

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

AGENDA

COMMITTEE ON MODERNIZATION AND CONSTRUCTION
FUNDS FOR TEACHING HOSPITALS
CAPITOL SUITE - MAYFLOWER HOTEL
2ND FLOOR

1127 Connecticut Avenue, N.W.

Washington, D.C. 20036

Friday, June 6, 1969

10:00 a.m. - 4:00 p.m.

- I. Call to Order and Call of Roll: 10:00 a.m.
- II. Approval of Minutes - Meeting of June 28, 1968 TAB A
- III. Report on AAMC-COTH Testimony of March 27, 1969 before the Subcommittee on Public Health and Welfare of the House Committee on Interstate and Foreign Commerce TAB B
- IV. Discussion of H.R. 11102 (Medical Facilities Construction and Modernization Amendments of 1969) TAB C
- V. Discussion and Development of Position on S. 2182 Introduced by Senator Yarborough (Hospital and Medical Facilities Construction and Modernization Amendments of 1969) TAB D
- VI. Discussion and Recommendations on Draft Position Statement, "The Teaching Hospital and Its Role in Health Planning at the Local and Area Levels" TAB E
- VII. Statement of the AAMC Before the Subcommittee on Labor, Health, Education and Welfare of the House Committee on Appropriations on May 26, 1969 - Hill-Burton Appropriation Commented on by Merlin K. DuVal, M.D., Dean, College of Medicine, University of Arizona TAB F
- VIII. Discussion and Recommendations on Study of the Sources and Purposes of Capital Financing for Teaching Hospitals
- IX. Report on HUD Handbook "Mortgage Insurance for Nonprofit Hospitals" TAB G
- X. Report on DHEW Budget Presented by the Nixon Administration TAB H
- XI. Old Business
- XII. New Business
- XIII. Date of Next Meeting - on Call

Coffee and Rolls will be served at 9:00 a.m. and Luncheon at 12:30 p.m. in the same suite

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MINUTES

Committee on Modernization and Construction Funds
For Teaching Hospitals
June 28, 1968
Mayflower Hotel
10:00 a.m. - 4:00 p.m.

Present:

Richard T. Viguers, Chairman
Lewis H. Rohrbaugh, Ph.D., Vice Chairman
Robert C. Hardy
J. Theodore Howell, M.D.
Richard D. Vanderwarker
John H. Westermen

Also Present:

Charles W. Eliason, Director, Government Grants Programs,
Cedars-Sinai Medical Center, Los Angeles, California (attended at Dr. Littauer's
request)

Absent:

Charles H. Frenzel
Harold H. Hixson
John H. Knowles, M.D.
David Littauer, M.D.
John W. Kauffman, AHA Representative

Staff:

Matthew F. McNulty, Jr., Director, COTH; Associate Director, AAMC
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Grace W. Beirne, Staff Assistant, COTH
William G. Reidy, Editor, AAMC Bulletin
Peter A. Weil, Student Assistant, COTH
Valentina A. Weigner, Secretary, COTH

The Committee was joined for lunch at 12:30 p.m. by Howard N. Newman, White
House Fellow assigned to the Director of the Bureau of the Budget (On leave
of absence as Associate Director, Pennsylvania Hospital, Philadelphia, Penn-
sylvania.

I. Call to Order:

Chairman Viguers called the meeting to order and began discussion of the agenda promptly at 10:00 a.m.

II. Approval of Minutes - Meeting of February 19, 1968:

ACTION #1

THE MOTION WAS MADE AND SECONDED THAT THE MINUTES OF THE MEETING OF FEBRUARY 19, 1968 BE APPROVED AS CIRCULATED. IT CARRIED UNANIMOUSLY.

III. Report on Action Items from the February 19, 1968 Meeting (Listing of Action Items from Meeting of February 19th, Attachment A):

Report on Action #2

It was agreed that the question of the AHA definition of "teaching hospital" as opposed to that of COTH (as determined by "White Paper" and membership criteria) be referred to the COTH-AHA Liaison Committee and to the March COTH-AHA Meeting for Coordination.

Mr. McNulty discussed the definition of a teaching hospital. The AHA definition was distributed (copy attached and made a permanent part of these minutes) and it was noted to be extremely broad in scope covering "almost anyone that does anything" with respect to education for health care. The COTH definition to date qualified teaching hospitals by its use of the term "medical education". The possibility that this distinction should be abandoned was indicated by Mr. Westerman's remark that at the University of Minnesota the medical college is on a coequal basis with dentistry, nursing, and so forth. Further, Mr. McNulty indicated that the qualifying adjective "medical" often caused other health practitioners to defend

their particular areas of interest. This coupled with the current efforts of the AAMC to broaden their own views point to a more inclusive definition. Chairman Viguers indicated that in any legislation action the legislation itself would have to define the scope of intent. This is exactly what is being considered by legislators according to Mr. William Reidy who specified that university trained health professionals will be funded through the National Institutes of Health, while those in the "allied health professions" (including nursing and non university affiliates) will be funded through the Health Services and Mental Health Administration. Dr. Howell suggested that the teaching hospital data gathering capability of the Council of Teaching Hospitals of AAMC would have to be much expanded in order to define various types of institutions who qualify especially for use at Congressional hearings and suggested further that COTH attempt to coordinate its data gathering activities with that of AHA.

Mr. McNulty acknowledged these recommendations and indicated that a suitable definition of a teaching hospital will continue to be explored.

Report on Action #4

Mr. Hixson made the motion, seconded by Dr. Littauer, that the Committee forward the question of tax exemption for joint ventures to the Committee on Financial Principles, the AAMC Committee on Federal Health Programs and the AHA with the strong recommendation that these bodies explore the issue and go on record with a statement of concern and suggestion of remedial action.

Mr. McNulty then brought the recent legislation of tax exemption for certain joint hospital service organizations Revenue and Expenditures Control Act of 1968 (Section 109, Tax -Exempt Status of Certain Hospital Service Organizations) to the attention of the committee, noting that joint laundry services

were excluded. He indicated the law was awaiting Presidential signing and then Miss Beirne submitted that once signed, it will apply to corporate taxable years ending after the date the law is enacted.

IV. Report on Distribution of Supplemental Questionnaire to Retest Expressed Expansion Plans for Teaching Hospitals:

Dr. Bingham discussed the results of the questionnaire received from member hospitals indicating a 24,000 bed expansion program in teaching hospitals in the coming decade. A follow-up questionnaire requesting more detailed information has been mailed to member hospitals.

Mr. McNulty indicated that this project could serve as a source of vital data which will provide the base for recommendations to support modernization and expansion legislation. Chairman Viguers noted that the survey may serve still a broader function by providing a mechanism to "upgrade health as a public issue". He noted that public sector is currently concentrating on the need for quantity of health facilities (as opposed to higher quality) and this project capitalizes on that social trend. Thus the project could be politically advantageous.

V. Discussion of Two Recent Federal Health Agency Studies:

(1) Recommendation and Summary: A Program Analysis of Health Care Facilities (Office of Program Planning and Evaluation, Bureau of Health Services) The so called "Michael's Report!"

(2) Legislation Relating to Health Facility Construction and to Special Purpose Project Grants (Division of Hospital and Medical Facilities, Bureau of Health Services) The so-called Graning Report".

Mr. McNulty introduced this discussion with a brief summary of the background of the two reports. He noted that essentially the two reports represent divergent approaches to positive action with respect to Federal

assistance for construction and modernization. It was noted that the report being prepared by the National Advisory Commission on Health Facilities had not yet been completed, and that this study might well develop an additional approach.

