Interagency 1965 Task Force on
Health Care(Cohen, Chairman)

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H E A L T H C A R E T A S K F O R C E

S E P T E M B E R 10, 1965

A D M I N I S T R A T I V E - C O N F I D E N T I A L

Sept. 10, 1965

A D M I N I S T R A T I V E C O N F I D E N T I A L

HEALTH CARE TASK FORCE
Summary of Proposals

1. A program which would enable every child to have the medical care he needs to develop fully his capabilities. The standards of the program should be based on health considerations rather than ability to pay.

Estimated cost: First year, $471 million; five-year projection, $4.1 billion

The major emphasis is on an expanded maternal and child health and crippled children's program. The proposals include increased funds for the provision of services and grants for expansion of ambulatory care facilities (e.g., neighborhood health centers), intensive care units for high risk infants and specialized facilities for the care of the chronically ill and handicapped children. The proposals would increase present fiscal year authorizations to $411 million in 1967. Five-year total of $3.47 billion is projected.

Additional proposals in mental retardation, family planning, school health, immunization, dental caries and a Presidential Commission on Maternal and Child Health are included which would cost an additional $60 million above current authorizations.

2. A program of increased Federal assistance for modernization of obsolete hospital and medical facilities.

Estimated cost: First year, $526 million; five-year projection, $2.73 billion

Two alternative approaches are proposed to modernize obsolete hospital facilities and provide the required number of new hospital beds. The first proposal is essentially an expansion of the present Hill-Burton program of grants for construction of facilities. The second proposal would abolish the existing program and replace it with a new Federal loan program. Thus, instead of the government granting funds, it would subsidize the cost of money directly through loans or through the payment of interest on commercial loans.

The funds would be equally available for both modernization and new construction. A third approach, combining a mixed grant/loan subsidy program could also be developed

The suggested expanded grant program would increase current expenditures from $220 million to $350 million with the major increase in funds for modernization and replacement.

The loan program, if direct, might require $3-$4 billion in the next ten years. If the government paid the interest on loans, it could require $100-$150 million annually.

It is essential in considering these proposals to recognize that the loan program has been considered and rejected repeatedly by the Public Health Service in the last 15 years because of the possible increase in patient care costs and the popularity of the present Hill-Burton program in Congress. These considerations must be weighed against the fact that the program will probably always be underfinanced, it has met few of the metropolitan hospital needs, and it is now considered a deterrent to further development of hospital facilities by some leaders in the field.

The other significant proposals include a major program of support for group medical practice; for construction of community mental retardation facilities; for research and demonstration in hospital design, construction and operation; and for renovation of Public Health Service hospitals. The preliminary estimated program costs are group practice, $50 million; mental health centers, $95 million; research, $20 million; and Public Health Service hospitals, $11 million annually (average over three years).

3. <u>A program for the construction of new nursing and other extended care beds to meet expanded needs and reduce hospital costs.</u>

Estimated cost: First year, $175 million; five-year projection, $875 million

A program is proposed to increase the annual authorization for constructing long-term care facilities to $125 million

annually and to develop a special project grant program of $50 million to demonstrate the advantages of long-term care complexes specifically designed for the aged. These programs would permit public or nonprofit agencies to effectively enter the field that is currently dominated by proprietary nursing homes. The program would not, however, detract from the opportunities for private profit making institutions to develop.

4. A program for better utilization of existing and prospective nursing and other non-hospital bed capacity.

Estimated cost: First year, $23 million; five-year projection, $85 million

The heart of this program is a major expansion of Public Health Service grants for the development of home care services by hospitals. In addition, recommendations are made to provide patient evaluation and utilization review program support.

5. Additional personnel training proposals to meet both existing and future demands for medical and paramedical personnel.

Estimated cost: First year, $200 million; five-year projection, $1.02 billion

New programs are proposed to provide large-scale Federal support for the education and training of middle-level health professionals (e.g., physical therapists, occupational therapists) and for a program of vocational education for all categories of health workers with 1-2 years of post high school education, based on the existing practical nurse training program. The combined cost of these programs would be $330 million in 5 years or an average of $66 million per year.

Additional programs are proposed to initiate or expand Federal assistance in continuing education of physicians, nurses and other health personnel; in financial support for physicians during internship and residency; to aid in the recruitment of individuals for health careers; and

to develop a major staff and research program in all aspects of health manpower. These programs could cost as much as $792.5 million over a five-year period. The estimated maximum first year cost could be $152 million.

6. Other program proposals which could achieve significant medical gains in a relatively short time.

Estimated cost: First year, $143 million; five-year projection, $970 million

Ten proposals are submitted suggesting support for two major international health programs; a program for detection and treatment of cervical cancer; two medical care projects (intensive care units, community health care); a training program for ambulance drivers; a program to effectively combat dental caries and another for salmonellosis; a major program to develop biomedical information systems (Statewide, hospital, medical school, group practice, medical libraries and health departments); and a nation-wide program to encourage physical fitness and proper nutrition, particularly among children and youth. Preliminary estimates were possible in only six of the ten proposed programs, and these would cost an estimated $143 million the first year with a five-year projection of $970 million.

1. A program which would enable every child to have the medical care he needs to develop fully his capabilities. The standards of the program should be based on health considerations rather than ability to pay.

Summary - $471 million for one year, 5-year projection $4.1 billion

The major emphasis is on an expanded maternal and child health and crippled children's program. The proposals include increased funds for the provision of services and grants for expansion of ambulatory care facilities (e.g., neighborhood health centers), intensive care units for high risk infants and specialized facilities for the care of the chronically ill and handicapped children. The proposals would increase present fiscal year authorizations to $411 million in 1967. A five-year total of $3.47 billion is projected.

Additional proposals in mental retardation, family planning, school health, immunization, dental caries and a Presidential Commission on Maternal and Child Health are included which would cost an additional $60 million above current authorizations.

The Problem

In 1963, of the nation's population of approximately 187 million almost 40 percent were under 21 years of age. This represents a 33 percent increase in the child population in a decade. The pace of population growth has been accompanied in the past 20 years by an even more rapid growth of population in metropolitan areas.

Of the 34.6 million persons living in poverty during 1963 nearly 6 million were children under the age of 6, and 9 million were aged 6 through 17. Households judged poor thus included nearly a fourth of the nation's children under 18. An additional 7 million children are being raised on an income that, although above the poverty line, is still within its specter.

The family with income below the economy poverty line was larger, averaging about 4 persons, than the family with higher income, which had on the average 3.5 persons. The poor families, as a group, averaged two children each and the non-poor had one child. Poor households were larger, on the average, than families that were better off. Mainly, they included fewer adults and more children. Among families with children, the poor had more children. Of the 15 million children counted as poor,

nearly half were in families with five or more children, but the income for many of these large families was so low that they would be poor even if they had no more than two children to support. Not only were there more children in poor families, there were younger children, especially preschool children under age 6, making it more difficult for the homemaker to take employment and raise family income.

Of all the persons counted as poor, 10.7 million, or 3 out of 10, were non-white, reflecting the fact that the non-white population sustains a risk of poverty about three and one-half times as high as white persons. Indeed, it can be said that one out of every 2 non-white persons had to be considered as poor in terms of 1963 income. For young children the incidence of poverty was closer to 3 in 5. Non-white children under the age of 18 in families below the poverty line accounted for 5 3/4 million of the 15 million children considered in poverty.

A non-white child had four times the chance of being raised in economic deprivation as a white child, a disadvantage that was likely to continue in much this same degree almost throughout a lifetime. It would be less disturbing if poverty struck at random, with no one group signled out. The data make it clear that this is not so. Many of our children, because of

their color, the occupation of their parents, or the place they happen to live; because they have come into a family that will be a minus a father long before they are grown, or even because too many children have already arrived before them, are forced to live in poverty.

