LONG-TERM INSTITUTIONAL CARE FOR THE AGED

HEARINGS

BEFORE THE

JOINT SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-EIGHTH CONGRESS

FIRST SESSION

WASHINGTON, D.C.—DECEMBER 17, 18, 1963

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

28-737 WASHINGTON : 1964

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C., 20402 - Price 35 cents

SPECIAL COMMITTEE ON AGING

GEORGE A. SMATHERS, Florida, *Chairman*

PAT McNAMARA, Michigan
CLAIR ENGLE, California
HARRISON A. WILLIAMS, JR., New Jersey
MAURINE B. NEUBERGER, Oregon
WAYNE MORSE, Oregon
ALAN BIBLE, Nevada
FRANK CHURCH, Idaho
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
EDWARD V. LONG, Missouri
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
RALPH YARBOROUGH, Texas

EVERETT McKINLEY DIRKSEN, Illinois
BARRY GOLDWATER, Arizona
FRANK CARLSON, Kansas
WINSTON L. PROUTY, Vermont
KENNETH B. KEATING, New York
HIRAM L. FONG, Hawaii
E. L. MECHEM, New Mexico

J. WILLIAM NORMAN, Jr., *Staff Director*
JOHN GUY MILLER, *Minority Staff Director*

JOINT SUBCOMMITTEE ON LONG-TERM CARE

FRANK E. MOSS, Utah, *Chairman*

PAT McNAMARA, Michigan
CLAIR ENGLE, California
HARRISON A. WILLIAMS, JR., New Jersey
MAURINE B. NEUBERGER, Oregon
WAYNE MORSE, Oregon
FRANK CHURCH, Idaho
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
EDWARD V. LONG, Missouri
RALPH YARBOROUGH, Texas

EVERETT McKINLEY DIRKSEN, Illinois
BARRY GOLDWATER, Arizona
FRANK CARLSON, Kansas
KENNETH B. KEATING, New York
HIRAM L. FONG, Hawaii
E. L. MECHEM, New Mexico

FRANK C. FRANTZ, *Professional Staff Member*

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

STATEMENTS

ADDITIONAL INFORMATION

LONG-TERM INSTITUTIONAL CARE FOR THE AGED

TUESDAY, DECEMBER 17, 1963

U.S. SENATE,
JOINT SUBCOMMITTEE ON LONG-TERM CARE
OF THE SENATE SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The joint subcommittee met at 10:20 a.m., pursuant to call, in room 4230, New Senate Office Building, Senator Frank E. Moss (chairman) presiding.

Present: Senators Moss, Williams, Muskie, Neuberger, Keating, and Fong.

Present also: Frank C. Frantz and Jay B. Constantine, professional staff members, and Gerald P. Nye, professional staff member (minority).

Senator Moss. The subcommittee will come to order.

The first order of business will be for the chairman to apologize for being late. It is a long story and I won't burden you with it. We will go right ahead.

I would like to welcome all of you here to this first hearing of the Subcommittee on Housing for the Elderly and the Subcommittee on Health of the Elderly, acting jointly in a comprehensive study of the adequacy of long-term institutional care for the Nation's aged population.

Nursing homes, homes for the aged, and similar institutions represent a major element in the living arrangements needed especially for very elderly people. The average age in nursing homes now is about 80 years—two-thirds are over 75—and the population over 75 is our fastest growing age group.

Apart from the aspect of shelter, such institutions have a great contribution to make to the restoration and the maintenance of health for the infirm aged. Advances in medical knowledge have opened great new possibilities for services to the nursing home patient. It has been amply demonstrated that conditions causing physical and emotional dependency are often reversible, and that for a great many cases techniques are available that can promote and prolong self-care and independence in daily living.

The nursing home and the home for the aged with nursing services are potentially centers where this knowledge and these techniques can be brought to bear for the benefit of the aged patient. Thus, the interest of the Subcommittees on Housing and Health converge as we take up this subject and I want to express my appreciation to Senator McNamara and his subcommittee for their willingness to cooperate and give their time to this joint inquiry.

Our first hearings, today and tomorrow, will focus on Federal programs which are now helping to construct or finance new nursing

homes and helping to pay for nursing home care. The hearings will serve to give us an inventory of present Federal interest in the nursing home field.

I think we should explore whether our present programs to assist in construction of nursing homes are producing the kinds of facilities which fit in best with modern practices in caring for long-term patients. We need to be sure that high standards are being consistently applied in the development of these new facilities, and that appropriate steps are taken to assure the safety and proper care of patients placed in nursing homes under Federal programs.

I am looking forward now to hearing from these witnesses who are most familiar with the operations of our programs.

Senator McNamara, unfortunately, has some other commitments which prevent him from being here as we open these hearings. However, he has a statement which he wishes to make. Without objection, it will appear at this point in the record.

STATEMENT BY SENATOR PAT MCNAMARA

It is particularly fitting that the Joint Subcommittee on Long-Term Care begin its study of nursing homes during this week before Christmas. We who will be fortunate enough to be able to celebrate the holidays with family and friends must properly concern ourselves with the problems of those many thousands of older people in institutions who have neither friends nor relatives.

Their needs and situation are complex—and urgent. The problems of some one-half million aged citizens cannot be simply summarized in terms of reference to the "forgotten Americans." We are going to have to take a long hard look at what so often are depressing dumping grounds. We are going to have to thoroughly examine the quality of medical care, food, and housing provided. We need to examine those arrangements, if any, for safeguarding the limited financial resources of patients.

We must devote major attention to the role of the Federal Government in the financing of long-term facilities and services. Public assistance recipients comprise the majority of nursing home patients—and the Federal Government contributes hundreds of millions of dollars annually toward their care. What are we getting for this money? What are we not getting for this money? Are present financing arrangements sufficient to pay for the type of care that is needed? What standards are employed to safeguard the public interest? How adequate are these standards and how meaningful is their enforcement? What new or expanded requirements should the Government employ in the interest of assuring the safety and proper care of long-term patients?

These important questions must be answered. Their consideration—and hopefully, the solutions developed—are vital not only to those now in long-term care institutions but, with the older population growing so rapidly in numbers, to millions more who might conceivably need such care in the not-so-distant future.

In recognition of the importance of this subject, the Subcommittee on Health of the Elderly was more than pleased to cooperate with the Subcommittee on Housing in combining to form the Joint Subcommittee on Long-Term Care. Senator Moss knows that he will have the wholehearted cooperation of all of the members of the Subcommittee on Health as he leads this significant study.

Senator Moss. Before I call the first witness I want to see if either of my colleagues has a statement he would care to make at this point.

Senator KEATING. No, Mr. Chairman.

Senator FONG. I haven't any, Mr. Chairman.

Senator Moss. Senator Williams is on the way but we will proceed. We will hear from the President's Council on Aging, represented by the Honorable Ellen Winston, Chairman of the Executive Committee of the Council.

Here is Senator Williams. Do you have a statement, Senator?

Senator WILLIAMS. Not at this time, thank you. I don't wish to delay the witness. I will leave my statement with you to be placed in the record

Senator MOSS. Thank you, Senator Williams. Your remarks will appear at this point in the proceedings.

STATEMENT BY SENATOR HARRISON A. WILLIAMS

Mr. Chairman, I would like to take a few moments to commend the Subcommittees on Health and Housing for working together on a study of major importance to our older citizens and to everyone who is concerned about their well-being.

I would also like to point out that the Subcommittee on Frauds and Misrepresentations Affecting the Elderly has a special interest in the findings of the two subcommittees. Undoubtedly, many reputable persons are now planning or operating worthwhile nursing homes of great benefit to elderly Americans who would otherwise have no care or lodging when they need it most.

But it is equally obvious, I believe, that many less scrupulous persons look upon the growing number of citizens over 65 years of age as a market to be exploited in every way possible.

At a time when there is growing need for nursing home facilities, it would be unlikely that promoters have overlooked this area as a potential source of such exploitation.

Already, many questions can be asked about the operations of what may be a small but growing number of nursing home operators. For example.

1. How many really can live up to the promises they make to those who look for security and care in their final years?

2. Have elderly persons agreed to turn over their property or power of attorney to nursing home operators without fully realizing the potential consequences?

3. If advertising is involved, how accurate are the promises and descriptions of service?

4. Are State standards rigidly maintained in all such institutions? If not, why not? Do States adequately police the receipt of welfare checks?

Mr. Chairman, I believe that your plans for joint hearings and investigation will help us find answers to these and other questions. The Subcommittee on Frauds and the Elderly will, of course, work in every way possible with you to find those answers and to help you present them to the public.

As a member of the Housing Subcommittee and the Subcommittee on Frauds, I will take a double interest in the subject; and I thank you for all your courtesies and interest in this subject.

Speaking now primarily as a member of the Housing Subcommittee, I would like to add two other thoughts about the hearings.

Recently we were shocked by the deaths of elderly citizens in fires at Atlantic City, N.J., and in Norwalk, Ohio. It is my understanding that the Norwalk fire destroyed a structure clearly operated as a nursing home. The New Jersey structure was a hotel at which many of the temporary guests happened to be elderly.

Soon after the two fires, an official of the National Fire Protection Association made the declaration that thousands of elderly persons are living in firetraps. He said that such dangers can exist only because of public indifference.

Mr. Chairman, such indifference can exist only because officials and the public do not have the facts. I think it is part of our duty here to determine the extent to which such dangers do exist, and I am gratified that you plan to include this matter in your agenda of studies.

My other thought is that the question of high costs in some nursing homes should receive subcommittee attention. I am especially concerned about the fact that some beds in high-price nursing homes remain empty while demands mount for unavailable beds in public or low-cost nursing homes. This problem has grown more acute in recent years. I am sure we will hear more about it as the hearings continue, and I am equally sure that conscientious operators of reputable nursing homes will join us in our search for facts.

Such reputable operators sometimes suffer from the bad reputation of a minority in their midst. Protection of our older citizens should be in the interest of every American.

Senator Moss. Dr. Winston, will you come forward?

Dr. Winston is also Commissioner and will speak for the Welfare Administration. Is that correct? You are doing double duty, you are wearing two hats, Dr. Winston. You may proceed under either one.

STATEMENT OF HON. ELLEN WINSTON, COMMISSIONER, WELFARE ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. THOMAS B. McKNEELY, CHIEF, DIVISION OF MEDICAL CARE STANDARDS, BUREAU OF FAMILY SERVICES, AND CHARLES E. HAWKINS, LEGISLATIVE REFERENCE OFFICER

Dr. WINSTON. Thank you, Mr. Chairman and members of the subcommittee.

With your permission, I would like to speak first in my capacity as Commissioner of the Welfare Administration of the Department of Health, Education, and Welfare. I have with me Dr. Thomas McKneely of the Bureau of Family Services of the Welfare Administration and Mr. Charles Hawkins of the Office of the Commissioner of the Welfare Administration.

I appreciate being given this opportunity to discuss with you the Welfare Administration's interests and concerns with respect to long-term health facilities, especially nursing home facilities.

We are deeply and increasingly concerned with the subject because of the large numbers of persons dependent on public funds for medical care and because of the growing amount of public assistance money involved in the purchase of such care for recipients of medical assistance for the aged (MAA) old-age assistance (OAA), aid to the blind (AB), and aid to the permanently and totally disabled (APTD).

In the calendar year 1962, of the $919,166,000 of public assistance money used to purchase medical care, 34 percent, or $274.5 million, was spent for nursing home care. Public assistance recipients were utilizing about 60 percent of the nursing home beds available at that time.

There is an upward trend in the proportion of OAA recipients in nursing homes and we anticipate greater expenditures in this area as additional nursing home beds become available, as the aged segment of our population (where we find the greatest incidence of chronic illness) increases in number, and as the average age of OAA recipients goes up.

A study of the characteristics of OAA recipients made in 1953 showed that 3.5 percent (90,000) of all such recipients were in nursing or convalescent homes. Another study in 1960 showed the comparable proportion to be 6.3 percent (147,000). By January 1962, 6.7 percent of all OAA recipients were in nursing homes but the number had declined to slightly more than 130,000. For the same month, however, 13 States reported 35,000 MAA recipients in nursing homes. (Reporting for MAA was on a voluntary basis. Oregon, Puerto Rico, and Washington provided nursing home care under their MAA programs but did not submit reports.)

For January 1962, OAA payments for recipients in nursing homes totaled $15.7 million—an average of $120.72 per recipient. The

total included $5.6 million in money payments to recipients and $10.1 million in vendor payments to the nursing homes. For the 13 States reporting for MAA, the average per recipient for nursing home care was $221.04.

Total amounts of vendor payments for medical care have been reported for more than a decade. Until recently, however, comparatively large amounts of payments were not distributed by type of care. The tabulation which follows shows total payments, amounts for nursing home care and amounts not distributed by type of care for the special types of public assistance (all of the federally aided public assistance programs) and for OAA and MAA separately for fiscal years 1961 and 1963. The amounts are in thousands of dollars.

	Total	Nursing home care	Not distributed
Fiscal year 1961:			
Special types of public assistance [1]	$468,843	$124,049	$67,082
Old-age assistance	294,156	86,761	40,663
Medical assistance for the aged	42,002	22,290	7,161
Fiscal year 1963:			
Special types of public assistance [1]	895,479	302,088	59
Old-age assistance	408,291	133,336	30
Medical assistance for the aged	287,375	136,249	29

[1] Old-age assistance, medical assistance for the aged, aid to the blind, aid to the permanently and totally disabled, and aid to families with dependent children.

It will be noted that as a result of improved reporting, the amounts not distributed in 1963 were much smaller than the comparable amounts in 1961. Yet, for OAA, if the entire undistributed amount for 1961 were combined with the amount reported for nursing home care, the total would be less than the amount reported for nursing home care for 1963. (The amount distributed to OAA nursing home care in 1957 was only $38.4 million.) It will be noted, too, that for 1963, the amount reported for MAA exceeds the amount for OAA.

Data on the numbers of recipients of nursing home care for fiscal year 1963 will not be available for several months.

The Welfare Administration is involved in the purchase of nursing home care because a State may receive Federal matching funds to provide such medical services for recipients of OAA, MAA, APTD, and AB. Except for MAA, the State may meet the cost of nursing home care for a recipient in one of three ways: by including in the money payment to the recipient an amount which he needs to pay for such care; by making direct payment to the supplier of nursing home care; or by a combination of the two methods. Under MAA, the State must make the payment to the provider of the care.

There are certain legal requirements that States must meet to obtain Federal financial participation in assistance to recipients who are in institutions. The general requirement is that if a State includes payment of assistance to persons in institutions, there must be a State standard setting authority with responsibility for establishing and maintaining standards. This was a part of the 1950 amendments to the Social Security Act and became effective for States July 1, 1953.

The institution providing the public assistance recipient with nursing home care must be subject to standard setting and meet certain health and safety standards, as determined by the State standard setting authority, and the recipient of the care must fall

within the spelled-out definition of a "patient" if a vendor payment is made. Each State determines the extent of its nursing home program for public assistance recipients, and the Federal Government participates financially within the matching formula for the category.

In actual practice, there is wide variation among the States as to the amount of nursing home care provided recipients, how much the State can pay for such care, and under what conditions such care will be paid for. In addition, the amount of care provided may vary from program to program within a State.

For instance, at the present time only 29 States and Guam, Virgin Islands, Puerto Rico, and the District of Columbia have implemented that part of the Kerr-Mills Act providing for Federal participation in a medical assistance for the aged program—a program designed to provide help in purchasing medical care to persons over 65 not receiving OAA who cannot afford the medical care they need. Seven of these jurisdictions that have MAA programs in operation do not make provision for the payment of nursing home care.

Despite the differences between programs in the several States, there are certain broad approaches the Federal Government can take, and is taking, to make nursing home care more widely available, and to increase the quality of the nursing home care public assistance recipients receive.

We are encouraging State standard setting authorities to review the standards applying to nursing homes and to revise them upward. The Public Health Service is promoting higher standards and has created a nursing home branch to give greater emphasis to developing standards. We hope soon to have a model standard that States can draw from in setting their standards. This is an important area because there is no Federal standard, other than being subject to a State standard setting authority, that nursing homes must meet to qualify for Federal-State public assistance payments. Another way of describing the situation is that the nursing home must meet the particular licensing standards of the State in which it is located.

There should be no spending of public assistance funds for care which does not meet the health needs of recipients or does not reflect a reasonably good quality of care. Unfortunately, today, we are paying for second- or third-rate nursing home care for many public assistance recipients. The term "nursing home" is used widely and indiscriminately. This need not and should not be.

Some of the problems around the present quality of nursing home care received by public assistance recipients rests with the public assistance agencies. If the States impose too low maximums on how much will be paid per month for nursing home care, this, in effect, imposes a maximum on the quality of care which can be expected. The amount that public assistance pays has much to do with the quality of care simply because public assistance programs are paying for about 60 percent of the patients in nursing homes every month. In this connection, it must be pointed out that State appropriations determine the levels of all public assistance programs.

We do not know exactly how much a quality nursing home bed should cost per month. We believe that nursing home charges, like

other costs of medical services, should be based upon carefully determined costs. But costs must be established by cost-accounting systems—systems that are not used by the vast majority of nursing home operators.

The Public Health Service is engaged in helping establish uniform cost accounting systems for nursing homes and from this we should get a better idea of what should be paid for this type of care for public assistance recipients.

When such data becomes available, the States will have a firmer basis upon which to request money from their respective legislatures for this type of public assistance expenditure. At the present time States are paying from $40 in the money payment (Mississippi) to $260 by vendor payment (Connecticut) per patient, per month in OAA.