Dr. Bingham cited the chief characteristics of the two documents, noting that the "Michael's Report" recognizes the problem of obsolescence but that it is not tied specifically to the teaching hospital or to the inner city. Modernization is defined broadly and one can generalize that this report stresses the use of all the elements existing in the administration of Hill-Burton (Harris) funds.

On the other hand, the Graning Report is more specific in its recommendations; for example, recommendation Number 3 specified the type of funding to be employed. Moreover, it differed from the Michael's survey by departing from the system of administration now in use and recommending new tactics such as "Special Purpose Project Grants". The estimates of this program were for the backlog of modernization \$15 billion expenditure, exceeding the "Michael's" projected figures by \$5 billion.

Because the National Advisory Commission on Health Facilities is still to issue its report, Mr. McNulty speculated that the staff led by Dr. William L. Kissick may emphasize the total systems approach: to allow funding to get at the gaps in the delivery of a universal basic standard of health services.

In answer to the compliments of Mr. Westerman to the staff, Mr. McNulty stated that COTH enjoys, at the moment, a good entry into the health facility modernization and construction funding agencies in the federal government along with general acceptance by these groups of the teaching hospital as the principal cutting edge. COTH strategy has been to work with groups designing

legislation and influencing legislators rather than creating schisms within the many health agencies.

VI. Report by Committee Members of Recent Contact with Assigned Members of President's Advisory Commission on Health Facilities. Staff Report on Washington Activities:

Mr. McNulty drew the attention of the Committee to the "General Statement of the Teaching Hospitals' Contribution to the Ideal of Excellence in the Health Care of the Nation", a report submitted to the National Advisory Commission on Health Facilities by COTH. He noted that this statement had been submitted at the request of the Commission's staff.

Chairman Viguers in accord with the other members of the Committee recommended refraining from further contacts with the staff of this Commission until such time as the basis of their judgment should alter significantly.

VII. Discussion and Committee Disposition of Proposed "White Paper" on the Need for Modernization and Construction Funds for Teaching Hospitals - Meeting Society's Expectations for Excellence in Service and Education (Most recent draft distributed May 23, 1968):

The "White Paper" on the Need of Modernization and Construction Funds for Teaching Hospitals entitled, "Meeting Society's Expectations for Excellence in Service and Education" was discussed by all the members of the committee. Effectively four alterations were recommended to the staff as follows:

- (1) Definition of teaching hospitals and non-teaching hospitals be reworded (page 3)
- (2) The cost per square foot for non-teaching hospitals be changed from \$30-35 to \$40-45
- (3) The figures on escalation be revised up.
- (4) That various formulae for federal subsidy be simply listed with an example

in order to permit the federal government to decide which funding program it would prefer. Thus the need for rather than the means by which funds are disbursed is emphasized.

VIII. Report on AAMC Study of Facilities for Health Education and Report on New York Chapter, AIA, Proposal for Health Facilities Laboratory:

Mr. McNulty discussed two reports in a summary form: Report on the AAMC Study of Facilities for Health Education and Report on the New York Chapter, AIA, Proposal for Health Facilities Laboratory.

A proposal by the AAMC to create a data bank on new medical school constitution to replace the outdated PHS, Guide on Construction and Medical Facilities seemed a related area of interest of the COTH organization. Accordingly, Mr. McNulty asked for an expression of interest in this proposal as well as a proposal by a prominent New York architect to create a Health Facilities Laboratory.

Members of the Committee were much in favor of the data bank and the laboratory. Dr. Howell shared his experience with the occasional parochialism of architects and thus recommended an eclectic approach in the study to be undertaken. Chairman Viguers and other members of the Committee concurred with the suggestion.

IX. Statement of the AAMC Before the Subcommittee on Labor-Health Education and Welfare of the Committee on Appropriations - U.S. House of Representatives:

Mr. McNulty pointed out the distinct paragraph dealing with the vital role of the teaching hospitals in the education of health manpower.

X. Bill to Establish a National Health Council and a Joint Congressional Committee on Health:

It was noted that Senator Edward Kennedy's proposed bill was a worthwhile philosophical view. More significantly, it indicates, according to Mr. Reidy

a desire on the part of this Senator to become the new health champion.

It was noted that Senator Mondale of Minnesota had replaced Senator Robert Kennedy on the Senate Subcommittee on Labor and Public Welfare.

XI. New Business:

Chairman Viguers called for new business of which there was none.

XII. Date of Next Meeting:

A future meeting will be on the call of the Chairman.

XIII. Adjournment:

The meeting was adjourned at 3:50 p.m.

STATEMENT OF
DAVID E. ROGERS AND RICHARD T. VIGUERS
IN BEHALF OF
THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES
CONCERNING H.R. 6797 and H.R. 7059
BEFORE THE
HOUSE OF REPRESENTATIVES
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
MARCH 27, 1969

Mr. Chairman and Members of the Committee:

I am David E. Rogers and I am Dean of The Johns Hopkins University School of Medicine and Medical Director of The Johns Hopkins Hospital in Baltimore. With me today is Mr. Richard T. Viguers, Administrator of the New England Medical Center Hospitals, of Boston. On this occasion, we are spokesmen for the Association of American Medical Colleges, which consists of all the medical schools in the country, 29 distinguished academic societies which include most of the members of faculties of medical schools, and 340 of the leading teaching hospitals in this country. The Association has recently been reorganized so it can more effectively represent the institutions and organizations which play the principal role in the education of large numbers of health personnel for the future, vital roles in the improvement of methods of diagnosis and treatment, and essential roles in the advancement of knowledge.

We strongly support the objectives of the Hospital and Medical Facilities Construction and Modernization Amendments of 1969 and similar legislation the committee is now considering.

Mr. Chairman, if it is agreeable to the committee, I will direct my comments to the importance of urban and teaching hospitals in the total

pattern of providing health services, and Mr. Viguers will comment on the specific proposals under consideration and certain other important aspects of this legislation.

We are confident that other spokesmen will present the needs of community hospitals for modernization and construction, and will focus our remarks on urban and teaching hospitals because it is their roles and needs with which we are the most familiar.

I would like first to make the point that the largest and most important urban hospitals are all teaching hospitals and many of them were the predecessors of the medical schools with which they are now intimately related. For example, The Johns Hopkins Hospital was a highly effective institution for nearly 10 years before The Johns Hopkins Medical School opened its doors. A great many urban hospitals less closely affiliated with medical schools have for years been the setting in which interns, residents, nurses, technicians, and therapists have been educated. In those very few instances in which teaching hospitals are located in small cities--such as Gainesville, Florida; Madison, Wisconsin; and Iowa City, Iowa--their role is similar to that of urban hospitals in all but one major respect.

The primary role of every hospital is providing diagnosis and treatment for patients. Every urban hospital is of major importance in providing services for the patients in its immediate vicinity. Typically they are located in the "inner city", so they are a primary and vital resource for the people who live and work there. They are also of very great potential importance to everyone in their region, because they serve

as "hospitals of last resort" to which some patients with complex and severe problems are referred for definitive care.

Many of the urban and all other teaching hospitals have long been the settings in which the problems of patients receive the closest and most detailed study and the places where knowledge gained in research laboratories is first applied to those problems. Most improvements in methods of diagnosis and treatment have first been developed in these institutions and then used in smaller community hospitals after they have been perfected and people trained in their use in large hospitals have become available. As hospitals and medical schools are developed in parallel, the bridge between the laboratory and the bedside has become very short indeed. This research function makes heavy special demands on the teaching hospital. The rendering of advanced medical care requires highly skilled health practitioners coupled with prodigious technical apparatus to aid in performing the many diagnostic, therapeutic, and rehabilitative functions so characteristic of the teaching hospital. These hospitals are now also becoming important centers for experimentation in different health delivery systems.