Of the 15 million children being reared in poverty, 6½ million, or 43 percent, were growing up in a home with at least 5 youngsters under age 18. Indeed, the poverty rate among families rose sharply from 12 percent, when there was one child in the home, to 49 percent when there were six or more children. The number of families of six or more persons in poverty probably increased during the last decade.

More than one-third of all poor children were in families in which the head was currently unemployed or out of the labor force, but nearly 40 percent of the children in poverty were in families of a worker with a full-time job all through 1963. Families of fully employed heads were in poverty partly because they were large -- 20 percent had at least five children compared to only 5 percent of those who were not poor.

With changing patterns of family stability, many women are being left to bring up their children alone -- especially among the non-white population. In 1960, only two-thirds of

the non-white children under age 14 had both their father and mother in the home. The current statistics suggest that about 6 percent of white children and more than 20 percent of non-white children were living only with their mother.

Of the 1½ million children under age 6 living in March 1964 in a family headed by a mother, but with no father present, 600,000 had a mother either working or looking for a job. Seventy percent of these children were in the poverty status, compared with 90 percent of the fatherless children with mothers not in the labor force.

By standards prevailing in most States, even if a mother could qualify for aid, the amount paid would probably leave her and her family below the poverty line. In only 4 States would the maximum amount payable to a mother of three, assuming she met all the eligibility requirements, be as much as 90 percent of the economy poverty threshold.

In 1963 the average family of four living in poverty would have about 70¢ per day per person for food and only $1.40 for everything else. It has been estimated that it would take an aggregate of $11.5 billion to raise all the poor just to the economy poverty level and an additional $8 billion to bring them up to the low-cost standard.

Although there have been impressive improvements in the availability of health services and in overall morbidity and mortality figures, there is increasing concern with the widening gap between our goals in child health and the present realities as illustrated by the different infant and maternal mortality rates among the rich and the poor. Comparing trends for ten selected countries since 1935 it is evident that the infant mortality rate in the United States commenced to level off in 1950, whereas in ten other economically developed countries it continued to fall. If present Swedish infant mortality rates prevailed in the United States, approximately 40,000 fewer infant deaths would be recorded each year. In the United States the primary determining factors in this are those associated with poverty. The effects of poverty and the lack of adequate housing, education, health services, recreation, employment opportunity, and social mobility are reflected not only in high infant mortality but in the development of chronic, disabling physical and emotional disorders which markedly affect the ability of children to learn and to participate effectively in modern society.

Certain segments of the childhood population have high morbidity and mortality rates ascribable to causes that have been successfully controlled in other groups. This high risk population is generally in the lower socio-economic group. Non-

white neonatal mortality rates are half again as high as those of white infants and mortality rates for non-white infants 1 through 11 months are three times those of white infants. The problems accounting for these excess morbidity and mortality rates among non-whites are basically related to poverty, ignorance, and indifference. Success in controlling the infectious diseases that are largely responsible for these high infant mortality rates has been achieved in middle and upper income groups through sanitation, good nutrition, adequate housing, immunization, proper prenatal and obstetrical care for women and proper child health services.

Poverty and its attendant circumstances are clearly the sources of increased health hazards, many of which can be prevented or ameliorated by comprehensive health care services of high quality. The existing fragmentation, inferior quality and availability, lack of coordination, and varied distribution of medical care services available to the poor militates against such a possibility. More attention must be given to this as a national health and political problem requiring coordinated, effective action at the local, State, and Federal level. Concern for the problem must not remain within the province of compartmentalized government bureaucracies and professional disciplines involved.

It is now recognized that low birth weight babies (5½ pounds and below) represent not only those that are born prematurely but also a sizeable number who are full-term but critically small at birth. The total of low birth weight infants in this country is nearly 334,000 annually, or about 8 percent of the over 4 million annual births. It is significant that this 8 percent of total births accounts for over half of all neonatal deaths. Many of those who survive suffer permanent damage.

There are a large number of children suffering from chronic physical and emotional disorders which markedly limit their ability to achieve adult levels of physical, intellectual, and social function and which are modifiable in some degree -- prevention, amelioration, compensation, or cure. For example, of the 4.1 million children born each year, about 3 percent (123,000) -- at birth or later -- will be classified as mentally retarded. The 29,000 children in 1964 who were served by the 94 clinics in the country supported with maternal and child health and crippled children's funds represents only a small fraction of the children who need this kind of help. A large number of these children also have physical handicaps. Despite the growth in the number of clinics serving mentally retarded

children, and the increase in the number of children served, waiting lists remain long. Lack of sufficient numbers of trained personnel to staff clinics is a major reason why applications for services for mentally retarded children exceed existing resources.

Additional disorders of this type would include major congenital malformations; severe sensory defects (e.g., vision, hearing); neurological disorders (inherent and acquired); other major chronic diseases and hereditary disorders, etc. The predominant unmet handicapping conditions of today's children in the United States are, however, social and psychological, not physical. Much of the psychiatric care is after the fact rather than preventive.

A number of children are born today with only a slight chance of achieving their developmental potential. It is apparent that some families are not equipped socially, intellectually, economically, or emotionally to provide an adequate environment for child development. Conception of the child should be desired and planned by parents. At the present time family planning advice and services are not equally available to the rich and the poor.

The problem of school health cannot be viewed in its usual narrow context but it must be considered within the framework of the health of children of school age. The usual program of school health includes a healthful environment, health services, education of the handicapped, and health education. School health services often constitute a major component of community health services. In many communities, the money expended, personnel involved, and services rendered far exceed that of other official and voluntary agencies combined. It has been estimated that over $100 million is expended each year in school health programs, most of it in local funds, and nearly 20,000 professional health persons are involved either on a part-time or a full-time basis.

Notably among the deficits in today's educational program is health education. Present health education programs are a sorry blend of morality, folklore, distortions and incompetence. Studies indicate that a majority of teenagers experiment with alcoholic beverages before graduation, often beginning at age 13-14; a majority of smokers begin between the ages of 10 and 15 (one million of today's school children will die of lung cancer before reaching age 70 if present smoking patterns and death rates for smokers continue); early promiscuity and illegitimate

births are on the increase (nearly 40 percent of unwed mothers are 15 to 19 years of age); venereal disease infects more than 250,000 young people annually.

Although these problems may derive largely from unstable socio-economic and psychological factors, they also reflect misinformation and distorted attitudes that might have been prevented by sound health education.

Present Programs

There are a variety of programs which have a direct or indirect bearing on the health of children. The basic legal authority for the programs developed through the Maternal and Child Health and Crippled Children's Programs in the Children's Bureau dates to the basic act of 1912 (42 USC, Ch. 6); Social Security Act, Title V, Parts 1 and 2 (42 USC, Ch. 7, Subch. V); Reorganization Act of 1945; and the new Child Health Program Amendments P.L. 89-97. These new amendments permit an expansion of present programs in such a way that it will be possible to coordinate programs effectively at the local level with boards of education, welfare departments and health departments. The Mental Health Project Grants administered by the National Institute of Mental Health, as well as the new legislative authority to

support programs in mental health and mental retardation, help to cover previous gaps in services available.

Additional funds to support child health programs are provided by the Economic Opportunity Act, Public Health Service grants for migrant workers health programs, and by the broadened program authorized for the Office of Education.

