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# *The Hospital Survey and Construction (Hill-Burton) Act*

Hospital construction, renovation, and repair were greatly curtailed during the Great Depression and World War II. The depression years were simply years of want and despair, during which work of all kinds came to a near standstill. Money was scarce, unemployment was widespread, and the future seemed bleak; consequently, planning for the future seemed futile.[1]

After the inauguration of Franklin D. Roosevelt as president in 1933, there was some renewal of hope. Roosevelt was a picture of optimism, saying there was nothing to fear but fear itself. Under his administration, direct relief programs were undertaken with great speed by the federal government. Work programs followed quickly, and public works projects followed with less haste and more planning under the direction of Harold L. Ickes, secretary of the interior and head of the Public Works Administration (PWA).

The PWA constructed public buildings: post offices, municipal and county buildings, state university classrooms and other schools, and so on. In a few cases, hospitals benefited from the PWA programs.

More than bricks and mortar and labor were needed to build hospitals, however, as the following story about Governor Frank Murphy[2] of Michigan illustrates. Murphy, a favorite of Roosevelt's, went to Washington to ask the president for money to build hospitals in rural areas of Michigan, where inpatient care was unavailable. Roosevelt directed Murphy to Ickes. Ickes,

in turn, consulted with Josephine Roche, assistant secretary of the treasury, who was in charge of the Public Health Service (then a part of the Department of the Treasury).

Roche was concerned because the program that Murphy was proposing for the construction and equipping of hospitals did not even include start-up money for the operation of the hospitals. There was a meeting between Murphy and Ickes, which was also attended by Josephine Roche; Abe Fortas, under secretary and general counsel of the Department of the Interior; and I.S. Falk from the Bureau of Research and Statistics of the Social Security Administration. Falk remembers that meeting:

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**FALK:**[3]

I remember that meeting in Mr. Ickes' office because I had the unhappy task to say, "This is no go, because the very communities for which the governor wants the help for these small rural hospitals are, in general, communities that don't have hospitals because they can't support them. What will you do with these hospitals if you build them? How will you maintain them? Let's give some thought to where the money is to come from to support them."

We had a long session in which I was the most unpopular person in the room.

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Another aspect to the situation was that, not only would assistance be needed for operating expenses, but also the medical and nurse staffing would be a problem in rural areas. It has been the unhappy discovery of many rural areas that new buildings alone will not attract the desired professional staff. During this time, schools of medicine and schools of nursing, along with everything else, were feeling the effects of the Great Depression and were not growing with an eye to future population increase and its needs.

Many of the leaders of the health field realized the inadequacy of existing facilities and the need for national planning for the construction of medical care facilities, for support for educating professional and paraprofessional health care personnel, and for providing access to and financing of health care for all.

George Bugbee became the executive secretary of the AHA in 1943, just when some persons were asking, What will we do when the war is over? (Victory seemed inevitable then.) Within a reasonable time after the end of the war, millions of men and women in the service would be returning home and would expect, rightly, that health care, education, and social programs sufficient to take care of everyone's needs would be in place. Bugbee was conscious of the necessity of planning for the postwar period. The federal government, at least in the person of Dr. Thomas Parran, the surgeon gen-

eral of the U.S. Public Health Service, was thinking of postwar health care needs also.

As a first, formal step in planning for the future, the AHA passed what became known as the Bishop resolution. This resolution provided the foundation for a series of initiatives that culminated in the Hill-Burton Act.

George Bugbee recalls the role of AHA in establishing the Commission on Hospital Care, and lobbying for Hill-Burton.

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**BUGBEE:**[4]

At the American Hospital Association's 1943 convention, the house of delegates passed a resolution which had taken a great deal of work. It was called the Bishop resolution.

The resolution essentially recommended three things: voluntary health insurance; federal aid for the construction of hospitals where they were needed; and government aid for those who couldn't pay for care. It's interesting that that's always the proposal made contrary to national health insurance. You either have entitlement for everyone, or you only give it to those who need it. The association took the conservative side. You could argue whether it should have or should not have. That's a different story and a philosophical dividing point.

On the last day of the convention, a group of us were in what I suspect was Jim Hamilton's[5] suite. He was president of AHA that year [1943]. I don't recall exactly who was there. Hamilton was and E.A. van Steenwyk[6] [one of the early pioneers in Blue Cross] was and I was. There were about eight or ten people in total.

I remember van Steenwyk saying: "Now that the association has a policy [the Bishop resolution], what are we going to do about it? There isn't any use in it just sitting there, we'd better do something!"

That resolution, in a sense, gave me authority to move. I thought: He's right, I'd better move. I had been in office only two or three months, but action was indicated. You will recall that one of the three items of policy was, build hospitals where they are needed.

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## Commission on Hospital Care

There was at that time no complete directory of hospitals listing the location, ownership, number of beds, or services offered. The principal source of information about health care in the United States was still the report of the Committee on the Costs of Medical Care.

As a first step, Hamilton and Bugbee and Bugbee's colleagues decided that a study was needed to assess the current situation, evaluate existing

facilities and services, make projections, and offer recommendations for action after the war was over. The ultimate result of this decision was the establishment in 1944 of the Commission on Hospital Care.

The commission's charge was to study the nation's need for hospital and medical facilities and to make plans for the postwar period. Many persons believe that it was partly as a result of the commission's work that the Hill-Burton Act was passed in 1946.