A third major role of these institutions is that of serving as an environment in which the education and training of physicians, nurses, technicians and therapists take place. For example, a medical student begins to learn how to study the problems of patients in the hospital setting before the end of his second year or earlier, and spends nearly all of his time in that setting during the third and fourth years. A typical young physician spends four years working very hard as an intern and then a resident before he moves on to some other role in the profession.

The hospital is the setting for an even larger portion of the education and training of many other categories of health personnel.

At the most recent annual meeting of the AAMC, several far-reaching recommendations relating to an increased output of physicians were adopted. It is now the official position of the Association, in agreement with the wishes of Congress, that prompt and strenuous efforts be made to expand the enrollment of medical schools as a response to the demands and needs of society for more and better trained physicians and other health workers. To achieve this, new medical schools are being built and existing medical schools are expanding their classes. All of these training and educational advances require clinical facilities, and it is imperative that we increase our outpatient and inpatient facilities to provide the clinical basis for training the increased numbers of many categories of health personnel.

The tremendous accomplishments of the Hospital Construction Program since it was enacted more than two decades ago and the responses to that program on the part of local and state governments are well known to the members of this committee. It is no exaggeration to say that if this farsighted program had not been initiated and been extended and improved by subsequent actions of the Congress, we would have already faced a shortage of facilities for meeting the health needs and demands of our society that would have been disastrous. The early emphasis of the program on the creation of hospitals and health facilities in small cities and towns was justified by the fact that at the time there were hardly any modern health facilities in those communities throughout our country. We believe that the emphasis of the program should now shift toward meeting the

needs of urban and teaching hospitals. In the last two decades, there has been an enormous movement of people from rural to metropolitan areas and society has placed increasing demands upon urban and teaching hospitals, but adequate ways to meet their needs for modernization and construction have not yet been developed. State, local and private sources have traditionally been the primary supporters for the construction and modernization of urban and teaching hospitals. Those sources cannot now provide the additional funds needed with the speed required. An imaginative program of Federal support, such as proposed in this legislation, is needed to insure that these institutions will be able to sustain their standards of excellence and respond to the needs and demands of society.

The urban and teaching hospitals are likely to be the loci of the confrontation when the forces of rising expectations and effective demands meet head-on with the hard facts of acute shortages of manpower and facilities. This nation and its teaching hospitals face a major crisis. We urge that the committee give favorable consideration to this legislation and that the Congress promptly enacts it.

I would like now to ask that Mr. Viguers comment on certain specific recommendations that the Association of American Medical Colleges has with regard to this legislation, after which we will be most pleased to answer any questions the members of the committee may have.

TESTIMONY OF THE
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ON H.R. 7059 AND H.R. 6797, "HOSPITAL AND MEDICAL FACILITIES
CONSTRUCTION AND MODERNIZATION AMENDMENTS OF 1969"
BEFORE THE
HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE OF THE
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
MARCH 27, 1969

Mr. Chairman and Members of the Subcommittee:

I am Richard T. Viguers, Administrator of the New England Medical Center Hospitals. I am Chairman of the Committee on Modernization and Construction Funds for Teaching Hospitals of the Council of Teaching Hospitals, Association of American Medical Colleges. I appear today on behalf of the Teaching Hospitals and the AAMC.

As a preface to my comments, Mr. Chairman, I reiterate our pleasure at being given this opportunity to appear before this Subcommittee today to discuss this very important legislation and to stress additionally the observation that teaching hospitals have very extensive needs for facility modernization and construction.

I have with me a position statement entitled "Meeting Society's Expectations for Excellence in Service and Education". This statement was prepared by the Council of Teaching Hospitals of the Association of American Medical Colleges. This statement reflects most accurately and completely the collective thinking of the Association on the type of legislation before us today. In the interest of the time of the Committee, Mr. Chairman, I shall not read this statement but I do respectfully request that it be included in the record of these hearings.

Mr. Chairman, we recognize that many definitions of teaching hospitals exist. For purposes of clarity, I would like to state the working definition that will serve as the framework for this discussion. A teaching hospital, as commented on in this statement, is one in which the education of physicians and other health manpower is continually taking place. It is the teaching hospital which is producing the health manpower which is so vital if we are to extend and improve our health care system and meet the health care expectations of our fellow Americans. This complex of resources and activities must be so arranged and operated that excellence of patient care, teaching and research are not compromised - but in fact are enhanced in every way possible.

Before commenting on the specifics of this legislation, I would like to make several general observations on the existing pattern of hospital economics and the effect of these economic considerations on capital financing for teaching hospitals.

Without the national emphasis that has attended the sharply mounting operating costs for all hospitals during the last two decades generally, and specifically in the last four years, the teaching hospital system has been steadily heading into an even more troubled dilemma with regard to its capital costs.

Reimbursement formulas of third-party agencies are increasingly based upon "costs" incurred by individual hospitals or health agencies. The "costs" are frequently defined to include allowances for interest on

borrowed capital and depreciation. Theoretically, depreciation funds might be used to retire indebtedness or be applied toward replacement or modernization of buildings and equipment. However, depreciation allowances related to original cost do not suffice to replace plant and equipment during a period of inflationary economy and revolutionary technological development. Depreciation allowances paid to an individual teaching hospital do not assure the institution of necessary funds for capital expenditures for new programs to extend medical care to more and more of society, to obtain the technical equipment to make available the advances in medicine, and to teach medical students and other health science personnel. The intermittent need for capital is in large measure independent of a regular flow of funds arising from a reimbursement formula. A teaching hospital in greatest need for capital at any given time may be the institution with the least available funds at that given time.

The amount of capital funds for building modernization and equipment required by a modern teaching hospital to stay abreast of the rapid technological advances is not only growing, but the sources available to the teaching hospital for capital funds are becoming more restricted.

The teaching hospital is directly related to the fastest moving, least predictable, quickest changing technologies to ever confront an industry. As Dr. Rogers has stressed, there is literally no facet of the escalating developments in the physical and biomedical sciences that does not have very profound implications for teaching hospital facilities. The very rapid pace of hospital technology is highly visible from one year

to the next in both structure and equipment. In addition, very significant numbers of these teaching hospitals are starting from bases of physical plants that are long outmoded.

Let me take just a moment to cite several studies that document the magnitude of the problem that faces the teaching hospitals of the nation:

1. In 1967 the Council of Teaching Hospitals of the Association of American Medical Colleges (although the Council only numbers 350 in membership, there are housed within these institutions approximately 23% of the nation's non-profit acute beds) sampled its membership to determine the extent of need for modernization and expansion. This sample included 250 member hospitals. Federal and Canadian hospitals were not included. Replies were received from 214 hospitals, providing an 85% return. Of the approximately 115,000 beds represented in this survey, 35% were over 35 years old. An additional 16% were between 21 and 35 years old. Of the 214 responding hospitals, 120 planned to replace 27,500 beds over the next ten years, and 142 planned to add 24,000 beds during the same period of time. For all forms of construction, including replacement, renovation and expansion, the estimated attendant cost for the ten-year period is \$4 billion.
2. The Hospital Planning Council for Metropolitan Chicago, in studying six teaching hospitals in that metropolitan area in 1966 determined that the costs of modernization for these six institutions would approximate \$156 million and the costs

of replacement, \$300 million.

3. In Philadelphia the capital needs for modernization, replacement and expansion of the hospitals either operated by or affiliated with the area's 5 medical schools as reported in 1968 would total \$278 million as determined by the Philadelphia Hospital Survey Committee.

We have spoken of a crisis facing our nation's teaching hospitals.