We would like to see all States make provision in their public assistance programs for the payment of nursing home care when needed by their recipients, and the removal of unrealistic limits as to the duration of such payments where they now exist. Considerable progress has been made in this area in the last decade, and this progress is continuing.

It has been only 13 years since the Social Security Act was amended to provide for Federal matching to allow States to make vendor payments for medical care such as nursing home care, and even then the Federal financial participation in this area was held within the then existing limits of the Federal maximum on monthly assistance payments.

Subsequent amendments have broadened Federal financial participation in State medical payment plans for public assistance recipients and, in 1960, the Kerr-Mills Act provided a new program—medical assistance for the aged.

While we would like to see all States have MAA programs in operation, 33 programs have been put into operation during the 3 years that the legislation has been on the books. Several additional programs are scheduled to go into operation during this fiscal year. Some of the existing MAA programs are being improved and strengthened.

All of this activity has a direct bearing on the various public assistance nursing home programs for they are tied into the States' approaches to the provision of medical care in general. Additional motivation to adopt or improve these programs comes from the fact that the number of citizens needing home care is increasing, despite (or, sometimes, because of) the advance in medical science and the growing effort to bring health services into the recipient's home rather than move the patient to the services.

In this connection, it is important for States to offer a wide range of services and to require detailed determination of how best to meet the needs of the individual. Too often persons have been placed in nursing homes who could have received appropriate services in their own homes, thus promoting their happiness and also at less cost. Likewise, any program should provide for periodic review as to whether individuals can leave the nursing home.

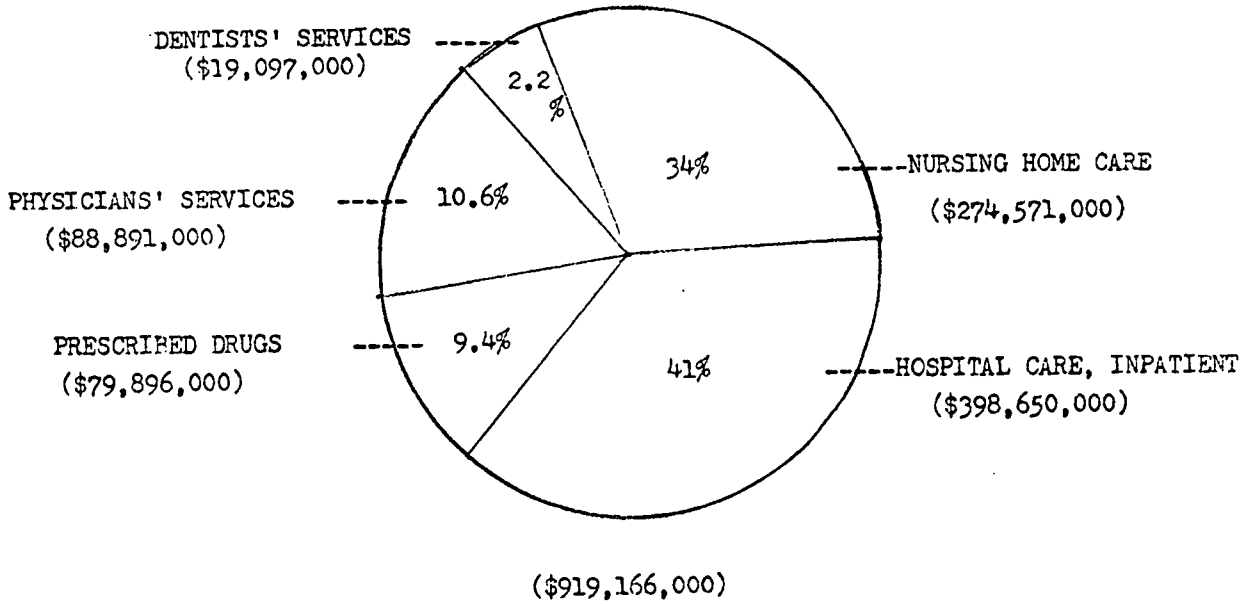
We have a number of charts and tables which provide detailed analysis of many of the things discussed today which I would like to submit for the record. I will be glad to try to answer any questions.

Senator Moss. Thank you. The tables will be included in the record at this point. We will be able, then, to study in some detail all of the information that is set out.

(The tables and charts referred to follow:)

PUBLIC ASSISTANCE

DISTRIBUTION OF THE MEDICAL CARE DOLLAR-Calendar Year 1962



($919,166,000)

Public assistance recipients in nursing homes, January 1962

Category	Number of persons in nursing homes	Number persons on money payment only	Amount	Number persons on vendor payment only	Amount	Number persons on combined money-vendor payments	Amount
Old-age assistance (OAA)	130,270	42,468	$4,190,464	29,248	$3,482,348	58,554	$8,053,673
Aid to the permanently and totally disabled (APTD)	20,493	10,016	1,111,448	3,505	456,911	6,972	994,369
Aid to the blind, (AB)	3,235	1,901	230,781	355	47,392	979	140,510
Medical assistance for the aged (MAA)	34,893	----------	----------	34,893	7,712,603	----------	----------

Medical care services under old-age assistance, December 1962

Services [1]	Availability, by number of jurisdictions			Limitations
	Total	Vendor payment	Money payment	
Physicians' services	44	38	6	Number of visits usually restricted.
Dental care	39	30	9	Frequently limited to relief of pain or necessary extractions; some States which permit dentures limit circumstances under which they are authorized.
Hospitalization	51	49	2	Usually limited as to nature of illness or duration of care.
Nursing home care	50	35	15	Maximum $100 or less per month in individual money payment in 3 States; in others, rates for specific kinds of care limited.
Prescribed drugs	42	34	8	Limited to specified illnesses in some States; monthly amount per recipient limited in others.

[1] Many jurisdictions through the vendor payment also provided other medical services, such as special nursing care in the patient's own home, transportation to receive medical care, or rehabilitation services (outpatient laboratory and diagnostic services, physical or speech therapy, and prosthetic appliances or special equipment).

NOTE.—54 jurisdictions have OAA programs.

Medical care services under medical assistance for the aged, December 1962

Service	Availability, by number of jurisdictions	Limitations
Physicians' services	27	In 3 jurisdictions only on an outpatient clinic basis; in 11, limitations on number of visits during a given period or nature of illness or conditions covered.
Dental care	13	Some restrictions in all jurisdictions; e.g., 1 restricted dental care to persons in nursing homes, and most did not provide for dentures.
Hospitalization	28	Varying limitations as to number of days of hospital care and the nature of medical need; e.g., emergency or life endangering conditions.
Nursing home care	20	In 4 jurisdictions only posthospital care.
Prescribed drugs	17	In 5 jurisdictions only on limited basis or directly related to hospital or nursing home care.

NOTE.—28 jurisdictions had MAA programs.

PUBLIC ASSISTANCE: VENDOR PAYMENTS FOR MEDICAL CARE BY TYPE OF SERVICE, CALENDAR YEAR ENDED DEC. 31, 1962

TABLE 1.—*Special types of public assistance and general assistance: Payments for vendor medical bills: Total amount, amount for which type of service was not reported, and amount in all States reporting for specified type of service, by program, calendar year ended Dec. 31, 1962*

[Amounts in thousands]

Program	Total	Type of service not reported [1]	In all States reporting for specified type of service [2]							
			Total for specified types of services	Physicians' services	Other practitioners' services	Inpatient hospital care	Prescribed drugs	Nursing home care	Dental care	Other
	Amount of vendor payments for medical care [3]									
Total	$919,166	$20,294	$898,871	$88,891	$4,547	$398,650	$79,896	$274,571	$19,097	$33,219
Special types of public assistance	817,518	55	817,464	82,043	4,469	332,934	77,274	271,382	18,528	30,834
Old-age assistance	383,146	29	383,117	47,301	3,149	135,373	47,021	126,398	6,417	17,458
Medical assistance for the aged	250,862	26	250,836	5,452	338	121,057	5,122	117,343	213	1,312
Aid to families with dependent children	96,678	----	96,678	21,957	470	43,086	13,995	222	10,006	6,942
Aid to the blind	9,806	----	9,806	1,477	101	2,872	1,886	2,364	392	716
Aid to the permanently and totally disabled	77,025	----	77,025	5,857	411	30,546	9,249	25,056	1,500	4,406
General assistance	101,647	20,240	81,408	6,848	78	65,716	2,622	3,189	569	2,386
	Percentage distribution									
Total	100.0	2.2	97.8	9.7	0.5	43.4	8.7	29.9	2.1	3.6
Special types of public assistance	100.0	(4)	100.0	10.0	.5	40.7	9.5	33.2	2.3	3.8
Old-age assistance	100.0	(4)	100.0	12.3	.8	35.3	12.3	33.0	1.7	4.6
Medical assistance for the aged	100.0	(4)	100.0	2.2	.1	48.3	2.0	46.8	.1	.5
Aid to families with dependent children	100.0	----	100.0	22.7	.5	44.6	14.5	.2	10.3	7.2
Aid to the blind	100.0	----	100.0	15.1	1.0	29.3	19.2	24.1	4.0	7.3
Aid to the permanently and totally disabled	100.0	----	100.0	7.6	.5	39.7	12.0	32.5	1.9	5.7
General assistance	100.0	19.9	80.1	6.7	.1	64.7	2.6	3.1	.6	2.3

[1] These amounts cannot be distributed in the same way as the amounts shown for the various types of service because (1) some States may not provide through the vendor payment all of the specified services and (2) amounts for the types of service include data for States reporting a partial distribution of vendor payments.

[2] Includes amounts in States that reported a partial distribution of vendor payments by type of service.

[3] For States operating pooled funds or other prepayment plans, data represent payments out of these funds to specified type of vendor. Totals do not agree with those shown in tables 2-11 of "Source of Funds Expended for Public Assistance Payments" which represent assistance payments into these funds.

[4] Less than 0.05 percent.

Public assistance: Provisions for nursing home care in the programs of old-age assistance and medical assistance for the aged, by State, November 1962

State	Old-age assistance				Medical assistance for aged	
	Maximums and methods of payment			Range or maximum rate set by State	State has MAA	Nursing home care included in scope of services
	Money payment	Vendor payment	Combination			
Alaska		(1)		Usual rate	No	
Alabama		$125.00		$225	Yes	Not provided.
Arkansas		105.00		$165	Yes	Same as OAA.
Arizona		(1)		$125	No	
California	$116			$126, $150, $175	Yes	For long-term care
Colorado			$195	$250	No	
Connecticut		(2)		$260.87 (MAA)	Yes	Rate paid.
Delaware	75	(3)		$150	No	
District of Columbia	100			$100	No	
Florida		100.00		$300	No	
Georgia		$125.00–175.00		$200	No	
Guam					Yes	Not provided.
Hawaii		(1)		As paid	Yes	Same as OAA.
Idaho		(2)		$175 (MAA)	Yes	Rate paid.[2]
Illinois			(1)	$85, $98 [4]	Yes	Not provided.
Indiana			(1)	(5)	No	
Iowa		(1)		$80 [4]	No	
Kansas	(1)			(5)	No	
Kentucky	115			$135	Yes	Do.
Louisiana		165.00		$125 to $265	Yes	Same as OAA.
Maine				$190	Yes	Not provided.
Maryland	(6)	[6] 61.50		$105 to $131	Yes	Do.
Massachusetts		(7)		$204	Yes	Same rate as OAA.[7]
Michigan	[8] 90			$180 to $210	Yes	Do.[9]
Minnesota		(1)		(5)	No	
Mississippi	40			$150	No	
Missouri		(1)		$250	No	
Montana	[10] 100	(10)		Local rate	No	
Nebraska	(1)			(5)	No	
Nevada		135.00		$225	No	
New Hampshire	[11] 165	[11] 165.00		$165 to $195	Yes	Not provided.
New Jersey		(1)		$180 to $190	No	
New Mexico		(1)		$116; $175	No	
New York			(1)	(5)	Yes	Same as OAA.
North Carolina	175			$175	No	
North Dakota		(12)		$143; $170 to $252	Yes	Same rate as OAA.[12]
Ohio		(1)		$100 to $160	No	
Oklahoma			$110–150	$110 to $150	Yes	Do.[13]
Oregon		(1)		$145 to $192 [4]	Yes	Do.[14]
Pennsylvania	(1)			$115 to $180	Yes	Do.[15]
Puerto Rico					Yes	Not provided.
Rhode Island	(1)			$113, $156, $186	No	
South Carolina	[16] 60	[16] 150.00		$150	Yes	Same rate as OAA.[16]
South Dakota	(1)			$75 to $165 [4]	No	
Tennessee		80.00		$100, $150	Yes	For 90 days a year.
Texas		180.00		$180	No	
Utah		(1)		$120 to $200	Yes	Same as OAA.
Vermont		(1)		$145, $175	Yes	Not provided.
Virgin Islands					Yes	Do.
Virginia		150.00		$150	No	
Washington		(1)		$104 to $194	Yes	Same as OAA.
West Virginia	135			$135	Yes	Same rate as OAA.
Wisconsin		(1)		(5)	No	
Wyoming			[17] 180	$180	No	

[1] Payment to meet deficit between recipient's income and cost of care up to the maximum rate set by State for kind or amount of services needed.
[2] Nursing home care for aged persons eligible for assistance is provided in MAA.
[3] Legislation permitting vendor payments enacted but not yet implemented.
[4] For basic costs; additional amounts are allowed for specific services needed.
[5] Rates negotiated by local department of welfare, subject to review by States.
[6] Vendor payments are made only in behalf of persons in certain chronic-care hospitals; money payment is used for care in other kinds of homes.
[7] Payment to meet deficit between recipient's income and cost of care; only short-term care in OAA; short and long-term care in MAA program.
[8] Supplementation by county from general assistance funds up to appropriate rate.
[9] After hospitalization for acute condition; 90 days within a 12-month period.
[10] Care related to remedial eye care is paid for by vendor payment; for other conditions, through money payment to recipient up to $95 (plus $5 for personal needs) plus supplementation from county general assistance up to local rate.
[11] Vendor payment used only for care in public medical facilities; money payment to recipient includes allowance for care in private nursing home up to rate.
[12] In OAA, 30 days; all long-term care in MAA; in both programs vendor payment is made as needed to meet deficit between available income and cost of care.
[13] Vendor payment for nursing care component of nursing home care in OAA and MAA; board and room component met through money payment in OAA, by recipient in MAA.
[14] Up to 52 days per benefit year after at least 1 day of hospital care, based on ratio of 4 days of such care for each unused day of the 14 days' hospitalization.
[15] Only in an institution operated by a county authority.
[16] OAA and MAA: vendor payment used only for posthospital nursing home care, usually up to 90 days; for other conditions. OAA only, money payments to $60.
[17] Maximum vendor payment is $100 per month; additional money payment up to $80 made to recipient for such care plus allowance for personal incidentals.

Common Factors in States' Plan Provisions for Nursing Home Care

1. Public assistance is intended to supplement available resources of the person who is eligible for assistance, i.e., to meet the gap between his resources and the cost of care which he needs, up to the level recognized by the State as its standard of assistance.

2. Some States provide for payments to meet completely this gap or deficit in the person's budget; other States set maximums on the amounts which can be paid toward the cost of care.

3. States generally will not participate in any plan for nursing home care in which the amount charged exceeds the maximum rate set in the State plan for the kind of care needed by the person.

4. When the maximum rate which the State has set exceeds the maximum payment which the State will make and the person's income is not sufficient to make up the difference, supplementation may be received up to the maximum rate from sources not usually available to the person as income. (For example, maximum rate, $250; maximum payment, $100; person's income, $100; supplementation from county fund, $25 and from person's church, $25.)

5. States making vendor payments for nursing home care also provide to the person who has insufficient income a money payment to meet personal care needs.

6. States using the money payment method include in the award an amount for such personal care needs separate from the amount for board-room-care costs.

7. Generally nursing home care is not limited as to duration; exceptions to this rule for either OAA or MAA are given in footnotes to the table.

