND. If the State agency thought that some modernization project was worthy of support, even if it had started and perhaps made tentative arrangements for a loan, the State agency hands would not be totally barred by this bill to recommend interest subsidy for its loan. Is that a fair statement?

Mr. STAGGERS. I want to be as clear as I can, and I cannot make too much of a commitment, but I would say this: That the State agency would have to abide by whatever the law says. There are certain parts of the bill where I believe the State agency could make a discretionary judgment on it, but they would have to abide by whatever the law says.

Mr. CLEVELAND. Mr. Chairman, I thank the gentleman. His views have reassured me as to my particular concern and I yield back the balance of my time.

U.S. SENATE,
Washington, D.C., April 9, 1969.

HON. RALPH YARBOROUGH,
Chairman, Labor and Public Welfare Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Mr. Verne Pangborn, Director of the Hospital and Medical Facilities Section of the Nebraska State Health Department, has communicated his views to me on the proposed Hill-Burton program changes which currently are being considered.

He has read in the news media about these suggested changes and has discussed them with the Nebraska Hospital Advisory Council.

He did not ask me to get in touch with you but I thought you should have his views for consideration in the decisions which your Subcommittee on Health as well as the full Committee on Labor and Public Welfare will be making, since he has been intimately involved in administering the Hill-Burton program at the state level since its inception. He advised me as follows:

"We are all greatly concerned about the very limited amount proposed for 'grants-in-aid' and the trend toward assuming that the problem of hospital construction can be met by a loan program.

"While the loan program holds the immediate appeal of no appropriations, or minimal appropriations to meet interest subsidy, in the long run it will cost more than a grant-in-aid program. The borrower must pay off the principal plus the modest interest, and the Federal Government must contribute the interest subsidy provided in some of the bills. Therefore, the Federal Government will contribute in interest subsidy almost an amount equal to the principal of the mortgage which provides that the payment of the principal by the borrower must be added to the patient's bill, and the amount of subsidy from the Federal

Government must still be borne by the taxpayer. This looks to me like doubling the cost, complicating the administration of the program, and still only getting one hospital construction project for the money.

"This may be an oversimplification of the problem but it is just the way I see it here in working with many communities out over the State. There are enough construction projects in this State right now to use a billion dollars a year annual appropriation for grants-in-aid under the Hill-Burton program in accord with the ground rules now in force."

With best personal regards, I am

Sincerely yours,

CARL T. CURTIS,
U.S. Senator.

AMERICAN ASSOCIATION FOR HOSPITAL PLANNING,
June 25, 1969.

Hon. RALPH W. YARBOROUGH,
Chairman, Senate Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.

GENTLEMEN: It is my understanding your Committee has just concluded hearings on health facility construction legislation and that the record is still open for the comment of interested parties.

As President of the American Association for Hospital Planning, I am writing to you and to the other members of the Committee in support of *S. 2182*. The Committee interest in appropriate federal legislation to assist in meeting hospital and health facility construction needs is appreciated. Of the several Bills on this subject currently before the Congress, *S. 2182* would more nearly take care of the problems to which it is addressed. There is a very great need among our Nation's hospitals for new construction, expansion, modernization and replacement. And, there is need for assistance in securing the necessary capital financing. The Congress has always been responsive to these needs. By enactment and funding of legislation such as *S. 2182*, the Congress can provide a very significant impetus to improved hospital facilities and services in this country. Favorable action on *S. 2182* is, therefore, urged.

The American Association for Hospital Planning, established in 1950, is a national organization comprised of many individuals active in hospital and health facility and health services planning and in program development.

The opportunity to express support of *S. 2182* for the record is appreciated.

Yours truly,

GEORGE A. LINDSLEY, *President.*

AMERICAN PUBLIC HEALTH ASSOCIATION, INC.,
Washington, D.C., June 16, 1969.

Hon. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
New Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: On behalf of the American Public Health Association, the largest public health organization in the United States, I am pleased to have this opportunity to submit our recommendations on your bill, S. 2182 that would extend the Hill-Burton Act.

In assembling the data furnished by the States, the U.S. Public Health Service has documented the need for new construction and modernization of health care facilities. Hence, I will not discuss at length these statistics that are available to you and the other members of the Committee. In brief, the State Hill-Burton Authorities report a backlog in new construction of health care facilities at an estimated $5 billion and an urgent need for the modernization of health care facilities at an estimated $11 billion. These measures of the problem are evidence sufficient to the compelling case for extending and expanding the Hill-Burton Act.

The Congress has clearly indicated through Public Law 89–749, and its amendments, that comprehensive health planning is an important tool for achieving the national goal of improved health services for all Americans. This landmark legislation created statewide comprehensive health planning agencies in the 54 jurisdictions. These agencies are charged with performance of a broad-based planning process encompassing all programs within the States' boundaries which affect the health of people. This legislation established the concept of Federal-State-local partnership for health and strengthened the States' role in the

planning for certain formula and project grants. Despite this expression of Congressional interest and intent, only a small segment of the total Federal aid that impacts on each State comes within the coordinative scope of this comprehensive agency.