Although created by the AHA, the commission was an independent entity. It was financed by outside sources, including the W.K. Kellogg Foundation, and its report was published by the Commonwealth Fund. The commission also operated under its own board of directors. (See Appendixes D and E.)

The commission's report, "Hospital Care in the United States," not only collected information, it visualized a regional hospital system, with primary, secondary, and tertiary care given on the basis of hospital size and available services.

George Bugbee and others, particularly the commission's associate director, Maurice Norby, discuss the forming and operation of the commission.

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**BUGBEE:**[7]

Jim Hamilton and I—I think Hamilton was the primary leader, although Graham Davis[8] was high in the association's councils and he was in charge of the hospital division of the W.K. Kellogg Foundation—were a part of an effort made to create a Commission on Hospital Care. It was hard going to raise the money for the commission. The Kellogg Foundation pledged a certain amount, and we solicited many other people. I can remember going to the Carnegie Foundation. They said that all that we were trying to do was measure leaves in a whirlwind. However, largely due to the help of Morris Fishbein [editor of the *Journal of the American Medical Association*], we were able to get to Basil O'Connor,[9] who was the chairman of the March of Dimes. He gave us some money, and there was, I believe, a little from a third source. It didn't amount to much. Later the Public Health Service supplemented the funds.

We persuaded Dr. Arthur Bachmeyer, then associate dean of biological sciences at the University of Chicago and superintendent of the University of Chicago Hospitals and Clinics to become the commission's director. He said that he would do it, but he couldn't spend more than half time. It was then that we persuaded Maurice Norby,[10] who was working with Rufus Rorem[11] at the Blue Cross Commission, to take the principal staff job. The orderliness of the commission's report and its success were partly due to Art Bachmeyer, but due a great deal more to Maurice Norby.

The commission was chaired by Thomas S. Gates, the president of the

University of Pennsylvania, a very public-spirited man. We spent a lot of time, some with Mr. Gates, who was to do the appointing [of the commission members], trying to figure out who should be on such a commission. I would say there were about 25 members. It became a pattern for foundation-supported commissions, including a few years later the Commission on Financing of Hospital Care.[12]

Maurice J. Norby, who was the staff member that probably did the most work on the Commission on Hospital Care, and I consulted with quite a few people on how you establish such a commission. The ingredients we wanted were representatives from all walks of life. We wanted labor and industry and farmers, who, at that time, were more powerful because their numbers were a great deal greater. We wanted providers, blacks, whites, women, etc. We had really quite a representative commission. It was important, because later the fact that it was representative was very helpful in the passage of the Hill-Burton Act.

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Bugbee, Bachmeyer, and Norby were quite successful in putting together a strong commission.[13] In addition to Gates as chairman, the commission included Edward Ryerson, chairman of the board of Inland Steel Corporation, as vice chairman; Sarah Gibson Blanding, president of Vassar College; Willard C. Rappleye, dean of the medical school at Columbia University; Joseph W. Fichter, head of the Ohio State Grange; Albert W. Dent, president of Dillard University in New Orleans; Clinton S. Golden, assistant to the president of the United Steel Workers; and Herbert C. Hoover, former president of the United States.[14]

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**BUGBEE:**[15]

There's always been a question whether the Commission on Hospital Care and its findings and report led to the Hill-Burton Act. Well, having been there, I am inclined to think they are related, but hardly as direct a lead-in as later the Public Health Service said. They were the ones who indicated that it was the source. I don't feel it was.

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Maurice Norby was the associate director of the commission. He went there from Blue Cross, partly because he felt that "someone ought to be identified with hospitals who was in Blue Cross." As associate director, Norby carried the day-to-day responsibility for the commission and, as suggested by Bugbee, did most of the commission's work. His observations on the commission, its work, and its accomplishments follow.

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**NORBY:**[16]

The American Hospital Association, with the Bishop resolution, demonstrated an awareness of the need to provide care for people who needed

assistance. They also showed that they understood that the demand for hospital-based services would increase and that more hospitals would be needed. The AHA also recognized that a fact base and data were needed to document what existed in the way of hospital physical facilities and to guide the future development of hospitals.

To obtain these data, the AHA, and really I think it was George Bugbee working with a committee of the board, drew up a plan for a study which could be presented to outside agencies in order to obtain financial assistance. The result of this effort, as you know, was the Commission on Hospital Care.

Once financing was obtained and the commission was formed, it operated completely independently of the AHA.

I got involved because, though Arthur Bachmeyer was the commission's director, he could only spend half time on the project. As a result, he wanted an assistant. Later he changed the title to associate director. Whether he asked for me or whether George Bugbee suggested me to him, I don't know. I do know that the two of them approached me together and asked if I would be willing to work full-time on the commission.

I studied the commission's prospectus and decided to do it. At the time, I was the director of research at the Blue Cross Commission with Rufus Rorem. In fact, part of my reason for taking the job was that I thought that someone ought to be identified with hospitals who was in Blue Cross. At that time no Blue Cross administrator had been a hospital administrator [except John R. Mannix]. None of them had been identified as people knowledgeable about hospitals. All they were supposed to be worrying about was dollars. Let the hospital administrators run hospitals.

It was my feeling that trouble was brewing between Blue Cross plan directors and hospital administrators, basically because hospitals knew Blue Cross directors did not fully understand the problems of hospital administrators. Plan directors were just asked to provide the dollars to run hospitals.