This crisis is a result of many social forces. Among them are:

1. The teaching hospital, by virtue of its size and location (usually 300 beds or more in an urban or metropolitan setting) cares for a high percentage of patients from the immediate locality and surrounding regions, and maintains the resources of physical plant, skilled health personnel, complex equipment and a spectrum of services necessary for comprehensive, high quality health care;
2. The teaching hospital contributes significantly to the education of the nation's physicians. In fact, the national medical internship programs and the national medical residency programs for education and training of the medical specialists of this country, as well as many dental, nursing and other allied health science discipline education programs, take place almost exclusively in teaching hospitals;
3. The teaching hospital occupies a critical and central role with other health care programs for initiating the national norms and standards for patient care; and,

4. The teaching hospital is the locus of much of the scientific investigation that is done to advance the state of medical knowledge and patterns of medical care.

With these observations as a broadly based commentary on the critical need of teaching hospitals for modernization and construction funds, we want to indicate, Mr. Chairman, that we are in support of the bills introduced both by Mr. Rogers and the members of this Subcommittee (H.R. 7059) and by the Chairman of the full Committee (H.R. 6797). However, because of the vastness of the need and the immediacy of the problems, we would urge that the larger authorization as contained in H.R. 6797 be adopted. Accordingly, Mr. Chairman, we will address our comments primarily to that legislation. However, we wish to indicate emphatically our support of any legislative measure that will get the job done! The needs of teaching hospitals as one of the most significant vertabrae of health care, education and research of our nation are so great that we urge no doctrinaire approach but only immediate solutions, in which we will join and support vigorously the constructive, affirmative action of the Subcommittee and Committee.

In reviewing the proposed legislation, we believe the following points to be particularly pertinent:

1. The introduction of this legislation to expand and extend the very successful Hill-Burton Program is supported with certain suggested redirections. Since the inception of the original Hospital Survey and Construction Act of 1946, the

funds specifically for modernization.

With regard to this provision, and others on which we will comment in a moment, but at this time Mr. Chairman, we do call the attention of the Committee to the recently completed Report to the President by the National Advisory Commission on Health Facilities (December, 1968). That Commission in its report indicated the following:

"The multiple responsibilities of teaching hospitals for the education of health manpower and scientific research in addition to patient care, result in unique and extensive requirements for assistance in modernization."

The Association is in complete agreement with this statement by the National Advisory Commission. Additionally, many of these hospitals are located in urban areas, and in accordance with recent social mandates, are expanding greatly the existing patient care service functions and responsibilities as well as introducing new forms of care, such as alcoholic and drug addiction clinics, geriatric clinics, community centers, neighborhood health centers, etc. With regard to this specific point, I quote from an Office of Economic Opportunity publication entitled "The Neighborhood Health Center" in which it is noted "Each Neighborhood Health Center has a direct link to a hospital in the community, usually a teaching hospital." At the same time, these teaching hospitals are continuing to serve as regional referral centers for those medical and surgical cases that pose unusual difficulties in terms of diagnosis and therapy. To add yet another dimension to this progression, and as previously emphasized, these institutions also serve as a national

program has expended \$3.1 billion in support of construction and modernization of health care facilities whose total costs come to \$10.4 billion.

Further elaboration of the tremendous benefits to society contributed by the original and successor Hill-Burton programs is unnecessary. The accomplishments and benefits have been documented amply and effectively and are well known to you, Mr. Chairman, and your Committee. The success of the program as a clearly visible example of private enterprise, local, state and national government cooperative partnership is such that, unless there is an alternative so visible and potentially effective as to speak for itself, the present program should be amended to meet delayed needs and new needs - but not abandoned.

The increased authorization amount in H.R. 6797 for the next three years for new construction grants is most gratifying. Our only immediate concern is to emphasize the greatly increased need for these types of funds in our urban areas where so many of the teaching hospitals of the country are located. We respectfully suggest that the allotment formula for construction grant programs be adjusted to conform with the allotment formula contained in H.R. 7059, which provides that allotments shall be made among the states on the basis of population, the financial need, and the extent of need for construction of such facilities.

2. The authorization of appropriations for modernization grants as specified in Title I, Part A, Sec. 102 (a) (2) represents a very significant and progressive legislative attitude to provide

resource through the production of physicians and other allied health manpower. In accordance with the observation by the National Advisory Commission of the unique and extensive requirement of teaching hospitals, as well as other social factors outlined, we recommend strongly that consideration be given to some degree of priority for these hospitals that serve as the nucleus of our health care system not only for this modernization grant feature but for the other provisions contained in this bill.

3. The provision of H.R. 6797 for loan guarantees for modernization and construction for private non-profit hospitals, Title II, Part B of the legislation, is an additional element of the legislation which we endorse. As I just mentioned we again urge consideration of the findings of the National Advisory Commission on Health Facilities with regard to teaching hospitals.
4. We endorse the concept of loans for construction and modernization of public hospitals and other public medical facilities as specified in Title III, Part C of the H.R. 6797 proposed legislation. Of the 350 teaching hospitals that are institutional members of the Council of Teaching Hospitals, 74 are public hospitals (49 of which are state-owned university teaching hospitals). By this is meant that the ownership of these hospitals is vested in a municipality, a county, a state or a hospital district. I am sure that you, Mr. Chairman, and the members of the Committee are aware of the manifold problems that are facing public institutions in such areas as New York, Chicago, Detroit and my own city of

Boston. We believe that special appropriation authority for these teaching hospitals, which have for so long played such an important role in intern and resident education for this country, is a very significant legislative interest.

Mr. Chairman, a recent study conducted by our Council of Teaching Hospitals indicated that visits to the emergency departments of the member hospitals increased 66% during the six-year period from 1961-62 to 1967-68. Because of this very rapid increase, it is with enthusiasm that we endorse the provision contained in H.R. 7059 which provides for grants for the modernization of emergency room service in general hospitals as a benefit to society for the improved treatment of accident victims and the handling of other medical emergencies.

In closing, Mr. Chairman, I do want to emphasize that teaching hospitals are facing extraordinarily difficult times with regard to funding modernization and construction programs. Several ongoing legislative programs are conceived of by some as offering relief but this is true only to a limited extent. As a specific for instance occasionally there have been identified funds available under the program for Health Profession Educational Facilities Construction Act (P.L. 90-490) as a suitable point of access for teaching hospital funding. For most teaching hospitals this act is at best only a theoretical possibility for essentially two reasons: (1) the appropriations for this program over the past several years, when coupled with the wide range of health professions educational facilities it is designed to serve, have not allowed any real measure of relief for

teaching hospitals: and, (2) because the application for funds for teaching hospitals is tied necessarily to medical school affiliation.

Many fine teaching hospital institutions, though non-affiliated, are denied immediately any possible access to such funds. We would acknowledge however, Mr. Chairman, that if these limitations of limited funds and restricted access were removed, both of which have deterred any major source of funding for teaching hospitals, this program might prove very useful for such interest.

Finally, Mr. Chairman, we support H.R. 6797 which extends the authorization of \$60 million a year for three years for research and demonstrations relating to health facilities and services. H.R. 7059 does not include such a provision. This authorization has made possible the establishment of the National Center for Health Services Research and Development which could play an important role in improving the quality and scope and reducing the cost of health services available to the American people. We therefore, strongly favor the authorization of H.R. 6797 which would extend the work of this institution for three more years but we think that the authorization of \$60 million should be increased after fiscal 1970 to a level of perhaps \$100 million by 1973. These relatively small amounts for applied research can be compared with the \$1.1 billion the National Institutes of Health spend yearly for biomedical research.

