APPENDIX F

*Excerpts from the Testimony of George Bugbee before the Senate Committee on Labor and Public Welfare, March 19, 1954**

The American Hospital Association and the 5,500 member hospitals it represents are interested in the health of the American people. They have joined together to make the highest possible quality of care available to all the people. It became obvious to us many years ago that the kind of health care available to any segment of the population was directly related to the availability of hospital services.

The hospital is fundamental to the modern practice of medicine and is the means by which the advancements of medical science can be brought to the people. Further, the establishment of standards and controls by the medical profession which are essential to the welfare of the people are best attainable within hospitals. Thus, the existence of good hospitals makes for better medical care, and the absence of hospitals may result in very limited or no medical care. The lack of hospital facilities in many areas of the country is a serious deterrent to meeting the health needs of the people residing there.

It was with this background of thought that the American Hospital Association adopted the position that Federal funds were necessary to assist in providing hospital facilities in needy areas. A mechanism of providing Federal funds on a matching basis to the states was visualized. Therefore, the active support of the Hospital Survey and Construction Act by this Association was a natural consequence.

In general, we are highly pleased that past operations of the Hospital Survey and Construction program have so warranted public support through accomplishments under the Act that additional expansion is recommended. We believe the proposals embodied in S. 2758 are constructive in character. We are appearing before the Committee to raise certain questions which occur to us and to suggest technical changes which we think might more satisfactorily accomplish the objectives of the sponsors of S. 2758.

Representatives of the American Hospital Association have regularly

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had opportunity to appear before this Committee in regard to hospital construction grants, this being the thirteenth time we have been privileged to present testimony on the subject before a Congressional Committee. We would like to quote very briefly from testimony in March 1946 before the House Interstate and Foreign Commerce Committee. What was said then is equally true today.

Aware of the Need

"The American Hospital Association is concerned with this Act because it will vitally affect our own field of humanitarian endeavor. We were one of the first organizations to offer our support to this legislation, and we have followed its legislative progress closely, because we are keenly aware of the need for the additional hospital facilities that may be provided under it, while on the other hand we are apprehensive of the dangers involved if this program is not wisely and carefully carried out…

"The Hospital Survey and Construction Act proposes Federal grants-in-aid to assist the states to build hospitals and health centers in communities and areas where they are most needed. The nationwide program is to be under the general supervision of the Surgeon General of the United States Public Health Service, who will consult with a Federal Hospital Council of experienced hospital authorities in establishing over-all standards and regulations and in approving state construction programs. The administration of the program in each state will be carried out by authorized state governmental agencies.

"The program has two purposes: First, to inventory existing hospitals and survey the need for additional hospitals and develop programs for the construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic and similar services to all of the people and, second, to construct public and other nonprofit hospitals in accordance with such programs.

"In other words, the design of this legislation is to develop an *integrated* system of hospitals and health centers that will make these facilities more readily available to an increased number of people, especially to serve rural or needy areas. The program is thus directly related to the health and welfare of the nation…"

The success of this Federal program is a direct result of the care with which the original legislation was drafted to insure that certain principles were followed. Intimately concerned with the revision of the legislation in the Senate Committee were Senator Lister Hill of Alabama, a sponsor of the legislation, and the late Senator Robert A. Taft of Ohio.

Rights of the States

Senator Taft's particular contribution to this legislation, much of which he personally rewrote, related to the specific delineation in the Act of the intent of the legislation with a minimum granting of latitude to the Federal administrative agency for the interpretation of Congressional intent. Second, he was insistent that within the carefully spelled out purposes of the Act that the states be given maximum administrative authority.

Further, the requirements that the states were to comply with in order to be granted funds by the Federal Government were clearly stated and the Act unequivocally orders the Federal administrative agency to grant funds where the states comply with these requirements.

There are other broad philosophical concepts in the Act which are not there by chance. The Act requires local participation as an earnest of assumption of local responsibility for the successful operation of the facility. The Act requires that each state shall inventory all facilities and develop a state plan to delineate those hospital facilities which should be constructed to bring present facilities up to a proper level.

Further, the state plan must order proposed construction projects by priority before granting funds, which insures that local applications in each state will receive attention on the basis of priority of need rather than on the basis of political pressures.