I thought that, if I could work for this national study, I might be identified as someone in Blue Cross who knew the hospital problem. I would be looking at what hospitals are. The Commission on Hospital Care was created to find out what the hospital is and to identify what it should be doing in the future.

So I took a leave of absence from the Blue Cross Commission. I thought I would spend two years on the Commission on Hospital Care.

The commission's first task was to determine what the present hospital was. To, in effect, define the creatures we were dealing with and determine where they were located.

The American Medical Association had a list of hospitals, however

their list had no detailed information and only included about a fourth of the nation's hospitals.

I went to the Census Bureau and, after some cajoling with the director, developed a good working relationship. He assigned me one of his assistants. Together, we built a list of all the places where people had died in the United States. We went through that list and eliminated lots of things just by the name of the place. Finally he let us go deeper into the records and see the characteristics of the places on the list, by the replies that they had made on income tax records. Actually, we shouldn't have had that data. It was a tedious job.

We also asked the state hospital associations for the names of all their hospitals. We asked the nursing home association for all of theirs, and we asked the state health departments for all the health facilities they licensed. We sifted all these names until we finally got some 14,000 places that we thought might be hospitals. Then we developed a questionnaire that we then mailed to all these places. We asked them questions which would help us to identify whether or not they were hospitals.

At the same time that we were doing this, we also were thinking about the questions we were going to ask hospitals to find out the kinds of services they rendered, what their financial condition was, what it was costing them to run the place, what their plans were for the future, and so on.

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Paralleling the interest of the Commission on Hospital Care was that of the Public Health Service (PHS), particularly Surgeon General Thomas Parran.[17] Parran was concerned with what would be expected of his department with respect to meeting postwar health care needs. What he wanted was definitive data, updated data.

Parran had taken several steps to prepare for a potential federal program of planning and building hospitals. One was to have Dr. Vane Hoge, of the Public Health Service, enroll at the University of Chicago in the graduate course in hospital administration in order to prepare himself for administration of any program that might be enacted. (Hoge in fact did become the first Hill-Burton administrator.) Another was to have a PHS physician assigned to the staff of the Commission on Hospital Care to participate in the work of the commission. The first person assigned was Dr. Robert Morey, who resigned from the PHS shortly afterward to enter private practice. He was succeeded by Dr. David Wilson, who later went on to become president of the AHA.

The relationship of the PHS to the commission, however, was more than just assigning a liaison person to the commission staff. The PHS was involved in writing legislation. To do this, it needed data—information such

as the commission was collecting. The commission, on the other hand, did not have the capacity to process its data.

Norby saw an impossible situation unless he got help, so he went to Parran.

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**NORBY:**[18]

We recognized, however, that we were also going to need even more technical help. So I went to see Dr. Parran, who at the time was surgeon general of the Public Health Service.

I initiated the meeting with Dr. Parran. However, before I went I knew, from other sources, that he needed information and that he had a couple of hundred thousand dollars of postwar planning money available. Parran needed the data in order to administer properly the hospital construction program which was anticipated to begin after the war.[19]

We reached an agreement with the Public Health Service. They eventually provided us with help in first devising the questionnaire we needed and then in tabulating the data.

Parran loaned me a fellow named Rollo Britten, a statistician on the Public Health Service staff. He worked for me on a half-time basis, about every other week. Rollo was devising a questionnaire we needed. Bachmeyer was very good at anticipating the kind of information we should have. He knew hospital operations, so he could get the ideas for questions to Rollo and Rollo would word them and put them in sequence.

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At the time the questionnaires were being prepared for mailing, the W.K. Kellogg Foundation asked the Commission on Hospital Care to do a study of Michigan hospitals; the foundation needed data on which to base their considerations of requests for grants and other support.

The timing was propitious, because it enabled the commission to conduct a pilot study in 200 or 300 hospitals.

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**NORBY:**[20]

We got the questionnaire all ready, then Kellogg said they would give us some money if we would do a pilot study in Michigan, thus testing our questionnaire for the national study.

We actually ran this small study, a pilot study for the state of Michigan. There was a special report—it was all bound in a special book—reporting findings. In the process, we identified errors in our questionnaire and in methods and procedures.

We finally devised a 41-page questionnaire. Then we thought, when we get all these answers coming in, what are we going to do with the volume of information?

Dr. Parran said, "You send out the questionnaire because I need the information." He liked the big questionnaire. This information was available nowhere else. He said, "I'll help you tabulate it and handle the data."

He employed me as a dollar-a-year man to supervise a staff of about 20 people, whom he paid and who worked in our building in Chicago. They were to code the data from the questionnaires. Rollo had set it up so that the data could be transferred to punch cards for tabulation on IBM machines. I think we had 12 cards for each questionnaire.

I should say that Parran agreed to give us this assistance with the understanding that the data was to be considered as having been collected by his staff and that it would all be available to him—so he could say when he came up before Congress, "This is the information I have collected."

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The commission considered it a necessary function of the staff to keep the public and the health field informed as to the progress of the study. This reporting was done principally by means of a newsletter. Norby talks about the newsletter and its distribution.