28-737—64——2

TABLE 25.—*Old-age assistance: Numbers of recipients in nursing homes who received only money payments, only vendor payments, and both money and vendor payments, and amount of such payments, by State, January 1962* [1]

(Of States not listed, Idaho, Puerto Rico, and the Virgin Islands had no provision for care, and California reported no recipients in nursing homes. For Alaska, Arizona, and Guam, the numbers of recipients in nursing homes were insignificant; for these 3 States, no report was submitted. Oregon was unable to submit a report)

State	Recipients in nursing homes					Assistance payments for recipients in nursing homes						
			Type of payment					Type of payment				
										Both money payments to recipients and vendor payments to nursing homes		
	Total	Percent of program recipients	Only money payments to recipients	Only vendor payments to nursing homes	Both money payments to recipients and vendor payments to nursing homes	Total payments	Average amount per recipient	Only money payments to recipients	Only vendor payments to nursing homes	Total payments	Money payments to recipients	Vendor payments to nursing homes
Total	130,270	6.7	42,468	29,248	58,554	$15,726,485	$120.72	$4,190,464	$3,482,348	$8,053,673	$1,455,233	$6,598,440
Alabama	2,176	2.2	3	10	2,163	280,367	128.85	63	1,003	279,301	49,347	229,954
Arkansas	2,313	4.2			2,313	215,407	93.13			215,407	11,565	203,842
Colorado	3,167	6.3			3,167	492,610	155.54			492,610	257,857	234,753
Connecticut	4,047	29.1		875	3,172	720,659	178.07		124,396	596,263	21,634	574,629
Delaware	20	1.7	20			1,390	(2)	1,390				
District of Columbia	120	4.0	120			10,366	86.38	10,366				
Florida	3,542	5.0			3,542	368,296	103.98			368,296	47,580	320,716
Georgia	1,568	1.7	472		1,096	165,087	105.29	29,993		135,094	8,768	126,326
Hawaii	46	3.6	46			2,985	(2)	2,985				
Illinois	10,266	15.1		4,759	5,507	1,282,246	124.90		564,608	717,638	64,288	653,350
Indiana	2,983	11.8	465	440	2,078	331,501	111.13	23,445	53,074	254,982	127,735	127,247
Iowa	4,624	14.2			4,624	607,651	131.41			607,651	49,982	557,669
Kansas	4,394	16.5	4,394			443,197	100.86	443,197				
Kentucky	750	1.3	750			75,194	100.26	75,194				
Louisiana	3,160	2.5	533	20	2,607	403,178	127.59	47,010	2,449	353,719	46,119	307,600
Maine	1,276	11.4		14	1,262	187,608	147.03		433	187,175	6,310	180,865
Maryland	1,801	18.9	1,468	165	168	159,273	88.44	143,778	4,873	10,622	597	10,025
Massachusetts	374	.6		374		43,551	116.45		43,551			
Michigan	6,920	12.7	6,920			621,504	89.81	621,504				
Minnesota	7,304	16.4		7,224	80	1,128,985	154.57		1,117,578	11,407	3,802	7,605
Mississippi	612	.8	612			24,075	39.33	24,075				
Missouri	8,673	7.8	1,338	6,592	743	682,802	78.73	102,542	519,250	61,010	15,711	45,299
Montana	872	13.7	872			61,552	70.59	61,552				
Nebraska	3,040	22.1		86	2,954	361,892	119.04		8,758	353,134	68,282	284,852
Nevada	129	5.1			129	21,599	167.43			21,599	1,035	20,564

New Hampshire	1,466	31.0	1,129		337	201,646	137.55	163,217		38,429	1,236	37,193
New Jersey	4,012	21.6	5	2,209	1,798	723,383	180.30	1,050	337,356	384,977	14,833	370,144
New Mexico	530	4.9			530	74,409	140.39			74,409	9,858	64,551
New York	199	.3	138	61		27,153	136.45	17,163	9,990			
North Carolina	87	.2	87			12,972	149.10	12,972				
North Dakota	10	.2		8	2	1,367	(2)		988	379	113	266
Ohio	11,058	12.5	11,058			1,319,909	119.36	1,319,909				
Oklahoma	6,084	7.0			6,084	909,657	149.52			909,657	442,477	467,180
Pennsylvania	3,076	6.3	3,076			331,952	107.92	331,952				
Rhode Island	1,144	17.9	1,144			150,847	131.86	150,847				
South Carolina	760	2.6	707		53	50,959	67.05	41,668		9,291	1,341	7,950
South Dakota	1,112	13.2	1,112			144,529	129.97	144,529				
Tennessee	1,133	2.2		178	955	98,930	85.55		11,951	84,979	11,582	73,397
Texas	6,518	3.0	5,250		1,268	527,431	80.92	362,404		165,027	90,028	74,999
Utah	773	11.2		436	337	97,712	126.41		52,698	45,014	3,615	41,399
Vermont	769	13.9			769	104,670	136.11			104,670	3,845	100,825
Virginia	1,305	9.1		976	329	142,304	109.05		95,638	46,666	2,840	43,826
Washington	7,963	17.5		3,669	4,294	1,081,203	135.78		377,342	703,861	38,390	665,471
West Virginia	685	3.8	685			52,919	77.25	52,919				
Wisconsin	7,212	22.1		1,152	6,060	956,827	132.67		156,412	800,415	42,542	757,873
Wyoming	197	6.9	64		133	24,731	125.54	4,740		19,991	11,921	8,070

[1] States reporting for a month other than January were as follows: California, March 1962; Hawaii, October 1961; Massachusetts, November 1961; and Minnesota, North Carolina, Utah, and Texas, February 1962.

[2] Not computed; base too small.

NOTE.—Total number of recipients in January 1962: 2,258,450 in OAA.

TABLE 26.—*Aid to the blind: Numbers of recipients in nursing homes who received only money payments, only vendor payments, and both money and vendor payments, and amount of each payment, by State, January 1962* [1]

(Of States not listed, Guam, Puerto Rico, and the Virgin Islands had no provision for care, and North Dakota reported no recipient in nursing homes. For Alaska, Arizona, and Delaware, the numbers of recipients in nursing homes were insignificant; for these 3 States, no report was submitted. Oregon was unable to submit a report)

State	Recipients in nursing homes					Assistance payments for recipients in nursing homes						
			Type of payment					Type of payment				
										Both money payments to recipients and vendor payments to nursing homes		
	Total	Percent of program recipients	Only money payments to recipients	Only vendor payments to nursing homes	Both money payments to recipients and vendor payments to nursing homes	Total payments	Average amount per recipient	Only money payments to recipients	Only vendor payments to nursing homes	Total payments	Money payments to recipients	Vendor payments to nursing homes
Total	3,235	3.3	1,901	355	979	$418,683	$129.42	$230,781	$47,392	$140,510	$26,568	$113,942
Alabama	18	1.1			18	2,232	(2)			2,232	222	2,010
Arkansas	67	3.4			67	6,027	89.96			6,027	335	5,692
California [3]	49	.4	49			9,313	(2)	[4] 9,313				
Colorado	8	3.0	8			1,481	(2)	1,481				
Connecticut	43	14.9		7	36	8,445	(2)		1,201	7,244	226	7,018
District of Columbia	5	2.4	5			475	(2)	475				
Florida	12	.5	12			792	(2)	792				
Georgia	24	.7	24			1,468	(2)	1,468				
Hawaii	9	(3)	9			1,417	(2)	1,417				
Idaho	2	1.5			2	259	(2)			259	24	235
Illinois	235	8.1		64	171	32,533	138.44		8,316	24,217	1,998	22,219
Indiana	163	8.7	34	31	98	22,500	138.04	2,723	4,455	15,322	8,842	6,480
Iowa	121	8.8	121			13,355	110.37	13,355				
Kansas	64	11.2	64			6,343	99.11	6,343				
Kentucky	6	.2	6			623	(2)	623				
Louisiana	41	1.5	5	2	34	5,265	(2)	524	170	4,571	636	3,935
Maine	22	5.4		1	21	3,673	(2)		42	3,631	105	3,526
Maryland	32	7.6	23	3	6	2,836	(2)	2,301	138	397	22	375
Massachusetts	206	9.2	192	8	6	43,456	210.95	40,309	1,069	2,078	981	1,097
Michigan	75	4.4	75			6,719	89.59	6,719				
Minnesota	153	14.6	1	152		22,282	145.63	119	22,163			
Mississippi	38	.9	38			1,506	(2)	1,506				
Missouri [3]	150	3.1	150			9,707	64.71	9,707				
Montana	40	13.0	40			3,098	(2)	3,098				
Nebraska	174	24.2		3	171	22,634	130.08		287	22,347	4,443	17,904

Nevada	9	5.1			9	1,807	(3)			1,807	90	1,717
New Hampshire	67	27.8	50		17	9,343	139.45	7,269		2,074	81	1,993
New Jersey	38	4.1	11		27	6,845	(3)	1,888		4,957	122	4,835
New Mexico	15	4.3			15	1,935	(3)			1,935	98	1,837
New York	81	2.4	79	2		16,133	199.17	15,807	326			
North Carolina	62	1.2	62			7,246	116.87	7,246				
Ohio	212	6.1	212			25,016	118.00	25,016				
Oklahoma	83	4.7			83	12,414	149.57			12,414	6,211	6,203
Pennsylvania [1]	500	2.3	500			61,462	122.92	61,462				
Rhode Island	12	10.4	12			1,541	(3)	1,541				
South Carolina	46	2.7	43		3	3,244	(3)	2,726		518	68	450
South Dakota	5	3.2	5			561	(3)	561				
Tennessee	13	.5	13			775	(3)	775				
Texas	47	.8	47			3,267	(3)	3,267				
Utah	16	9.2		4	12	2,203	(3)		463	1,740	110	1,630
Vermont	3	2.9			3	459	(3)			459	15	444
Virginia	70	5.9		45	25	8,274	118.20		5,208	3,066	286	2,780
Washington	74	10.6		29	45	10,624	143.57		3,058	7,566	421	7,145
West Virginia	11	1.2	11			950	(3)	950				
Wisconsin	110	12.3		4	106	15,623	142.03		496	15,127	972	14,255
Wyoming	4	(3)			4	522	(3)			522	360	162

[1] States reporting for a month other than January were as follows: California, March 1962; Hawaii, October 1961; and Minnesota, Texas, and Utah, February 1962.

[2] Includes data for some recipients who received money payments made without Federal participation.

[3] Not computed; base too small.

TABLE 27.—*Aid to the permanently and totally disabled: Numbers of recipients in nursing homes who received only money payments, only vendor payments, and both money and vendor payments, and amount of such payments, by State, January 1962* [1]

(Of States not listed, Alaska, Arizona, Indiana, and Nevada had no program; Guam, Puerto Rico, and the Virgin Islands had no provision for care; and Oregon was unable to submit a report)

State	Recipients in nursing homes					Assistance payments to recipients in nursing homes						
			Type of payment					Type of payment				
										Both money payments to recipients and vendor payments to nursing homes		
	Total	Percent of program recipients	Only money payments to recipients	Only vendor payments to nursing homes	Both money payments to recipients and vendor payments to nursing homes	Total payments	Average amount per recipient	Only money payments to recipients	Only vendor payments to nursing homes	Total payments	Money payments to recipients	Vendor payments to nursing homes
Total	20,493	5.5	10,016	3,505	6,972	$2,562,728	$125.05	$1,111,448	$456,911	$994,369	$133,476	$860,893
Alabama	289	2.3	----------	5	284	34,484	119.32	----------	517	33,967	3,175	30,792
Arkansas	562	7.5	----------	----------	562	55,701	99.11	----------	----------	55,701	2,810	52,891
California	195	1.1	195	----------	----------	17,550	90.00	17,550	----------	----------	----------	----------
Colorado	401	7.1	401	----------	----------	56,868	(2)	56,868	----------	----------	----------	----------
Connecticut	410	17.4	----------	68	342	75,869	185.05	----------	10,475	65,394	2,428	62,936
Delaware	5	1.1	5	----------	----------	262	(2)	262	----------	----------	----------	----------
District of Columbia	46	1.7	46	----------	----------	4,500	(2)	4,500	----------	----------	----------	----------
Florida	315	2.6	315	----------	----------	20,283	64.39	20,283	----------	----------	----------	----------
Georgia	176	.7	176	----------	----------	10,931	62.11	10,931	----------	----------	----------	----------
Hawaii	185	19.0	159	26	----------	28,411	153.57	21,731	6,680	----------	----------	----------
Idaho	551	30.0	407	11	133	25,103	45.56	4,370	1,161	19,572	1,590	17,982
Illinois	1,367	6.1	----------	522	845	175,218	128.18	----------	64,650	110,568	5,915	104,653
Iowa	176	23.2	176	----------	----------	15,577	88.51	15,577	----------	----------	----------	----------
Kansas	998	24.0	998	----------	----------	102,180	102.38	102,180	----------	----------	----------	----------
Kentucky	141	1.7	141	----------	----------	14,392	102.07	14,392	----------	----------	----------	----------
Louisiana	699	4.1	254	3	442	80,335	114.93	23,906	410	56,019	3,193	52,826
Maine	149	6.6	----------	3	146	21,998	147.64	----------	160	21,838	730	21,108
Maryland	553	8.8	346	39	168	46,951	84.90	34,690	1,526	10,735	624	10,111
Massachusetts	997	9.9	----------	997	----------	172,057	172.57	----------	172,057	----------	----------	----------
Michigan	1,107	19.2	1,107	----------	----------	100,234	90.55	100,234	----------	----------	----------	----------
Minnesota	410	15.0	14	394	2	26,174	63.84	881	25,170	123	102	21
Mississippi	59	.5	59	----------	----------	2,328	39.46	2,328	----------	----------	----------	----------
Missouri	1,057	6.9	1,027	30	----------	76,194	72.09	73,551	2,643	----------	----------	----------
Montana	99	7.7	99	----------	----------	7,107	71.79	7,107	----------	----------	----------	----------
Nebraska	381	17.6	----------	8	373	46,145	121.12	----------	868	45,277	8,476	36,801

New Hampshire	119	25.9	82	----	37	17,033	143.13	12,374	----	4,659	139	4,520
New Jersey	706	9.5	3	295	408	134,031	189.85	403	41,764	91,874	5,288	86,586
New Mexico	134	4.8	----	----	134	19,747	147.37	----	----	19,747	3,217	16,530
New York	1,435	4.1	1,332	103	----	333,182	232.18	309,480	23,702	----	----	----
North Carolina	34	.2	34	----	----	5,375	(2)	5,375	----	----	----	----
North Dakota	49	4.1	----	13	36	10,590	(2)	----	2,626	7,964	841	7,123
Ohio	1,296	8.8	1,286	----	10	151,131	116.61	149,399	----	1,732	1,377	355
Oklahoma	1,014	9.5	----	----	1,014	154,717	152.58	----	----	154,717	76,181	78,536
Pennsylvania	479	2.7	479	----	----	55,766	116.42	55,766	----	----	----	----
Rhode Island	128	4.5	128	----	----	14,242	(2)	14,242	----	----	----	----
South Carolina	198	2.5	188	----	10	13,008	65.70	11,212	----	1,796	296	1,500
South Dakota	80	7.3	80	----	----	10,431	130.39	10,431	----	----	----	----
Tennessee	176	1.6	176	----	----	10,358	58.85	10,358	----	----	----	----
Texas	211	2.8	211	----	----	13,386	63.44	13,386	----	----	----	----
Utah	525	14.8	----	166	359	66,732	127.11	----	17,640	49,092	4,048	45,044
Vermont	66	7.6	----	----	66	8,683	131.56	----	----	8,683	330	8,353
Virginia	354	5.4	----	254	100	39,026	110.24	----	25,227	13,799	862	12,937
Washington	1,149	16.3	----	451	698	153,098	133.24	----	42,156	110,942	5,762	105,180
West Virginia	83	1.2	83	----	----	7,048	84.92	7,048	----	----	----	----
Wisconsin	908	20.9	----	117	791	125,785	138.53	----	17,489	108,296	5,012	103,284
Wyoming	21	3.6	9	----	12	2,507	(3)	633	----	1,874	1,080	794

[1] States reporting for a month other than January were as follows: California, March 1962; Hawaii, October 1961; Massachusetts, November 1961; and Minnesota, North Carolina, Texas, and Utah, February 1962.

[2] Not computed; base too small.

CLASSIFICATION OF 32 MAA PLANS ACCORDING TO COMPREHENSIVENESS OF CONTENT AND SCOPE OF SERVICES, OCTOBER 1, 1963

1. Comprehensive medical services [1] (4 agencies): Hawaii, Massachusetts, New York, North Dakota.
2. Intermediate (21 agencies):
   (*a*) All five major kinds of services with significant limitations affecting one or more [2] (7 agencies): California, Connecticut,[3] District of Columbia, Kentucky, Utah, Washington, West Virginia.
   (*b*) Three or four major services provided—with significant limitations affecting one or more [2] (14 agencies):
      Arkansas (H, NHC, Pract., Dent.)
      Guam (H, Pract., Dent., Drugs)
      Idaho (H, NHC, Pract.)
      Louisiana (H, NHC, Pract., Drugs [4])
      Maryland (H, Pract., Dent., Drugs)
      Michigan (H, NHC, Pract.)
      New Jersey (H, NHC, Pract.,[5] Dent.,[6] Drugs [6])
      Oklahoma (H, NHC, Pract.)
      Oregon (H, NHC, Pract.)
      Pennsylvania (H, NHC, Pract.[7])
      Puerto Rico (H, NHC, Clinic [8])
      South Carolina (H, NHC, Clinic [8])
      Tennessee (H, NHC, Drugs)
      Virgin Islands (H, Pract., Drugs)
3. Minimum (two major services with or without significant limitations on one or both) (7 agencies):
      Alabama (H, Pract.)
      Florida (H) [9]
      Illinois (H, Pract.)
      Maine (H, Clinic [8])
      New Hampshire (H, Pract.)
      Vermont (H, Pract.)
      Wyoming (H, Clinic [10])

[1] Hospital (inpatient) care, nursing home care, practitioners' services, dental care, prescribed drugs (i.e. pharmaceutical services) with no significant limitations on conditions needing care or an extent of care.
[2] Such as "only for acute illness or injury", or "as recommended by physician, 14 days per fiscal year."
[3] Dental care provided only for recipient in a nursing home facility, but since such recipients comprise a large percentage of the caseload the State is classified as providing such services.
[4] Prescribed drugs only to patients in nursing homes.
[5] As provided in home health care for recipient confined to his dwelling.
[6] After eligibility for one of three "primary services" is established.
[7] As provided through the home-hospital plan for continuing medical treatment after a period of hospitalization.
[8] Comprehensive services in outpatient clinics available in all sections.
[9] Home nursing care provided as the "noninstitutional" medical care.
[10] Outpatient clinic and special services in doctors' offices.

Source: Bureau of Family Services.