The present Federally supported State crippled children's programs for the medical care of crippled children reach less than one-half of the children requiring such services. There are approximately 375,000 children receiving services, but at least an additional 483,000 who need them. There are many potentially handicapping conditions (e.g., epilepsy) that are infrequently included in State programs. In the case of epilepsy about 40,000 children (over six times the number served in 1959) would receive care if all the States provided service at the optimum level. Expansion of services for conditions in certain other diagnostic groups to their respective optimum rate levels would benefit other children as follows: the number of children with strabismus who would receive physicians' services would be increased from 10,709 to about 68,800; with diseases of the ear and mastoid process, from 20,540 to some 192,000; with congenital heart and other malformations of the circulatory system, from 14,450 to over 59,500. As a group, children receiving services

for different types of congenital malformations would increase in number from 61,367 to over 230,000.

The lack or inadequacy of maternal and child health services, including family planning, financed under existing programs is clearly evident. An increasing number of State Governments are supporting family planning services through local health and welfare programs. The number has risen from 12 in 1960 to 26 in 1965. The Federal Government supports local family planning services through general grants in aid to States under a program administered by the U.S. Public Health Service; through a grant in aid program for maternal and child health administered by the Children's Bureau of the Welfare Administration; through the public assistance medical care programs supported by grants administered by the Bureau of Family Services of the Welfare Administration; and through community action programs supported by grants from the Office of Economic Opportunity.

The number of individuals utilizing family planning services and the amounts spent for this purpose is not known.

The Child Health Program Amendments under P.L. 89-97, increase the funds available for maternal and child health services over current authorizations by $5 million for Fiscal Year 1966 and by $10 million each succeeding year. The funds will

increase from $45 million in Fiscal Year 1966 to $60 million in 1970 and after. The authorization for crippled children's services and child welfare services are increased by the same amounts. Such increases will assist the States, in all these programs, in moving toward the goal of extending services with a view of making them available to children in all parts of the State by July 1, 1975.

Under Part 4 of Title V of the Social Security Act (as amended) grants for special maternity and infant care projects are authorized to reduce the incidence of mental retardation caused by complications associated with childbearing. The authorized appropriations will increase from $5 million in Fiscal Year 1964 to $30 million annually for 3 years after Fiscal Year 1965.

There is authorization in P.L. 89-97 for grants to institutions of higher learning for training professional personnel for health and related care of crippled children, particularly the mentally retarded and children with multiple handicaps. The funds authorized will increase from $5 million in 1960 to $17.5 million by 1969 and each succeeding year.

A new provision is added, authorizing the Secretary of Health, Education, and Welfare to carry out a 5-year program of special project grants to provide comprehensive health care and

and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families. The grants are to State health agencies, to the State agencies administering the crippled children's program, to any school of medicine (with appropriate participation by a school of dentistry), and any teaching hospital affiliated with such school, to pay not to exceed 75 percent of the cost of the project. Projects will provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, including dental services, for children in low-income families.

An appropriation of $15 million is authorized for the Fiscal Year ending June 30, 1966; $35 million for the Fiscal Year ending June 30, 1967; $40 million for the Fiscal Year ending June 30, 1968; $45 million for the Fiscal Year ending June 30, 1969; and $50 million for the Fiscal Year ending June 30, 1970.

The passage of the Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (P.L. 88-156) authorized, for the first time, grants to States and Territories for comprehensive mental retardation planning. The planning is collaborative and interagency in nature, with participation of agencies responsible for services in education, employment, rehabilitation,

welfare, health, and the law, including both community agencies and residential programs. Funds totaling $2.2 million were made available for two fiscal years, 1964 and 1965.

Basic planning grants of $30,000 each were allocated and awarded to all the States and Territories (except American Samoa), and supplemental planning funds totaling $579,998 were awarded to a total of 35 States and Territories for a variety of extended planning projects. These grants have made it possible for the States and Territories to begin comprehensive mental retardation planning. Close Federal-State liaison has been maintained in this effort.

The majority of States are well along in their planning, and are discovering areas of concern that will require considerable coordination of activities. Some of these areas of concern are: lack of adequate statistics on the extent and distribution of the mentally retarded in the State; attention to special needs of the retarded in certain ethnic groups within the total population; and planning at the community level and integration of this planning with the overall State plan.

P.L. 89-97 extends the grant program begun under P.L. 88-156, thus enabling the States to begin implementing their comprehensive plans to combat mental retardation. The program

will provide the States with long-term experience in collaborative activities, and will more clearly demonstrate to them the value of this relatively new approach in mental retardation.

The Mental Retardation Facilities and Mental Health Centers Construction Act of 1965 (P.L. 89-105) amends two existing laws which provide funds for training of teachers of handicapped children and research and demonstration projects related to special education.

The program of training of teachers of mentally retarded and other handicapped children is extended for an additional three years. The existing law authorized the program through June 30, 1966. The present Amendments extend it through June 30, 1969. Authorizations for appropriation will increase from $19.5 million in Fiscal Year 1966 to $37.5 million in Fiscal Year 1969.

The research and demonstration program is also extended to 1969 with increased authorizations for appropriations. The present law authorized funds only through June 30, 1966. In addition, as part of the research and demonstration authority, the Commissioner of Education is authorized to make a grant to an institution of higher learning for the construction, equipping and operation of a facility for research and demonstration in the field of education of handicapped children. Authorization for

appropriations will increase from $6 million in Fiscal Year 1966 to $14 million in 1969.

From 1958 through 1963 the Office of Education administered, under the provisions of P.L. 85-926, a graduate fellowship program in the education of the mentally retarded. In October of 1963 this law was amended and vastly expanded by P.L. 88-164 to include not only the area of the mentally retarded, but also the areas of the seriously emotionally disturbed, deaf and hard of hearing, crippled and other health impaired, speech handicapped and visually handicapped.

In addition, the $1 million authorization was increased to $11.5 million for Fiscal Year 1964, $14.5 for Fiscal Year 1965, and $19.5 for Fiscal Year 1966.

For Fiscal Year 1965 approximately $36,000,000 was requested by 254 institutions of higher learning and 50 State education agencies applying for participation in the program. The total of $14,500,000 was available and awarded. Over $14 million was requested for the training of teachers of mentally retarded children.

Approximately 2,500 persons will receive training in the education of the mentally retarded under Fiscal Year 1965 funds. At least 55,000 trained teachers of the mentally retarded are needed.

During the second award year (Fiscal Year 1965) of the expanded grant program under P.L. 88-164, 153 colleges and universities were awarded grants in the education of the mentally retarded. These colleges and universities were located in 47 States, District of Columbia, and Puerto Rico. In addition, each of the 50 State education agencies was awarded grants in the area of mental retardation.

In addition to training of teachers, P.L. 88-164 also authorizes a 3-year research and demonstration program in the education of handicapped children. Authorized to be appropriated each year was $2 million. In Fiscal Year 1964, $1 million of the $2 million was appropriated. During this year, the Office of Education received almost $6 million in requests. Twenty-two percent of the proposals were funded.

In Fiscal Year 1965, the full authorization was appropriated. Approximately $850,000 was used for continuation costs and $1,150,000 for new research. It is estimated that project applications requesting approximately $7 million were processed this year.

The new construction program in P.L. 89-105 deserves a special word. The research center constructed under this program would have the major objectives of research, demonstration, and dissemination. It would concentrate human and financial resources

on the critical and difficult problems involved in the education of handicapped children, and would bring together the best researchers and the best teachers, as well as research trainees.

The 1965 Social Security Amendments include a new medical assistance program for the needy under Title IX. The establishment of a new medical assistance program under the Social Security Amendments of 1965 should do much to improve the quality and quantity of medical care and services made available to persons unable to pay for such care. Up to this time the medical care provisions of the public assistance programs have tended to be piecemeal with few or no statutory requirements. In putting all of these provisions under a single program, with a more adequate statutory base and Federal participation that is both higher and uniform for all aged groups (including children) relatively immediate improvement and progressive improvement in the next decade should result.