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**NORBY:**[21]

I had assembled a list of some 15,000 names. I had obtained the names and addresses of presidents of school boards, for example, the presidents of farm bureaus, presidents of trade associations, professional associations, and so forth—all kinds of groups. They became the mailing list for our newsletter. After we got a chapter approved by the commission's board, I would have a staff editor summarize it into a four-page printed report, a newsletter, setting out the thoughts of the Commission on Hospital Care on whatever the particular subject was. These short reports in effect became a preview of our final report.

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## The Hill-Burton Legislation

Besides establishing the Commission on Hospital Care, the AHA did other things to obtain legislation aiding hospital construction.

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**BUGBEE:**[22]

The establishment of the Commission on Hospital Care was only one expression of the intent of the association to drive for legislation to aid in the construction of hospitals.

One of the major issues in any legislation was whether nonprofit hospitals should be eligible for grants. There had been major work relief programs for years prior to the war, and only one of those programs allowed

grants to be made to nonprofit hospitals. Since nonprofit or voluntary hospitals were providing most of the nation's short-term hospital care, it did not seem right that they be excluded from being eligible for assistance. Certainly, the nonprofit group didn't like it.

In addressing this issue, a planning committee—Postwar Planning Committee was its title—was set up under the AHA's council on government relations. It met in Washington. It began trying to figure out what might be done to see that the nongovernment hospitals were considered in any postwar building program.

On the Postwar Planning Committee was Dr. Vane Hoge. I think the action of the committee was due to Vane and his boss, Surgeon General Dr. Thomas Parran.

Parran thought, "Things are coming together. Let's draft legislation for aid to hospitals." He brought the draft to the Postwar Planning Committee. The committee said that the draft was just what they had been looking for.

The essential points were that each state have a plan, pick the neediest areas, and federal aid was to be varied between the states according to need. The aid was to go within the state to government and nonprofit hospitals by priority of need. This in a way is what Hill-Burton turned out to be, with considerable embroidery, one way or another.

The bill, as first drafted by the Public Health Service, seemed good. Then the question was how to get it introduced. I won't go through all of it, but about that time I became registered as a lobbyist. I intended that we pass that bill. Its passage was one of the successes of my life. However, even with that success I certainly was an amateur lobbyist. In fact, I never liked lobbying. I think some of the most disagreeable jobs I was confronted with were hanging around outside the House or Senate waiting to catch some person who didn't want to see me to ask how he was planning to vote. Or going to his office and trying to get in.

In any event, we had a bill. The question was, who were we going to get to introduce it? When I went to Cleveland to succeed Jim Hamilton at the Cleveland City Hospital, I was appointed by the then-mayor, Harold Burton. Harold Burton later became a United States Senator, and after that a justice of the Supreme Court. At the time I am talking about, he was in the Senate. So I went to see Harold Burton. He agreed to introduce the bill, with one reservation—and that was that Senator Robert Taft, the senior senator from Ohio, had to agree.

I went to see Taft and he did agree. He was getting ready to run for the presidency. He said, "I have a labor bill and I have this and that—education bill—and I need a health bill." He later rewrote the bill, because he said he was going to make it a model for federal grants-in-aid programs.

He believed (and, I believe, too) that states in such a program should

have some independence of action. His interest was fueled by the fact that the state of Ohio about that time had done something that caused the federal government to hold up millions in Social Security benefits. This included the pay of those in state government administering the program. The federal government said that the state was not administering the Social Security program the way it should be. Taft was furious about the federal government's action. He was going to fix the Hill-Burton bill so it wouldn't happen with that.

The bill was introduced January 10, 1945 [and signed into law on August 13, 1946].

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**CRUIKSHANK:**[23]

I know a little about what that was.

It was an incident involving Social Security and unemployment compensation, which was administered by the state. The funds, however, came out of the federal government. The federal government could declare a state out of compliance.

Arthur Altmeyer was then the chief administrator of the Social Security Act (unemployment insurance was then a part of Social Security). Davey, who was at that time Governor of Ohio, had introduced politics into the checks that went out to the unemployed. Altmeyer declared them out of compliance and shut off the funds to the state of Ohio, which was a risky thing to do, but it was a thing which established the authority of the federal government in that whole area. Of course Taft didn't like that: Davey was one of his buddies.

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John Mannix was an important part of the Cleveland scene when George Bugbee was administrator of the Cleveland City Hospital during the time that Harold Burton was mayor of the city. Mannix spoke of Bugbee's and Burton's interest and efforts in hospital planning several years before the Hill-Burton Act.

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**MANNIX:**[24]

The major development in hospital planning came about 1941, when George Bugbee, who was administrator of Cleveland City Hospital, which later became Metropolitan General Hospital, became interested in facility planning. For all practical purposes, there had been no hospitals built during the 1930s. No one had money to build facilities during the depression years.[25] At that time, Harold Burton was mayor of Cleveland, and George Bugbee's boss. Concern on the part of both Bugbee and Burton regarding hospital facilities resulted in the establishment of a joint hospital committee. This was a committee of 30 people, 10 appointed by the mayor, 10 by the hospital

association, and 10 by the Council of Social Agencies (Cleveland Welfare Association).

The interest of Bugbee and Burton during this period affected the national situation, because Burton became a United States senator.

While in the Senate, Burton became interested in the whole problem of hospital facilities. It should be remembered, we had a period of about 15 years during the 1930s and World War II years when there was a large increase in population, with little building of hospitals in the country. There was a tremendous shortage of hospital beds nationwide in 1945. The interest of Senator Burton resulted in the Hill-Burton Act and the federal financing of hospital facilities.