REPORT FOR PERIOD SEPTEMBER 1–OCTOBER 31, 1963: ACTIVITIES OF THE 54 JURISDICTIONS TO PUT INTO EFFECT THE PROGRAM OF MEDICAL ASSISTANCE FOR THE AGED

A. Programs in effect (33 jurisdictions):

Alaska	Kentucky	Oregon
Alabama	Louisiana	Pennsylvania
Arkansas	Maine	Puerto Rico
California	Maryland	South Carolina
Connecticut	Massachusetts	Tennessee
District of Columbia	Michigan	Utah
Florida	New Hampshire	Vermont
Guam	New Jersey	Virgin Islands
Hawaii	New York	Washington
Idaho	North Dakota	West Virginia
Illinois	Oklahoma	Wyoming
Iowa [1]		

B. Plan submitted; not in effect (one State): South Dakota.[2]

C. Plan being drafted (three States): Kansas, Nebraska, and Virginia (all effective January 1, 1964).

D. Legislation enacted; plan not yet submitted [3] (three States): Minnesota (effective July 1, 1964), North Carolina (effective July 1, 1963), and Wisconsin (effective July 1, 1964).

E. Need legislation (12 States):

Alaska	Indiana [5]	Nevada [6]
Arizona [4]	Mississippi	Ohio [4]
Colorado [4]	Missouri [5]	Rhode Island [4]
Delaware	Montana [4]	Texas [7]

F. Have authority for MAA; implementation indefinite (two States): Georgia, enacted 1961—no funds available; New Mexico, has legal authority—1963 appropriation request denied.

[1] Plan pending approval (effective Dec. 1, 1963).
[2] To become effective upon approval of State's plan.
[3] Effective dates refer to legislation only.
[4] Considered by 1963 legislature; not enacted.
[5] Vetoed by Governor.
[6] Enabling legislation of 1963 was contingent upon amendment of Sales and Use Tax Act, which was defeated by majority of voters in May 1963.
[7] Passed resolution for constitutional amendment which, when ratified by popular vote, may be followed by enabling legislation.

APPENDIX C. MAJOR TYPES OF SERVICES AND LIMITATIONS

Medical assistance for the aged: Provision of major types of services under State plans, June 1963

State	Hospital care	Nursing home care	Physicians' services				Dental care	Prescribed drugs [1]
			Office	Home or in nursing	Hospital			
					Outpatient	Inpatient		
Alabama	X		X	X				
Arkansas	X	X	X		X		X	
California	X	X	X	X	X	X	X	X
Connecticut	X	X	X	X	X	X	X	X
District of Columbia	X	X		X	X	X	X	X
Guam	X	X		X	X	X	X	X
Hawaii	X	X	X	X	X	X	X	X
Idaho	X	X	X	X				
Illinois	X		X	X	X	X		
Kentucky	X	X	X	X			X	X
Louisiana	X	X	X	X	X	X		X
Maine	X				X			X
Maryland	X		X	X	X		X	X
Massachusetts	X	X	X	X			X	X
Michigan	X	X	X		X	X		
New Hampshire	X		X	X	X	X		
New York	X	X	X	X	X	X	X	X
North Dakota	X	X	X	X	X	X	X	X
Oklahoma	X	X		X	X	X	X	
Oregon	X	X	X	X	X	X		
Pennsylvania	X	X		X				
Puerto Rico	X	X			X			
South Carolina	X	X			X			
Tennessee	X	X						X
Utah	X	X	X	X	X	X	X	X
Virgin Islands	X			X			X	X
Vermont	X		X	X				
Washington	X	X	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X	X	X

[1] These are drugs prescribed by physicians as contrasted to drugs over the counter. Excludes drugs for hospitalized patients.

Senator MOSS. Dr. Winston, I think you said the range of payments for nursing home care for people on old-age assistance varies from $40 to $260 in the two extremes among the States; is that correct?

Dr. WINSTON. That is correct.

Senator MOSS. Will you tell me what the spread on medical assistance for the aged runs in the same context?

Dr. WINSTON. Actually in terms of medical assistance for the aged it will depend on what the particular items are in the program and of course, they are substantially different, depending on the type of service. In the supporting tables you will find detail on this to the extent that we are able to give it.

Senator MOSS. That is because the program varies from State to State on how much medical assistance is extended; is that correct?

Dr. WINSTON. Yes; under the medical assistance for the aged the requirement is that the States have at least one institutional and one noninstitutional item of medical care which gives them substantial leeway. In turn, of course, they determine what the scope of these particular programs will be. Under the law, these are matters for State determination and the kind of program that a State sets up is determined very largely by the availability of State and sometimes, in addition, the local matching funds.

Senator Moss. I understand there have been about 100,000 recipients of long-term hospital and nursing home care in the old-age assistance program transferred to the program of medical assistance to the aged.

Can you tell me the States that have done this and why?

Dr. WINSTON. According to our figures we have about 81,000 cases, I think, that have been reported to us as transfers. We have the list of States that have made extensive transfers. I would like to enter those in the record to be sure that we are correct in our listing here. We can also, in doing so, give the number of transfers by State. Of course, this is permissible under the Federal law, and States in terms of their overall programing and financing have found that from their point of view this is a desirable thing to do.

(The information is as follows:)

Cases approved for medical assistance for the aged that were receiving another type of assistance at time of approval, States approving such cases, October 1960–September 1962 [1]

State	Total	Other type of assistance received at time of approval for medical assistance for the aged				
		Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children	General assistance
Total	81,423	75,987	1,792	2,619	47	978
Alabama	1				1	
California	17,972	16,131	1,033	668		140
Connecticut	4,346	4,317		2	6	21
Hawaii	222	221		1		
Idaho	1,350	1,222	11	109	8	
Kentucky	195					195
Massachusetts	22,553	21,874		546	6	127
Michigan	3,934	3,495	30	82		327
New York	28,677	27,517	542	466	8	144
North Dakota	1,053	1,051		2		
Oregon	460	31	94	308	16	11
Pennsylvania	88	9	79			
Utah	508	75	1	432		
Vermont	2			2		
Virgin Islands	1		1			
Washington	61	44	1	1	2	13

[1] Subsequent to September 1962 information has been supplied on transfers only for the 1st 6-month operation of a new medical assistance for the aged program.

Dr. WINSTON. I think it does point up the fact that we have a good many people, older people, throughout the country who are receiving or have been receiving old-age assistance primarily because of the fact that they had medical needs. As long as we only had the old-age assistance program for meeting their needs there really was no choice.

Senator Moss. You think generally, then, it was because the new program more fitted the circumstances of the person who was then transferred to it?

Dr. WINSTON. I think that is one answer to the question. I also think one has to take into account the fact that the matching ratios vary and that by and large States are going to seek the highest Federal returns on the dollars they put up that are available among the several alternatives open to them.

Senator Moss. The medical assistance for the aged program is a medical care program, but is it not true that many people receiving nursing home care under it are really just receiving custodial care?

Dr. WINSTON. I would like to ask Dr. McKneely, who is a physician responsible for the day-to-day direction of this program, to answer that question.

Senator Moss. Thank you. Will you answer that, Dr. McKneely?

Dr. MCKNEELY. From the standpoint of the Federal requirements in this area we ask the State to determine that each person entering a nursing home has what is termed "patient status." That is that he is in need of medical care and that there is a continuing plan for medical supervision to meet his medical needs.

Senator Moss. Your answer would be that there is a requirement that there be a medical need. It could not be just strictly custodial care?

Dr. MCKNEELY. That is correct.

Senator Moss. Thank you.

Do my colleagues have questions? Senator Neuberger, do you have a question?

Senator NEUBERGER. I have been interested in following the implementation of the Kerr-Mills bill and I notice you said 29 States have implemented it; but that is in many different degrees, is it not?

Dr. WINSTON. That is right; that is in many different degrees because there is great leeway which is possible under existing legislation. The extent of implementation is determined very largely, as I pointed out earlier, by the State matching funds that are available.

Senator NEUBERGER. In looking at some of these State reports on their implementation of Kerr-Mills we find that the cost of the administration is so terribly high. Do you know anything about that and do you predict that it will drop in time? Is this just a natural result of putting a program into effect?

Dr. WINSTON. I would like to answer the question but I am looking to Dr. McKneely to see if he has any data on Oregon. I don't believe we have any specific information on your State but I will be glad to try to get it.

(The information referred to follows:)

OREGON MAA: ADMINISTRATION AS A PERCENTAGE OF VENDOR PAYMENTS

Oregon's MAA program illustrates how misleading it is to relate the cost of State and local administration to assistance payments. Vendor payments were first made under this program in January 1962, but applications for assistance were acted on beginning with the preceding October. Thus, administrative costs were incurred in 1961 even though no vendor payments were made in that year. The attached table shows that administrative costs as a percentage of vendor payments have declined steadily from 38.2 percent in January–June 1962 to 3.5 percent in July–September 1963. One cannot infer, however, that this drop reflects in "improvement" in administration. The reasons for the decline are given below:

1. When any State initiates a new program, initial costs are apt to be higher than usual because of nonrecurring expenses. For example, expenses for equipment for new staff members are incurred, much staff time and consultation must be devoted to planning the new program, etc.

2. The cost of establishing initial eligibility for assistance is usually considerably greater than the cost of keeping a recipient on the rolls month after month. When a new program is initiated, a much larger number of applications have to be worked on than the normal number that could be expected after the program has been in effect for some time. On the other hand, when substantial numbers of recipients in nursing homes are transferred from OAA to MAA, the

amount of vendor payments is increased greatly with a relatively small increase in MAA administrative costs. This occurs because eligibility for assistance has already been established under OAA and has been charged to that program. The transfer of nursing home cases from OAA to MAA accounts for almost all of the decrease in the percentage relationship between administration and vendor payments that occurred between January and June 1963 (13.3 percent) and July and September 1963 (3.5 percent).

Period	Vendor payments	Administration	Administration as a percent of vendor payments
July–December 1961		$66,396	
January–June 1962	$231,178	88,221	38.2
July–December 1962	292,804	55,633	19.0
January–June 1963	389,072	51,562	13.3
July–September 1963	1,291,697	45,518	3.5

Dr. WINSTON. There are certain things we know about any new program, that in the beginning when you are establishing policies, when you are setting up procedures, your administrative costs are going to be very high. Some States have higher costs than others for a great many reasons.

We also know that after a program gets into operation your administrative costs will tend to go down as the size of the program increases. In other words, this is a relatively expensive program to administer if you have few recipients of the program or if it is a very limited program so that you don't offer many services or finance them very well. Proportionately your administrative costs are going to be higher. So that all of these factors enter into the situation.

We have a number of States operating programs of medical assistance for the aged which now have administrative percentages which I think we would consider quiet reasonable.

Senator NEUBERGER. Is it true that people transferred from OAA to MAA are the most expensive cases and are therefore accounting for a major portion of the expenditures? Now, is not this what is happening in a lot of States, like Massachusetts and all; there is a switching from one program to the other?

Dr. WINSTON. I think actually that the bulk of that transfer has already taken place. It took place at the time another program became available and, hopefully, at this point as older people come in and they are evaluated in terms of their need they are put on what appears to be the appropriate program for them at the given time.

Now of course older people are just like everybody else. They need a change in program from time to time as needs change, so obviously we can expect some transfer back and forth but not of the scope of the earlier transfers.

Senator NEUBERGER. In my own State, which I watch very closely, I think the reason that the cost of administration is very high is because there are so many restrictions on the use of the program. The more you do that the more you have to investigate to see whether there is relative responsibility. You know, you have to have a caseworker on each one. It naturally is going to cost a lot more.

Dr. WINSTON. You are absolutely right on that point. Where we have these very involved requirements for eligibility and they have to be checked out with the greatest of care and eligibility has to be

periodically redetermined in terms of these qualifications you send your administrative costs up.

We in public welfare have known for many years that there are certain types of eligibility requirements that are very expensive to administer and in fact probably do not from that point of view achieve the real purposes behind setting them up.

Senator NEUBERGER. I recommended to my Governor, my welfare commission, that they put people on welfare under Kerr-Mills and take advantage of it. They will get the Government to pay a little bit more. I think the States that I have followed rather closely that are getting a bigger proportion of the funds have done that exactly. Any State that does not take advantage of it is missing a bet.

Dr. WINSTON. Of course, for the States that are getting large sums of money, you have two factors: The size of the load under the program and then the extensiveness of the program because, by and large, after all the States that are getting large sums of money also are the ones that have the more comprehensive programs of care.

Senator Moss. Thank you. Senator Williams?

Senator WILLIAMS. I have just one question, Mr. Chairman.

I wonder if you people have authority to deal with safety standards or is that purely a matter of local law and regulation?

Dr. WINSTON. Under the Federal act we can require a standard-setting authority.

The States have the responsibility for determining the standard-setting authority. For nursing home standards the public health agency is the standard-setting authority in 45 jurisdictions and the State welfare agency is the standard-setting authority in 5 jurisdictions.

Senator WILLIAMS. Have you come to any conclusions as to the adequacy of the standards and also the adequacy of the enforcement of them?

Dr. WINSTON. Since the standards relate again to medical factors as well as other factors I would like to ask Dr. McKneely to comment first on your question.

Dr. MCKNEELY. In general, the standard-setting agencies or authorities in the State have focused attention on the safety of the plant such as fire protection, sanitation, food supplies, space, and the like.

In some States they have given attention to patient care. I think there are problems in two areas. One is the level of the standards themselves and the other is a matter of enforcement of standards. We have from time to time heard that States lack the money to hire sufficient personnel to carry out adequate inspections. We might point out that there is no direct Federal participation in the cost of the standard-setting agency under the present arrangement. There is limited participation in planning for certain areas but not in the direct operation of the standard-setting authority.

Senator WILLIAMS. It seems quite obvious that if the standards and regulations for safety are adequate, certainly the enforcement is not. We have had a tragic rash of horrible fires and disasters. The description of the recent nursing home fire in Ohio is just grisly; the lack of safety and opportunity for the elderly people in that home to escape, bolted doors, no attendants, a whole list of inadequacies.

Dr. MCKNEELY. There arise in the States sometimes situations which make it difficult to enforce safety standards. From reports

we have had we understand that some of the nursing homes in the State of Ohio have gone to the courts and fought, and I don't know whether they obtained injunctions, to prevent the health department from enforcing the standards that they have established, at least they were fighting to prevent enforcement of standards.

These are problems that the State enforcement or standard-setting agencies face. Sometimes the laws are drafted inadequately to give the standard-setting authority sufficient support when cases come before them.

Senator WILLIAMS. Thank you.

Senator Moss. When your agency sets standards of safety, do you then have to rely on the State enforcement agency to see that the standards are complied with?

Dr. MCKNEELY. We do not set the standard. The requirement is that there be a standard-setting authority in the State with responsibility to establish and maintain standards, but this is a position that is rather difficult sometimes for us in that we do not have the authority under our law, as I see it—I am not a lawyer, you understand—but we don't have authority to set the standards in terms of requirements.

Now we could set standards in terms of guidelines, recommended standards. As a matter of fact, the Public Health Service is working on some of those now and we are, too. But they cannot be required, as I understand it, at the present time by the Federal program.

Senator Moss. If you were giving monetary assistance to the States that have standards of safety, but you know full well they were not being enforced, do you have any recourse or power to withhold funds or do anything to compel enforcement?

Dr. WINSTON. Actually the way this thing works in practice is that you have the standard-setting authority in the State.

One State agency must defer to another State agency in that area in which it has the legal responsibility. Of course one can always raise questions but what happens as a result of raising the question can vary substantially as you well know.

I think that actually in this area which is obviously of great concern to the committee and of great concern to us, we must increasingly seek to work with the Public Health Service which is in a position to encourage and help State health departments improve their standards for nursing homes. You will remember that when I referred to this in my testimony I referred to raising the standards upward.

Again, this is a pretty new area and it is not only actually the question of the standards the public health agency sets and how broad they are in scope, that is whether they get into such questions as staffing to provide patient care, but you also have, usually in a State, some agency that operates in the field of safety from fire so that the health department in turn is working with some other standard-setting bodies within the State.

From our point of view we can encourage, we can "educate," but we have to recognize where the legal authority lies.

Senator Moss. To what extent do you inquire into the standards of health care, whether it is adequate? Is that question for Dr. McKneely or for you?

Dr. WINSTON. In the first place, I would like to refer to some of our material and then I will ask Dr. McKneely to pick up on it.

Actually in terms of the State's standard-setting authority that agency has the right and the responsibility to go into the institution, into the nursing home, and to inquire into all matters that affect the health and welfare of the patient.

It is part of the responsibility of the standard-setting agency. But then, I think it is also important to recognize that under our definition of a patient in a medical institution we state as follows:

> A patient means an individual who is admitted to a medical institution on recommendation of a physician or dentist because of illness, injury, or other defect, and so on. Second, is receiving professional, medical, or dental treatment—

and there is further definition here. But the point I wish to make is that a patient is defined by a physician which means that the physician too is directly involved in this determination.

In other words, you do not put a recipient of financial assistance in a nursing home unless there has been a medical determination that this is the type of care that person needs and normally the physician will be generally familiar with the type of care which the institution is rendering.

Now I think Dr. McKneely probably wants to supplement that statement.

Dr. McKneely. I would rather follow up by answering a direct question, Senator Moss.

Senator Moss. I was wondering if you feel that there ought to be some power extended to your Department to require compliance with standards of safety and health care since the Federal Government is supplying a good part of the money that is being expended.

Dr. Winston. I think you are getting at the point here, sir, as to whether or not there should be some minimum Federal standards.

Senator Moss. Yes.

Dr. Winston. Which should be adhered to and for which we should have ways of checking compliance if Federal funds go into this kind of program.