The American Public Health Association urges that Congress should continue to support the charge it gave to the States under Section 314(a). It should make every effort to assure that the State health planning agency be given a clear and unequivocal role in the planning coordination of each new and revised Federal health program that Congress enacts. In particular, Congress should apply this principle to the legislation currently pending before your Committee which would amend Title VI of the Public Health Service Act relating to the construction and modernization of hospitals and other medical facilities. In order that whatever program emerges be consistent with the concept of comprehensive health planning and the partnership for health, a provision should be included in the bill assuring that the programs developed are in accord wit State comprehensive health planning under Section 314(a).

In extending the Hill-Burton Act, a primary objective must be legislative provisions that will facilitate a more efficient delivery of health services so that medical care costs can be reduced without any diminution of the quality of health services.

To this end, our Association recommends that the States be encouraged to prevent, through licensure procedures, the construction of health care facilities that are not needed. Under existing law, only the construction of facilities participating in the Hill-Burton Act can be regulated.

In addition, we recommend that the Hill-Burton Act be amended to encourage the formation of group practice medical care programs on a pre-payment basis. Such programs have demonstrated their efficiency in the utilization of health resources.

Our Association fully supports the priority that S. 2182 would give to general hospital construction or modernization projects that provide for extended care services in facilities operated by or affiliated with the hospital. We also recommend that the Federal share of construction costs be increased for projects that will reduce medical care costs. Such projects, through inter-facility and inter-agency cooperation such as home health and other necessary services, offer promise in reducing medical care costs.

We are especially pleased with the level of funding that S. 2182 proposes for the extension of the grant program and with the provisions for mortgage insurance and direct Federal loans for the construction and modernization of health care facilities.

May I respectfully request that this letter be made a part of the printed record of hearings.

Sincerely yours,

BERWYN F. MATTISON, M.D.,
Executive Director.

THE COOPERATIVE LEAGUE OF THE U.S.A.,
Washington, D.C., July 3, 1969.

Hon. RALPH W. YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: This statement is with reference to the legislation on construction and modernization of hospital and other medical facilities now being considered by your Committee—S. 2182.

The Cooperative League has both a generalized interest and a specific interest in this subject because the urgent needs of our population for a medical delivery system that will serve better the total population is a priority concern for every one of the over 20 million member families belonging to one or another of the organizations making up our federation of cooperative groups.

The particular interest derives from the special concerns of our valued member organization—the Group Health Association of America—which is one of the fastest growing segments in the cooperative field. Your Committee has heard from Mr. Brindle, the GHAA President, whose views we applaud and endorse.

One of the areas where there is urgent need is in making possible soon the construction of outpatient facilities and neighborhood health centers to take some of the pressure off the demand for hospital beds. It is recognized that many ambulatory patients for whom the clinic or neighborhood center would be more

suitable remain in the hospital overlong because such facilities are not available. The authorization in S. 2182 of $40 million for this purpose needs to be increased sharply.

Other areas on which the Committee should focus special attention are inner city health needs where the comprehensive health care in a neighborhood clinic close to the patient's home is often the answer.

You have probably heard of the fine record at the Columbia Point Neighborhood Center in Boston where in-hospital care for the 6000 people served dropped a dramatic four-fifths because, for the first time, preventive and comprehensive care replaced the episodic care or "patching up" these people had received earlier.

Priority 6 of the Bill is of the utmost importance and deserves the attention your Committee is giving it. This provides comprehensive health care, including outpatient and preventive care as well as hospitalization, and *especially for facilities to serve a defined population.*

We would add to the above emphasis a similar emphasis on a hospital-based medical group working together. It is vital that the *same medical staff* be in charge of care during the in-patient, ambulatory, and out-patient phases of treatment. Working from a single medical record, with easy access to each other, this type of medical practice has proved itself over and over as the best possible medical delivery system in terms of quality care, and in addition it results in what Dr. Ernest Saward, Medical Director of the Portland (Oregon) Kaiser Medical Group has termed "massive economies."

S. 2182 must be drafted so as to encourage the rapid development of this encouraging breakthrough in an otherwise dreary picture of mounting medical costs. This means a change in Section 605(e) of the Public Health Service Act which requires applicants to build outpatient facility be a hospital or public agency. This restriction would unnecessarily preclude other possible contributors to the solution of the medical cost problem from making their contribution, including some members of the Group Health Association of America. It is a restriction which must be removed if the organizations employing the prepaid group plan approach are to do their full part in improving the medical delivery system while reducing the costs to the patient at the same time.

The Cooperative League membership has a special concern for the provision of more adequate *extended care* facilities for those in the population whose health problems are best served in this way. Besides being the arrangement more nearly fitted to their needs, the adequate funding in this area will do much to relieve the overtaxed hospital facilities where patients ready for an extended care facility must remain if such a facility is not accessible. It is certainly false economy to stint in this category of our hospital requirements.

We hope your Committee will give consideration to these points and that this statement may be a part of its record.

Sincerely,

SHELBY EDWARD SOUTHARD.

BROTHERHOOD OF PAINTERS, DECORATORS & PAPERHANGERS
OF AMERICA, AFL–CIO,
Washington, D.C., July 3, 1969.

Hon. RALPH YARBOROUGH,
Chairman, Senate Committee on Labor and Public Welfare,
Old Senate Office Building,
Washington, D.C.