The Act insures that the Federal administrator will not act in an arbitrary manner, as it requires regulations and other administrative actions be approved by the Federal Hospital Council. Backing of the Federal Council also permits the Federal Administrator to administer the Act in an objective manner.

Inventory Avoids Duplication

The requirement for surveys is one of the most important features of the Act. For the first time, the Act provided for an actual inventory of all of the hospital resources within a state.... These studies and the ideal plan for hospitals which each state must prepare provided a guide for all construction, whether Federally aided or not. The plan avoids duplication and insures adequate facilities for all of the people within a state.

Much more could be said of the consistent and thoughtful study given to the preparation of this legislation. The Association participated in this study and has contributed to the very best of its ability not only in the preparation of the initial legislation and later amendments, but in its administration. We believe this is a proper function of our Association. We are, of course, proud of the accomplishments under the Act in bettering hospital care for the people of this country.

We are sure this Committee knows that this Act has been described as a model of local, state, and Federal partnership in meeting an important national need. We have endeavored, not only at the Federal level, but in states and localities, to stimulate and insure continuing participation in the successful accomplishment of these important objectives.

Shortly after the enactment of this legislation in the spring of 1948, the Association with the approval of the Public Health Service held working conferences country-wide with representatives from official state agencies and hospital administrators representing state and local hospital associations.

Annually, the American Hospital Association has cooperated with the association of directors of the state agencies administering this Act in providing opportunity for them to meet and discuss not only the day-to-day problems of operation under the Hospital Survey and Construction Act, but all aspects of hospital care which might affect administration of this program to insure adequate hospital facilities country-wide.

In the past two years, two members of the Association staff made visits to every newly operating hospital in four states which had received Federal aid under this Act to study the success with which these hospitals were providing community service . . . . A third member of the staff recently surveyed a number of health centers being constructed in the Southern states…

It is not the purpose of this testimony to delineate all of the efforts of the Association to insure the success of the program under the Hospital Survey and Construction Act. We are, however, endeavoring to establish for the Committee the responsible position that the Association has taken in order that our comments on the amendments may be evaluated in proper perspective…

Comments on S. 2758

The broad purposes, as stated in S. 2758, are substantially the purposes as stated in (the Hill-Burton Act) covering the survey and construction of hospitals. We presume that the amendments are suggested for two purposes:

–To provide for survey and construction of facilities not now covered under present legislation, or

–To provide a higher priority in the construction of certain types of facilities, even though they may be provided for under present provisions of the Act.

Our comments will be first directed to the examination of the four classifications of facilities outlined ... and defined in the amendments proposed....

In general, there has been difficulty in the field from the standpoint of classifying hospitals because hospitals generally were not constructed on the basis of any over-all planning. They grew up to meet local needs. Individual hospitals were developed to utilize the medical manpower available and to facilitate the type of practice being carried on in a community.

Generally, there is no clear-cut line of demarcation between the physical plants of different types of hospitals, whether they be the typical community general hospital or for the care of mental illness, tuberculosis, or other chronic illnesses. The type of patient to be treated, whether requiring long-term or short-term care, and, among other factors, the size community, have all affected the gathering together of facilities in the individual hospital.

We find some hospitals primarily classified for the care of chronic illness with laboratory, x-ray and all the facilities which would be present in the usual general hospital. On the other hand, we find some small general hospitals with no more in the way of diagnostic equipment than might be expected to be found in some units for the care of chronic illness or even a nursing home.

The American Hospital Association, concerned with the lack of standardization of definition of hospitals and related institutions in January of 1953, called together 29 individuals experienced in hospital operations, hospital statistics, prepayment for hospital care, and hospital licensure, in both this country and Canada, including representatives of the Public Health Service and of the Census Bureau of the Federal Government. These individuals were invited because of their experience with the problems created by lack of definition of a type of hospital ....

The significant findings of the Conferences were the following definitions:

> *Hospitals and Related Institutions: A* hospital or related institution is any establishment offering services, facilities, and beds for use beyond 24 hours by two or more non-related individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, or pregnancy.
>
> The above broad definition was subdivided into hospitals, nursing and convalescent homes, and domiciliary institutions. These were defined as follows:
>
> > *Hospitals:* A hospital is any establishment offering services, facilities, and beds for use beyond 24 hours by two or more non-related individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, or pregnancy, and regularly making available at least (1) clinical laboratory services, (2) diagnostic x-ray services and (3) treatment facilities for

(a) surgery or (b) obstetrical care or (c) other definitive medical treatment of similar extent.