I would say, sir, I think that is not a determination for an administrative agency because this would be determined by whether or not there was Federal legislation which permitted the establishment of standards.

We, of course, can now work with and encourage guides or standards but there is no basis for requiring that those standards be met.

Senator Moss. You would need additional legislative authority if you were to have the power to insist on compliance with the minimum standards.

Dr. Winston. I would judge so.

Senator Moss. Are there any further questions?

If not, thank you very much, Dr. Winston, Dr. McKneely, and Mr. Hawkins.

Dr. Winston, did you have some additional testimony you can give us as Chairman of the Executive Council of the President's Council on Aging?

STATEMENT OF HON. ELLEN WINSTON, CHAIRMAN OF THE EXECUTIVE COMMITTEE OF THE PRESIDENT'S COUNCIL ON AGING; ACCOMPANIED BY DR. LOUIS S. GERBER, CHIEF, NURSING HOMES AND RELATED FACILITIES BRANCH, DIVISION OF CHRONIC DISEASES, BUREAU OF STATE SERVICES, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. WINSTON. Yes, sir; I would like to put on another hat now.

The President's Council on Aging was established by Executive order on May 14, 1962. The membership consists of the Secretary of Health, Education, and Welfare, the Secretary of the Treasury, the Secretary of Commerce, the Secretary of Labor, the Administrator of Veterans' Affairs, the Administrator of the Housing and Home Finance Agency, and the Chairman of the Civil Service Commission.

Secretary Celebrezze, who is Chairman of the Council, asked that I serve as deputy and also Chair the Executive Committee of the President's Council on Aging and it is in that capacity that I am here.

I have with me Dr. Louis Gerber, who is providing the services for one of our committees. I would like to explain briefly how the President's Council operates. We have monthly meetings of the Executive Committee and then within the organization we function through special committees. There is a Committee on Employment, a Committee on Housing, a Committee on Nursing Home Care, and a Committee on Welfare Services.

Through the Committee on Nursing Home Care there are a number of activities underway that Dr. Gerber will be discussing. We have a new activity which we are beginning to gear up which will be a study of the entire continuum of care for older people. In other words, we will be studying the various types of circumstances under which older people live beginning with those who are quite independent, living in their own homes, and going through the various types of domiciliary care, we come eventually to the medically oriented facilities, including the nursing home programs and our Committee on Nursing Homes will be working with that segment of the program.

Now this all follows logically from the activities of the President's Council on Aging in this field to date, from the publication of this pamphlet on "Federal Aid for Nursing Homes" which we would also like to enter into the record, sir, to the special work that is being undertaken by the Committee on Nursing Home Care that Dr. Gerber is prepared to summarize for you.

(The pamphlet referred to follows:)

The Nation Needs More Nursing Homes

More than 10,000 Americans are over 100 years old; more than two and a half million are over 80. By 1970, there will be 3.7 million men and women in the 80 and over age group. When extreme old age is accompanied by infirmities, the most satisfactory plan both for the older person and for those concerned with his or her welfare may be for the elderly person to live in a nursing home.

Nor are the aged the only ones whose need for nursing homes is increasing; illness at all ages of a long-term nature requires the type of care provided by nursing homes.

Unfortunately, there is a national shortage of nursing homes. According to a recent Public Health Service inventory, the Nation has about 23,000 nursing homes, homes for the aged, personal care homes and rest homes. They can accommodate less than 600,000 persons. Only 9,700 of these homes are staffed and equipped to give skilled nursing care and they have room for only 388,700 patients.

At least half a million more beds are needed right now for long-term patients according to the total estimates of need made by the States. As lifespans continue to lengthen, as higher nursing home standards remove the dread which still prevents many older people from deciding to enter a nursing home, and as health insurance is extended to cover nursing home care, the demand for good nursing homes will grow apace.

Federal Resources to Meet This Need

Because the nursing home shortage is a nationwide problem, Federal assistance has been provided to stimulate and aid the construction and improvement of facilities to overcome the shortage. Much of this assistance is designed to encourage private individuals and corporations to build and operate homes; much is also authorized for the construction of public and other non-profit homes.

Government encouragement in the construction of nursing homes is part of a wider interest, although this booklet deals primarily with construction aids. Manuals and other materials on accounting systems, training of nurses aides, development of standards, staffing patterns, environmental health factors, and related subjects are available to individuals and groups who have an interest in providing skilled nursing home care. Consultation services and assistance in planning training sessions, seminars and other learning experiences can be arranged, also. (See reference to address of Field Offices, page 13 of guide.)

Expansion and improvement of nursing home facilities and services are of major concern to the President's Council on Aging. The Council works to assure most effective utilization of Federal resources and aids, both by identifying areas which

require coordinated action by two or more Federal programs and by promoting the sharing and dissemination of information on programs relating to the aging.

Four Federal agencies administer the funds appropriated for nursing homes. The programs vary in terms of the type of Federal support extended and the type of sponsor involved; however, their likenesses are more pronounced than their differences. In general, the objectives for all programs for nursing homes administered by the Federal Government are to increase the number and improve the quality of nursing home facilities.

Each of the four Federal agencies with programs designed to increase the numbers of nursing homes defines a nursing home. The specific definitions are given in the table guide beginning on page 7. Brief decriptions of the four programs follow:

FEDERAL HOUSING ADMINISTRATION. FHA, an agency of the Housing and Home Finance Agency, helps owners of proprietary (organized for profit) homes to get mortgage loans on favorable terms through established lending institutions by insuring the lenders against possible loss. Mortgage insurance can be obtained for remodeling as well as for construction of new homes, purchase of land, and cost of site improvement. A certification that the home is needed must be obtained before the insurance can be authorized. This help is for homes of at least 20-bed capacity.

Certain nonresidential facilities, such as recreational, social and other common facilities, as well as built-in fixtures and equipment, may be included in the mortgage. The maximum mortgage maturity is 20 years, and up to 90 percent of FHA's estimated value of the project when proposed improvements are completed may be insured for new construction. The maximum interest rates are 5¼ percent plus ½ percent mortgage insurance premium. Construction must meet the minimum standards established by FHA.

SMALL BUSINESS ADMINISTRATION. SBA makes loans to businesses whose annual receipts are less than a million dollars, when funds are not otherwise available on reasonable terms. This can be a direct loan or a participation loan jointly with SBA banks and other private lending institutions. Proprietary homes can get these loans for construction, expansion, improvements and general operations, including working capital. No specific size limitations are imposed other than the evidence that the proprietor is a small businessman.

The amount of the loan is limited by statute to $350,000. In a new business venture, the applicant is usually required to provide one-half of the funds necessary to complete and operate the facility. The mortgage may be carried for ten years and loans for working capital, generally five years. Construction loans have a ten-year maturity date plus estimated construction time. All or part may be repaid without penalty before due date and the interest rate is 5½ percent except in certain designated redevelopment areas and surplus-labor areas where an interest rate of 4 percent is permitted. A certificate of need is required before the loan can be processed.

AREA REDEVELOPMENT ADMINISTRATION—U.S. DEPARTMENT OF COMMERCE. ARA has designated certain parts of the country as "redevelopment areas" and in these sections loans can be

obtained for buying land as well as for constructing, expanding, improving, and equipping proprietary nursing homes. No funds are available for working capital. There is no limitation on size or minimum number of beds, but there must be evidence that the venture is economically sound and will provide new, permanent employment commensurate with the amount of financial assistance required. A certificate of need is also required.

A maximum of 65 percent of the aggregate project cost can be met by ARA. However, a minimum of 10 percent must be provided by the State or any agency, instrumentality, or political subdivision of the State or a non-governmental community or area organization. A minimum of 5 percent must be supplied by non-governmental sources as equity capital.

ARA will extend financial assistance only to the extent that it is not available from any other public or private source. Loans may be participating loans or a direct loan if no private lender can or will participate with ARA. The maximum mortgage maturity is 25 years but the machinery and equipment portion of the loans is generally limited to 15 years. ARA loans carry a 4 percent interest rate.

Public Health Service—U.S. Department of Health, Education and Welfare

PHS makes grants to State and local governments and to other non-profit organizations or associations through the Hill-Burton Program. These grants are for construction, expansion, alteration and remodeling of nursing homes. Necessary initial equipment may be included although the purchase of land and cost of site improvement may not be included. The amount of the grant varies according to the State plan to meet its hospital and health facility needs and may range from one-third to two-thirds of the construction cost as established by the State agency. It is possible for an applicant to obtain a loan rather than a grant if he prefers. When a loan is obtained the maturity shall not be more than 40 years after the date on which the loan is made. Grants under the Hill-Burton provision are made only to publicly owned or non-profit organizations.

DETAILS OF THE FOUR PROGRAMS. The table guides (see pages 7 to 13) give further details of these four programs. The tables are designed to enable community leaders and persons who are operating or planning nursing homes to know which program best meets their needs. Since the laws governing each program differ considerably, the guides merely indicate the type of aid available, general requirements for eligibility, and the agency which should be consulted for further information.

Nursing Homes Are Part of a Health Network

While there is considerable variation in the precise terms used in the Federal grants, loans, or mortgage insurance programs, and in their statutory limits, they are all designed to help meet the recognized need for many more good nursing homes. However, nursing homes are but one of several health facilities necessary in any community in its provision of total health services. Prospective applicants, be they individuals or organizations, need to

understand the total situation before going too far in making their own specific plans.

COORDINATED PLANNING

The most fundamental principle is that the home be part of a well designed plan for meeting the area's need for health facilities. With the shortage of homes and the inadequacy of funds from all sources to overcome the shortage, humanitarian, as well as economic reasons, make it imperative that the tax dollars of Americans be invested only in homes that meet a genuine and urgent need.

To assure that homes receiving Federal aid meet this test, every State has a planning agency responsible for knowing what types of health facilities are needed, the extent of the need, and where they are needed. In all but six* States, the State health department is the planning agency. All grants for public and non-profit homes must be approved by the planning agency and requests for mortgage insurance or loans for proprietary homes will be considered only when the planning agency has certified that the home is needed.

AREAWIDE PLANNING ADVOCATED. As the need for planning has intensified, it has become apparent that the work of the State planning agency needs to be supplemented with the more detailed planning that is possible when a smaller area is covered. Consequently, the American Hospital Association and the Public Health Service of the U.S. Department of Health, Education, and Welfare have recently issued a joint recommendation for *areawide* planning in every metropolitan community.*

The extent to which the recommendation is followed will largely determine whether this Nation can afford the high quality of care that science has made possible for the increasing millions of aged and chronically ill in our population.

WHY PLANNING IS SO IMPORTANT

. . . BECAUSE OF THE HIGH COST OF FACILITIES. Medical advances have added greatly to the cost of constructing and equipping all types of health facilities. Equipment for hospitals and nursing homes has become increasingly complex and expensive. It now costs a hospital more than twice as much per day to care for a patient as it did ten years ago and about four times as much as it did 20 years ago. The use of costly hospital beds for long-term patients who do not need the intensive care a hospital is equipped to give is an unjustifiable extravagance. The Public Health Service estimates that one-fifth of all patients now occupying hospital beds do not need to be there. As health insurance programs—government or private—become available to more older people, the overuse of hospital beds is likely to increase unless there is a planned program for placing patients in the facilities which best meet their needs.

*Florida: Development Commission, Tallahassee.
Louisiana: Department of Hospitals, Baton Rouge.
Mississippi: Commission on Hospital Care, Jackson.
New Jersey: State Department of Institutions and Agencies, Trenton.
North Carolina: State Medical Care Commission, Raleigh.
Pennsylvania: State Department of Welfare, Harrisburg.

*See Public Health Service Publications Nos. 877, 855, and 930-B-1.

. . . BECAUSE OF THE CHANGE IN HEALTH CARE PATTERNS. Most community health services and facilities were established when acute and communicable diseases were the chief health problems; but today, chronic conditions are the number one public health problem. Consequently, communities are having to readjust their health care patterns. The chief change required is a greater coordination of services and facilities.

The kind of facility a long-term patient needs often changes, not only because of fluctuations in his physical or mental condition, but also because of changes in the circumstances of those who are responsible for his welfare. Consequently, nursing homes, hospitals, home care programs, rehabilitation centers and facilities for the aged and chronically ill must be operated on a coordinated basis. A homemaker program and a portable meals program frequently permit an enfeebled or disabled person to return to his own home from a nursing home months earlier than otherwise—a desirable move from his point of view and from the community's. A good health facility or program is one that fits into the community's network of health resources, with cooperative arrangements which make it possible for the patient to move freely from one resource to another as his circumstances require.

Wherever he may be, the long-term patient needs the services of many different types of specialists in addition to those provided by the physician and the nurse. Speech, physical, recreational, occupational and other therapists, nutritionists, social workers, dentists—these are some of the professional people whose services can often help to retard the progress of a chronic condition, restore lost functions, and prevent mental and emotional, as well as physical, deterioration. Again, coordination is necessary so that services which are too specialized for each facility to maintain separately can be provided through pooling arrangements.

. . . BECAUSE OF THE CHANGE IN LIVING PATTERNS. The increasing concentration of the American population in large metropolitan areas is the third major factor which makes planning imperative. Which services and facilities should be developed in the core city to serve the total area; which should be decentralized for greater convenience? Without careful planning that takes into account both today's population and the expanded population that will be living in these metropolitan areas within the next decade, tremendous sums may be spent on facilities that either duplicate each other or fail to meet the real need.

STANDARDS WITHIN THE NURSING HOME

The second basic principle is that the nursing home must be able to offer not only a safe and pleasant environment but the services which will keep every patient functioning to his maximum capacity.

All States now have licensing requirements and in all but five,* the licensing agency is the State Health Department. The sponsor must give assurance that when the project is completed, it will be operated and maintained in accordance with minimum standards prescribed by the State agency for the maintenance and operation of such facilities.

*District of Columbia: District of Columbia Department of Licenses and Inspections.
Louisiana: State Department of Hospitals, Baton Rouge.
New Jersey: State Department of Institutions and Agencies, Trenton.
New York: State Department of Social Welfare, Albany.
Rhode Island: State Department of Social Welfare, Providence.

Because of the shortage of nursing homes, however, licensing requirements are often the minimum standards that will assure a patient's safety and comfort. How far these standards fall below optimum goals is indicated by the fact that many patients in nursing homes are more dependent than they would need to be if they had the full benefit of modern restorative services. Helping homes to meet the higher goal of optimum services is one of the purposes of Federal aid.

First Step in Getting Federal Aid

Your local health department or planning agency (or State planning agency if your community has no planning service) is your first point of call. There you can learn how the basic principles outlined above may affect your project. If yours is a non-profit project, the State or local planning agency will also assist you in applying for a grant.

If your project is a profit venture, your second point of call is the field office of the agency which offers the type of financial assistance you are seeking (see reference, page 13). There you will be helped to make your application.

You will save yourself much time and effort by making these calls at the earliest possible stage of your planning. Your talks with the specialists in these agencies are neither binding nor prejudicial and no charge is made for the consultative services you will receive. Their aim, like yours, is to help reduce the national shortage of nursing homes. If any type of Federal aid will enable you to develop a needed home, they are as eager as you to see that you get it.

	Federal Housing Administration		Area Redevelopment Administration	Public Health Service (Hill-Burton)
	Housing & Home Finance Agency	Small Business Administration	U.S. Department of Commerce	U.S. Department of Health, Education, and Welfare
STATUTORY AUTHORITY	Reorganization Plan 3 of July 27, 1947. FHA created by National Housing Act approved June 27, 1934, (48 Stat. 1246; 12 USC 1702) amended subsequently. Section 232, National Housing Act.	Small Business Act of 1953 (63 Stat. 282; 15 USC 631 *et seq.*) and 72 Stat. 384 as amended, and Small Business Investment Act of 1958 (72 Stat. 689, as amended).	Area Redevelopment Administration, by Secretary of Commerce, by Department Order 171 of May 8, 1961, and the Area Redevelopment Act (72 Stat. 47; 42 USC 2501).	Title VI, Public Health Service Act, August 13, 1946, (Public Law 725, 79th Congress, 42 USC 291) as amended.
AGENCY DEFINITION OF A NURSING HOME	A proprietary facility, licensed or regulated by the State (or, if there is no State law providing for such licensing and regulation by the State, by the municipality or other political subdivision in which the facility is located), for the accommodation of convalescents or other persons who are not accutely ill and not in need of hospital care but who require skilled nursing care and medical services, in which such nursing and medical services are prescribed by, or are performed under the general direction of, persons licensed to provide such care or services in accordance with the laws of the State where the facility is located.	Facilities to accommodate persons who are not acutely ill and not in need of hospital care, but who require nursing care and related medical services.	Facilities to accommodate persons who are not acutely ill and not in need of hospital care, but who may require nursing and related medical services.	A facility which is operated in connection with a hospital, or in which nursing care and medical services are prescribed by or performed under the general direction of persons licensed to practice medicine or surgery in the State, for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who do require skilled nursing care and related medical services. The term "nursing home" shall be restricted to those facilities, the purpose of which is to provide skilled nursing care and related medical services for a period of not less than 24 hours per day to individuals admitted because of illness, disease, or physical or mental infirmity and which provide a community service.