DEAR MR. CHAIRMAN: On behalf of the General Executive Board and the more than 210,000 members of the Brotherhood of Painters, Decorators and Paperhangers of America, AFL–CIO, I respectfully request that you do everything possible to assist in the passage of S. 2182 which is currently before your Committee.

It is my opinion that the bill is a most worthy one, and I am especially interested in the "Inclusion of Cost of Acquisition of Land." Senator, as you can realize, acquisition of land must be included in S. 2182 if the legislation is to be effective in any meaningful rehabilitation of the handicapped.

Thanking you in advance for your kind consideration of this matter, I am.

Very truly yours,

S. FRANK RAFTERY,
General President.

QUESTIONS SUBMITTED BY SENATOR JAVITS AND ANSWERS OF JOHN C. VENEMAN, UNDER SECRETARY, U.S. DEPT. OF HEALTH, EDUCATION, AND WELFARE

1. Public hospitals account for approximately 25% of the available health facilities and play a vital role in the delivery of health care. Under the Administration's guaranteed loan program they are excluded from participation, What alternative do you suggest?

2. In view of the Administration's opposition to the inclusion of public hospitals under the loan guarantee program, would you prefer as an alternative direct Federal loans to public facilities?

Answer. We continue to feel that loan guarantees should not be available to publicly owned health facilities, because of their unique advantages over privately owned health facilities in respect to acquiring needed capital. Specifically, as opposed to privately owned health facilities, publicly owned health facilities can look to the broad tax base as a source of capital as well as their having the advantage of selling bonds, the interest rate upon which is tax free. Further, since loan guarantee assistance to publicly owned health facilities will have an adverse impact on the existing and delicate competitive balance between the tax free bonds of local government and Federal issues, if the Committee should decide that special assistance should be given to publicly owned health facilities, over and above the grant program, we strongly recommend that this assistance be in the form of low interest direct Federal loans. We further recommend that the assistance be at the level not to exceed $75 million per year for the three year period. This alternative is recommended only if the Committee should decide that special assistance will be provided to publicly owned health facilities, over and above the grant program, and although we feel it is unnecessary, it will not, at the same time, affect this delicately balanced competitive situation that exists between tax free bonds of local governments and Federal issues.

3. Do you consider the loan guarantee program feasible without an interest subsidy as provided for in S. 269?

Answer. We believe that loan guarantees without interest subsidies are feasible and will assure that privately owned nonprofit health facilities will have adequate access to the capital markets. Since Medicare and Medicaid, as well as private third party payment systems, do in fact reimburse for depreciation and interest expenses, the privately owned nonprofit health facility would receive, through these reimbursement mechanisms, adequate assistance to pay off their loans and the interest thereon. The Federal guarantee of payment, combined with these forms of reimbursement, will provide adequate assistance in respect to acquiring the necessary capital for expansion or modernization.

4. In the Department's opinion, can the loan guarantee program produce sufficient resources for hospital construction without the grant program—can hospital securities be marketed in sufficient volume or adequate loans be arranged with the interest subsidy?

Answer. The early success of the FHA program of mortgage insurance for nonprofit hospitals indicates that capital in quantity will be stimulated under a loan guarantee program. As you know, this Department shares with DHUD, the responsibility for administering the FHA program of mortgage insurance for nonprofit hospitals. Two mortgage insurance commitments have already been issued through this program which only became operational in May of this year. There have been hundreds of inquiries concerning the program and 5 completed applications are expected shortly, and 33 are expected within the near future.

In addition, since the existing sources of capital for long-term financing are restricted to New York City, and three or four other large cities, across the Nation, there has been a tendency in the past for many hospitals located outside of these aeas, and not well known to the mortgage houses located in these capital-source areas, to compete on less than equal terms with other concerns seeking capital. This inability to compete on equal terms has sometimes led to inordinate difficulties in acquiring long-term financing. We feel that Federal loan guarantees will alleviate this situation and will insure that privately owned health facilities are able to acquire the necessary capital on the open market, in a competitive fashion, under much more favorable terms.

Although we do not expect every private nonprofit health facility to seek a loan and attendant loan guarantee of up to 90 percent of the cost of a project, the general policies of mortgage houses and banking institutions would not allow a

loan of 90 percent of the cost of a project, unless the loan is Federally guaranteed or insured.

5. I would appreciate your furnishing me with the necessary information to respond to the challenge that the individual states are presently permitted under law freely to adjust any Federal categorical assistance received under Hill-Burton to meet the State's needs.

Anwer. Your fifth request was for information which indicates that the States are presently not permitted freely to transfer funds among the five categories. The existing Act permits the transfer of allotments, under certain conditions, among three of the five categories and places a limitation on the amount that may be transferred from the fourth category and a prohibition on transferring funds out of the fifth category.

Specifically, allotment funds may be transferred among the Diagnostic or Treatment Centers, Long-Term Care Facilities, and Hospitals and Public Health Centers categories *only if there are no approvable applications in the category from which the funds are being transferred.* In the case of the Hospital and Public Health Center category, transfers may be made both if no approvable applications are pending or if the transfer would better carry out the purposes of the Act. Such flexibility is limited, however, to that category. Further, there is a limitation on the amount which may be transferred in a given fiscal year from the Modernization category to the Hospitals and Public Health Centers category. In fiscal year 1970, under the existing Act, no more than one-half of the modernization allotment may be transferred to the Hospital and Public Health Centers category. Finally, funds may not be transferred out of the Rehabilitation Facilities category. For your convenience, we have enclosed a graphic illustration of the existing limitation on the transferring of funds among the categories.