The new law requires that any State entering into the program provide, no later than January 1, 1967, inpatient and outpatient hospital services, laboratory and x-ray services, skilled nursing home services for adults, and physicians' services. By the same date it requires that States pay the reasonable cost of inpatient hospital services. It requires that a State's plan set forth the various standards and methods that it expects to

use to assure high quality care. It requires that the plan show progressive improvement so that by 1975 substantially all medically needy persons within a State will receive the medical care and services that they need. We understand that the Commissioner of Welfare expects to issue policy materials calling for the highest standards of care under the program that can be supported by the statute. We are fully in accord with this position.

The new law unfortunately does not include all medically needy persons. It does include all who are over 65 or under 21 (if States elect to extend their programs this far). Between the ages of 21 and 65 persons eligible are limited to the blind, the disabled, and the parents of children in families deprived of support by the death, absence, incapacity or unemployment of a parent.

The hospital insurance and supplemental medical insurance benefits under social security will do much to relieve welfare agencies of expenditures which they have been carrying for aged persons, particularly in the area of hospital care. With these funds and the additional Federal matching funds under the new program, States should be able to make very substantial gains in having a comparable program for all medically needy people. It is urgent that States avail themselves of the opportunities available to the fullest extent possible.

Objectives

The basic objective of the proposals is to develop a program that would permit every child to have the medical care (preventive, diagnostic, therapeutic, restorative) he needs to fully develop his capabilities.

Solutions to such basic problems as poverty, the uneven distribution of available health services, the administrative fragmentation, the segregation of services based on racial and economic factors, the inadequate case finding and insufficient follow-up with indicated services, the inferior quality of tax-supported medical care programs for children, the separation of preventive and curative services, the weakness of quality control measures and the separation of private and public medical care services are all among our immediate concerns.

The medical measures to which the present problems will respond must be components of a system of comprehensive, continuing health care of high quality available to all on the basis of health need without regard to the patient's ability to pay. The program should incorporate the following general principles in order to meet stated objectives:

(1) The opportunity to obtain the same quality and continuity of maternity and pediatric care available to private patients should be provided to patients relying on publicly financed medical care.

(2) Maternity and pediatric patients relying on tax-support for medical care should be provided coordinated, comprehensive medical care through an integrated program.

(3) Physicians and other professionals who provide services to mothers and children in public programs should be compensated for their services.

(4) Participation by physicians and hospitals in the provision of tax-supported medical care should require the application of currently accepted standards of both maternity and pediatric care as outlined by relevant professional associations.

(5) Family planning services should be made available on the same basis as other maternal and child health services, without discrimination against the poor, with freedom of choice for the individual within the dictates of his own conscience.

Proposals

1. Expanding Maternal and Child Health and Crippled Children's Services

A vast expansion of existing programs or the development of new approaches is clearly indicated to fill current unmet needs and the multiplying need for services, especially among

the poor. The proposals presented to meet the need incorporate as goals attack on three major obstacles to availability of services: (1) ability to pay; (2) fragmentation of tax-supported programs; and (3) lack of coordination in tax-supported programs for the poor.

A. Under Existing Children's Bureau Authority

Many large cities have only rudimentary maternal and child health and crippled children's programs in spite of the rapid increase in the population in those cities which are dependent upon public and voluntary agencies thereby greatly burdening these limited resources. In order to provide more adequate financial support for these two basic health programs, it is proposed that authorization for Title V, Parts 1 and 2, be substantially increased with increases earmarked for expenditures in cities meeting basic standards of quality, with populations in excess of an agreed upon figure (e.g., 100,000 or 250,000) and a high percentage of children in the population. To develop integrated, coordinated, high quality medical care programs at the local level State health departments or other State agencies administering the crippled children's programs need program support grants which can be used to expand the programs made possible under Title V, Part 2 of the Social Security Act.

There are already a great many specialized facilities for the diagnosis, treatment and rehabilitation of chronically ill and handicapped children with programs to provide comprehensive services for children (e.g., Children's Hospitals, special pediatric rehabilitation units, voluntary agencies and private facilities for outpatient services, children's services in general hospitals). There are, however, many unmet needs in the care of the chronically ill child. The programs and their supporting facilities should be developed on a State wide or regional basis through expansion of the crippled children's services. Many of the costs for services could be provided through existing crippled children's programs, an expansion of these programs, voluntary insurance, private payment and voluntary contributions. This program should also be related to the regional program for heart, cancer, stroke and other diseases.

These centers located in or affiliated with teaching hospitals would serve as a backup to other community hospitals, the community child health centers, the health department, private practitioners and all the other components of a community wide, comprehensive medical care program. They would have the following objectives:

(1) To provide for all infants and children referred completely adequate diagnostic and therapeutic services.

(2) To develop research programs with respect to the types of health problems they are required to handle.

(3) To give excellent training for physicians, nurses, technicians, auxiliaries and other types of health manpower for the kind of specialized diagnosis and treatment represented in the facility.

Community-wide, and area-wide, cooperative arrangements would have to be developed to make these highly specialized services available to those who need them. The centers should be located initially in areas of greatest need.

The development of facilities would probably cost about $500,000 to $1,000,000 each with operating costs provided by the expanded crippled children's program under Title V, Part 2. The objective should be to create these facilities in States where they do not now exist or are inadequate to meet the need. A program authorization of $5 million annually for five years is suggested.

In order to achieve the statutory objectives of extending these programs to children in all parts of the States the funds required initially would be $200 million annually for the crippled children's program and $120 million for Maternal and Child Health Services.

In order to prevent many of the problems arising in infants and children due to lack of prenatal, neonatal, infant or child care an expansion of existing authority under Title V, Part 4, could be used to provide high quality medical care for the one million mothers living in poverty. The present authorization has a maximum of $30 million and the legislation expires at the end of Fiscal Year 1968. The authority for this program should be extended and increased by steps to $300 million by 1975. The initial increase in Fiscal Year 1969 could be $60 million.

B. Medical Care Insurance

On several occasions it has been proposed to extend medical insurance coverage under Social Security to cover the approximately 2 million children under age 21 who are dependents of beneficiaries under this program. This would cover only a limited number of children (less than 5 percent) and would not include very many in the high priority group (infants and pre-school aged children).

An additional alternative that deserves consideration in the future is a comprehensive medical insurance program for all mothers and for children up to the age of six. This program could not be recommended until detailed actuarial, economic, medical, manpower and other studies are completed.

2. Maternal and Child Health Care Facilities and Services

A. Ambulatory Care

Adequate facilities need to be provided in major metropolitan areas and in rural areas (areas of greatest need) to permit easy access to health care. These facilities may range from a large outpatient department in a public or voluntary hospital to a small rural clinic or small neighborhood medical center. The facilities should include space for medical, dental and public health personnel as a minimum. They should be functionally related to a facility that provides a full range of inpatient, outpatient and home care services. In a community hospital these services would likely be provided by the hospital staff on a private basis.

A grant program should be developed for construction of facilities in areas of greatest need. Operating funds should be provided for a minimum period of 5 years. There should be no segregation of care on the basis of economic, social or other factors. There should be facilities to permit private patient

care of both privately supported and publically financed patient care. Grants could be given to State or local health departments, community hospitals, medical schools, local or State medical societies, and medical group practice organizations. Funds should be used for both new construction and renovation of existing outpatient, emergency room and other ambulatory care facilities.

These metropolitan (or rural) neighborhood maternal and child health centers could provide services in a specified area, such as a census tract, for which basic data on the population at risk was available. These centers could not only provide an excellent setting for patient care but they could be used for the education and training of medical students, physicians, nursing students and nurses, social workers, maternal and child health aides, as well as other auxiliary health personnel.