	Federal Housing Administration		Area Redevelopment Administration	Public Health Service (Hill-Burton)
	Housing & Home Finance Agency	Small Business Administration	U.S. Department of Commerce	U.S. Department of Health, Education, and Welfare
DESCRIPTION OF THE PROGRAM **Type of Funds Available**	Mortgage insurance for construction or rehabilitation of proprietary (privately owned and operated) nursing homes. No direct loans available. The FHA's role is to facilitate procurement of mortgage loans from established lending institutions on favorable terms by *insuring the lenders against possible loss.*	Direct loans or participation loans to profit-motivated small, privately owned facilities, . . . for construction, expansion, improvements, including working capital. 1. "Direct loan," may be made only if private lender cannot or will not participate with SBA in a loan. 2. "Participating loan, made jointly by SBA and banks or other private lenders.	Loans to private nursing homes for land, construction, expansion, improvement, and equipment, *only in redevelopment areas designated by ARA.* Loans are made only when financing is not available from any other source, public or private, and may not be working capital. New, permanent employment must be created. 1. "Direct loan," may be made only if private lender cannot or will not participate with ARA in a loan. 2. "Participating loan," made jointly by ARA and banks or other private lenders.	Grants-in-aid for the construction of new, or the expansion, alteration or remodeling of public or non-profit nursing homes. Projects are approved in accordance with priority and other provisions of a State plan prepared by the State administering authorities and approved by the Public Health Service. Applicants may, if they wish, accept a direct loan in lieu of a grant.
Maximum Interest Rates	5¼ percent, plus ½ percent mortgage insurance premium.	5½ percent, but in certain designated ARA and surplus-labor areas interest rate is 4 percent and run for maximum of 10 years.	4 percent.	For loans, determined by Treasury Department as prescribed in the Federal Act.
Type of Mortgage	Level annuity, declining annuity, or combination declining annuity.	Level annuity.	Not specified in law but normally declining annuity.	Not specified in law.
Maximum Mortgage Maturity	20 years.	Maximum, 10 years. Working-capital loans, generally 5 years. Construction loans, 10 years plus estimated construction time. All or part may be repaid without penalty before due date.	Maximum, 25 years. Machinery and equipment portion limited to useful life, generally not to exceed 15 years.	When applicant prefers a loan for all or part of estimated cost of construction, maturity shall not be for more than 40 years after the date on which the loan is made. All or part may be paid prior to maturity date.

	Federal Housing Administration		Area Redevelopment Administration	Public Health Service (Hill-Burton)
	Housing & Home Finance Agency	Small Business Administration	U.S. Department of Commerce	U.S. Department of Health, Education, and Welfare
GENERAL REQUIREMENTS				
Certificate of Need	Certification required from the State office responsible for handling Hill-Burton requests that there is a need for the nursing home in that locality, and that acceptable licensing and operating standards are in effect.	Applicant required to contact State office responsible for handling Hill-Burton requests (usually Health Department) to avoid duplication, and obtain certificate of need.	Certification required, from the State office responsible for handling Hill-Burton requests . . . that (1) there is a need for such nursing homes . . . and (2) . . . in force . . . reasonable minimum standard of licenses . . . that will be applied and enforced. . . .	State plans must show that there is a need for the proposed construction project in the area of location.
Management Requirements	Licensed operator is required. Sponsors interested in program *must* consult with FHA staff serving the area in which the nursing home is to be located before making a formal application for mortgage insurance.	Operator needs to show evidence of experience in the nursing home field; that he is competent to engage in such activity. Sponsor must show that the business meets "small business" standards.	Operator needs to show evidence of experience in the nursing home field; that he is competent to engage in such activity.	The sponsor must give assurance that when the project is completed, it will be operated and maintained in accordance with minimum standards prescribed by the State agency for the maintenance and operation of such facilities.
Size Limitations	Minimum number of beds, 20. Maximum size limited by certificate of need and FHA marketability determination.	No size limitation, except indirectly through restriction to a business where annual income is under $1 million per year.	No limitation, but must be economically sound and provide employment commensurate with the amount of financial assistance required.	No size limitation except that no application shall be approved for construction of a nursing home, not an addition to a hospital, with a capacity for less than 10 beds.

	Federal Housing Administration		Area Redevelopment Administration	Public Health Service (Hill-Burton)
	Housing & Home Finance Agency	Small Business Administration	U.S. Department of Commerce	U.S. Department of Health, Education, and Welfare
FINANCIAL REQUIREMENTS **Sponsor's Responsibility**	Sponsor must have total needed capital available for investment in the project. Sponsor may be a corporation, trust, partnership, or individual, subject to regulatory agreement with FHA as to method of operation.	Owner or borrower must show needed financing not available from personal funds, or on reasonable terms from another credit source, and that loan will be repaid out of earnings. Collateral is required.	Maximum of loan 65% of aggregate project cost. Minimum of 10% must be provided by State or any agency, instrumentality or political subdivision thereof, or a community or area organization which is non-government in character, as equity capital or a loan repayable only after ARA loan is repaid in full. Minimum of 5% must be supplied by non-governmental sources as equity capital or as a loan repayable after ARA has been repaid in full. Remaining 20% may come from any available source. ARA will extend financial assistance only to the extent that it is not available from any other public or private source.	Sponsor must be a public or non-profit agency or organization. In addition, it must provide a reasonable assurance that it is able to finance the applicant's share of the construction cost and that it is financially able to operate and maintain the facility. Documentation required to show manner in which any anticipated operating deficit will be met. If not operated as a non-profit facility for at least 20 years, the U.S. is entitled to recover a *pro rata* share of the cost.
Working Capital and Operating Deficiency Funds	As determined by FHA but not less than 2% of mortgage amount. To be held for specified period after completion of project.	Not applicable.	Not applicable.	Not applicable.
Construction Advances	Under commitment to insure advances, progress payments are made after initial endorsement of mortgage note for insurance, following approval.	Progress payments can be made following approval.	Progress payments are made following approval.	Not authorized. Periodic payments made on basis of certification by State agency of cost of construction work completed, services rendered and purchases made.

	Federal Housing Administration		Area Redevelopment Administration	Public Health Service (Hill-Burton)
	Housing & Home Finance Agency	Small Business Administration	U.S. Department of Commerce	U.S. Department of Health, Education, and Welfare
EXTENT OF ASSISTANCE AVAILABLE **Maximum Loan or Grant**	$12.5 million loan.	By statute: $350,000 loan. Where private lender participates in loan, amount of SBA share may be increased by amount of private lender's participation. Always total amount must be proportionate to investment of the owner of the business.	No absolute limitation. May not exceed 65% of aggregate project cost.	Rate established by the State agency. From 33⅓ percent to 66⅔ percent of allowable construction and equipment costs.
Maximum Loan Ratio	New construction—up to 90% of FHA's estimated value of project when proposed improvements are completed. Existing construction—same as new construction, with other limitations depending on whether (1) property is owned outright, (2) property owned is subject to existing indebtedness, (3) property to be acquired.	Can loan up to $350,000. If a bank participates, its share must be at least 10% of total.	65% of aggregate project cost. 10% minimum from governmental or community groups. 5% minimum equity.	Amount of loan may not exceed an amount equal to Federal share of estimated cost of construction. Where a loan and a grant are made, the total shall not exceed an amount equal to Federal share.
Non-Residential Facilities or Areas	Recreational, social, and other common facilities may be included in the mortgage as necessary to serve needs of occupants.	No restriction, as long as part of the specified business.	No restriction, as long as part of the specified business.	The proposed nursing home project must meet the requirements of the minimum standards set forth in Public Health Service Regulations.

	Federal Housing Administration		Area Redevelopment Administration	Public Health Service (Hill-Burton)
	Housing & Home Finance Agency	Small Business Administration	U.S. Department of Commerce	U.S. Department of Health, Education, and Welfare
Medical and Therapy Equipment	May not be included in mortgage.	May be included.	May be included.	Equipment necessary for the functioning of the facility as planned shall be provided in the kind and extent required to perform the desired service. Necessary equipment shall be included in the cost of project and is considered an essential part of the proposed facility.
Built-in Fixtures and Equipment	May be included in mortgage (examples, wardrobes, nursing stations, snack bars, actual kitchen equipment which becomes part of the realty).	May be included, as well as equipment not included in real estate mortgage.	May be included.	Built-in equipment specifically included in definition of allowable equipment.
Purchase of Land and Cost of Site Improvement	May be included in FHA's estimate of value.	May be included.	May be included.	May not be included.
Fees for Professional Services	Reasonable percentage may be included to cover professional services related to organizational and legal matters.	Reasonable fees for services rendered by attorneys, accountants, etc.	Reasonable fees for services rendered by attorneys, accountants, etc.	Cost of architects and consultants services may be included but costs for legal services may not.
Tax Status	Not tax exempt.	Not tax exempt.	Not tax exempt.	Grants made only to publicly-owned or non-profit agencies or organizations, tax-exempt status follows.

	Federal Housing Administration		Area Redevelopment Administration	Public Health Service (Hill-Burton)
	Housing & Home Finance Agency	Small Business Administration	U.S. Department of Commerce	U.S. Department of Health, Education, and Welfare
STANDARDS **Construction Standards**	Standards adopted to provide a basis of acceptability for the physical security for insured mortgages on nursing home properties. They are intended to assure present and continuing utility, durability, and desirability as well as compliance with basic safety and health requirements and nursing services incidental to the stated purpose. Details given in: *Minimum Property Standards for Nursing Homes*, FHA, No. 334 as revised.	Eligible projects required to meet SBA Construction Standards.	Eligible projects required to meet FHA Construction Standards.	In accordance with standards set forth in Public Health Service Regulations, Part 53, which are summarized, as they apply to nursing homes, in *General Standards of Construction and Equipment—Long-Term Care Facilities*, PHS No. 930, 1962.
Labor Standards	Prevailing wage.	Nothing in regulations to control rates.	Nothing in regulations to control rates.	In accordance with provisions of the Federal Act and Public Health Service regulations relative to provisions of the Davis-Bacon Act and Department of Labor regulations.
ADDITIONAL REFERENCES **Basic Informational Pamphlets**	*Nursing-Home Mortgage Insurance*, FHA No. 696. Single copy available from: Special Assistant for Nursing Homes, FHA 811 Vermont Avenue NW. Washington, D.C., 20411.	Single copy of *SBA Loans to Privately Owned Health Facilities* by writing: Office of Financial Services, SBA 811 Vermont Avenue NW. Washington, D.C., 20416.	*Share in Area Growth*, U.S. Department of Commerce, ARA. Single copy available from: Area Redevelopment Administration Main Commerce Building Washington, D.C., 20230.	*Aid for Community Hospitals and Other Health Facilities—Facts for Hill-Burton Applicants*, PHS No. 403. Single copy available from: Division of Hospital and Medical Facilities U.S. Public Health Service Bureau of State Services Washington, D.C., 20201.
Agency Field Offices	The addresses of the nearest field office may be obtained from the specific offices shown above. For example, if the facts in this booklet suggest that the Federal Housing Administration is the agency most likely to serve your needs, write: The Special Assistant for Nursing Homes, Federal Housing Administration, 811 Vermont Avenue NW., Washington, D.C., 20411, and request the address of their nearest field office and the informational booklet, *Nursing-Home Mortgage Insurance*, FHA No. 696.			

Senator Moss. Thank you, Dr. Winston, for that explanation. We shall be pleased, of course, to hear Dr. Gerber, who is Chief of the Nursing Homes Branch of the Public Health Service.

Dr. Gerber, you may proceed.

Dr. GERBER. Thank you.

The Committee on Nursing Homes, established in February 1963, includes, as members, representatives of the Public Health Service, Small Business Administration, Area Redevelopment Administration, Veterans' Administration, Housing and Home Finance Agency, and Welfare Administration. The Committee is chaired by the Surgeon General of Public Health Service.

Among a number of items discussed by the participants during initial Committee meetings, priority was given to two. The first is a study of the costs of skilled nursing home care based on the various prevailing levels of such care. This study is being carried out by the Nursing Homes and Related Facilities Branch of the Division of Chronic Diseases, Public Health Service, as a two-phase project: a pilot study of some 200 skilled nursing homes in cooperation with the American Nursing Home Association and the American Association of Homes for the Aged, primarily to test the methodology for the second aspect of the plan, a definitive study of costs of a representative national sample of skilled nursing homes.

The data will be analyzed on a regional basis, tabulated, and made available to all agencies, official and voluntary, as well as to individuals concerned with the licensure, regulation, and/or promotion of nursing homes. We hope to have the pilot phase completed early in 1964, the definitive study about 1 year later.

The second item in our work plan is the development of a suggested model State code for the licensing of nursing homes. The Committee has urged that the Council of State Governments carry out this activity for the Committee. The council has enthusiastically responded and is actively engaged in developing a model code.

The Committee is assisting the council in suggesting the best of the current State codes, as well as offering recommendations for an advisory committee for the council, to study and review draft of the proposed model code. It is hoped that the suggested code will be available to the States late in 1964.

The third item which we are engaged in discussing is the item which Dr. Winston has reported and is the overall study of the situation of the elderly with respect to housing, health, and so forth.

Senator Moss. Thank you, Dr. Gerber.

This study that is being carried on is expected to be completed when? Do you have a target time on that?

Dr. GERBER. Which study, sir?

Senator Moss. On the cost of care.

Dr. GERBER. We hope to complete the first phase early in 1964. We are hoping to select the month of February as a target month for the first phase which is primarily a testing of our methods. About a year later we hope to have the national study completed.

Senator Moss. To compare the various costs you will have to compare programs, too; isn't that true?

Dr. GERBER. We will attempt to relate the cost to the level of care given in that particular group of homes. In other words, we

hope to be able to say it costs so much in this area of the United States for this type of service and this type of home.

Dr. WINSTON. I might say, Mr. Chairman, that we are looking forward to the results of this study because it should be of great help to the State welfare departments. There will be a cost accounting basis for making determinations within the available funds of what should be paid for individuals who get their support through public welfare for varying levels of care.

Senator MOSS. Does the council feel that as a matter of policy only really first-rate nursing homes should be created or supported by Federal agencies?

Dr. WINSTON. The council has not really taken a position with regard to your specific question. I think we would say this, that in establishing a committee in the area of nursing home care, one of its four basic committees, it obviously was making a selection of an area in which the members of the council felt we needed much more information than we currently have.

I think, too, that this study of the continuum of care is going to be extremely helpful to us because it will clarify the different types of care that older people need at differing times. It will sharpen up the fact that there are wide variations and there are changing needs.

Today so often there is not real opportunity for selection of the best type of care for an older person. It is just really an either-or kind of thing in many communities. You leave him in his own home or you place him in whatever type of other care there is where there is a bed available.

Senator MOSS. Dr. Gerber, many authorities believe that a formal affiliation between a nursing home and a hospital is advantageous, results in better nursing-home care. Would you explain the advantages of this affiliation?

Dr. GERBER. There are several advantages to the nursing home and some also to the hospital. With respect to the nursing home, it permits the nursing home to utilize the consultants available on the hospital staff. For example, the hospital nutritionist may give nutrition consultation to the nursing home. The hospital administrator may give consultation to the nursing-home administrator who in many cases is untrained. In some instances the hospital medical staff can give assistance to the patients in the nursing home.

The hospital might have on its staff a person who is trained in the sanitation and safety aspects of a hospital who can help to make the nursing home safer. There are a number of advantages to the nursing home.

On the other hand, the nursing home can make available to the hospital beds for long-term-care patients who could be transferred from the hospital into the lower cost nursing-home bed from the high-cost hospital bed.

The nursing home also might make available to the hospital in some instances recreational services which few hospitals have available to them.

Senator MOSS. I think that about 90 percent of our hospitals are nonprofit institutions and the reverse is true, I think, of nursing homes. Does this difference pose any legal barrier to the kind of affiliation we are talking about?

Dr. GERBER. I cannot answer that, sir. It would depend on whether within the State there might be legal barriers. The Public Health Service in the past couple of years has actually sponsored 11 such affiliations as demonstrations. In none of these instances did we find any legal barriers. A number of these demonstrations have worked very well and the affiliations are continuing without our involvement or support. There could be legal barriers. It would depend, I think, entirely on the legal framework within which the nursing home and/or hospital actually engage in their activities.

Senator MOSS. If the nursing home does not have hospital affiliation how much medical service would be necessary for them to have on the staff or available?

Dr. GERBER. This would vary certainly from patient to patient depending on the patient's needs. Some patients in nursing homes require very little actual direct medical care. Others require a great deal of care. It would depend entirely on how the patient's physician sees the patient's needs.

Senator MOSS. Do you have any questions, Mr. Frantz?

Mr. FRANTZ. First, you pointed out that the need for services varies considerably depending on the patient's needs and the resources, but can you give a quick checklist of what basic services are required in a good nursing home? When you talk about a good nursing home, what does it have in it?

Dr. GERBER. A good nursing home would have a trained administrator who is aware of the needs of the patients in the older age groups. He would also be informed as to what constitutes an adequate nursing program, what constitutes an adequate nutrition program. He would be cognizant of what constitutes a safe nursing home from the standpoint both of accident prevention and the fire hazard.

He would have good rapport with community resources, the utilization of which is one of the major problems facing nursing homes today. They are isolated within the community. A good nursing home should have a registered nurse on duty. I can't say exactly for how many hours but certainly for a major proportion of the time.

It should have available to it a nutritionist or a dietitian as either a staff person or as a consultant who can advise the staff on the various nutritional needs of the different types of patients. Many patients of nursing homes require special diets.

A good nursing home would have good rapport with the medical society or with the local medical group which should have a great deal to say about such things as nursing home standards.

Mr. FRANTZ. Dr. Gerber, what services would you include? For example, should the home have physical therapy?

Dr. GERBER. Not necessarily a "department," but physical therapy services should be available to the home. I think the basic needs of nursing of patients are, first, medical care by a physician.