Thank you very much for this opportunity to appear before you on behalf of the Council of Teaching Hospitals and the Association of American Medical Colleges in support of this urgently needed legislation. We will be pleased to attempt to answer any questions the Subcommittee members may have or endeavor to provide any additional information requested by the Subcommittee.

MEDICAL FACILITIES CONSTRUCTION AND MODERNIZATION AMENDMENTS OF 1969

Provisions contained in H.R.11102 (Rogers)

- (1) Grants for the construction of public or other nonprofit hospitals and public health centers - \$135 million per year.
- (2) Grants for the construction of public or other nonprofit facilities for long-term care - \$70 million per year.
- (3) Grants for the construction of public or other nonprofit diagnostic or treatment centers - \$20 million per year.
- (4) Grants for the construction of public or other nonprofit rehabilitation facilities - \$10 million per year.
- (5) Special projects grants for the modernization of emergency rooms of general hospitals - \$10 million per year.

Grants for modernization of the facilities referred to in the preceding paragraphs total \$50 million for the fiscal year ending June 30, 1971, \$55 million for 1972, and \$60 million for 1973.

For Loan Guarantees for Construction and Modernization of Nonprofit Hospitals and Other Medical Facilities the amount approved is \$300 million for the fiscal year ending June 30, 1971, and for the next two fiscal years, of up to 90 percent of the cost of a project, with payment of one-half of the interest, or, if lower, the interest which would become due at an interest rate of 3%. The Loan Guarantee Program is also extended to publicly owned facilities, but without interest subsidy.

An additional section was added to the legislation which would require an applicant to file, at least annually, with the State agency, a statement to show the financial operations of the facility and the costs to the facility of providing health services, and the charges made for providing such services. It is considered this provision has been included as a data gathering device for national studies on hospital costs. House Report No. 91-262 includes a

section titled ADDITIONAL VIEWS OF MR. MOSS, MR. DINGELL AND MR. OTTINGER (John E. Moss (D) California; John D. Dingell (D) Michigan; and Richard L. Ottinger (D) New York which state that in their opinion the bill as reported is deficient in five areas.

- (1) The formula by which construction funds are allocated to the States discriminates against the States with the greatest need.
- (2) The allocation of funds between new construction programs and modernization programs is grossly inequitable, allowing more than twice as much support for new construction as for modernization.
- (3) There is no provision for establishing community diagnostic and treatment centers in metropolitan areas with low per capita income.
- (4) There is no provision for badly needed coordination between the plans of Hill-Burton State agencies and those of State and area comprehensive health planning agencies created under P.L. 89-749.
- (5) There is no provision for a flexible program of direct assistance to communities where there is a critical lack of health facilities.

House of Representatives

Chamber Action

Medical Facilities Construction and Modernization Amendments of 1969: By a record vote of 351 yeas, the House passed H.R. 11102, to amend the provisions of the Public Health Service Act relating to the construction and modernization of hospitals and other medical facilities by providing separate authorizations of appropriations for new construction and for modernization of facilities, authorizing Federal guarantees of loans for such construction and modernization and Federal payment of part of the interest thereon, authorizing grants for modernization of emergency rooms of general hospitals, and extending and making other improvements in the program authorized by these provisions.

Rejected a motion to recommit the bill to the Committee on Interstate and Foreign Commerce by a voice vote.

Agreed to the committee amendments.

Rejected the following:

By a teller vote of 51 yeas to 75 nays, an amendment that sought to alter the Hill-Burton formula to bolster funds to urban States. Prior to the teller vote, the amendment was rejected by a division vote of 42 yeas to 57 nays;

An amendment that sought to establish an emergency fund for hospitals in critical need (rejected by a division vote of 25 yeas to 64 nays);

An amendment that provided for a transposition of funding for "new construction" and "modernization";

An amendment that provided that applications for assistance under Hill-Burton programs would have to be consistent with areawide or Statewide programs;

An amendment that sought to provide \$15 million to build diagnostic or treatment centers for depressed urban areas (by a division vote of 8 yeas to 68 nays); and

An amendment that would provide for Federal assistance for persons displaced by construction or expansion of Federal facilities.

H. Res. 428, the rule under which the bill was considered, was adopted earlier by a voice vote.

The amendments were agreed to. The SPEAKER. The question is on the engrossment and third reading of the bill. The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Mr. EDWARDS of Alabama. Mr. Speaker, I offer a motion to recommit. The SPEAKER. Is the gentleman opposed to the bill?

Mr. EDWARDS of Alabama. I am, Mr. Speaker, in its present form.

The SPEAKER. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. EDWARDS of Alabama moves to recommit the bill H.R. 11102 to the Committee on Interstate and Foreign Commerce.

The SPEAKER. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER. The question is on the motion to recommit.

The motion to recommit was rejected.

The SPEAKER. The question is on the passage of the bill.

Mr. NELSEN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The question was taken; and there were—yeas 351, nays 0, answered "present" 1, not voting 80, as follows:

[Roll No. 76]

YEAS—351

- Abbitt, Abernethy, Adair, Addabbo, Albert, Alexander, Anderson, Calif., Anderson, Tenn., Andrews, Ala., Annunzio, Arends, Ashbrook, Ashley, Aspinall, Baring, Beall, Md., Belcher, Bell, Calif., Bennett, Berry, Betts, Blaggi, Biester, Bingham, Blackburn, Blanton, Boggs, Boland, Bolling, Bow, Brademas, Brasco, Brickley, Brooks, Brotzman, Brown, Mich., Broyhill, N.C., Broyhill, Va., Buchanan, Burke, Mass., Burlinson, Tex., Burlinson, Mo., Burton, Calif., Burton, Utah, Bush, Lutton, Byrne, Pa., Byrnes, Wis., Cabell, Caffery, Carter, Casey, Cederberg, Celler, Chamberlain, Chisholm, Clancy, Clark, Clawson, Del., Clay, Cleveland, Cohelan, Collier, Collins, Colmer, Conable, Conte, Corbett, Corman, Coughlin, Cramer, Cunningham, Daddario, Daniels, N.J., Davis, Wis., Dawson, de la Garza, Delaney, Dellenback, Denney, Dennis, Derwinski, Devine, Diggs, Dirgell, Donohue, Dorn, Dowdy, Downing, Duiski, Duncan, Dwyer, Eckhardt, Edmundson, Edwards, Calif., Edwards, La., Ellberg, Erlenborn, Esch, Eshleman, Evans, Colo., Farbstain, Feighan, Findley, Fish, Fisher, Flood, Flowers, Foley, Ford, William D. Fountain, Fraser, Frelinghuysen, Fulton, Pa., Fulton, Tenn., Fuqua, Gallianakis, Garmatz, Gaydos, Gettys, Glaimo, Gibbons, Gilbert, Goldwater, Gonzalez, Goodling, Gray, Green, Oreg., Green, Pa., Griffin, Griffiths, Gross, Grover, Gude, Hagan, Haley, Halpern, Hamilton, Hammer-schmidt, Hanley, Hanna, Hansen, Idaho, Hansen, Wash., Harsha, Hastings, Hathaway, Hawkins, Hechler, W. Va., Heckler, Mass., Henderson, Hicks, Hogan, Hollifield, Hosmer, Howard, Hull, Hungate, Hunt, Hutchinson, Ichord, Jacobs, Jarman, Joelson, Johnson, Pa., Jonas, Jones, Ala., Jones, N.C., Jones, Tenn., Karth, Kastenmeyer, Kazen, Kee, Keith, Kling, Kleppe, Koch, Kuykendall, Kyl, Landgrebe, Landrum, Latta, Leggett, Lipscomb, Lloyd, Long, La., Long, Md., Lowenstein, Lujan, Lukens, McCarthy, McClosky, McCloskey, McClure, McCulloch, McDade, McDonald, Mich., McEwen, McFall, McMillan, MacGregor, Maddog, Mahon, Mailliard, Mann, Marsh, Martin, Mathias, Matsunaga, May, Mayne, Meeds, Meskill, Michel, Mikva, Miller, Ohio, Minish, Mink, Minshall, Mize, Mizell, Mollohan, Monagan, Montgomery, Moorhead, Morton, Mosher, Murphy, N.Y., Myers, Natcher, Nedzi, Nelsen, Nichols, Nix, Obey, O'Hara, Olsen, O'Neal, Ga., O'Neill, Mass., Ottinger, Passman, Patten, Felly, Perkins, Pettis, Pike, Pirnie, Poage, Poff, Pollock, Preyer, N.C., Price, Ill., Pryor, Ark., Pucinski, Purcell, Quile, Quillen, Rarick, Rees, Reid, Ill., Reid, N.Y., Riefel, Reuss, Rhodes, Rogers, Colo., Rogers, Fla., Rooney, N.Y., Rooney, Pa., Rosenthal, Restenkowski, Roth, Roudebush, Roybal, Ruppe, Ruth, Ryan, St Germain, St. Onge, Satterfield, Saylor, Schadeberg, Scherle, Schneebell, Schwengel, Scott, Sebellus, Shipley, Shriner, Sikes, Sisk, Skubitz, Smith, Calif., Smith, Iowa, Smith, N.Y., Snyder, Staggers, Stanton, Steed, Steiger, Ariz., Steiger, Wis., Stokes, Stratton, Stubblefield, Sullivan, Symington, Taft, Talcott, Taylor, Teague, Calif., Teague, Tex., Thompson, N.J., Thomson, Wis., Tiernan, Tunney, Ullman, Utt, Van Deerlin, Vander Jagt, Vanik, Vigorito, Waggonner, Waldie, Wampler, Watkins, Watson, Watts, Weiacker, Whalen, Whalley, White, Whitehurst, Whitten, Widnall, Wiggins, Williams, Wilson, Bob Wolf, Wright, Wyatt, Wylder, Wylie, Wyman, Yates, Zablocki, Zion, Zwach