Nursing and Convalescent Homes: A nursing or convalescent home is any establishment offering services, facilities, and beds for use beyond 24 hours by two or more non-related individuals requiring treatment or care for illness, injury, deformity, infirmity, or abnormality, including at least room and board, personal services, and nursing care.

Domiciliary Institution: A domiciliary institution is any establishment offering services, facilities, and beds for use beyond 24 hours by two or more non-related individuals requiring room and board and personal services which they cannot render for themselves because of a deformity, infirmity, or abnormality.

Careful examination of these definitions will indicate that, without any question, an institution providing care for chronically ill patients may often be classified as a hospital. On the other hand, there will be many institutions, some of which are now called hospitals, which, because of lack of laboratory, x-ray, and intensive day-to-day medical care, would better be classified as a nursing and convalescent home.

We do not believe that the definition of "hospital for chronically ill" and "nursing home" in Senate Bill 2758 clearly indicates the type or classification of facility that the Bill is intended to benefit. In fact, we question that it will accomplish its purpose on the basis of such a differentiation. The basic problem is to provide more beds for the patients in need of long-term care, a group presently inadequately cared for and one which, because of the aging of the population, is increasing greatly in number.

The chronically ill need care in facilities of different types, and the grouping of these types of facilities is affected by the size of the community and various other factors.

On Needs of the Chronically Ill

Some chronically ill patients are in need of surgery and other intensive care which requires all of the diagnostic and treatment facilities of the general hospital. *A* second group of chronically ill patients may need only some of the facilities available in a general hospital, but for an extended period. For example, they may need physical therapy, occupational therapy, as well as periodic medical and diagnostic services.

Where a sufficient number of this second group of patients can be gathered together, they may be cared for in a special unit of a general hospital or in a chronic hospital, which will be somewhat less expensive to construct.

Such patients may need less nursing care, and operating costs will be less than for care of the typical acutely ill patient receiving short-term care in a general hospital.

A certain number of the chronically ill may not require extensive medical care and concomitant facilities, for example, patients with inoperable cancer or with disabling forms of heart trouble, and those badly crippled with arthritis. Such patients primarily need kindly attention, adequate nursing care, and some recreational facilities. Depending on the degree of acuteness of their illness, such patients may be cared for in a nursing home.

It is sometimes possible, where there are large numbers of chronically ill, as in a metropolitan community, to have facilities specially constructed and staffed for patients who are classified by degree of medical and nursing care required. 'Where this is possible, if the average patient needs less treatment and nursing care than is available in the average general hospital, the cost of the facility and the cost of maintenance of the facility decrease.

An example of the complexity of caring for patients, separated by classification, was illustrated in the discussions in the Classification Conference to which we have referred. That group generally agreed that most homes for the aged were nursing homes, as the aged who need only domiciliary care at time of admission to the home, during their period of residence inevitably became ill and required nursing care.

It is undoubtedly true that some homes for the aged would not have such nursing care available even when needed, and, indeed, it is one of the dangers of establishing institutions with limited care that patients who require more nursing care or more intensive medical supervision may suffer because the specialized facility is not equipped to meet their need. The conferees concluded that homes for the aged inevitably became nursing homes.

Danger in Varied Facilities

A particular danger of multiple grades of facilities for the care of long-term patients is the tendency for patients to remain in a facility having a relatively low level of care when professional services and technical facilities available in a higher type of facility are required for good care and rapid rehabilitation.

It is generally agreed that many patients receiving long-term care in nursing homes and in chronic hospitals might be rehabilitated or made more nearly independent of care if they had opportunity for intensive medical care in a general hospital. From this standpoint alone, construction of different types of facilities often may be inadvisable.

In the small community of the size in which most hospitals have been built under the Hospital Survey and Construction Act, it would be likely that the one hospital is for

not only the patient acutely ill and in need of general short-term hospital care, but, in addition, the acutely ill chronic patient who might be cared for in a chronic hospital or in a nursing home.

The degree to which these patients might be wisely segregated in separate facilities from the standpoint of adequate care rendered on an economical basis has never been fully delineated. Strong argument can be made that, in such a small community, all patients except those needing solely nursing care with only occasional medical care might best be treated in one unit.