6. While agreeing with your objectives and efforts to provide facilities for better medical care for long-neglected segments of the population and supporting the concept of free-standing ambulatory care facilities, I would like your response to the criticism that free-standing ambulatory care facilities fail to integrate into the total health care delivery system.

Answer. While we can agree that a free-standing ambulatory care facility not owned by a general hospital could fail to functionally integrate its program of health services with a general hospital, we intend to preclude this possibility if Section 304(b) of S. 1733 is favorably considered by the Congress. Section 304(b) would permit a nonprofit private agency, which does not own a general hospital to receive grant assistance to assist in the construction of a free standing ambulatory care facility, when such a facility provides services primarily to the urban or rural poor. We envision that our regulatory authority under S. 1733 would be used to require that project sponsors, other than general hospitals, receiving grant assistance to construct a free-standing ambulatory care facility would be required to provide assurance that the services and facilities of a general hospital, would where medically appropriate, be made available to patients utilizing the free-standing ambulatory care facility. This assurance, which would be in the form of an agreement with a general hospital, would speak to such areas as reciprocity in terms of staff privileges, as well as patient transfers.

7. It has been stated by one of the expert witnesses at these hearings that his opposition to the bloc-grant principle was concern that the bloc-grant program might result in reduced overall appropriations—would you comment on that theory?

Answer. While there may be concern on the part of some that the bloc grant principle, as opposed to categorical grants would result in reduced overall appropriations, we know of no evidence which supports this theory.

The CHAIRMAN. The hearings are now adjourned on the legislation for medical care facilities construction and modernization.

Thank you for your excellent testimony and the time and effort you so generously contributed.

(Whereupon, at 12:55 p.m., the hearing was adjourned subject to the call of the Chair.)

24-4.1 Purpose
24-4.2 Transfer Between Categories Within the State
24-4.3 Transfer Between States

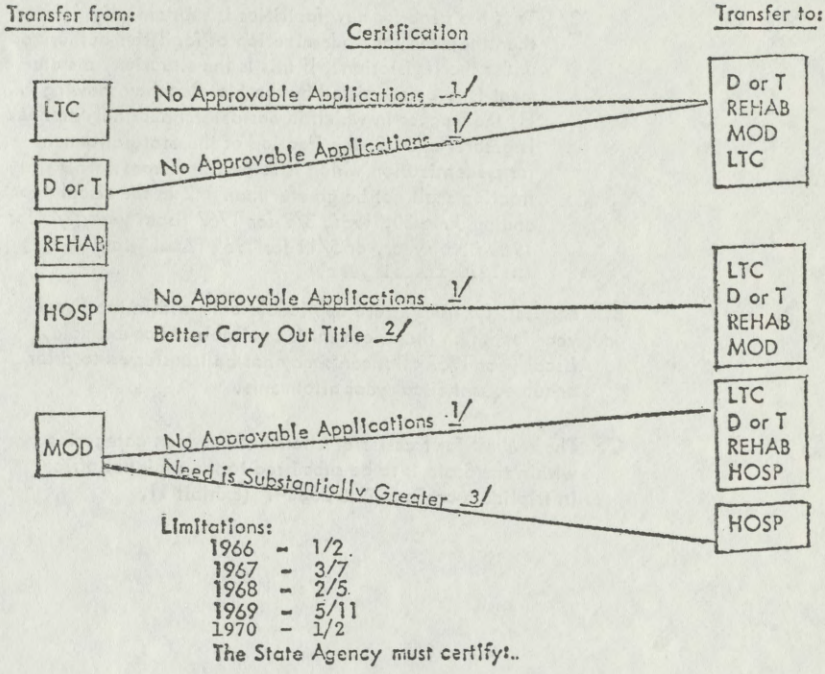
24-4.1
Purpose

The purpose of this Part is to present policies and procedures for transfers of allotments between categories and between States.

24-4.2 Transfer of Allotment Between Categories Within the State

Transferable Categories

A. A State may request that any portion of its allotments, other than rehabilitation, be added to one or more of its allotments as follows:



Limitations:
1966 - 1/2
1967 - 3/7
1968 - 2/5
1969 - 5/11
1970 - 1/2
The State Agency must certify:..

24-4.2 Transfer Between Categories (cont'd)

Transferable Categories (cont'd)

1/ That it has afforded prospective project applicants a reasonable opportunity to apply for funds in the specific category for which the request is made, and that there are no approvable applications for the funds sought to be transferred;

2/ That the transfer will better carry out the purpose of the Federal Act (P.L. 88-443). If this certification is used, a statement must be included showing how this objective will be accomplished;

3/ That the need for new facilities is substantially greater than the need for modernization of facilities authorized under the legislation. If this is the situation, a statement is to be submitted by the State agency showing (1) the manner in which it was determined that the need is greater and (2) the fraction of the State allotment for modernization which is to be transferred. This fraction shall not be greater than 1/2 in the fiscal year ending June 30, 1966; 3/7 for 1967 fiscal year; 2/5 for 1968 fiscal year, or 5/11 for 1969 fiscal year; or 1/2 in 1970 fiscal year.