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Introduction of the legislation was only one step. Bugbee's next task was to help develop support for its passage.

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**BUGBEE:**[26]

We asked members of the Commission on Hospital Care for support on the Hill-Burton legislation. The representative of the farm bureaus [the grange] was terribly key in getting support in the House for the bill. With the labor man [Golden], we immediately went to Nelson Cruikshank, who was on the staff of the health and welfare committee of the AF of L. He was very supportive.

When I went to the American Medical Association they had been so against everything that they essentially said they needed something to be for. So they agreed to support it, and they did testify in support of it, but reluctantly as far as their inner circle was concerned.

It was almost two years before the Hill-Burton Act was passed—with great authority to the states. Taft was thinking that what the states did wrong would be less bad than what would happen if it were a national program. That was his philosophy.

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James Hague, who came on the AHA scene later (1953–1977), underscored Bugbee's point, both with respect to Taft's role and the operation of the Hill-Burton program.

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**HAGUE:**[27]

As I am sure you know, Burton is just a name on Hill-Burton. It's Taft's name which probably belongs there, because it was Taft who did the work, who came up with the grants-in-aid program.

Hill-Burton was really intended to provide seed money for hospital construction, and it surely did. I have seen charts of the money that went

into hospital construction during the Hill-Burton years. Hill-Burton was a substantial fraction, but it was a minority of the funds that were spent.

Taft insisted on local control. That's why there has been no scandal. I know of no Hill-Burton scandal. That's because individual hospital boards had to raise local community money. Their reputations were on the line.

[On reviewing the manuscript, Hague asked that this narrative carry an explicit statement that his comments are based on extensive interviews he had with Bugbee and Norby, who, unlike himself, were at the scene of the action. He believes his remarks are accurate but thinks the reader should know that they are based on hearsay—reliable hearsay, to be sure, but hearsay nonetheless.]

## The Hill-Burton Formula

Senator Taft wanted to make Hill-Burton a model for federal grants-in-aid programs. As finally devised, the act provided a higher percentage of aid to poorer states. Bugbee commented on the question of whether it set a pattern for later federal programs.

**BUGBEE:**[28]

I think certainly it set a pattern, and I'll tell you why.

How much a previous pattern there was, I don't really know. I sat in on the executive sessions of the Senate committee which rewrote the bill. On that committee were Senator Murray, who seldom came and deputized Lister Hill to chair the committee; Robert Taft; Robert LaFollette, Jr., from Wisconsin; a senator from Missouri; and another from Louisiana.

The consequential ones were Taft and Hill. Hill tended to give Taft anything he wanted, within reason. I think Lister Hill felt that help in passage from the Republicans and the priority he would get for aid to the South were what he needed. They probably were.

Later, when Oveta Culp Hobby became secretary of the Department of Health, Education, and Welfare under Dwight Eisenhower, she somehow was able to persuade the administration and Congress to make the Hill-Burton formula apply for all Department of Health, Education, and Welfare grants. The cities certainly got a blow when that happened.

The Senate committee, with the Hill-Burton program and its grants-in-aid formula, was creating not only new law, but also the basis for new public policy. I.S. Falk was involved in the policy discussions. Falk was the

director of research and statistics for the Social Security Administration. He and his staff played a key role in developing the Hill-Burton formula.

His recollection of the events, problems, and accomplishments follow.

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**FALK:**[29]

The Hill-Burton bill began as a bill-drafter's rehash of the hospital construction program that had been Title XII in the Wagner National Health Act of 1939, S. 1620. It also drew on S. 3230, of the 76th Congress—the Wagner-George National Health Act of 1940—which provided for both construction and early year maintenance support grants and which was favorably reported by Senator Murray (Committee on Labor and Education) in Report Number 1558, April 30, 1940, but which was not enacted. It was subsequently in the Wagner-Murray-Dingell bill.

The bill was introduced in 1943 and was referred to Senator Murray's committee. A subcommittee of the full Senate committee actually did the work on the bill. Lister Hill was chairman of the subcommittee on that bill for executive committee review in the Senate (not public hearings).

The situation was somewhat complicated because the bill had been introduced in the Senate by Hill and Burton. Before the bill came up for review, Burton had been appointed to the Supreme Court, so that, when the bill was to go through executive hearings and markup, it was all on the Senate side, with Hill handling it alone because Burton was no longer there.

I remember those executive sessions very well, having been heavily involved. Vane Hoge, Louis Reed, and others in the Public Health Service, George Bugbee from the AHA, and others also participated in those sessions.

The bill was in difficulties because the financial proposals in it, the federal distribution of funds to the states, were unacceptable to the states represented in the subcommittee (mainly Senator Allen Ellender of Louisiana). Also, LaFollette from Wisconsin and Robert Taft had problems with the bill—but for different reasons.

Lister Hill was in a quandary about what to do. He and Murray put their heads together. They called me one day and told me the situation behind the scene. They asked me if I would figure out some kind of financing arrangement that would make the bill potentially acceptable. Bob Taft had said that there was no point in giving a lot of federal money to the rich states but that it was OK to give it to the poor states. LaFollette had said, "Which are the rich states? None of us is rich enough to deal with this problem."

Allen Ellender said, "Why should we give money to New York State and Massachusetts in order to build hospitals? They have got all the hospitals they can use and more. We need them down in poor little Louisiana."