This interweaving of type of hospital and type of patient is an important factor in the hospital field. Many times, facilities are interchangeable. While beds built for long-term patients *can* be less expensive than similar facilities for the care of patients staying for a short time, this is not always true. As a practical matter, we have repeatedly heard of an older but usable facility which has given many years of service for the short-term patient being replaced by new physical facilities, with the older quarters being then used for patients needing less technical care for chronic illness.

Definition Questioned

We might, incidentally, call to your attention, the wording . . . "not acutely ill" as a part of the definition of patients to be admitted and cared for in a "nursing home." We believe this would not accomplish the intended purpose of the amendment. The patients generally cared for in nursing homes are not necessarily "not acutely ill." As a practical matter, many of them are acutely ill but are not in need of and cannot benefit from intensive medical care. For example, terminal cancer patients may be very acutely ill and require intensive nursing care even though the need of day-to-day medical care may be very limited.

We believe that without question the definition of a hospital in the Hospital Survey and Construction Act was intended to include the type of patient facility this Committee wishes to provide for in hospitals for the chronically ill and probably in nursing homes. In support of that, we call to the attention of the Committee the definition which is embodied in the present (Hill-Burton) Act:

> (e) the term 'hospital' (except as used in section 622 (a) and (b)) includes public health centers and general, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, out-patient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals, but does not include any hospital furnishing primarily domiciliary care;

Referring to the definition of hospitals and related institutions, which this Association's special conference committee developed, it will be seen that domiciliary

institutions are defined and that they include the only types of facilities which were not intended under the original Act and do not appear to be contemplated under S. 2758. On the other hand, hospitals for chronic disease are clearly envisoned under the present Act.

The testimony of this Association on the Hospital Survey and Construction Act presented in 1946 to your Committee pointed out that facilities alone do not provide a complete health service for the American people. The Association, at that time, recommended that the Federal Government, in an act structured like the Hill-Burton program, stimulate the assumption at local and state level of the responsibility for adequate financing for the care of non-wage and low-income groups.

More Resources Needed

To a great extent, those persons suffering chronic illness will be found in the non-wage and low-income groups. Without more resources than have been made available to date through private charity and local welfare funds there can be no broad increase in the number of beds for chronic patients. We particularly call to your attention the exhaustive studies of the Commission on Financing of Hospital Care, an organization sponsored by the American Hospital Association, which, following an expenditure of $550,000, has so clearly delineated this difficulty.

We would suggest that this Committee request the Public Health Service to determine whether applications for beds for the care of chronic disease have been refused by state agencies for lack of adequate priority within each state.

Our experience . . . leads us to believe that this Committee will find that there have been almost no such refusals, that, on the contrary, most of the state agencies have done everything within their power to stimulate applications from government and nonprofit agencies to provide beds for the treatment of chronic illness, which they fully understand is an area of high priority of unmet need.

The main deterrent to the construction of chronic disease beds, in the opinion of this Association, will not be affected greatly by the provisions of S. 2758. Correction will only come if local, state, and Federal Government provide added funds for payment of care for those with chronic illness in order that there may be funds available to operate the type of facilities we are discussing.

Diagnostic or Treatment Centers

The over-all purpose of Title VI of the Public Health Service (Hill-Burton) Act is to provide facilities for the diagnosis and treatment of patients.

The Act (Public Law 725) clearly specifies that it includes "clinic" and "outpatient." There is not agreement in the hospital field or in the medical profession on the meaning of the terms "clinic" or "out-patient diagnostic facilities." These terms are used synonymously to mean various types of facilities for the care of ambulatory patients. At the present time, ambulatory patients are cared for, for the most part, in the offices of private physicians.

These physicians may be working solo or in group practice. There is a growing tendency to locate offices in connection with hospital facilities. Groups of doctors practicing medicine together often call these facilities "clinics." The term clinic is also used to indicate the out-patient facility operated by a hospital and also facilities operated by other agencies for the care of indigent and medically indigent patients. In fairly recent years a number of so-called "clinics" have been set up by hospitals for out-patient facilities for private patients.

All of the major studies in the hospital field in recent years and most recently, the studies of the Commission on the Financing of Hospital Care, point out the importance of utilizing out-patient services, whenever possible. This will often make in-patient admissions unnecessary. This would include diagnostic and treatment services in doctors' offices, which would avoid the heavy expense of in-patient admission.