Second, nursing care by competent professional nurses.

Third, adequate nutrition.

Fourth, adequate social services. Many patients in nursing homes have severe emotional problems and severe family conflicts or family problems which a social worker can be of great help to.

In addition, there are a number of other services which may or may not be necessary, again depending on the patient. But all patients need medical care, nursing care, and nutrition services.

Senator Moss. Thank you, Dr. Gerber. I understand that you have an additional statement on chronic diseases; is that correct?

Dr. GERBER. Yes, sir.

Senator Moss. We will be very glad to have that. Would you like to proceed?

Thank you, Dr. Winston.

Dr. WINSTON. Thank you, Mr. Chairman.

Dr. GERBER. The Division of Chronic Diseases has a twofold mission: First, to assist communities in the prevention of chronic diseases and disability; and, second, to assist communities in making the lives of those who have some form of chronic illness as free from disability and impairment as possible, within the scope of existing knowledge.

Since passage of the Community Health Services and Facilities Act in 1961, the Division has expanded rapidly in the scope and complexity of its programs designed to aid the chronically ill and the aged.

During 1962, the first year of operation under the Community Health Services and Facilities Act, a total of 44 project grants were approved and funded, and the figure has by now reached 73. Of these, 21 are in the area of direct services provided in the home (14 homemaker and 7 home-care projects) and 11 are projects for the coordination of care services.

Coordination projects are those programs whose primary goal is the planning, developing, and coordinating of community services for the chronically ill and the aged through such mechanisms as central information and referral programs.

Of the 14 homemaker projects, 13 are demonstrations, mainly in urban communities. Of the seven home-care projects, six are of a demonstration character. The other is a comparative study of home care versus clinic care. Also, a national study of meals-on-wheels programs has been financed.

These are all ongoing programs, the majority of which have been in operation for less than a year. None of the 43 projects mentioned have been in operation for more than 2 years.

It can, however, be stated that care of the sick at home, information and referral activities, homemaker programs, the raising of standards of nursing homes, and State and community appraisal of the needs of the chronically ill and aged are now generally accepted by health departments as responsibilities.

The magnitude of the problem in the United States is perhaps best exemplified by the fact that three out of four older Americans have a chronic disease or conditions.

The adequate use of medical and paramedical skills to benefit the chronically ill and aged in the hospital, the nursing home, and the private residence can be met only with organization and coordination on a communitywide basis.

Because each State, each professional group, and each individual student of the subject tends to define the phrase "nursing home" differently, it should be made clear at the outset that the Public Health Service has been required to establish an official set of definitions which are employed in discussions of long-term care facilities.

A "skilled nursing home" is understood to be a home that provides skilled nursing care as its primary and predominant function.

In addition, we identify "personal care homes" and "residential care homes." Both categories are divided between those providing

some skilled nursing care and those providing no skilled nursing care. These five groupings collectively compose the area of responsibility of the Nursing Homes and Related Facilities Branch, Division of Chronic Diseases.

Over half a million patients (592,800 in 1961) averaging 80 years of age, are living in some 23,000 nursing homes and related facilities (homes for the aged and other institutions provididing long-term or residential care) in this country.

The mission of our program is to provide leadership in the nationwide movement to improve the quality of patient care in these institutions, with special emphasis on the so-called skilled nursing homes, of which there are about 10,000 at the present time, with roughly a third of a million aged patients.

Senator MUSKIE. Dr. Gerber, you have referred to three different categories of nursing homes, skilled nursing homes, personal care homes, and residential care homes?

Dr. GERBER. Yes, sir.

Senator MUSKIE. Ideally they all ought to be skilled nursing homes, ought they not?

Dr. GERBER. No, sir; because some of these individuals do not require skilled nursing care. They may require only custodial care.

Senator MUSKIE. Would you say that to some degree the lower categories of care are provided where the higher category ought to be provided? I am thinking of my State, for example. I suspect some of the nursing homes there would provide higher quality of care if the economics of the situation permitted it.

Dr. GERBER. Yes, sir.

Senator MUSKIE. Would you say that the lower categories are provided because this is all that can be afforded by the patients who utilize the homes? I wonder to what degree these three categories are dictated by the economics of the situation and to what degree by the kind of care that ought to be provided?

Dr. GERBER. According to our definition the categorization is dictated primarily by the type of service given within the facility. The skilled nursing home is for patients who need much nursing care. The others provide less skilled nursing care and more custodial care.

Senator MUSKIE. Have you evaluated the nursing homes throughout the country in terms of these categories so that you can identify all of them? Can you tell me in my State, for example, what nursing homes qualify as skilled nursing homes and which ones personal care homes and which ones residential care homes?

Dr. GERBER. Offhand, sir, I can't. I believe Dr. Graning in the Division of Hospital and Medical Facilities might be able to give you those. He has more information on the actual breakdown in the States of the different types of nursing homes. I don't have a nationwide breakdown on that information.

I can certainly get it for you.

(The information referred to follows:)

Number of nursing homes and related facilities reported, by primary type of care provided, by State, 1961 [1]

State	Skilled nursing care			Personal care with skilled nursing care			Personal care without skilled nursing care		Residential care with skilled nursing care			Residential care without skilled nursing care	
	Facilities	Beds		Facilities	Beds		Facilities	Beds	Facilities	Beds		Facilities	Beds
		Total	Skilled nursing care		Total	Skilled nursing care				Total	Skilled nursing care		
Total reported	9,582	330,981	329,576	1,327	81,132	19,660	9,254	121,160	158	12,059	3,144	1,022	24,700
Alabama	28	1,171	1,171	58	1,811		5						
Alaska	1	15	15	1	250	65	2	5					
Arizona	15	591	591	33	876		31	755					
Arkansas	93	3,573	3,573										
California	842	24,836	24,836	20	1,898	123	3,229	24,741					
Colorado	148	5,138	5,138						1	100	30	7	122
Connecticut	211	7,244	7,214	17	1,694	742	213	2,737					
Delaware	16	378	378	19	411								
District of Columbia	11	351	351	20	153	44	52	364	10	1,629	624	10	279
Florida	232	7,867	7,867	38	874		38	694					
Georgia	53	1,825	1,825	53	2,026		68	1,031					
Hawaii	11	556	556	4	62		25	199	2	84	3	5	11
Idaho	61	1,716	1,716	2	15		50	370	2	75	30	10	183
Illinois	626	22,803	22,803	67	8,428	1,925	180	3,260	1	56	6		
Indiana	396	8,807	8,807						15	2,494	972	105	5,180
Iowa	374	9,199	8,957	25	2,108	519	319	3,549				81	5,374
Kansas	22	1,065	1,029	15	701	142	391	7,800				25	190
Kentucky	57	2,331	2,186	149	3,951	644	85	1,403					
Louisiana	118	4,419	4,419										
Maine	188	2,919	2,919	2	114	38	129	1,283					
Maryland	156	5,257	5,062	10	1,055	293	21	152	9	684	144	1	26
Massachusetts	744	23,270	23,046				491	7,721	2	400	154	17	612
Michigan	235	11,319	11,044	117	2,518	181	663	3,017	54	4,408	899	104	2,293
Minnesota	308	11,329	11,329	38	3,929	1,054	108	1,768					
Mississippi	70	1,957	1,957	6	60		19	239	2	220	56	33	561
Missouri	369	15,801	15,801	2	54		80	2,135					
Montana	38	1,171	1,097	7	114	15	77	970	1	4		14	131
Nebraska	83	2,944	2,944	4	149		253	4,730				1	6
Nevada	21	465	465				13	139					
New Hampshire	115	3,257	3,257	58	1,011	10	1	2	7	256	7	10	63
New Jersey	193	8,899	8,899	38	3,347	1,132	321	4,364					
New Mexico	33	618	618	1	5		77	479					
New York	704	29,571	29,571	174	27,854	10,778	578	7,424					

North Carolina	37	1,117	1,117	1	90							292	5,066
North Dakota	10	459	419	5	638	196	70	1,794					
Ohio	770	22,400	22,400	36	1,341		91	1,130					
Oklahoma	110	3,753	3,753				308	6,013				53	518
Oregon	182	6,563	6,457	8	622	168	103	2,523					
Pennsylvania	311	22,594	22,594				485	15,892				72	1,789
Puerto Rico	4	123	123	6	676		10	465					
Rhode Island	111	1,970	1,970	63	1,552								
South Carolina	63	1,807	1,807										
South Dakota	28	933	933	21	1,221	128	70	972					
Tennessee	142	2,967	2,967	13	541		65	985					
Texas	322	9,999	9,999	3	103		256	5,405					
Utah	22	673	673				96	1,449					
Vermont	110	1,633	1,633	5	93		22	185	3	51		48	354
Virginia	173	4,672	4,672	17	1,458	25	23	791	4	25		60	486
Washington	325	13,754	13,716	12	1,758	248	66	1,111					
West Virginia	53	1,738	1,738										
Wisconsin	216	10,624	10,624	155	5,363	1,170	58	984	44	1,550	219	71	1,431
Wyoming	21	490	490	4	208	20	12	130	1	23		3	25

[1] Reports not received from Guam and Virgin Islands.

Senator MUSKIE. Is there a substantial economic problem in upgrading nursing homes to the level where they ought to be providing needed care?

Dr. GERBER. Yes, sir.

Senator MUSKIE. Do you have any measure of that problem at all?

Dr. GERBER. We will not have that until we have completed our national cost study. At that time, we should be able to say within the particular region of the country what the actual cost of care is at different levels of service.

We do not have this information presently. But when we do have cost data we should be able to know what it actually costs to give good care. On that basis, then, it certainly should be helpful to welfare agencies to establish payments for welfare recipients based on actual cost accounting studies.

Senator MUSKIE. Do you have any judgment on that point now? Is it your feeling that payments to welfare recipients now are adequate to meet the cost of care?

Dr. GERBER. I can only give you a guess and that is that they are not always sufficient to give high quality care.

Senator MUSKIE. Would you say they are substantially lower than they ought to be?

Dr. GERBER. I think in many States they are substantially lower. For example, a State that pays only $40 a month for nursing home care is obviously not supporting high standards.

Senator MUSKIE. Do the States tend to limit themselves to the amount of money they can get from the Federal programs as payments for nursing home care? To what degree do the States supplement the payments available from the Federal Government?

Dr. GERBER. This varies from State to State. If Dr. Winston is still in the audience I am sure she can answer it far better than I can.

Senator MUSKIE. Dr. Winston is not here. I wonder if we could have that for the record. I would be interested to know to what degree the States supplement the Federal payment by an effort of their own.

In raising the question I am not critical. I know there are demands on the States' financial resources too. I think it would be interesting in the record if we knew how many States do undertake to supplement the Federal payment beyond the minimum matching requirements that are provided by law now.

Dr. GERBER. I will obtain this information for you.

(The information referred to follows:)

The Federal share of assistance payments under the program of old-age assistance is determined on the basis of a formula that is applied to total expenditures for assistance payments but not to any particular item, such as nursing home care. State expenditures for assistance payments include amounts for cash payments made to individual recipients who may use such payments in whole or in part for nursing home care; and amounts for payments made on behalf of recipients to medical vendors, including nursing homes. The Federal share is computed on the aggregate of such expenditures up to a monthly maximum of $85 times the number of recipients. Thus the limitation on the Federal share of assistance payments is with respect to the total and not with respect to any particular item, such as nursing home care.

In some States, the total amount expended for old-age assistance exceeds $85 times the number of recipients; this excess must be financed from non-Federal funds, either State or local or a combination thereof. In October 1963, 13 States expended $10.5 million for such excess amounts. Like the Federal share, the State share, including these excess amounts, can be related only to total payments

and not to any particular item of expenditure. For this reason, it is not possible to identify the amount of such excess payments with expenditures for any particular item of need, such as nursing home care. All that might be said is that if nursing home payments comprised, let us say, 50 percent of total assistance payments, they comprised a like proportion of the payments in excess of the maximum amount on which the Federal claim could be computed.

The States that made such excess expenditures and the amounts involved for the month of October 1963 are as follows:

Amount of expenditures for old-age assistance payments in excess of $85 times the number of recipients

Total	$10,549,500
Alaska	900
California	5,997,000
Colorado	989,100
Illinois	65,600
Iowa	161,700
Kansas	159,200
Massachusetts	365,000
Minnesota	1,098,200
Nevada	8,000
New Hampshire	72,600
New York	344,700
Oklahoma	781,400
Wisconsin	506,100

In medical assistance for the aged all expenditures made by State assistance agencies for nursing home care (and other medical care) in behalf of eligible recipients are matched with Federal funds in accordance with the Federal medical percentage.

Senator MUSKIE. Dr. Gerber, one label which you did not place on these homes is the convalescent home. That is a familiar term to some people. Can you distinguish between a nursing home and a convalescent home?

Dr. GERBER. We don't define a convalescent home. Some States do have this within their State definitions. As you know, each State, almost every State has a different definition of these different types of facilities.

A convalescent home generally is a home in which patients might be referred to following hospital discharge as a temporary facility before the patient goes home. I think in this country this is generally not a common practice. But I think it is a practice that could be perhaps encouraged.

I believe it would get patients out of expensive hospitals into lower cost facilities and yet would give them the skilled nursing care that he would require until they are ready to go home.

Senator MUSKIE. Are you familiar with the definition of skilled nursing homes that was used in the so-called King-Anderson bill last year, in the form that was finally enacted by the Senate?

Under that definition would the personal care home and residential care home and the convalescent home qualify for inclusion in that program?

Dr. GERBER. I believe they would if they were affiliated with a hospital. Hospital affiliation is a prime requirement.

Senator MUSKIE. In my State very few, if any, of these homes are affiliated with hospitals.

Dr. GERBER. This is true across the country.

Senator MUSKIE. So this would be a very real limitation on nursing home participation in the medicare program as it was spelled out in the King-Anderson bill?

Dr. GERBER. I believe now as it stands that would be a limitation.

Senator MUSKIE. What is your view if you have one, on whether or not that limitation would be too restrictive in the light of the needs?

Dr. GERBER. I think it would be a serious restriction because, as you have indicated, it would cover a very small percentage of the patients who need help because they are in nursing homes which have no affiliation with a hospital.

In addition, the patient under the King-Anderson program going in a nursing home must come from a hospital, which again I believe would limit the number of persons who would benefit.

Senator MUSKIE. If a decision as to whether or not a patient ought to be transferred from a hospital to a nursing home were left to the hospital, would there be a tendency on the part of the hospitals to reduce the number of referrals?

Dr. GERBER. I cannot answer that question. I am not certain. There might be a tendency but I think it might depend entirely on the hospitals. There are some hospitals which have a utilization rate which is almost 100 percent, who are desperate for additional beds, and who might utilize this situation to transfer some of their long-term patients out.

Senator MUSKIE. In the States where hospital affiliation is rare would it be useful to delegate to the States or to the Federal agency authority to qualify nursing homes for participation in such a program without attempting to do it in the legislation, itself?

Dr. GERBER. I believe that such decisions must be made by the Congress, but, of course, flexibility would be furthered by modification of the qualifications.

Senator MUSKIE. This does verge on one of the critical problems on the Senate floor last year and it was a problem that disturbed many Senators. In Maine, for all practical purposes, I doubt if there would be any participation for nursing homes, yet we have hospitals which are overcrowded as in most States and they might be reluctant to refer patients to nursing homes, indeed would be inhibited from doing so if the nursing homes could not participate.

It seems to me if we come to consider such legislation again that some thought ought to be given to a mechanism on an incentive basis perhaps which might induce all qualified nursing homes in a situation of this kind to improve the quality of the care that they provide.

It would give more flexibility to the program and might indeed result in upgrading nursing homes in the long run. I think the record could stand a little constructive thinking on this point.

I do not want to belabor it, Dr. Gerber. I probably have diverted you from the main stream of your presentation here this morning. Why don't you proceed with your statement?

Dr. GERBER. The health of these patients is, of course, the responsibility of thousands of physicians throughout the country. Neither the Public Health Service nor any State or local health department contemplates interfering in any way with this vital physician-patient relationship.

It is, rather, our goal, and our responsibility to support, as effectively as we can, the private physician's efforts to restore and maintain the physical and mental well-being of those of his patients who reside in nursing homes.

The best way to support the physician, we believe, is to make available the professional services of other health workers (such as the

nurse, the physical therapist, the nutritionist, and the social worker), organized, whenever possible, on a "team" basis.

Business management, sanitary engineering, health education, and many other types of skill have also major contributions to make to the acceptable operation of both proprietary and nonprofit nursing homes (9 out of 10 nursing homes are proprietary in nature).

We believe that the basic health professions function best as a team under the physician's direction. Each individual nursing home patient has specific needs; the physician must "write a prescription" calling for various types of health service that collectively meet those needs. The health professions reinforce one another's work and, when their services are coordinated by the physician, we may say that the prescription has been filled.

Filling these prescriptions for all nursing home patients will eventually raise the quality of patient care in nursing homes to the level of the best care currently available. It is the ultimate goal of our program.

We function—as all Federal programs most appropriately function—not in direct contact with individual nursing homes but through State and local official agencies, national professional and voluntary organizations, and similar instrumentalities.

Our tools are: (1) Financial support of State and community projects designed to test or demonstrate methods of improving patient care and (2) professional consultation. We are responsible for contributing guidance and planning for the equitable and judicious distribution of Federal grant funds of several types. Our consultation service to State and local official agencies and other nonprofit groups is supplied on the same team basis that we recommend for direct professional service to nursing homes. To this extent we practice what we preach.