I can remember pulling some of my staff together and saying, "I am not altogether happy with some of the provisions that the Public Health

Service and the AHA have put into this bill. I liked it better the way we had it in the 1939 Wagner bill or in the Wagner-George bill of 1940 or in the Wagner-Murray-Dingell bill, but that's past history. Let's see what we can do to straighten this out." So we drafted a whole series of alternative financing provisions.

The main problem was to get a financial formulation that would be applicable to the perspectives of rich states and poor states, big states and small states, and so on, because the needs and issues were diverse. The key problem was that the drafters had been working with specifications that were based on fixed formulas for grants. You couldn't get enough flexibility in the programs with a provision of that kind. So, two or three people of my staff who were very knowledgeable in this field (we had been working extensively on diverse federal grant patterns for public assistance and health programs) really put their heads together with me and said, "We'll have to put together a variable plan formula that is peculiarly adaptable to the hospital field."

Of course, in the hospital field there were two different categories of variables that produced coinciding results: the question of the need of the state or the community for federal aid in general, and the question of the particular community's need for hospital care. The key to that problem is that, if the community, statewide or part of a state, is poor, generally it has fewer hospital beds, and it has a higher need for support. If it is a well-to-do area, or a well-to-do community, it has a more generous supply of hospitals, more generous support for them, and less need for general federal support. So we said, "Let's play with that kind of formula."

We tried various approaches to a variable grant formula. Finally, we came up with a particular variant that was accepted by the subcommittee and enacted.

It is a peculiar formula. I have never really understood why it was accepted. The second or third time at the executive sessions of the subcommittee we had a list of the states on a blackboard and showed how this formula would work; when we got through with a presentation, Lister Hill took a canvass of the committee—the subcommittee was there and some other members of the full committee. He asked, "How many here understand what we have been talking about?"

One hand went up. It was Senator Taft's. He said, "Because I know what he means when he says a square of the allotment percentage derived according to the factors required to be considered."

We had formulas through which the states with per capita income equal to or above the national average would get lesser shares of the federal appropriations. It was a compromise formula. We had to work in that square in order to get big enough grants to the poorest states, granting them the

credit, so to speak, in the formula because (a) they had more financial need for hospitals than the richer states, and (b) they had more need for hospital care. So we squared the formula.

Alanson Willcox had been sitting in.[30] He was the assistant general counsel for the Public Health Service. He drafted the report for the Lister Hill–Murray committee. If you read that report you will find some very skillful writing.

The bill went through the full Senate committee, the Senate, and the House in a breeze.

That is how the Hill-Burton formula came into being, with its famous (or infamous) square formula. The fellow whose ingenuity made that formula possible was a member of my staff named Daniel Gerig. I never forget to give him credit for it.

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Hill-Burton was quite a step forward in federal support.

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**FALK:**[31]

It [the Hill-Burton Act] was not only the first major health legislation enacted after the war, but it had another nearly unique quality. It was the first bill enacted by Congress with a grant formula since the days of 1870 or 1880 or 1890, when a variable grant formula was used in the land grant and related acts.

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Under Hill-Burton, the federal government was to make money available under prescribed conditions; for example, it required a state plan, matching funds from local applicants, and so on. The states certified that they would observe the various conditions, thereby becoming eligible for their share of the federal funds.

At the level of the individual institution, the Hill-Burton grant was only intended to provide partial funding for any approved project. The applicant—as opposed to the community—had to bear the nonfederal share of the project's cost. The applicant also had to agree to various conditions for construction and for subsequent operations.

The portion of a project's costs that had to be met by the applicant could be determined individually, within specified limits, by each state.

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**FALK:**[32]

The states got the federal money. The state could say to the applicant that was going to build a hospital that it—the applicant—would have to find the money, not the state agency. A state could say that we get so many million federal dollars (according to the formula), we have applications for so much money, any applicant that meets such and such conditions can get up to (not to exceed, let's say) 50 percent of their expected costs from this

federal grant pool, or 40 percent, or 33 percent. Some states had a 50 percent formula, I don't think there were any higher than that. Connecticut had a 33 percent provision. That was a variable with the state, dependent on how best to spread the federal grant which they got through the federal formula among the applicants whom the state agency could properly approve.

The state didn't have to put any of its own money into the program except for the support of their own administrative expenses.

As good as the bill was, there were two provisions that caused trouble. One caused a potential problem immediately and the other later. The first was President Truman's objection that an advisory council of nongovernment persons could override the surgeon general on some provisions for approval or nonapproval of applicants. The president thought it was at least bad policy and possibly unconstitutional. When he signed the bill into law he said he had first considered a veto, then accepted the bill, but announced he would ask Congress later to amend the act.

The other element in the bill that caused a problem was the provision that allowed federal grants despite "equal but separate" operation of aided institutions. Until the Supreme Court's decision came on that, the bill remained intact except for amendments later.

In general, except for the separate but equal provision, the act was flawless, at least in providing federal grants to the states, with no required matching by the states (the applicant institution had to provide the matching funds) but with a carefully developed set of conditions which the state and the federal agency would be required to see that the applicant met. It was not until the 1970s that we got the beginning of a new battle about the Hill-Burton Act, about the availability of "free" services from Hill-Burton–aided hospitals or other facilities for people who couldn't pay. That issue is still going on. The performance by the federal bureaucracy on this has been outrageous, because they have blatantly amended the contract agreements under which grants were received by applicants, and spent by them, by putting on requirements that go beyond those that were contracted for when the original aid was awarded.