Time Period

B. Requests for transfer are applicable only within the fiscal year for which the allotment is available. For example, fiscal year 1967 allotments may not be transferred to prior or subsequent fiscal year allotments.

Form

C. The request for transfer of allotment between categories within the State is to be submitted to the regional office in triplicate on Form PHS 2530-1 (Exhibit 1).

JOINT PREPARED STATEMENT OF THE U.S. CONFERENCE OF MAYORS AND THE NATIONAL LEAGUE OF CITIES

The United States Conference of Mayors and the National League of Cities are well known to this Committee. We have testified or submitted statements to this Committee before on the subject of the current hearings—modernization and construction of hospitals and other medical facilities—and appreciate the opportunity to do so again. There is hardly a subject of greater concern to us, or of all the people in America, than the subject of health, and the facilities required for proper health care.

As you know, we represent an urban constituency; we are voluntary associations of hundreds of cities throughout the country. It is a commonplace that our country is becoming increasingly urban, and that there is increasing concentration in our giant metropolitan areas. But not everyone lives in a metropolitan area, large or small, and not everyone is going to. We represent the great urban complexes such as New York, Chicago, and Philadelphia, but we also represent smaller cities such as San Leandro, Salem and Hampton. We are here to speak for both the large and the small. And in addressing ourselves to this issue we have kept very much in mind the fact that small and large cities frequently have different needs, as rural and urban America frequently have different needs and priorities. And that, therefore, a sound health care facility program will take into account those different needs, and yet serve all of our nation as any Federal program must. The need for more and better health centers, nursing homes, clinics and so on—is a national problem, and we speak in those terms. We are just as interested in having comprehensive health care facilities available in the suburbs as in the central city, in smaller as well as larger communities.

But it does seem to us that the changes in our Federal health facility programs have not kept pace with the actual changes in the United States. The Hill-Burton legislation was originally designed to deal with a situation and a set of problems very different from those we face today. The priority need then was for adequate hospital care within reach of everyone, and it was the rural areas of the country which were most lacking in health facilities. The need then was to set in motion a rational planning process on a state-wide basis for dealing with the equitable distribution of medical facilities, primarily hospitals, throughout the states. The Hill-Burton program over the years has been a splendid success; it did very well indeed the job it was designed to do for the United States of the nineteen-forties and fifties. Our associations have repeatedly endorsed this great legislation.

We now believe, however, that dramatically changing conditions necessitate basic changes in our approach to the problem of providing adequate health care facilities. While the Hill-Harris and other amendments in 1964 and 1966 extended the basic provisions of the Act to include modernization of existing facilities as well as new construction, added a priority based on needs, and provided for metropolitan regional planning councils, these changes and additions to the original legislation have not proved adequate. They have been helpful. On balance, nevertheless, the Hill-Burton program has been of great benefit to the rural areas, of significantly less benefit to the larger cities, and in some instances of virtually no benefit at all. We believe, therefore, that the time has come for a major updating of the program not just piecemeal changes.

There are a number of reasons why we say this. First, everywhere we look we see the signs of the extraordinary changes in our society, what amounts to a revolution in science and technology, remarkable growth and mobility, major population shifts, astonishing affluence. But there is poverty and hunger, too, as we know; and the gains made by most Americans have not been shared by all Americans. In the large central cities of our burgeoning metropolitan areas, conditions have deteriorated. Congress is well aware of the plight of the cities, and has enacted many programs specifically designed to help the cities deal with the crisis they face. Legislation has been passed to combat poverty, help meet housing needs, provide community facilities, prevent air and water pollution, improve education—to name but some. Yet while we are spending more money on health care than any civilized nation in the world, no one who is familiar with the facts will disagree with the assertion that we are far from our goal of providing adequate health care facilities. Nor have we attacked this problem

with the same sense of urgency, or the same relevance to conditions in America today as was the case in other fields.

In many large cities we are worse off today than we were when Hill-Burton was conceived. We can neglect the health facility crisis of the cities no longer. The health care facilities of, say Detroit or New York, are not used just by those who happen to live in the neighborhood or even in the city. The great urban hospitals are regional and even national. Philadelphia, which has benefited very little from the Hill-Burton program, is a good example of the problem. There are many hospitals in the city, which is also the county, and so it is low on the Hill-Burton list of priorities on a state-wide basis. But Philadelphia has estimated that nearly 20% of the patients cared for by hospitals located in Philadelphia are residents of the surrounding seven counties of the metropolitan areas, including three counties in the State of New Jersey! It is also true, according to the Hospital Survey Committee of Philadelphia, that a substantial percentage of patients using the hospitals in two of the counties adjacent to Philadelphia are residents of the city. The problem is metropolitan, regional and multi-state. It is national in the sense that the medical facilities of the great urban centers like Philadelphia are where much of our medical personnel obtain their education and training, the same doctors, nurses, aides, who then distribute themselves to places of their own choosing throughout the country. But such trained personnel are already in short supply. What will happen if the municipal hospitals, many of them teaching and training institutions affiliated with great medical schools, have to close down because of hopeless obsolescence and lack of municipal borrowing capacity? Philadelphia alone estimates its needs at $642 million just for replacement and modernization of the general and medical school hospitals.