One of the major criticisms of much prepayment of hospital and medical care is that it does not provide for out-patient services for diagnosis and treatment, with the result that great pressure is stimulated for in-patient admissions. Both the prepayment plans and the hospitals are fully aware of this situation and some experimentation is going on.

However, there is a great difference of opinion as to the advisability of providing out-patient services through health insurance because of the difficulties of controlling over-use and resulting heavy demand on the funds of the prepayment plan. Without careful study and planning, the whole prepayment movement could be damaged seriously.

Services and Facilities

From the first discussions of the Hospital Survey and Construction Act in 1945, there has been confusion in understanding the difference between providing services which the community may want and need as contrasted with solely the construction of facilities. Neither the Hospital Survey and Construction Act nor S. 2758 will do more than provide facilities. No funds are provided for maintenance, and the funds for facilities are granted only on application by the local community or the state.

New facilities are most significant and have certainly greatly improved the distribution of medical and hospital service, but the construction of facilities alone cannot

force new concepts of medical care.

There is no question of the need for more adequate diagnostic services country-wide. Careful and accurate diagnosis is one of the most difficult and challenging day-to-day responsibilities of physicians. Physicians can be assisted in performing this service by having adequate x-ray and laboratory facilities and other diagnostic tools available.

However, facilities in themselves do not lead to the pooling of the knowledge of a group of specialists, and facilities for diagnosis should not be constructed to serve ambulatory patients unless there is assurance that they will be used by the medical profession in a community to provide services and are so badly needed as to justify Federal funds.

S. 2758 proposes the construction of diagnostic or treatment centers. However, such centers are not clearly defined. It would be difficult to know what facilities are to be inventoried within a state using the definitions in S. 2758, or to establish necessary standards without a clearer definition.

Medical Cooperation Vital

All doctors' offices are diagnostic and treatment centers as defined in S. 2758. Hospitals are diagnostic and treatment centers, and, in that sense, the present Hospital Survey and Construction Act is providing such centers.

It is not clear in this bill just what out-patient facilities are to be given the priority of a separate classification with an appropriation of $20,000,000 per year. If private-pay out-patient facilities, as part of a hospital, are to be built to care for patients who now go to doctors' private offices or to the offices of private groups of doctors, then there will need to be developed a new type of plan of medical practice in many communities. This will need the cooperation of the medical profession or it cannot succeed. The bill provides that such facilities must be sponsored by nonprofit or governmental agencies and not a clinic owned and operated by physicians.

Some consideration has been given to the advisability of constructing facilities in outlying communities which might be used by one or two physicians practicing in such a community. Such a facility would provide, at a minimum, x-ray and laboratory equipment and technical personnel for the tests needed by these physicians. In most instances, it would be presumed that physicians in such communities could provide the minimum type of equipment and facilities needed from their own resources. However, in sparsely settled communities, the provision of such facilities by the town or county might encourage a physician to practice in such a setting and give him the assistance of diagnostic or treatment facilities needed for good medical care.

The Kellogg Foundation, in some of the western counties in the lower peninsula of

Michigan, has experimented with the construction of such facilities. It is our information that these facilities, once provided, have not been easy to operate. In such a small community, it is difficult and expensive to obtain and retain the x-ray and laboratory technicians needed for good quality of care. Physicians who are specialists in radiology and pathology are needed to supervise the work of the technicians and interpret the diagnostic tests for the physicians. Such professional services are very difficult to secure in an outlying community.

Expensive to Operate

Under the present Hospital Survey and Construction Act, a number of states have constructed "community clinics" which were equipped with minimal x-ray and laboratory equipment and a few beds for patients needing emergency care who could not be transported to a larger hospital. However, very few states have constructed such facilities as they are expensive to operate, particularly so if adequate quality of service is to be maintained.

If the "community clinic," with a few beds, or with no beds but only simple diagnostic facilities, is contemplated for construction as a "diagnostic or treatment center," we would raise questions as to whether such facilities should be given the encouragement implicit in the special appropriation of $20 million and the priority provided by S. 2758.

We suggest that the development of diagnostic and treatment facilities in areas where there are hospitals, which are not to be in any way associated with these hospitals, should be studied very carefully. It would appear to be contrary to the whole progressive development of health services in this country and not in keeping with the economies which must be practiced in behalf of the public.