This program could form an excellent adjunct to the regional heart, cancer and stroke programs. The initial funding for planning, facilities and operations should be $50 million with an increase to $100 million in Fiscal Year 1968 and $150 million by Fiscal Year 1970.

B. Intensive Care Units for High Risk Infants:

Intensive care units in teaching hospitals should be developed to provide intensive, comprehensive care for newborn infants at high risk (e.g., premature, low birth weight, cardiac, hyaline membrane disease). First priority should be given to facilities providing services for those in greatest need (e.g., metropolitan hospitals with 1,000 or more deliveries per year). In most instances remodeling of existing facilities will be required, personnel will have to be trained and professional and auxiliary staffs augmented. A construction grant should be provided and, in addition, funds to meet all operating costs of these units should be provided. Funds should be provided to cover the cost of patient services, transportation to the unit from other hospital facilities and teaching activities.

The development of the special intensive care units for infants at risk should be related to the Children's Bureau program for maternity care for high risk mothers.

An effort should be made to develop this program as a service to all who need it. The program would also serve as a mechanism for research and training. Each intensive care unit might require funding of approximately $300,000 to $750,000. The total cost for 20 centers per year would be $6 million to $15 million.

A program of this nature could result in the need for construction or remodeling of obstetrical and neonatal care facilities and a vastly expanded program for the training of physicians, nurse-midwives, nurses, technicians, social workers and the full range of paramedical and auxiliary personnel involved in the care of mothers and children.

3. Programs for the Mentally Retarded

A. Day Care Centers for the Severely Handicapped

There is need for Federal financial support for day care centers for the severely handicapped. These are children with I.Q. below 40 and most school programs will not take them. The programs should have proper medical supervision and physical, occupation and speech therapy may be required. Funds to provide transportation for the children will be required. The initial costs of this program could be $10 million annually.

B. Staffing of Mental Retardation Centers

Under provisions of P.L. 88-164, Title I, Part C, it has been estimated that approximately 100 applications for construction will be received during Fiscal Year 1966. Approximately 25 of these projects should be completed during 1966 and the remainder during 1967.

At the moment it would appear that 3 out of 4 of the facilities to be constructed would include some aspects of a diagnostic and evaluation clinic in the program to be carried out within the facility to be constructed. While it was anticipated that when construction of these facilities was completed some of the existing mental retardation clinics which are supported with maternal and child health and crippled children's funds would move into these facilities, the State plans for construction and the priorities and priority area established by the State construction authorities make it appear now that many of these facilities will be constructed in areas in which there are no existing clinics. Priorities have been assigned chiefly to areas in which there are no facilities. This means that the construction program will create the need to staff additional clinic programs in areas where these programs now do not exist.

It is anticipated that the average cost of staffing of these clinic programs will be approximately $60,000 per year per program. This cost figure would fit in with the guidelines developed by Public Health Service for P.L. 88-164, Title I, Part C (a diagnostic and evaluation facility to be planned to serve 200 new cases per 1 million population area). A $60,000 operating budget would permit a clinic to deal with a total case load of 400 (200 new and 200 carried over for continuing

service). The facilities to be constructed therefore would serve approximately 30,000 additional children and their families per year. This, combined with children now served by existing clinical programs (2% of the mentally retarded children under 21 years of age) would permit clinic services to be offered to approximately 3½% of the retarded children under 21 years of age in this country.

The cost of staffing these additional diagnostic and evaluation centers would be approximately $4.5 million per year. Additional maternal and child health and crippled children's funds will need to be sought for the purpose of staffing these newly constructed centers.

As an alternative, it is proposed that new legislation be formulated for the staffing of community facilities for the retarded. Under present legislative authorities, several Federal agencies -- the Bureau of State Services (PHS), the Children's Bureau (Welfare Administration), Vocational Rehabilitation Administration, National Institute of Mental Health (PHS), and possibly the Office of Education -- may be able to support community mental retardation facilities (Part C, Title I, P.L. 88-164). Such authority, however, is frequently limited to demonstration projects rather than ongoing programs, or only to financial support for professional personnel. Furthermore,

support by these agencies can only be granted to facilities with programs relevant to these specific agencies' mission and responsibilities. Considering that many facilities contemplated will provide a wide range of services embracing the program objectives of several agencies, these limitations pose serious obstacles to effective administration. Staffing of facilities under Part C should incorporate the same principles now applied to the construction grants; namely, a variable grant formula, with matching State and local funds administered by a single State agency. The initial cost of this program would probably be $10-20 million with a gradual increase to $75-100 million by 1975.

4. Family Planning Programs

It is essential that the Department of Health, Education, and Welfare provide national leadership in the field of population studies relating to education, health services and welfare and in the expansion of health services to include family planning. This requires designating an Assistant Secretary to carry Departmental responsibility in this field. There should be adequate professional staff at the Departmental level and in the Public Health Service, Welfare Administration, Office of Education and Food and Drug Administration.

A policy should be established to authorize expenditure of Federal funds for family planning as part of health services. The Welfare Administration should make it clear to State and local welfare agencies the specific categories of funds available for family planning services. The time is long overdue to stop discriminating against the poor in terms of the basic right to determine when and how many children they wish to have. There should be complete freedom of choice in these programs, a variety of methods (including rhythm) should be available if desired and the individual must be free to act within the dictates of his conscience.

In addition, a vastly expanded program of research and research training in fertility, fertility regulation and fertility control methods should be stimulated, initiated and supported by the National Institutes of Health. A serious bottleneck to program expansion is the shortage of laboratory space available in universities and research institutions. To overcome this, NIH should be authorized to provide 100 percent funding for fertility research facilities during the next 5 years.

There is little new legislative authority required to carry out the suggested programs except for positions that may be required and the authority required to give 100 percent support for research facilities.

5. Programs for the Emotionally Disturbed

In view of the special authorization (Section 231) in P.L. 89-97 there is no immediate need for legislative proposals for Fiscal Year 1967 beyond those authorized.

6. Special Programs Affecting Children

A. Prevention of Dental Caries

A nationwide program to prevent dental caries should be fully supported by the Public Health Service through grants for the construction of fluoridation facilities for community water supplies and a vigorous public health educational program on the value of water fluoridation and the use of toothpaste and/or vitamins with fluoride supplements. The cost of the program is difficult to estimate without more detailed study, but it might average $10 million per year for a 10-year program

B. Immunization

The present nationwide immunization program should be fully supported to insure that every infant and child in this country is adequately protected against smallpox, measles, diphtheria, pertussis (whooping cough), tetanus and poliomyelitis. This program is adequately funded under PHS authorization, but it requires full support by the Surgeon General, the Secretary of the Department of Health, Education and Welfare, and the President.

C. School Health

A nationwide program of health education should be initiated through all of the nation's primary and secondary schools to make available sound, practical, scientific knowledge about health and disease to the children and youth of this country. Special emphasis should be given to nutrition, accident prevention, smoking, sex education, dental health, physical fitness, immunization, emotional health and normal development. Such a program would require the application of modern methods of communication, including the use of small group discussions, reading material, audiovisual aids, radio and television. The program should use all these channels of communication and a program to evaluate effectiveness should be included in the financing. A minimum estimate of the cost of this program is $50 million annually.

7. A Presidential Commission on Maternal and Child Health

While in no way delaying the implementation of proposals submitted by the Task Force, A presidential commission should begin now to carefully review the present state of maternal, infant and child health in this country, existing services, research and training programs. These should be compared with those in other countries. A commission could conduct such a review and report to the President not later than November 30, 1966, with a series of recommendations to improve maternal and

child health services, programs of research and training and programs of international cooperation. A budget of $1-2 million should be adequate. The Commission's study could be an excellent prelude to a White House Conference on Children and Youth in 1970.