And these are the very same hospitals, which because of their location in the core cities of the giant metropolitan areas, must also serve the immediate community—the needs of those who do in fact live in their neighborhood of the inner city. And as we all know, the needs of these people are the greatest, the mose demanding. Has this situation not reached the point in New York where the Mayor has threatened to close down some of the hospitals for lack of funds? Surely this problem has reached the crisis stage.

Second, the issue of financing is very important to us. For the city with a limited borrowing capacity, at a time when financial demands are staggering, guaranteed loans are in many cases unworkable. A city which is already in serious financial trouble because of the enormity of its need for new and better services, obviously cannot help itself by going bankrupt, even were the law to permit it. The distinction that must be kept in mind here, as the Subcommittee is aware, is the difference between the voluntary community institution and the public, usually city or county, facility. It is the municpal hosptal or health facility which derives no benefit if the city cannot raise the requisite matching funds in the market, and it is the municipal public facility which is bearing perhaps more than its fair share of the increasing demand for services. By not giving direct aid to the public agencies we are penalizing those who most need support. We are failing the institutions and we are failing the people the institutions serve.

Third, there is what seems to us the logical need to integrate Federal health care facility programs with other Federal health programs. The Partnership for Health Act (P.L. 89–749)—the public health services programs, and the Regional Medical programs—comprehensive health planning, public health programs, and the delivery of health services and the facilities for those services should all be rationally and successfully related. We believe this makes good sense; that it would be foolish—as we look at the facilities issue—not to mesh it with other compatible Federal health programs towards the goal of a national network of health care systems. If our ultimate goal is comprehensive health care for everyone then our medical facilities program should contribute to that goal. As the National Advisory Commission on Health Facilities put it: "The Nation must now concentrate upon organizing health facilities and other health resources into effective, efficient, and economical community systems of comprehensive health care available to all."

Fourth, and especially critical from our point of view as urban representatives, is the need to relate our health programs to other Federal programs, particularly as they affect the urban areas. This is not merely a matter of compassion. It is also a matter of sound policy, including economic policy. If we do not help the cities

solve their public care problems, we will be punishing those who most need and can least afford adequate care. Children cannot get the benefits of improved education if they are too sick to attend school. The jobless cannot benefit from manpower training programs if they are too sick to participate, or so sick they fall back in the programs. Sick people cannot educate or work themselves off the welfare system. So if we help those whose need is greatest we are doing ourselves, as well as them, a service. The cost to the Federal government, and to our country, will surely prove greater in the long run if we are short-sighted about dealing effectively with our health facilities problems right now.

Those, then, are some of the new conditions, the unresolved problems, and unmet needs which—as we see it—make the Hill-Burton program obsolete. The question, of course, is: How can we best deal with these new issues? We have some recommendations we respectfully urge the Subcommittee to adopt:

First, we believe there must be a substantial grant as well as a direct loan program for publicly owned facilities, with a high proportional share of the overall cost to be borne directly by the Federal government.

The National Advisory Commission on Health Facilities states the need for grants: "Capital should be made available through grants to support the modernization and construction required for innovative programs for health care, for the development of comprehensive health systems where they are presently nonexistent, and for the modernization and expansion of basic health facilities where it is critical."

The need is most critical in the cities, and the cities have not received their fair share of the benefits of the Hill-Burton program. They are not likely to receive the priority they need from the existing state agencies, and so our second recommendation is that the grants be made directly to the cities. This is not unprecedented. There are many programs allocating grants directly to municipalities and counties, and the Hill-Harris amendments established a priority for modernization in urban areas based on extent of need. If the large city is to provide a quality health delivery system for the special needs of the inner city and at the same time maintain the service it performs on a regional, even multistate basis, it must have a good deal of flexibility in planning and local options. It can then, of course, also integrate its planning both on a state-wide and regional basis.

The need for long-range planning speaks for itself—that was the point, after all, of the original Hill-Burton Act. But the planning is now more complicated by the changing population and living patterns, and the inability of the state agencies alone to take into account the local and regional issues. There must be flexibility, not only because one city will opt for a different health delivery service system from another, but because a suburb's or smaller city's needs may be altogether different, and the options should be available to decide locally what kind of facility has the highest priority—hospital or nursing home or ambulatory facility.

A direct loan program to the cities will not be nearly so effective as a grant program, for some cities, up against their legal borrowing capacity limit, cannot use any loan programs at all. But as a supplement to a grant program, and in combination with a grant program, we can see some usefulness in direct loans to cities for publicly-owned facilities. We think such loans should be made by the Federal government at a 2% rate of interest, as in the case of REA programs.

Third, special emphasis in any new program must be given to modernization and reconstruction of existing facilities at the same time that the need for new neighborhood health facilities, ambulatory facilities, nursing homes, and facilities for extended care, rehabilitation and others is recognized.

There are significant differences in the Chairman's bill, S. 2182 and Senator Javits' bill, S. 1733 which we would like to point out. However, neither bill fully meets the needs of highly urbanized areas either for support of new systems of medical care facilities or for replacing and modernizing presently inadequate facilities.