S. 2758 recommends that each state, with funds provided for surveys, inventory all "diagnostic or treatment centers" and provide a plan under regulations to be promulgated by the Surgeon General for a sufficient number of such units to serve the entire population. We believe that all of the comments we have listed above raise particular questions as to the practicality of an inventory and state plan required by S. 2758 for this type of facility.

Rehabilitation Facilities

We are in complete agreement that not enough is being done to rehabilitate the sick and injured. Nevertheless, that is the primary function of all physicians and all hospitals and they are most conscious of that responsibility. The question is, what new type of facility emphasis is needed?

There are rehabilitation centers connected with hospitals in this country which are doing an outstanding job. In many respects, the difficulty is not a lack of facilities or

funds for facilities but rather a lack of trained physicians and other personnel interested in the special medical and psychological problems needed to carry rehabilitation to levels not reached at present. Success has been very much a matter of the dynamic leadership of a few specially trained physicians.

We recognize the difficulties involved in making a state plan for the type of rehabilitation facility defined in S. 2758. In many areas of the country the proposal to build such facilities separate from rather than in relationship to general hospitals will be seriously questioned.

Survey and State Plan

S. 2758 provides for a survey of the four categories: diagnostic or treatment centers, hospitals for the chronically ill, rehabilitation facilities, and nursing homes. The original Act required that all states survey all facilities defined as hospitals, including many of the facilities here contemplated. It would seem that a new state plan solely for four classifications of facilities is very cumbersome, and that, with a new Federal appropriation for inventorying and making a plan, it would be necessary to inventory all hospital facilities as well as these four separate categories which are so unclearly defined.

The basic Act requires that the state shall periodically revise its state plan. In many instances, it has been some time since the states have had sufficient resources to carefully re-inventory all hospitals. It would appear that it would be wise, in appropriating funds, to require a re-inventory of all hospitals, including the four categories suggested in S. 2758.

A new plan of all hospitals facilities would be helpful in every state and would insure a re-evaluation of all priorities for all the different classifications of hospitals which may be aided in construction under Public Law 725.

The proposals in S. 2758 that states match survey funds with 50 per cent state matching money and that each state be granted a minimum of $25,000 of Federal matching money seem wise.

General Comments

Earlier, it was suggested that the purposes of S. 2758 must be either one or both of the following:

–To provide for survey and construction of facilities not now covered under present legislation, or

–To provide a higher priority in the construction of certain types of facilities, even though they may be under present provisions of the Act.

Considering S. 2758 in relationship to these purposes, the following comments are offered:

1. Chronic hospitals are clearly eligible for a construction grant under Public Law 725.
2. Nursing homes may be eligible under the Act and could be brought under it by regulation, even though that has not been true up to the present time.
3. All hospitals often care for patients who are chronically ill, and certainly all facilities for the long-term care of patients should be planned in an integrated system as all classifications very much interweave and are inter-related and may wisely all be provided for in some communities in one unit.
4. The categorization of appropriations for chronic hospitals and nursing homes, while admittedly giving a priority, may lead to separate construction or may prevent the construction of other facilities which will generally contribute to the care of chronic patients.
5. No type of diagnostic or treatment facility for ambulatory patients seems to warrant a priority or need for Federal construction money which would justify a separate definition of facility and the priority given by a separate appropriation.
6. Categorization of facilities in five types which are but variations of hospitals will tend toward the construction of separate types of facilities where one facility might much better serve multiple purposes.
7. Separate appropriations for each of the types of facilities authorized will result in a very small allocation of money to each state and may well not be applied for in every state by any eligible applicant during the period for which it is available.
8. Two separate state plans for facilities which can often not be wisely separated seems cumbersome and would better be handled on one survey.

As we have tried to visualize the problems involved in carrying out the intent of 5. 2758, we are concerned with the difficulties involved in establishing priority for the various facilities to be constructed. The funds as stipulated must be maintained separately, and it will not be possible to shift funds from one category to another in the event it seems desirable to do so.

If it is found through experience that there is little or no demand for funds in a state for one or more types of facilities suggested in the proposed amendments, it would be well to allow the expenditure of these funds for other needed facilities. This would avoid the accumulation of especially allocated funds and major criticism of the over-all program.

All of the facilities envisoned under the present Act and S. 2758 are believed to contribute to better health care in each state.