2. A program of increased Federal assistance for modernization of obsolete hospital and medical facilities.

Summary

(Estimated total cost $2.73 billion in 5 years with a first year cost of $526 million.)

Two alternative approaches are proposed to modernize obsolete hospital facilities and provide the required number of new hospital beds. The first proposal is essentially an expansion of the present Hill-Burton program of grants for construction of facilities. The second proposal would abolish the existing program and replace it with a new Federal loan program. Thus, instead of the government granting funds, it would subsidize the cost of money directly through loans or through the payment of interest on commercial loans. The funds would be equally available for both modernization and new construction. A third approach, combining a mixed grant/loan subsidy program could also be developed.

The suggested expanded grant program would increase current expenditures from $220 million to $350 million with the major increase in funds for modernization and replacement.

The loan program, if direct, might require $3-4 billion in the next ten years. If the government paid the interest on loans it could require $100-150 million annually.

It is essential in considering these proposals to recognize that the loan program has been considered and rejected repeatedly by the Public Health Service in the last 15 years because of the possible increase in patient care costs and the popularity of the present Hill-Burton Program in Congress. These considerations must be weighed against the fact that the program will probably always be underfinanced, it has met few of the metropolitan hospital needs and it is now considered a deterrent to further development of hospital facilities by some leaders in the field.

The other significant proposals include a major program of support for group medical practice; for construction of community mental retardation facilities; for research and demonstration in hospital design, construction and operation; and, for renovation of Public Health Service hospitals. The preliminary estimated program costs are group practice, $50 million; mental health centers, $95 million; research, $20 million; and Public Health Service hospitals, $11 million annually (average over 3 years).

The Problem

There are six specific areas of need in the health facility construction field which need special attention and emphasis:

1. There is need for additional general hospital beds to meet the continuing growth of population, population shifts and growing demands.

2. There is the need to stimulate the modernization or replacement of older hospitals. While from a dollar standpoint the need is mainly in the metropolitan areas, it does not stop there.

3. There is need to bring about a further redistribution of facilities in metropolitan areas and to bring about a better balance in urban hospital resources.

4. The fourth area requiring attention is the need for long-term care facilities.

5. There is need to expand community facilities for the mentally ill and mentally retarded.

6. There is need to stimulate the expansion of group practice, particularly in association with community-based hospitals.

Accepting all these needs as important, we will focus on modernization, replacement and new beds; community mental retardation facilities and group practice in this section. The problem of long-term care facilities will be considered in another section of the Health Care Task Force report (section 3).

Perhaps the most significant aspect of the development of modern medicine has been the increasing importance of the hospital in the treatment of disease. Much of this importance results from the nature of technical change in medicine. At one time, all of the technology of medical care was encompassed by the physicians' bag and the role of the hospital was primarily custodial. Today, the practice of medicine requires the use of large quantities of capital equipment for diagnosis, treatment, and even prevention of disease. More and more, this capital has been centered in the hospital, as has more of the manpower needed to produce medical care.

The hospital has become the focal point, not only for the care of the acutely ill individual requiring inpatient services, but for those requiring a spectrum of care ranging from the outpatient care of ambulatory patients to home care, emergency room care and long-term care.

Great progress has been made over the last two decades in developing a nationwide system of good short-term, acute general hospitals through the Hospitals and Medical Facilities Act (Hill-Burton). Little assistance, however, has been available to the older hospital, particularly in the metropolitan area, for modernization in order to keep abreast of the rapid scientific and technological changes in hospital care. The Hill-Burton program has stimulated planning at the State and community level for acute, general hospital beds, but the planning for psychiatric facilities, for long-term care facilities, and for facilities for ambulatory and home care has tended to follow separate paths or to have developed very little. Only recently has it become clearly recognized that there is not a sharp distinction between facilities and services required for the various kinds of patients now classified as acute chronic, mental, or tubercular.

A very important factor in the equation was introduced in 1965 with the passage of the Medicare bill (Public Law 89-97). It is significant that the States with the smallest relative supply of expansion potential under Hill-Burton (States with large urban populations) tend to be those with the largest potential increased demand for services resulting from the

Medicare program. While it is possible that this new demand can be met by other programs, it is significant that the basic hospital supply legislation provides little assistance to the implementation of a major and far-reaching piece of legislation which will so clearly affect the demand for services.

In many respects the Hill-Burton Act has contributed greatly to the improvement and extension of hospital services. Not only have more hospital beds been provided, but this legislation has resulted in an increased awareness of deficiencies, stimulation of planning and improvement in operations. The rural areas and communities with population under 100,000 people have been well served.

One of the major deficiencies of the program has been the limited allocation of funds for modernization or replacement of obsolete facilities. In addition, there have been insufficient grant funds available for new experimental programs in design, construction and operation; for long-term care facilities; for urban hospitals; for ambulatory, emergency and home care services and facilities.

Reporting on the first 14 years of the Hill-Burton Program in 1961, the Public Health Service reported that nearly half of all projects (2,697 projects and 104,770 beds) were

for new beds while the remainder (2,991 projects with 134,176 beds) were for additions and alterations. The approved program included an expenditure of $4.93 billion with $1.55 billion Federal and $3.38 billion State and local funds.

Two-thirds of all Hill-Burton projects have been in smaller cities, towns or rural areas. Only 22 percent of the beds provided and Federal fund expenditures have been in cities of over 100,000 people.

There are over 2,000 hospitals with more than one million hospital beds that currently require modernization or replacement. Over 80 percent of the hospitals of 500 beds or more (primarily urban) need this kind of help. The total cost will exceed $3.5 billion in the coming decade.

It is apparent that many people now believe that although the present Federal grant in aid programs were all right in their day, they are now a major deterrent to a rapid program of development. The amounts of money Congress is willing to grant each year encourages very costly delays. Sponsors are forced to wait their turn because communities insist they must have the assurance of Federal matching before they are willing to go ahead. A great many worthwhile projects are delayed for years. Also, an increasing number of projects must depend upon their ability

to obtain sizeable commercial loans for the matching portion. This makes for much higher patient costs as the high interest rates are added.

In recent years the concepts of caring for the mentally ill have changed dramatically with the emphasis on community oriented facilities providing comprehensive services. However, too many mental patients are still resident in large, over-crowded, ill-equipped, under-staffed, isolated, State institutions.

The needs for community oriented facilities for the mentally retarded to receive comprehensive services relating to prevention, case finding, diagnosis, education, training, rehabilitation, employment, and care have only begun to be met. The development of these facilities at the community level should permit many mentally retarded to remain in their own communities rather than live in large, over-crowded State institutions.

In urban areas particularly there is a need for an expansion of hospital outpatient home care and emergency care services and facilities to provide the appropriate types of services and to reduce the unnecessary demand for expensive inpatient care which results when other, more appropriate, facilities are not available.

An increasing proportion of this country's population uses the emergency rooms of hospitals as their principal source of primary medical care for acute, urgent and non-emergency problems arising during weekends, at night and often at other times, as well as for major medical emergencies. There is need not only for an expansion of facilities, but for a well organized 24-hour emergency service at the local level.

An additional problem exists because very little experimentation has been done in hospital design and construction. The capital expenditure required for a hospital is such that few institutions have been able to finance medical innovations. There have been even fewer experiments combining the benefits of an organized group practice with a modern hospital facility in order to study the potential savings in dollars as well as the potential improvements in the quality of inpatient and outpatient care that might result from such arrangements.