To update our medical facility legislation we need some new definitions. We concur with the American Hospital Association, who pointed out in their testimony that "The definition of facilities should be changed to 'ambulatory care facilities' so that other methods and facilities for the care of ambulatory patients by members of the medical staff in carrying out the program of the hospital, including such systems as group practice, may be included." We need new definitions of "general hospitals," to include acute psychiatric inpatient care facilities; and we should specifically include extended care facilities.

The point is that the development of comprehensive health care systems can be accomplished in different ways in different communities; we must give the communities both the flexibility and options to utilize the Federal support in the way that constitutes the most effective system for their community.

While we agree with Secretary Finch that there is a need for the "expansion of other kinds of medical facilities which can reduce the pressure on hospitals," the grant program which he proposes does not include the construction and modernization of acute hospital beds *at all*, and this would be disastrous for the cities. The "$500 million loan guarantee authorization in S. 1733 for nonprofit hospitals" which the Administration proposes does not include public facilities in its definition of nonprofit hospitals. But even if it did, it is of no help. The cities cannot afford the cost of such a program, at today's prevailing interest rates. Nor can they go out and borrow the money needed because of their financial straits. We can see very little help for the cities in the Administration's recommendations as embodied in S. 1733. The cities would be shortchanged by this combination grant-loan program, even though the Administration, wisely we believe, suggests dropping the old rural priority of the Hill-Burton Act, and suggests, or appears to suggest—it is not clear—a new formula that might be more fair to the urban areas.

A word must be said about the amounts of money stipulated in the bill, of course, since money is a paramount issue. S. 2182 increases the authorizations of Hill-Harris, which we approve, while S. 1733 in most instances is totally inadequate. The Administration program will not begin to do the job.

We would like to see both the minimum and maximum of the Federal share of the cost of any project increased. We believe the ceiling on the Federal share of publicly-owned modernization projects is much too low. The plain fact is that the cities do not have the money that is required to cope with this situation, as the Congress has recognized in other Federal programs.

Both bills before the Committee, and the testimony of the Administration, recognize the need to increase the Federal share of costs, though in varying ways and degrees. But the important relationship of the *total* amounts authorized to the Federal share must be kept in mind lest the end result of increased Federal support, which is all to the good, be diminished by an inadequate total authorization.

We must also remember the increase in operating costs to the city as these needed medical facilities are developed—still another aspect of the city's financial burden.

The new priorities in S. 2182—for hospitals to provide extended care, for outpatient facilities located in the ghettos, and to projects for facilities which will provide comprehensive care—are execllent, and we strongly urge the Committee to incorporate them all in the new legislation. This is absolutely vital. The requirement in H.R. 7059 to have all new projects after July, 1971 give reasonable assurance of extended care under the supervision of the professional staff of the hospital to which the facilities are connected is highly commendable.

Secretary Finch proposed, as has been done in the past, that twenty per cent of the grant funds appropriated by the Congress be reserved for direct project grants made by the Secretary of HEW for "innovation projects or projects reflecting critical needs of national significance." Such projects would be eligible for 90% of the project cost. In view of the total amount of money recommended by the Administration for the grant program, $150 million, the number of projects that could be supported at 90% of cost under an allotment of 20% or $30 million would be pitifully few indeed. But we believe the flexibility of the approach, the concept, is fine; and we hope that the Congress, which has rejected this approach in earlier years, will reconsider its judgment. S. 2182 includes provision for direct loans to public agencies up to 90% of cost for both construction and modernization, at 3% interest, with a $225 million revolving fund over three years. S. 1733 has no such direct loan program. We reiterate that in addition to a direct grant program, a direct loan program at 2% might be helpful in some cases.

On the question of proper planning, we prefer the general approach of S. 2182 which requires the 314(b) agencies to provide for adequate representation of various interests. As we see it, that representation should consist of a balance of public, private and consumer interests. We think this is important, that the special needs of the urban areas be better represented in the planning process. Secretary Finch, in stating the Administration's position, also asked that "each

project seeking financial assistance under this title should be submitted for review and comment to the appropriate areawide planning agency created under the provisions of Section 314(b) of the PHS Act. The State Hill-Burton plan should be approved by the State health planning agency created under Section 314(a) before awards from the State allotment are approved and funded." We agree in principle, but would like to ensure balanced representation on the state planning agencies. The relationship of these state planning agencies to the cities has not always been a happy one. May we also say, on the subject of planning, that we heartily endorse Secretary Finch's statement that he has under consideration legislation "that would provide for reimbursement through medicare and medicaid only to institutions whose future capital expenditures are in conformance with State and local plans."

S. 2182 extends the authorizations under Section 304 (National Center for Health Services Research and Development) from 1970 to 1975. S. 1733 has no such provision. The Administration has asked for a deferment. We point out that this affects primarily teaching and training programs, for which there is certainly a demand.

S. 2182 provides for grants and loans for equipment which certainly would be useful. S. 1733 has no such provision.

S. 2182 authorizes a special project grant of $10 million a year for modernizing emergency rooms of general hospitals. We believe the development of emergency services, including financing for new emergency rooms where none exist and are needed is very important. This provision should be expanded and the authorization increased. A special project grant for emergency room facilities is the appropriate way to finance this need.