NAYS—0 ANSWERED "PRESENT"—1

Edwards, Ala.

NOT VOTING—80

- Adams, Evlins, Tenn., Morse, Anderson, Ill., Fallon, Moss, Andrews, Fascell, O'Konski, N. Dak., Flynt, Ayres, Ford, Gerald R., Patman, Barrett, Foreman, Pepper, Bates, Frey, Philbin, Beville, Friedel, Pickle, Blatnik, Gallagher, Podell, Bray, Gubser, Powell, Brock, Hall, Price, Tex., Broomfield, Harvey, Rallsback, Brown, Calif., Hays, Randall, Brown, Ohio, Hébert, Helstoski, Rivers, Burke, Fla., Horton, Sandman, Cahill, Johnson, Calif., Scheuer, Camp, Kirwan, Slack, Carey, Kluczynski, Springer, Chappell, Kyros, Stafford, Clausen, Don H., Langen, Stephens, Conyers, Lennon, Stuckey, Cowger, McKneally, Macdonald, Udall, Culver, Mass., Wilson, Daniel, Va., Miller, Calif., Charles H., Davis, Ga., Mills, Winn, Dent, Morgan, Young, Dickinson

So the bill was passed. The Clerk announced the following points: On this vote: Mr. Gerald R. Ford for, with Mr. Edwards of Alabama against. Until further notice:

- Mr. Hébert with Mr. Anderson of Illinois, Mr. Kirwan with Mr. Ayres, Mr. Carey with Mr. Bates, Mr. Kyros with Mr. Rallsback, Mr. Barrett with Mr. Morse, Mr. Miller of California with Mr. Andrews of North Dakota, Mr. Rivers with Mr. Hall, Mr. Charles H. Wilson with Mr. Chappell, Mr. Evin of Tennessee with Mr. Harvey, Mr. Randall with Mr. O'Konski, Mr. Fallon with Mr. Broomfield, Mr. Brown of California with Mr. Patman, Mr. Dent with Mr. Sandman, Mr. Davis of Georgia with Mr. Price of Texas, Mr. Adams with Mr. Springer, Mr. Morgan with Mr. Cahill, Mr. Mills with Mr. Helstoski, Mr. Lennon with Mr. Burke of Florida, Mr. Beville with Mr. Stephens, Mr. Fascell with Mr. Brown of Ohio, Mr. Gallagher with Mr. McKneally, Mr. Hays with Mr. Horton, Mr. Murphy of Illinois with Mr. Stafford, Mr. Moss with Mr. Gubser, Mr. Kluczynski with Mr. Podell, Mr. Philbin with Mr. Bray, Mr. Ronan with Mr. Langen, Mr. Slack with Mr. Camp, Mr. Young with Mr. Foreman, Mr. Macdonald of Massachusetts with Mr. Blatnik, Mr. Johnson of California with Mr. Don H. Clausen, Mr. Culver with Mr. Brock, Mr. Flynt with Mr. Cowger, Mr. Pepper with Mr. Thompson of Georgia, Mr. Pickle with Mr. Dickinson, Mr. Udall with Mr. Winn, Mr. Stuckey with Mr. Scheuer, Mr. Conyers with Mr. Friedel, Mr. Daniel of Virginia with Mr. Powell.

Mr. EDWARDS of Alabama. Mr. Speaker, I have a live pair with the gentleman from Michigan, Mr. GERALD R. FORD. If he had been present, he would have voted "yea." I voted "nay." I withdraw my vote and vote "present."

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. JARMAN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on the bill just passed.

The SPEAKER. Is there objection to the request of the gentleman from Oklahoma?

There was no objection.

CONGRESSMAN ANNUNZIO CALLS ATTENTION TO CHICAGO DAILY NEWS EDITORIAL COMMENDING REPUBLIC OF ITALY ON 23 YEARS OF OUTSTANDING PROGRESS

(Mr. ANNUNZIO asked and was given permission to address the House for 1 minute, to revise and extend his remarks and include extraneous matter.)

Mr. ANNUNZIO. Mr. Speaker, on Monday, June 2, 1969, the Italian Republic celebrated the 23d anniversary of the establishment of their democratic form of government, and I included in my remarks in the CONGRESSIONAL RECORD on that date an editorial from the Chicago Sun-Times commemorating this important occasion.

HOSPITAL AND MEDICAL FACILITIES CONSTRUCTION AND MODERNIZATION
AMENDMENTS OF 1969

Provisions contained in S. 2182 (Yarborough)

The existing categorical grant program with affirmative changes would be extended and expanded for a five-year period starting Fiscal Year 1971. Grants for construction and modernization of hospitals and other medical facilities would total \$2,190 million, of which \$515 million would be available for modernization. Federal project grants to assist in the modernization of emergency rooms of general hospitals in the amount of \$10 million for five years is authorized. Starting Fiscal Year 1971, a new five-year program of loan guarantees to aid in the construction and modernization of privately owned non-profit health facilities in the amount of \$400 million annually with interest subsidies to be paid by the Federal government at a rate of 1/2 of the interest up to 6% and 1/3 of the interest thereafter would be authorized.

Additionally, there would be provided a new five-year program of direct Federal loans for the construction and modernization of publicly owned health facilities with a maximum five-year authorization of \$750 million. The loans would bear an interest rate of 3% annually and would be available for a term not to exceed 25 years.

The existing grant category of assistance entitled diagnostic treatment centers would be retitled out-patient facilities, and at the same time, redefined to permit privately owned nonprofit facilities other than general hospitals to receive this assistance.