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Every state that wished to participate in the Hill-Burton program was required to develop a plan for implementing the program. Richard Stull, who later became president of the American College of Hospital Administrators, was a young man with much of his career ahead of him when he was approached to perform this task for the state of California.

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**STULL:**[33]

Graham Davis left the Duke Endowment to go to work for the W.K. Kellogg Foundation. There Graham was approached by a Dr. Phillip Gilman,

retired chief of surgery at Stanford Medical School, in San Francisco, California. He asked Graham about getting somebody to do the statewide planning for their Hill-Burton program. They couldn't find anybody; they didn't know anybody. Graham told them they should contact me. I got a letter from Gilman. I had never planned a major state program. I didn't know anything about it, but I had the confidence of youth.

So I took the gamble and accepted the job, much to my wife's dismay because she thought there were still Indians west of the Mississippi. Nevertheless, I took on the assignment and went to the California State Department of Public Health. My first responsibility was to develop the survey approach, direct the study, and write the plan to be adopted by the state and subsequently by the Public Health Service for approving Hill-Burton programs in California.

I recruited a staff. A lot of them were ex–military people. We trained them in the use of the survey forms and then initiated the surveys, learning all about the state and all about the health facilities in the state and what had to be done. Then we began the process of developing a state plan. Concurrently with this I worked with the legislature to pass enabling legislation in the state of California so that the state would then match federal and local funds. So the funds were one-third national, one-third state, and one-third local, which was quite important for California.

## Hill-Burton's Accomplishments

It is both a flaw and strength of human nature that one tends to forget the circumstances that surrounded the need for and that shaped certain decisions and actions. The recent criticisms of the Hill-Burton Act are an example of this. The following observations of Kenneth Williamson, former head of the AHA's Washington bureau, provide a final perspective within which to consider the importance and contribution of Hill-Burton.

**WILLIAMSON:**[34]

The Hill-Burton Act was a big thing. Hill-Burton is under the gun now, you know. Hospitals are criticizing it all over the place.

I read a letter in the *New York Times* recently from a man who should have known better but [who] exhibited an enormous lack of information and knowledge of the past, because he criticized the federal government for its participation. He mentioned Hill-Burton. He mentioned Medicare and Medicaid and so on. Without those things there would be no hospital field today. Hospital care would be a government program.

Hill-Burton came at a time when we had just had World War II. There

had been little invested in the hospital field for some years before the war. It was a period of great neglect of the hospital plant of America and of neglect of all the areas of the country that had no hospitals.

Also, a new kind of physician came out of the war. In fact, he came out discarding the little black bag. He was a guy who was used to having organized means at his disposal. He was trained differently, too. So, a new kind of doctor had come back, and the American people were hearing about the great advances in "modern medicine." Yet in thousands, I mean thousands, of communities all over America there was absolutely no means for modern medical care. You can imagine the pressure that came out of that.

Really from George Bugbee's leadership the hospital field saw that and realized that something had to be done or it was going to burst the bounds some day. There had to be a means by which the health needs of the American public would be met, and that meant more hospitals.

So the Hill-Burton program came about. It was terribly important to the hospital field. There isn't anybody who can see 25 or 30 years ahead and be sure about how certain words will later be interpreted. There is language in the act which said that the hospitals would have to give, within their ability, some free care. It was a very casual thing. It was put in to give a kind of assurance. Now those words are being interpreted in a hard way by the government. Hospitals are being pinned down; they are damning Hill-Burton, but, if they only knew it, Hill-Burton is one reason we still have voluntary hospitals.

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After the long preparatory work of the Commission on Hospital Care and the planning and lobbying of George Bugbee and some of his colleagues at AHA, plus the extensive involvement of officials and staff people of the Public Health Service, Congress passed what is commonly called the Hill-Burton Act.

The Hospital Survey and Construction Act was signed into law by President Harry Truman in August 1946, becoming Title VI of the Public Health Service Act.[35] The act was designed to be a federal-state partnership, with the federal government providing grants to assist states in inventorying their existing hospitals; surveying the need for the construction of public and nonprofit hospitals; and constructing public and nonprofit hospitals in accordance with the programs developed by the states.

The act carried an initial annual appropriation of $75 million. By the time the program expired in the late 1970s, it had provided approximately $4 billion in grants to nearly 4,000 hospitals and $1.9 billion in loans and loan guarantees to almost 300 hospitals.

George Bugbee once said that passing Hill-Burton was one thing, but that eternal vigilance was needed to protect the act from the tinkering and

tampering of well-meaning and ill-meaning persons and forces. Some amendments were made through the years as they became necessary, but many attempts to drastically change the act were turned aside. To see Bugbee in action defending Hill-Burton, read his testimony before a Senate committee considering a change in the act (Appendix F).

Regardless of how it is viewed today, the Hill-Burton program was a landmark effort, establishing the foundation of much of today's hospital system. Not only did it accomplish its goals of increasing the nation's supply of hospital beds and of improving their distribution through regionalization, but it did so in a manner that established a new template for future federal-state relationships.

## Notes

(Transcripts of the oral histories cited here are housed in the library of the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. The Oral History collection is a joint project of the Hospital Research and Educational Trust and the AHA.)