On the whole, the Chairman's bill, S. 2182, more nearly meets today's critical urban needs. We note particularly the desirable changes in the allocation formula. We agree that the squaring factor should be eliminated, and the formula based on population, financial need, and the extent of the problem. This would be in keeping with the new urban priorities which we firmly believe this legislation must reflect.

We would like to make one recommendation which we do not find in any of the proposals, namely that the Secretary of HEW be given the authority to waive the local share of the cost of the provision of ambulatory facilities in poverty areas. This is an example of the need to relate Federal programs in the inner cities to one another.

In conclusion, we submit the resolution on Health Facilities Construction, adopted at the Annual Meeting of the United States Conference of Mayors in Pittsburgh, Pennsylvania on June 18, 1969, and the Policy Statement of the National League of Cities, adopted at the Annual Meeting in New Orleans, Louisiana in December, 1968.

[Attachment 1]

RESOLUTION ADOPTED AT THE ANNUAL MEETING OF THE U.S. CONFERENCE OF MAYORS
PITTSBURGH, PA.

20. HEALTH FACILITIES CONSTRUCTION

Whereas the pressing need of our cities for financial assistance programs designed with municipal financing considerations in mind has been demonstrated time and again, yet health facilities construction programs continue to provide neither sufficient resources nor the possibility of municipal use within the constraints of local financing systems; and

Whereas at the same time that demands on cities' hospital and other health facilities have been increasing, these facilities have deteriorated—many to the point of obsolescence—and little federal assistance has been available for modernization of structures and equipment; and

Whereas the major federal program for assisting the construction and modernization of health facilities, the Hospital Construction Act of 1946, as amended, is nearing expiration and requires legislative action this year; and

Whereas the Administration has recommended legislative changes that would restrict construction and modernization grants and offer a program of long-term loan guarantees for which municipal facilities would be ineligible: Now, therefore, be it

Resolved, That the U.S. Conference of Mayors urges Congress to extend the Hospital Construction Act, revised to provide for: (1) The long-overdue requirements for modernization and renovation of inadequate and obsolete general hospitals. (2) New approaches to facilities construction such as comprehensive neighborhood facilities and clinics.

[Attachment 2]

NATIONAL LEAGUE OF CITIES NATIONAL MUNICIPAL POLICY

HEALTH

2.500 Health goals

Adequate medical care is no longer a privilege, nor even a concession, but the right of every citizen. This specifically includes those Americans—one out of five—who do not really know what adequate health care is: they are too poor to pay for it; they don't know where to find it; or they live too far from the nearest doctor or medical center to receive it.

The delivery of health services is part of the more general problem of poverty, undereducation and joblessness. Members of families with annual incomes under $2,000 are confined to bed by sickness and disability nearly twice as many days as those in families with incomes in excess of $7,000 annually. Fifty percent of poor children are not fully immunized against smallpox or measles. Sixty-four percent have never seen a dentist. Forty-five percent of mothers whose children are born in public hospitals have had no prenatal care. For the poor, the risk of dying before the age of 35 is four times the national average. The problem of health care is no less severe for millions of senior citizens who experience the greatest need for health services at a time when their incomes are lowest.

We need a redirection of health expenditures and a renewed attack upon the problems of illness in our society.

2.501 Health planning

(*a*) Provide increased federal funding for improved state, regional and local comprehensive health planning to be directed toward the needs of the community.

(*b*) Coordinate planning at the local level under various federal health programs such as Hill-Burton, Mental Health, Vocational Rehabilitation, Medicare, Medicaid, Neighborhood Health Centers and provide funding on a direct federal-local basis.

2.502 Delivery of health services

(*a*) Provide federal assistance for neighborhood health centers with staffing available during the hours most convenient to neighborhood residents.

(*b*) Institute imaginative public health education programs to make all neighborhood residents aware of what constitutes good health practices.

(*c*) Emphasize preventive services and combine them with treatment facilities to lower overall health-care costs.

(*d*) Provide comprehensive medical care for every needy mother and infant.

(*e*) Expand maternal and child health programs to reduce the high rate of infant mortality.

(*f*) Make available information and counseling on family planning to those families who want it.

2.503 Health manpower

(*a*) Bring the cost of health care under control by increasing the supply of health professionals and by innovation in their use and reimbursement.

(*b*) Increase federal and state funds to—

1. build classrooms and other facilities at existing or new local institutions to train health workers;
2. expand enrollments and improve curricula;
3. strengthen loan, scholarship, and other financial aid programs available to health personnel in training;
4. recruit and train qualified minority group members for health careers; and
5. develop more nonprofessional personnel to replace and supplement higher level personnel in short supply.

2.504 Medical facilities

(*a*) Expand federal and state financial assistance for the rehabilitation and construction of medical facilities.

(*b*) Give special attention to the modernization and replacement of older hospitals in central cities.

(*c*) Place emphasis, wherever possible, on facilities other than hospitals, such as ambulatory care centers, nursing homes, intermediate care facilities, day care centers, and rehabilitation centers.

(*d*) Increase the availability of health services by ensuring maximum use of all existing medical facilities.