With all the reservations as to the wisdom of the technical approach to accomplish the stated objectives in S. 2758, and with a definite impression that without correction wise administration will be difficult, it is suggested that, at a minimum, the following amendment would be helpful in correcting certain of the difficulties, though it is realized that such an amendment would reduce the planned priority:

> "Sums 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 the first six months of the next fiscal year (and for such six months only) in addition to the sums allotted to such state for such next fiscal year, and thereafter shall be available to such state for obligation during the next six months for construction of any projects eligible under part C of this title."

We believe that a more effective accomplishment of the objectives might be attained by the following amendments to Public Law 725, the Hospital Survey and Construction Act:

1. Define and include nursing homes.
2. Define and include rehabilitation facilities.
3. Assign priority to all facilities for the care of long-term patients with the exception of those for the care of mental illness or tuberculosis.
4. Require a re-inventory and re-survey providing additional funds for Federal matching on a 50 per cent basis with a minimum allotment to each state of $25,000.

President Eisenhower, in his health message to Congress, recognized the need for additional facilities and the major problem of the care of the chronically ill, and the ever-growing number of aged in the population. He has suggested that the Hill-Burton grants-in-aid program be utilized as a basis for working out solutions to these problems.

The American Hospital Association is fully in accord with the President, both as to the seriousness of the problems and the need for a solution as well as the wisdom of considering the Hill-Burton Act as a means of assisting in finding the answers. We are, however, greatly concerned that no amendment weaken a highly successful and workable program or fail to achieve the successful results which S. 2758 is planned to accomplish.

The Hospital Survey and Construction Act was a non-partisan proposal. The American Hospital Association is a non-partisan organization. We believe that the health

goals for the American people enunciated by President Eisenhower and by the sponsors of S. 2758 are universally acceptable, but that their successful achievement is more likely through modification by changes which we are prepared to submit to the Committee.

We wish to reiterate our strong desire to cooperate with this Committee and with the Administration in the development of legislation to further meet the health needs of the American people along sound lines.

Excerpts from Interrogation of Mr. Bugbee by Members of the Senate Subcommittee

Senator Lister Hill (interrupting Mr. Bugbee's description of AHA support of the Hospital Survey and Construction Act). You speak of your support of that act. I think you are very modest. You and I know the inspiration which you gave, the thought you gave, to bringing that act into being and, of course, you recall how you sat in day after day and week after week with Senator Taft and myself and other members of the subcommittee as we wrote that legislation. You, along with the representatives of the Public Health Service, sat right in our executive session when we were trying to write that act, and get the best act we could.

Mr. Bugbee. I appreciate, Senator Hill, that recognition of the fact that we have followed it very closely, and it gives me an opportunity to express our appreciation of the time and effort that you have given to the act, too, through the years to make it an effective program.

Senator Hill. One of the most important things was writing into this act the fact it was to be administered and operated at the state level and not from Washington.

Mr. Bugbee. Yes, sir.

Senator Hill. Isn't that true?

Mr. Bugbee. It is true, and it was fundamental to the Association's support of the legislation.

Senator Hill. The Association insisted on that and met with a ready response from both Senator Taft and myself; isn't that true?

Mr. Bugbee. That is correct, sir.

* * *

Senator Hill. In other words, you not only sat in and helped all you could in writing this act, but you and your Association through the years have kept in touch with its operation and have kept what we might call a continuing study; is that right?

Mr. Bugbee. We have tried to do so.

Senator Hill. Of the act and its operations and results and effects?

Mr. Bugbee. That is correct.

Senator Hill. Is that correct, sir?

Mr. Bugbee. That is correct, and it is very complicated legislation aimed at meeting an important need; and, to the degree we could, we have tried to be helpful.

* * *

Senator Hill. We have a declaration in the budget as to the $62 million which would be authorized under this bill, but, of course, that is not a budget estimate as yet, and it couldn't be a budget estimate until the legislation was passed, but we have a budget estimate for the next fiscal year of only $50 million. Now, isn't this true: that most of the things this bill would provide in the way of construction can be done under the original act?

Mr. Bugbee. Yes.

Senator Hill. Is that correct?

Mr. Bugbee. I would think most of the types of facilities could be, Senator, though I believe there may be merit to making very clear that they are included.