The bill would also permit, at the option of the State agency, an increase in the Federal share by 20% of any project which would assist in reducing the costs of delivering care or otherwise improve the capabilities to deliver health care.

The legislation would provide a five-year authorization of \$450 million to assist in projects relating to research and demonstration to improve health facilities and services. As of this writing no hearings have been scheduled on the bill.

THE TEACHING HOSPITAL AND ITS ROLE
IN HEALTH PLANNING AT THE LOCAL
AND AREA LEVELS

Prepared by
Staff, Council of Teaching Hospitals

INTRODUCTION

It is believed that the recent Federal Legislation dealing with planning in the field of health has inadequately identified and provided for the unique role of the teaching hospital. While the history and contemporary developments of these laws indicate in one case a categorical thrust and in the other a non-categorical approach, both of these tend to be viewed as complementary rather than competitive activities. Section 900 of P.L. 89-239 has perhaps the most direct statement on this new role of medical schools and teaching hospitals when it indicates that a major purpose of the Act is " ... to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions and hospitals ... ".

Coordinated planning for health and medical care facilities and services is a subject which has been given increasing importance of late. The recent position of the American Hospital Association tying reimbursement to planning gives emphatic evidence to this. During this same time, a number of planning groups have been created to describe and evaluate existing facilities and to plan programs for the provision of needed facilities and services on areawide or regional bases. The development of these groups has arisen primarily through the exhibited health care needs of the community, supported by attempts at systematic analyses of existing resource and future community requirements.

The prime objective of coordinated planning, on a community or on a regional basis, is considered to be: the optimum utilization of a community's or a region's hospital and health related facilities, services and manpower from the standpoint of institutional use, professional use,

and use by the consumers of these resources - the patients. The teaching hospital must remain an integral part of any plan to reach these objectives. It can neither ignore nor be ignored by the planning group in its region. Its special nature and role, however, must be understood and allowed for in the planning process.

THE NATURE OF THE TEACHING HOSPITAL AS AN INSTITUTION

The teaching hospital traditionally has had as one of its primary responsibilities the education of young physicians and other members of the health team. The physicians include undergraduate medical students in the clinical aspects of the curriculum, house officers at all levels, and postdoctoral fellows - currently the most rapidly growing group. Since the education and training programs for all students revolve around the patient, the hospital must first of all be a place of care for sick people.

The teaching hospital has special social responsibilities in terms of its unique goals that may critically alter its function as contrasted to a hospital which is primarily patient-service oriented. As has been emphasized throughout this paper, the multiple goals of education and training, patient care, health research and community service require careful assessment in order to insure an equitable distribution of productivity among the four activities.

As William L. Kissick has noted,¹ "In general, health manpower has not received the attention accorded to the other services." This attitude can be extended to the specific activities of manpower production, which in all too few instances is taken into consideration by the various health planning agencies.

¹William L. Kissick "Health Manpower in Transition" in The Milbank Memorial Fund Quarterly, (Vol. XLVI, No. 1) January, 1968, Part 2, Pg. 53.

In noting the unique contributions of teaching hospitals in terms of its patient care, education, research and community service functions, as these contributions relate to health planning, it is necessary to have some workable, operational definition of the planning process.

Sigmond in discussing this concept has suggested the following:²

"The emphasis in health planning is on goal setting, development of programs to overcome obstacles to achieving goals, and continuous re-evaluation of goals and programs. Most simply stated, planning is thinking in advance as a basis for doing."

Although teaching hospitals are in agreement with the aims and goals of health planning, especially as described in theoretical terms as stated above, when implementation plans are developed, particularly in terms of bed ratios or other quantitative indexes, the nature of the teaching hospital is such that standardized or other easily applied criteria do not apply to it in the same way that they may to others.

As the trend toward structuring hospital services in accordance with regional systems of medical care organization grows, it is becoming increasingly apparent that teaching hospitals will be expected in the future to serve even more than at present as regional referral centers. They will become increasingly, hospitals to which patients in need of specialized diagnostic and therapeutic facilities that are not generally available in the community may be referred. Additionally, teaching hospitals will undertake a significant new role in caring for the ambulatory patient. Further they will be looked to more and more as the loci of

²Robert M. Sigmond, "Health Planning", Medical Care, May-June, 1967, pg. 117.

production of workers of all sorts for the entire health field. Finally they will continue to be institutions where new concepts and new programs are tested. While these are elements which remain to date largely undetermined and undefined, the application of certain standard quantified indices (such as beds per thousand population) relating to community service needs have been introduced. These are almost sure to produce to the detriment of the community, an inequitable program for teaching hospitals and their multiple functions.

Among the reasons for this are:

1. Most "bed needs" models or other program indicies are based on finite geographic areas which circumscribe the service areas for most hospitals. Most teaching hospitals have a much larger service area than that utilized in the geographically specialized planning report.
2. Many planning models used to obtain "total bed needs" fail to take into consideration established referral patterns of physicians. The teaching hospital, with its broad array of sophisticated personnel and equipment must often be prepared to accept large numbers of referral patients, although planning models do not usually account for this feature of activity.
3. The "total bed needs" as identified by planning bodies assumes that all hospitals are essentially equal in their delivery. Bed needs should be based on the capability of the individual hospital taking into account the total service, education and research nature of the institution.

4. Many beds and other program elements which have been established for research and education purposes should not be included in planning estimates as these beds are not generally accessible, due to highly selective admission requirements established by diverse clinical departments. Allowance should be made for this as for increased length of stay resulting therefrom.
5. There is no means currently available for including in many of the planning criteria a factor that would allow for the multiple products of the teaching hospital, particularly in the areas of health manpower production and in health care administration research.

With these noted deficiencies in the quantitative criteria that are most usually employed by planning agencies, there is a need for a positive action statement by the Council of Teaching Hospitals dealing with the responsibilities of teaching hospitals in relating to planning agencies.

THE TEACHING HOSPITAL AND PLANNING

Teaching Hospitals recognize their responsibilities to support planning in the following ways:

1. To encourage each teaching hospital institution to identify within its organizational structure a focal point designated to interact with a constituent planning agency.
2. To encourage each teaching hospital institution to provide a leadership role in the development, formation and continuing operation of areawide, regional and other planning efforts.
3. To encourage, as an integral factor of planning, the continued development of needed educational facilities and the

STATEMENT OF
THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES
IN SUPPORT OF APPROPRIATIONS FOR
THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
May 26, 1969

Mr. Chairman and members of the Committee, I am Merlin K. DuVal, dean of the newly-developing College of Medicine at the University of Arizona. It is a privilege for me to have been invited by the Association of American Medical Colleges to present to you some of the views we hold on the subject of increased health manpower, but with specific emphasis on health facilities construction in the fields of medicine, dentistry, osteopathy, public health, nursing, optometry, podiatry and veterinary medicine.

As the purchasing power of our citizens increased, subsequent to World War II, a paradox appeared. I refer to the fact that in spite of our increasing affluence the health needs of a substantial portion of our people have not been met. Subsequently, certain steps have been taken to begin correcting this deficiency, such as meeting the cost of health care for the aged and for the medically indigent, and providing for members of the armed forces and for the veteran. We have also provided funds to increase substantially, both the quality and the quantity of medical research; to close the gap between the experimental laboratory and the bedside through Regional Medical Programs; and to encourage and stimulate the development of local solutions to the problems of sanitation, air and water pollution, facilities, services and personnel that relate to health through Comprehensive Health Planning.