**1.** There was at least one exception to the stoppage of hospital building during the war: Congress in 1941 passed the Lanham Act, which provided for the building of hospital facilities in burgeoning war industry areas.

**2.** Murphy was mayor of Detroit from 1930 to 1933, when he resigned to accept an appointment by President Franklin D. Roosevelt as governor general of the Philippines. In 1936 he returned to Michigan and was elected governor. He failed to be reelected in 1938, probably because of his refusal to remove sit-down strikers from the automobile plants in Flint by force. Roosevelt appointed him attorney general in 1939. He remained in that job only a short time, until Roosevelt appointed him an associate justice of the U.S. Supreme Court in 1940. Murphy served on the Court until his death at age 59 in 1949.

**3.** *I.S. Falk, In the First Person: An Oral History.* See Profiles of Participants, in the center of this book, for biographical information.

**4.** *George Bugbee, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

**5.** See Profiles of Participants for biographical information.

**6.** Van Steenwyk, director of the Blue Cross plan in Minneapolis, was a pioneer in the field and the first person to use a blue cross as the symbol for a group prepayment plan.

**7.** *Bugbee, Oral History.*

**8.** Davis was president of the AHA in 1948 and was probably the only non–hospital administrator ever to serve in that post. He was head of the hospital division of the W.K. Kellogg Foundation for a number of years. Before that, he had been with the Duke Endowment in a similar position.

**9.** O'Connor was a former law partner of President Franklin D. Roosevelt.

**10.** See Profiles of Participants for biographical information.

**11.** See Profiles of Participants for biographical information.

**12.** The Commission on Hospital Care did not study the financing of hospital care, so a few years later the Commission on Financing of Hospital Care was formed to do so.

**13.** Bachmeyer was a good choice to direct the commission. He was a prodigious worker, and he had first-hand knowledge of the problems of hospitals and of providing health care. His associate director, Maurice J. Norby, had had extensive experience in the Blue Cross Commission, as director of statistics and research under C. Rufus Rorem, as well as experience as the developer and first director of the Blue Cross plan in Pittsburgh. Norby was also knowledgeable about the operation of the AHA, because in his Blue Cross Commission work he had been housed at AHA headquarters and had worked alongside AHA officials.

**14.** The remaining members of the Commission on Hospital Care were Katharine J. Densford, director, School of Nursing, University of Minnesota; Evarts A. Graham, chairman, department of surgery, Washington University School of Medicine; Wilton L. Halverson, director of public health, State of California; Charles F. Kettering, vice president and director, General Motors Corporation; Ada Belle McCleery, former administrator, Evanston (Illinois) Hospital; James Alexander Miller, professor of clinical medicine, Columbia University; Leroy M. S. Miner, former dean, School of Dentistry, Harvard University; Claude W. Munger, director, St. Luke's Hospital, New York City; Rt. Rev. Msgr. Thomas O'Dwyer, director of Catholic charities and hospitals, Archdiocese of Los Angeles; William F. Ogburn, chairman, department of sociology, University of Chicago; Clarence Poe, editor, *Progressive Farmer,* Raleigh, N.C.; J. Barrye Wall, editor, Farmville (Virginia) *Herald*; Frank J. Walter, administrator, Good Samaritan Hospital (Portland); and Matthew Woll, vice president, American Federation of Labor.

**15.** *Bugbee, Oral History.*

**16.** *Maurice J. Norby, In the First Person: An Oral History.*

**17.** Parran was appointed surgeon general in 1936 by President Franklin D. Roosevelt. He continued to serve as surgeon general under President Harry S. Truman, leaving to become dean of the School of Public Health at the University of Pittsburgh.

**18.** *Norby, Oral History.*

**19.** James Hague, director of publications and corporate secretary of the AHA, observed that:

> Dr. Parran had a notion of a big program that finally turned out to be Hill-Burton. He needed data to sell it to the Congress. . . . Dr. Parran had a political, legislative problem on his hands and he wanted those data and he wanted the fact-finding well done. So the PHS was the hidden financier of the whole thing. All the statistical work was done by PHS people. As the reports came out, they went to the PHS, so the PHS was privy to the data before those data were public. That work, of course, made the Hill-Burton legislation possible *[James Hague, In the First Person: An Oral History].*

**20.** *Norby, Oral History.*

**21.** Ibid.

**22.** *Bugbee, Oral History.*

**23.** *Nelson Cruikshank, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

**24.** *John R. Mannix, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

**25.** Bugbee said of that period, "Every hospital was planning a building fund drive."

**26.** *Bugbee, Oral History.*

**27.** *Hague, Oral History.* See Profiles of Participants for biographical information.

**28.** *Bugbee, Oral History.*

**29.** *Falk, Oral History.*

**30.** Years later, Willcox became the chief counsel for Aetna.

**31.** *Falk, Oral History.*

**32.** Ibid.

**33.** *Richard Stull, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

**34.** *Kenneth Williamson, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

**35.** Bugbee had held out for giving the federal council more than advisory powers in the Hill-Burton bill. This position was unpopular with President Truman. There was some intimation that the president might veto the bill for this reason and because of its separate but equal clause. When talking about the pens used in the signing of the bill Bugbee said, "I got two of the pens—sort of a consolation prize from friends. I wasn't invited to the signing, which was, I imagine, a calculated insult that I was too naive to care about. I had gone back and forth between Chicago and Washington so much I was delighted not to make another trip."