The Public Health Service hospital system requires extensive modernization of its current facilities. All of the hospitals have been erected since 1930 but they have been inadequately maintained and they are in unsatisfactory condition because funds have not been made available for necessary improvements and modernization. Federal hospitals should have the best of modern laboratory, x-ray, operating room, intensive care, and

other equipment. In addition to renovation of existing facilities, the PHS needs to study and develop new approaches to health care in its facilities.

The facilities are of little relevance unless they are staffed by qualified personnel and available to those who need them. In order to make services more effectively available many of the barriers that currently exist must be broken down. New government and private efforts which diminish and/or remove barriers to access to the preventive, curative, or rehabilitative services needed by the people are clearly required. Because problems and resources differ greatly from one community to another, the maximum local initiative should be encouraged in new approaches to the solution of these problems.

Present Programs

1. Hospital Facilities - modernization, replacement, and new beds - The Hill-Harris amendments (P.L. 88-443) authorized a new modernization program of grants beginning in fiscal year 1966. The amounts authorized to be appropriated are as follows:

1966	$20 million
1967	$35 million
1968	$50 million
1969	$55 million

The amount of $20 million would modernize and replace approximately 2,500 general hospital beds, and $50 million would modernize and replace approximately 6,250 general beds. Such a program would not keep pace with the additional general beds becoming obsolete each year and thus, our backlog would continue to increase.

The Hill-Harris amendments provide for annual appropriation authorizations for construction of hospitals which decrease in amount from $150 million in 1965 to $125 million in 1969.

2. Development of Group Practice, Ambulatory Care Facilities, and Physicians and Dentists Offices - Authority exists under present Public Health Service authority to provide grants to stimulate the development of medical, diagnostic, treatment and rehabilitation services; to promote research, experiments and demonstrations in redevelopment and utilization of hospital, clinic or similar services; to construct public or other non-profit diagnostic and treatment centers and to construct units of medical facilities which involve experimental design.

The Small Business Administration operates a program of loans to small businesses under which a private physician or dentist is eligible to apply for a loan for construction of office space. As of November 30, 1964, only 305 such applications had been approved since the program began in 1953.

The existing legislative authority and level of grant funding have not resulted in any significant change in the pace or pattern of group practice development or the development of adequate facilities for ambulatory care in urban hospitals. This has been true of hospital based, consumer or cooperative based and independent physician based group practice organizations, as well as medical school teaching hospitals, voluntary and public hospitals. The loan program operated by the Small Business Administration has been too small to have influenced significantly the development of health facilities and services in rural areas.

3. Community Mental Health Facilities - Public Law 88-164 authorized limited annual appropriations as follows for the construction of community facilities for the mentally retarded:

1965	$10,000,000
1966	$12,500,000
1967	$15,000,000
1968	$30,000,000

While these amounts were reasonable for the first two years of the program while State plans were being developed and State agencies were stimulating community interest, they fall far short of the amounts necessary to provide facilities having modern diagnostic, education, training and rehabilitation services for the mentally retarded.

Staffing grants, as such, are not now available. Grants are available from the Children's Bureau, the Office of Vocational Rehabilitation and the Public Health Service to support certain desirable services for the mentally retarded.

4. Research and Demonstration - At the present time approximately $10 million is available annually to support research and demonstration projects in hospital design, construction and operation.

5. Public Health Service Hospitals - The Public Health Service has authority for modernization and replacement of facilities but all requests for this purpose have been turned down, either in the Department of Health, Education, and Welfare or the Bureau of the Budget.

Objectives

To develop a Federal program for construction of health facilities that is fully responsive to the health needs of the nation, with emphasis on creating the needed facilities, setting standards of quality required for participation and the elimination of segregation for economic, racial or other reasons. Because of priority needs, emphasis should be given to metropolitan needs, to new organizational arrangements (hospital based group practice) and to an adequate program of research in

hospital design, construction and operation. It is essential also to make clear in all these programs that the role of the Federal Government is to augment the voluntary health enterprise, to devise a partnership between the Federal Government and the voluntary health enterprise, and to do so in such a manner as the health needs of the people may best be served.

Proposals

1. Hospital Facilities - modernization, replacement and new beds

A. Use of Existing Authority ($350 million)

Existing authority for the replacement and modernization of hospitals and other health facilities should be revised to provide from $100 million to $200 million annually for a five-year period. (Present authority $35 million for modernization.) Special consideration should be given to areas of greatest need; to urban hospitals; to hospitals that will develop adequate 24-hour emergency services; to hospitals that will develop group practice facilities or will develop integrated programs with existing medical groups. Facilities should be developed in hospitals to provide for comprehensive community care at home, in the office or outpatient department and within the hospital. When feasible, it should include a full spectrum of services

(preventive, diagnostic, treatment, rehabilitative) and should involve public and voluntary agencies, private practitioners and other health workers, as well as existing hospital personnel.

To increase the number of new general hospital beds and facilities to keep pace with projected population growth and the increasing demand for hospital based services (e.g., those resulting from Public Law 89-97) will require approximately 12,000-13,000 beds annually. The amount of $150 million in Hill-Burton funds when combined with private funds available could produce the needed new beds annually. At the present time about two-thirds of the funds are without Federal aid and about one-third is Federally aided. The Hill-Burton share amounts to about 12 percent of the total funds used for new construction. It is clear that there should not be any reduction in Hill-Burton grant funds available for new beds. It is also clear that the problem of new beds must be viewed in relation to modernization and replacement of existing beds as well as the demand for services.

B. Use of New Legislative Authority for a New Federal Hospital Facility Program Financed by Loans ($150 million)

All present Federal hospital facility construction programs should be terminated; and one new Federal direct loan program be developed, with the Federal Government making the money available

at a rate of only one-half to one percent maximum. Thus, instead of the Government granting funds, it would subsidize the cost of money through loans. Very large amounts of money could be allocated to the fund. The funds would be equally available for both new construction and modernization. The only interest charged would be sufficient to pay for the cost of administration; thus 0.5 to 1.0 percent would probably be adequate.

An alternate method of loan financing would be for the Federal Government to pay the interest on the commercial loans and provide a loan guarantee. In either case, the Federal Government would be paying the interest on the funds borrowed for construction of facilities.

In order to modernize and replace existing hospital beds it will cost approximately $3.5 billion in the coming decade. In addition approximately $2.5 billion will be required to create the new bed capacity required. The Federal funds required for full loans in the next ten years could then amount to $6 billion. Interest on this might average approximately $150 million annually during this period.

The new law should require sponsors to give various assurances, such as (1) must accept regional planning authority recommendations; (2) must establish essential relationships between acute general hospitals and long-term care facilities; (3) must

be nonprofit; (4) must provide 24-hour emergency service; (5) must participate in available programs of management improvement; (6) must be eligible for accreditation by the Joint Commission on Accreditation within a stated period; (7) must be eligible for and willing to participate in programs under P.L. 89-97; (8) must extend to affiliate long-term care facilities any intern or resident teaching program.

In other words, just as the Federal Government is now going to require the States to do certain things in order to get Federal dollars, they would spell out certain quid-pro-quo for institutions that would be eligible to receive Federal assistance under this massive new loan program.

2. Development of Group Practice, Ambulatory Facilities, Physicians and Dentists Offices

A. Use of Existing Authority ($50 million)

The existing authority to provide grants for the development of diagnostic and treatment centers, for the development of new or improved facilities for diagnostic and treatment services or for experiments and demonstration projects has not resulted in any significant change in the pace or pattern of group practice development. This authority could, however, be used for this purpose if emphasis was given to hospital based facilities, to

those affiliated with medical schools or other nonprofit medical institutions and to consumer based cooperatives.

The inability of certain types of communities, particularly small rural communities, to attract physicians and dentists to practice in these areas results in part from the absence of suitable office space, including laboratory and radiological facilities. Enactment of a proposal to permit public agencies or nonprofit organizations to receive grant funds for construction of needed facilities could definitely improve the current maldistribution problem.