The impact of this enormous swing in public policy has been to impose upon all of us a staggering new demand for manpower in the health

field. This is no idle observation; the American public, the Association of American Medical Colleges, the American Medical Association, and all other major associations of health professions have acknowledged that we are falling behind in the production of health manpower. In 1963, Congress demonstrated its interest and concern about this subject by introducing, and passing, the Health Professions Educational Assistance Act and, more recently, the Health Manpower Act, both of which had as common objectives increased enrollments of students in our health science schools.

Unfortunately, this effort has not been sufficient to meet the demand. True, there have been many good responses to the incentives which Congress provided. In the instance of medical schools, at least 15 states are now at one stage of commitment or another relative to starting a new medical school, five for the first time (Arizona, New Mexico, Rhode Island, Hawaii, Nevada); two for the second time (New Jersey and Connecticut); and two for the third time (Louisiana and Michigan). Twelve of these new schools have received assistance under the provisions of the Health Professions Educational Assistance Act. They have added 817 new, first-year positions, to our medical education capability.

At the same time, 45 of our existing medical schools have also responded, with the help of Federal funds, by increasing their enrollments by another 1062 places. Altogether, among schools of medicine, dentistry, osteopathy, nursing, public health, optometry, podiatry and veterinary medicine, 126 schools have responded by increasing their enrollments by over 4,500 students per year.

Unfortunately, this still isn't enough. Our schools are now being asked to expand their traditional missions and participate in new

programs of allied health professional education; to experiment and explore routes for educating and training new types of health personnel; to stimulate a demand for, as well as to provide, new programs of continuing education for practicing physicians; to provide professional consultation to government agencies; to become partners in new training and certification programs and, most recently, to become an active participant in both research and service through the distribution of health services, especially to our less privileged citizens.

Requirements such as these are arriving at a rate that is outstripping our new educational capacities. As a result, we are still importing 2000 new physicians a year--approximately 25-percent of our own annual output--from foreign countries. As Senator Yarborough has recently pointed out, this is in striking contrast to Russia, which is currently exporting approximately 2000 physicians each year to underdeveloped countries of the world.

Let me be more specific. While I have already referred to the response that has been made both by our existing educational institutions and through the commitments that have already been made to establish new medical schools, nevertheless, the Bureau of Health Professions Education and Manpower Training has also approved another 30 projects which would further increase our annual enrollments by 711 students. But the Bureau doesn't have the funds to make an award to any of these projects. The Bureau also has nine projects, currently before its Councils, which could add another 239 student positions and has 181 projects still pending. This is the backlog that remains in spite of having already obligated all of its currently-available funds. As of two weeks ago, the Bureau had a backlog of approved, but unfundable, applications

totaling \$209 million with another \$32 million in applications still being processed.

If one measures this extraordinary need against the original appropriation authorization of \$170 million, it can be seen that even if that figure were available we would still be behind. When this need is measured against the current request of \$141 million, this leaves us too far behind, with no immediate way to close the gap. Worse, many of the new medical schools, because of the large monetary commitments that are necessary to start, have found it necessary to complete their building programs in phases. Since they have already made the necessary commitment to respond to the Congressional incentives that were provided through the Health Professions Educational Assistance Act, it would seem to be unwise indeed not to provide enough funds now to see these projects through.

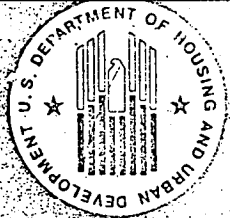
The situation with respect to construction funds is somewhat worse this year because of another factor. The new Health Manpower Act authorizes applicants to deal, for the first time, with a single Federal agency for the construction of multipurpose space. In other words, whether the space is going to be used for teaching, research or library purposes, it may now be treated as a single entity. This is a fine step, in the best judgment of many of us, and we compliment the members of Congress who framed this particular provision of the legislation. On the other hand, when the responsibility for funding the research and library space was transferred to the Bureau of Health Manpower no provision was made to meet these new needs. As a consequence, these spaces must now be funded by reducing the dollars that are available to the teaching program.

Let me reiterate as follows. We acknowledge the desirability of adopting public policy which seeks to make it possible for all of our citizens

to have access to the finest medical care that American medicine can provide. We also acknowledge the wisdom of continuing to support quality medical research. We agree with the high priority that has been assigned to opening new avenues for transferring our valuable and useful new knowledge to the clinic and to the bedside. But, having acknowledged all this, we must also admit that the successful achievement of these objectives is absolutely and irrevocably tied to manpower--to our ability to increase, substantially, our total educational capability in the health sciences. For this, every dollar of the originally-authorized appropriation of \$170 million is essential.

Mr. Chairman, we also want to urge that the ²⁵⁸~~253~~ million recommended by the Johnson administration for the Hill-Burton program be appropriated. The House Committee on Interstate and Foreign Commerce has recommended that the Hill-Burton program be continued by the passage of H.R. 11102, which authorizes that level of appropriation for construction grants and provides for a guaranteed loan program.

The rising demands for admission to hospitals and for the services provided by out-patient clinics and emergency rooms are so well known they need little emphasis to the members of this Committee. It does seem desirable to emphasize the crucial importance of a great many hospitals, such as the members of the Council of Teaching Hospitals of the AAMC, as the setting for the education of medical students, interns and residents, nurses, technologists and therapists in a number of disciplines. Expanding the capacity of hospitals to participate in the education of these health professionals is a crucial part of the national effort to provide additional health personnel. The needs of teaching hospitals to renovate or replace existing facilities or build new ones are very great, and the cost of construction continues to rise. We think that the appropriation for the Hill-Burton program in FY '70 is essential.



HUD NEWS

U.S. DEPARTMENT OF HOUSING
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WASHINGTON D.C. 20410

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Phone (202) 755-7327

FOR RELEASE:
Tuesday, April 29, 1969

FACT SHEET ON NONPROFIT HOSPITAL INSURANCE PROGRAM

A program to attract major private capital to help finance expanded hospital and related facilities

Needed Facilities

An estimated \$11 billion for modernization or replacement of obsolete health facilities is needed to meet present health care demands in the U.S. An additional \$6 billion is needed for new construction. This backlog of demand is rising. Methods of financing hospitals in the past no longer suffice. The main resources once available from local government, private foundations, and other contributors have receded. The main Federal hospital assistance program, under the 1946 Hill-Burton Act, only partially fills the needs. Funds available for Hill-Burton grants in fiscal 1969 totaled \$267 million. The Administration has budgeted the grant program at \$150 million for fiscal 1970.

Legal Authority.

The Nonprofit Hospital Insurance Program was enacted under Title XV of the Housing and Urban Development Act of 1968 (Public Law 90-448). That Act authorized HUD to administer the program as a new Section 242 of the National Housing Act (Public Law 73-479).

Nature of Program

Mortgagees are insured by HUD's Federal Housing Administration to finance new and rehabilitated (modernized) hospitals, including major movable equipment to be used in operating them. The mortgage amount for a hospital project may not exceed \$25 million or 90 percent of the estimated replacement cost of the project and equipment. The mortgage term is 25 years, and the current maximum interest rate is 7½ percent. The hospital must be owned and operated by nonprofit sponsorship.

Applicant Eligibility

Eligibility of hospital projects is determined by regional offices of the Public Health Service of the U.S. Department of Health, Education and Welfare. The Act provides that no application for mortgage insurance shall be approved unless the State Hill-Burton Agency has certified that a need exists for the facility and that reasonable minimum standards for licensing and operating hospitals are in force.

Preliminary applications should be made to the HEW regional office through the State Hill-Burton Agency in the State in which the hospital will be located. Proposals will be processed by the Health Facilities Planning and Construction Service of the PHS before FHA makes its commitments to insure the mortgages.

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VI