Senator Hill. I understand, but most of them could. For instance, a chronic hospital-

Senator Hill. Yes.

Mr. Bugbee. There is no question–

Senator Hill. Chronic hospital is written out, and even the word "clinic" appears here, and out-patient departments for ambulatory patients, and those sorts of things.

Now, what I am thinking of is, if we are only able to use $50 million, have only $50 million for next year, or most of next year, what will that do to the program we have been carrying on now since about 1947, or thereabouts?

Mr. Bugbee. Well, I think the 50 million alone would be less than could be spent wisely–it is, of course, the smallest appropriation that has been made under the basic act. On the other hand, as we have suggested in our testimony, we are hoping that the suggested supplemental appropriation will be made for the broad purposes of the act, with whatever additional priority need be given the types of facilities described in 2758.

Senator Hill. You would hope, then, that more than $50 million would be available this coming fiscal year?

Mr. Bugbee. Our Association would certainly hope so on the basis of the need for the construction of facilities.

Senator Hill. Did your surveys, the conferences you had here a year ago and other surveys that you made, show there is still a very great need for general hospitals, mental hospitals, and tuberculosis hospitals, as well as chronic hospitals?

Mr. Bugbee. The Public Health Service, of course, has the summary of the figures developed by the state plans, as to the degree of need for beds, but the four conferences held country-wide approached that same problem and there was much discussion as to the backlog of applications which could not be met out of the appropriations up to that period, and without exception the states reported that they had multiple applications for hospitals in areas where they were needed.

Senator Hill. According to the testimony we had yesterday from the Public Health Service, there is a need if we continue through the Hospital Survey and Construction Act to meet those needs, the needs we have since the act was passed, or certainly since about ’47, for almost 600,000 additional general, mental and tubercular beds and some 240,000 chronic disease beds.

Mr. Bugbee. Senator, it is a very substantial number. I would not be prepared to confirm those figures as necessarily exactly right, but we are far enough away from having the needed beds so that it has not been a question of worrying about national over-construction.

Senator Hill. I sit as a member of the Appropriations Committee and I have heard a good deal of testimony. I know surely there is a crying need not only for general hospital beds, but for beds for mental patients; isn’t that true?

Mr. Bugbee. That is correct, sir.

Senator Hill. Isn’t it true that so many of our mental hospitals and institutions for the mentally ill are terribly crowded and inadequate today?

Mr. Bugbee. Certainly the figures would prove that, and from what knowledge I have that is certainly true.

Senator Hill. Mr. Chairman, I have here a letter which just came this morning ... written by Mr. Clay H. Dean, director of the Hospital Planning Division of the Department of Public Health, Montgomery, Alabama. He is the man immediately in charge of the hospital construction under the Hospital Survey and Construction Act and, among other things, I note–as I say, I haven’t had time to read the letter in full, but I notice–this:

> We also feel the requirement for matching survey funds would work a definite hardship on Alabama and other states whose legislatures do not meet until 1955.
>
> Since the Legislature does not meet until the summer of 1955, it would be impossible to get any state funds for matching purposes.

That is for the survey.

I just bring this out because it poses the problem I had sought to pose in the earlier questions. It takes time to get this job done, just as it took several years, as I recall, before the last state finally met the conditions of the survey and of the state plan and having that

plan approved in order to come in and start construction. Wasn't that true?

Mr. Bugbee. That is my memory of it, Senator; yes.

Senator Hill. Mr. Bugbee, you stated:

> We believe that the health goals for the American people enunciated by President Eisenhower and by the sponsors of S. 2758 are universally acceptable, but that their successful achievement is more likely through modification by changes which we are prepared to submit to the committee.

Mr. Chairman, I would like to ask, if it is agreeable with the Chairman, if Mr. Bugbee may, not at this time, but in the next day or two, submit those changes to the committee.

Senator Purtell. We would be very happy to receive them, Senator.

Mr. Bugbee. I shall do so.

* * *

Senator Hill. On the record now.

I do want to commend Mr. Bugbee for his very excellent, fine, analytical, helpful statement here this morning.

Mr. Bugbee. Thank you very much.

Senator Purtell. I want to thank you, too, Mr. Bugbee... and it may be–I know you are most anxious to cooperate, as you always have been–the staff of this committee may wish to consult with you at a later time, and I know you will extend whatever you can in the way of help.