The Small Business Administration has authority to make loans for the construction of facilities that could be used for group practice clinics. In the current session of Congress H.R. 2987 and S. 508 have been submitted; hearings have been held in the House of Representatives, but the bill has not been reported out. Enactment of this proposal would stimulate the organization of additional voluntary prepayment plans, would stimulate the development of more group practice facilities and would aid in a better distribution and utilization of health manpower.

The funds available under current programs would have to be vastly expanded if any serious effort were undertaken by the Federal Government to stimulate the development of more group

practice units, particularly those affiliated with hospitals. A minimum requirement would be $50 million per year. This grant program seems preferable to the existing loan and mortgage insurance programs because of the greater financial incentive which it could give to hospitals, communities and nonprofit organizations to develop facilities for ambulatory care and group practice.

B. New Legislative Authority (Loan + $5 million grant)

Legislation could be sought for direct loans, loan guarantees and 3-5 year operating subsidy grants for voluntary and private organizations to aid in the construction of facilities for group medical practice and to help defray the operating costs in the first 3-5 years of operation. The operating subsidy should not exceed 30 percent and it should be used primarily for such basic service units as x-ray, laboratory, physical medicine and rehabilitation, and the total grant funds available should not exceed $5 million.

This program, if enacted, would represent a very significant departure from past practices with respect to hospitals, group practice organizations and other institutions involved in medical care. In the past, funds have been limited to financing demonstration projects or public funds have been used to pay for services actually rendered.

The proposed program could include hospital based, university or medical school based consumer group or cooperative based and independent group practice organizations. Special consideration should, however, be given to those institutions organizing to provide services in areas of unmet need such as urban slums or rural areas and by reducing costs and improving quality through a full integration of high cost diagnostic and treatment services (e.g., x-ray, physical therapy) in and out of the hospital.

The proposed program of matching grant funds or low interest loans to provide funds could lend particular encouragement to the development of group medical practice around hospitals. The funds could help the medical staffs of community hospitals and medical schools to organize themselves as group practice organizations within the framework of the hospital facilities. This could maximize the use of all diagnostic facilities of hospitals, it could discourage admission of patients when not indicated, it could improve the use of health manpower, it could extend many of the self regulating professional quality controls from inside the hospital to ambulatory services, and it could greatly improve the diagnosis of patients' illnesses and the course of treatment prescribed.

3. Community Facilities for the Mentally Retarded

A. Existing Legislative Authority ($95 million)

In order to accelerate the rate at which community facilities for the mentally retarded are constructed and stimulate communities to construct such facilities by providing staffing grants at a descending rate of Federal participation it is proposed to increase the facilities grants to $75 million annually ($35 million at present) and to provide at least $20 million annually for staffing. In this program careful consideration should be given to hospitals that develop comprehensive programs for the mentally ill, the alcoholic, the addict and others with special mental health problems.

B. New Legislative Authority

The only new legislative authority required is a five-year extension of the existing authority which expires at the end of Fiscal Year 1966.

4. Research and Demonstration

A. Existing Legislative Authority ($20 million to $50 million by Fiscal Year 1970)

A limited amount of money available through the presently administered programs has resulted in few, if any, really significant innovations in total hospital design and construction.

There have been many excellent studies conducted and these could be significantly improved and expanded if more funds were available. A research and demonstration program is needed that is commensurate with the public and private investment in hospital facilities. At the present time approximately $10 million is spent in this area of hospital research.

Modern medical care concepts and practices demand intensified hospital research efforts in such areas as: improved techniques for determining facility and service needs; functional design of hospital and group practice structures; hospital operating efficiency; hospital and medical care organizational patterns; coordination of resources; financing of health care; information systems in hospitals and other health care facilities; and alternate approaches to total patient care (e.g., group practice - prepayment, solo practice - fee for service, group practice - fee for service). A research program of this type should also include funds for the application of possibly significant developments on a sufficiently large scale to be meaningful. This should include equipment and facility, as well as operating costs.

This type of program could begin with a $20 million authorization and gradually expand to an annual authorization of $50 million.

B. New Legislative Authority

None

5. Public Health Service Hospitals

A. Existing Legislative Authority ($33 million in 3-years or $11 million annually)

A major program for the modernization and renovation of Public Health Service hospitals and other health care facilities should be undertaken immediately. The program as planned will require $33 million over the three-year period Fiscal Year 1966-1968. Following renovation and modernization the staffing required to provide high quality care will increase the operating budget from $57 million to $68 million per year.

Present Programs of Facilities Construction

Statute	Authority
P.L. 410 Sec. 318	Special project grants for assisting areawide planning of health and related facilities--50% matching basis--coordination of existing and planned health facilities and services.
P.L. 410 Sec. 600(a)	Assistance to States in programs for construction and modernization of public and nonprofit community hospitals and other medical facilities as necessary to furnish adequate services to all people.
P.L. 410 Sec. 600(b)	To stimulate development of new or improved facilities for medical, diagnostic, preventive, treatment or rehabilitative services.
P.L. 410 Sec. 600(c)	To promote research, experiments and demonstrations in redevelopment and utilization of hospitals, clinic or similar services, facilities, and resources and to promote coordination thereof and useful application of their results.
P.L. 410 Sec. 601	Authorization of appropriations for construction grants (formula)--public or other nonprofit long-term care facilities, diagnostic or treatment centers, rehabilitative facilities, general hospitals and public health centers.
P.L. 410 Sec. 610	Loans to applicants for projects for construction or modernization of hospitals and other medical facilities.
P.L. 410 Sec. 624	Conduct within the PHS and grants to states, political subdivisions, universities, hospitals, and other public and nonprofit private institutions for research, experiments, and demonstrations for development, utilization and coordination of services, facilities and resources of hospitals or other medical facilities, including construction of units of medical facility units which involve experimental architectural design or functional layout.

Statute	Authority
P.L. 410 Sec. 704	Grants (up to 50% of necessary construction costs) to public and nonprofit institutions for construction of health research facilities.
P.L. 410 Sec. 720	Grants for construction of teaching facilities for medical, dental, and other health personnel--to accredited public or other nonprofit schools, affiliated hospitals. Grants for new construction or major expansion of existing facilities may not exceed 66 2/3% of necessary construction costs. All other grants may not exceed 50%. Grants for schools of public health may be as great as 75% of necessary construction costs. (Expires June 30, 1966---S. 595, H.R. 3141, pending, would extend 5 years.)
P.L. 410 Sec. 761	Grants to assist public or nonprofit institutions to construct facilities for research and related purposes in human development to find causes, preventive and ameliorative measures in re mental retardation. Grants may not exceed 75% of necessary construction costs.
P.L. 410 Sec. 801	Authorization of appropriations for grants for construction of new facilities or replacement or rehabilitation of existing facilities for collegiate schools of nursing, associate degree or diploma schools of nursing. Grants for new facilities or major expansion of existing ones may not exceed 66 2/3% of necessary construction costs. All other may not exceed 50%.
P.L. 88-164 Sec. 121	Project grants for construction of university-affiliated clinical facilities for mentally retarded---inpatient and outpatient services; facilities to demonstrate specialized services for diagnosis, treatment, education, training and care; clinical training of physicians and other necessary specialized personnel. Grants may not exceed 75% of necessary construction costs.

Statute	Authority
P.L. 88-164 Sec. 131	Authorization of appropriations for grants to States for construction of public and other nonprofit facilities for mentally retarded.
P.L. 88-164 Sec. 200	Authorization of appropriations for grants to States for construction of public and other nonprofit community mental health centers.