To illustrate Public Health Service financial support of State and community projects, the following ongoing projects may convey an impression of the varied ways in which community health services funds are currently being utilized:

In San Mateo County, Calif., the department of public health and welfare is using a team of health professionals to analyze the needs of patients in long-term care facilities (including nursing homes), to prescribe the best placement and care for these patients, and to follow up its own recommendations for action.

At George Washington University here in Washington the education of nursing home administrators is being furthered through a home study program designed to meet their needs. Registration for the home study courses will be on a nationwide basis.

Boston College and Brandeis University in Massachusetts are cooperating in a 3-year study of the relative effectiveness of placement of aged patients in various types of long-term care institutions or providing home care services for them.

The Oklahoma State Department of Health is carrying on a demonstration program in the training of nursing home personnel in the fields of nutrition, occupational therapy, and social service.

The Rochester Council of Homes for the Aged, in New York State, is studying possibilities of foster home placement for patients in nursing homes in Rochester and Monroe County.

The mental health aspects of the nursing home problem have attracted increasing attention in recent years. Brief references to

28-787—64——5

two facets of this situation may be useful at this time. The first is the problem of the senile patient, and the second is the trend toward transfer of mental hospital patients to nursing homes.

Among nursing home patients, more than half are disoriented, at least part of the time. The proportion of confused patients mounts sharply, from about 25 percent of those under 55 years of age to half of those aged 65 to 74, and on up to nearly two-thirds of patients aged 85. From 25 to 35 percent of patients are incontinent of bowels or bladder, or both. It is well to recall that the average age of the nursing home patient is approximately 80 years.

Approximately 25 percent of all diagnoses for nursing home patients are "senility," an indefinite, loose, misused word which oftens covers up the failure to achieve a more definite diagnosis.

Thus, for example, a much used definition of senility is given as "the feebleness of mind and body incident to old age."

The great difficulty in finding a clear definition of "senility" probably is due to the fact that the amount of disturbance is a matter of degree. Thus, a senile patient may be ambulatory and physically fit, but more or less mindless; or he may be noisy, aggressive, antisocial, with difficulty in bowel and bladder control; or he may have serious physical handicaps, in additional to mental deterioration; or he may have any combination of mental and physical defects.

It should be obvious that there are many degrees of senility. In addition, senility may be an intermittent condition among some aged individuals. The senile patient requires a great deal of care by well-trained, patient, highly motivated personnel.

In a number of States programs have been planned and/or implemented for the transfer of certain mental hospital patients to nursing homes. This is a definite and active movement. The patients transferred are those who are not in need of the type of care available in such hospitals; that is, are relatively free of serious mental aberrations and not dangerous to themselves or to others.

Although programs of this type have been in action in some States for several years, considerable acceleration for the trend was given by the 1961 final report of the Joint Commission on Mental Illness and Health. This Commission received a mandate from Congress to survey the resources and to make recommendations for combating mental illness in the United States. The Commission recognized the need to save patients with mental illness from the debilitating effect of institutionalization as much as possible, to return them to community life as soon as possible, and to maintain them in the community as long as possible. It emphasizes the importance of aftercare facilities, including nursing homes.

In certain States the State hospital has retained responsibility for the patients supervision after he leaves the facility, through a liaison staff member (or a staff member of a State or local agency) who aids in the selection of the nursing home and keeps in close touch with the nursing home administrator. The staff person is available for emergencies, including readmissions to the hospital. In other States, however there is little or no followup of the patient.

No discussion of the current situation in the nursing home field would be complete without some mention of a highly significant development of recent years which recognizes the need for closer relationships between nursing homes and hospitals and seeks to improve these relationships through some type of affiiliation procedure.

Many variations in affiliation procedure have been reported from all parts of the country. At one extreme, the general hospital in a community may operate a nursing home as an actual annex or department of the hospital. At the other extreme, some good results have been obtained through the relatively informal method of affiliation agreements. The Public Health Service has stimulated and supported these agreements in some 11 communities.

For a period of 1 year, and at a nominal cost, the hospitals have made available to local nursing homes, staff specialists to act as consultants (in such areas as nursing, nutrition, management, medical records, and the like); in return the nursing homes have made beds available to the hospitals for long-term patients no longer requiring full hospital care.

After the initial, experimental year several communities have continued this type of affiliation, being convinced that the procedure was mutually advantageous.

Senator Moss. Thank you, Dr. Gerber. I was out for part of the time when you were testifying but I have heard a good deal of your testimony.

I appreciate your coming here to help us make this record. We will excuse you then, Dr. Gerber, and ask Dr. Graning, Chief of the Division of Hospital and Medical Facilities, to come forward.

We are happy to have you testify this morning, Doctor. You may proceed.

STATEMENT OF DR. HARALD M. GRANING, CHIEF OF THE DIVISION OF HOSPITAL AND MEDICAL FACILITIES; ACCOMPANIED BY WILLIAM BURLEIGH, SPECIAL ASSISTANT

Dr. GRANING. Thank you, sir. I have with me today Mr. William Burleigh, who is my special assistant in the Division of Hospital and Medical Facilities.

Mr. Chairman and members of the committee, I wish to thank you for inviting me to appear before this committee. Much work remains to be done before the very serious problems associated with the care of our aging population are solved.

I consider it a distinct privilege to play a part in these deliberations and hope I may make some small contribution toward the solution of the problem.

Prior to the 1930's, only a handful of nursing homes were in existence. Since that time however, many factors have operated to create serious demands for long-term care facilities which would provide economical and effective medical and nursing care for our chronically ill aged population.

Foremost among these pressures are the much higher ratio of aged persons in an ever-increasing population, the shift of our younger and middle-age population groups from hometowns in search of employment or greater economic advantage, and the inadequate space of efficiency housing in the urban and suburban areas to accommodate aging parents and grandparents.

In 1954, recognition of the growing needs for long-term facilities, Congress amended the Hill-Burton legislation to provide specific funds for construction of public and voluntary nonprofit homes, chronic disease hospitals, and other facilities for long-term patients.

Since that time one of the primary aims of the Hill-Burton program has been to stimulate the construction of such health facilities as are necessary to provide an efficient and well-coordinated network of services for those aged persons in need of acute care, long-term care, outpatient care, and rehabilitation.

While aged persons require more acute care as inpatients and outpatients of general hospitals as well as other health services, there is also a crucial need for a larger number of long-term-care beds providing skilled nursing services under medical supervision.

In further recognition of the growing needs in this area the Community Health Services Facilities Act of 1961, Public Law 87–395, was enacted. This legislation, among other things, providing for out-of-hospital services doubled the Hill-Burton appropriation authorization for construction of nursing homes from $10 to $20 million annually. A total of about 47,000 long-term-care beds have been built with Federal aid.

The current annual appropriation authorization of $20 million for chronic disease hospitals and $20 million for nursing homes will produce about 8,000 beds each year. While the number of beds produced outside of the program is not known precisely, this figure is estimated to be approximately 30,000 each year. Approximately 19,000 long-term-care beds are required annually to keep pace with increases in our aging population and the need to replace facilities becoming obsolete each year.

In 1954, when Federal aid in the construction of nursing homes was authorized under the Hill-Burton program there were just over 265,000 long-term-care beds available throughout the country, including beds in chronic disease hospitals and skilled nursing homes. Of these, only 155,000 met State standards of acceptability. Nearly five times this number or 730,000 beds, were estimated by the States at that time as being needed.

Today, after nearly 10 years of Hill-Burton assistance and an increasing volume of construction outside of the program, a total of 415,000 long-term-care beds are in existence with 256,000 classified by the States as acceptable. Although there are difficulties in establishing firm estimates of the number of beds needed the States now estimate a total need for over 800,000 long-term-care beds or some 550,000 more than the number of acceptable beds now available. The estimate, admittedly rough, is confirmed if long-term-care beds in all States were brought up to the level of the five States with the highest ratio of long-term-care beds per thousand elderly.

No estimate of the need for long-term-care facilities can be unqualified in its use. Too many unknowns may influence the estimate either upward or downward. For example, passage of the proposed legislation for medical care for the aged with the partial removal of the financial barrier to nursing home care could result in dramatic increases in the demand for additional long-term-care beds.

Conversely, expansion of other programs directed toward care of the chronically ill is a promising approach for stemming the growing pressure for long-term facilities. The extension of such programs as homemaker services, foster home placement and nursing care of the sick at home could substantially influence the demand and need for facilities for the chronically ill.

Increasing emphasis on preventative services and rehabilitation could also affect estimates of need for long-term facilities. Regardless of the direction which current estimates may take under varying future circumstances there is no question that present facilities are far from adequate numerically.

Only 1 out of every 10 homes offering skilled nursing care is under voluntary nonprofit auspices. Two major factors have deterred more extensive construction activity by such groups. Capital costs for construction are relatively high and the dramatic life or death attitude is not present in the long-term-care field as in the case of general hospitals. Of equal or greater importance is the problem of financial support for maintaining and operating facilities once they are constructed.

Community enthusiasm and interest for a general hospital is much easier to create than for long-term-care facilities. The general public is fully aware of the lifesaving equipment and facilities available in general hospitals and the fact that some member of the family may be in dire need of such services during any given period of time. On the other hand, the care of the chronically ill does not create the same dramatic image. The age distribution of most nursing home residents and the nature of their illness mean that in too many instances we are seeing a holding operation designed to restore an aged person to a degree of health and independent living which is taken for granted by younger population groups which in the main bear the brunt of construction and operational costs.

The inadequacy of financial support for paying the cost of care for long-term patients in nursing homes is also a deterrent to nonprofit sponsorship of long-term care and facilities. Despite progress in recent years, payments by the State and local welfare and public assistance programs in most instances do not cover the cost of adequate care for the indigent or medically indigent, chronically ill patients. Thus, operating deficits or a reduction of needed services occur. In some communities nonprofit groups are therefore reluctant to enter this field with its large initial outlay of funds for construction and its continuous year-to-year deficits in operating costs. It is generally felt by many authorities in the field that to hasten the establishment and maintenance of nursing homes under voluntary nonprofit sponsorship, public assistance grants should be increased in most parts of the country.

EMERGING TRENDS

Because of the ever-increasing desire of our society to provide more adequately for our aging population the patterns of health care are changing to meet today's need. Certain emerging trends can be detected that at present appear to shape the future of health care for the aged. Among these are the changing concepts of the general hospital and of homes for the aged, the increased emphasis on restorative and preventative services and new kinds of services and working arrangements.

These are so interrelated that each interacts with the other. But I shall discuss them separately in an effort to simplify a complex picture of changing concept of the general hospital.

First, there are changes in our expectation of the general hospital. The concept of the truly general hospital today provides the full

complex of health care services including as one important component the care and treatment of the long-term patient. It no longer serves only the acutely ill. New and imaginative arrangements for care of the chronically ill and new approaches to prevention, treatment and rehabilitation are now found in some general hospitals. These innovations contribute substantially to their expanding role in health affairs.

One emerging trend is for experiments which integrate health services with other functioning organizations in a community such as health centers, nursing homes, homes for the aged, and rehabilitation centers.

Another is the development of close cooperation between hospitals and other official and voluntary health services.

CHANGING CONCEPT OF HOMES FOR THE AGED

Again, the traditional role of the home for the aged primarily as a shelter for the elderly has changed markedly in recent years. Changes in our culture, our economy, particularly since the advent of social security, have caused a significant decrease in institutionalization of the well elderly solely for reasons of shelter.

At the same time there has been a shift toward admission of those needing a protective health environment because of approaching or advanced infirmity. The emphasis thus appears to be increasingly toward health care rather than residential care in these facilities for the aging.

RESTORATIVE SERVICES

Another emerging pattern in the health care for the elderly is the provision of more restorative services. Growing numbers of chronically ill and disabled persons, the rising costs in medical and institutional care and benefits of restorative treatment have combined to bring about the recognition of the value of rehabilitation service for the long-term patient.

Evidence of the results obtained for these patients has encouraged hospitals and other medical care facilities to place increased emphasis on the programs for restorative therapy designed to achieve the highest maintainable level of function.

PREVENTIVE SERVICES

Closely related to the concept of restoration and preservation of maximum function is the growing recognition of the need for prevention of physical, emotional, and social dependency and disability. Prevention is an integral part of the total care program and should involve the family physician.

A number of community agencies and institutions have inaugurated various kinds of preventative programs and services. These services limited primarily by the availability of professional resources include different forms of case-finding programs, specialized clinics, adult education programs and health maintenance and nutrition, and counseling services in senior centers and social agencies.

AFFILIATION BETWEEN FACILITIES

All too frequently general hospitals, nursing homes, homes for the aged, and other kinds of facilities providing specific kinds of care for the aged operate independently of each other. Such a circumstance rarely provides the best of care on an efficient and economical basis.

Accordingly, authorities in the field are making every effort to stimulate operators of hospitals, nursing homes, and homes for the aged to develop formal work agreements to assist in promoting adequate and uninterrupted patient care for the chronically ill. Such formalized relationships assure optimum utilization of scarce personalized personnel, facilitate patient transfers when necessary, help to eliminate duplication of expensive facilities and equipment and encourage continuous overall medical supervision of patient care.

The last trend I should like to mention briefly is the emergence of the new kinds of services.

Day centers, while still in the experimental stage, have been developed in a few communities to provide an intermediate service between inpatient hospital care and relatively independent community living. Patients are in these facilities for a varying number of hours during the day and then returned to their homes.

These programs may be operated as part of the general hospital, a community mental health center, a home for the aged, or in conjunction with other community facilities. Although primarily for mental patients, some serve a broader group of the chronically ill.

One other example is that of central referral services. Specialized programs offering information and referral services to long-term patients have been developed in a number of communities, frequently as a part of or in cooperation with local community health and welfare councils. Occasionally these services are provided in local health departments.

Programs range in complexity from the development of a simple roster of resources to a well-organized activity providing, (1) person-to-person counseling to help patients and their families find the appropriate service to meet their needs; (2) information about health, welfare, and recreational facilities and services; and (3) referral to employment, housing, and long-term medical facilities. Significantly these activities may represent a first step toward coordinated community planning.

By way of summary, I have tried to paint with a broad brush the facts that (1) under the provisions of present legislation the Federal Government has played a helpful role in constructing nursing home beds, (2) that there is substantial need for additional beds, (3) that there are at present understandable financial deterrents to nonprofit sponsorship of nursing homes but that these could in large part be removed, (4) a changing concept is occurring with regard to the purpose of a general hospital and of homes for the aged, and (5) that the contributions of restorative services and a better appreciation of the value of preventative services may help to improve the situation with reference to medical care for the elderly who are ill.

Finally, it is significant that with reference to nursing home construction the late President Kennedy recommended in his health message that the authorization for the construction of nursing homes should be increased from $20 million to $50 million annually.

Mr. Chairman, my interest in this problem is great but I have touched only a few highlights. I will be glad to elaborate on any of these points to the extent of my ability.

Senator Moss. Thank you very much, Dr. Graning. We appreciate your testimony.

You talk about the changing concept that we have of nursing homes and care to be given. Are our Federal programs oriented to the new concepts? To what extent are we facilitating the building of the modern, improved nursing home?

Dr. GRANING. I can assure you, sir, with reference to any nursing home that the Federal Government has had a part in building, it has met the very finest standards we have been able to think up.

These particular homes have all of the safeguards built into them in terms of safety and design that the best architects can conceive.

Senator Moss. The safety factors are checked carefully, but when you say "architect and design" are you talking about design for the modern trends in caring for people?

Dr. GRANING. Yes, sir.

Senator Moss. Under the Hill-Burton funds, part (G) of the Hill-Burton Act, how do you allocate these funds among different facilities like nursing homes and chronic disease hospitals, rehabilitation centers?

Do you have a formula by which you break them down into various categories?

Dr. GRANING. Each State receives its allotments based on a formula included in the legislation. It is then at liberty to decide whether it will invest this money in a chronic disease facility or in a nursing home.

Senator Moss. So, it is at the State level where final allocation is made?

Dr. GRANING. Yes, sir.

Senator Moss. Can you tell me how deeply the State agencies go into this problem in determining their needs so that when they break the funds down they can channel them into the needed area?

Dr. GRANING. Under the provisions of the basic Hill-Butron Act each State has to develop a plan which assays acceptable beds within the State in relationship to the population served in that area. Each so-called medical trade area then, in terms of where the people are going for care, is rated in terms of available beds as measured against population. This establishes a priority schedule within the State, and communities then know where they stand in relationship to needs of other sections of the State.

The community with the greatest need has first call on this money.

If they are able to raise their local share and desire to do so, they then proceed with construction.

Senator Moss. Does each State use the same sort of evaluation, the same standard in evaluating the need of various communities? In other words, do you provide a method for the States to use?

Dr. GRANING. The methodology is quite standard, sir, but the yardstick that is used by the States in terms of measuring the acceptability of existing beds has varied among States.

Senator Moss. Do you have the data on the percent of total space in a typical Hill-Burton nursing home devoted to other than patient bedrooms?

Dr. GRANING. Your question again, sir.

Senator Moss. The total space in a typical Hill-Burton nursing home devoted to other than the patient bedrooms?

Dr. GRANING. I was looking to see if we had that figure. We have established a requirement of 50 square feet for 75 percent of the beds or 37½ square feet for all beds, for dining, occupational therapy.

We have at the moment data here on the space per bed in federally and nonfederally aided programs but I don't have the relationship, the specific relationship you are asking for; in other words, the space devoted to nonbed area.

If you would like this, sir, we can see if we have it.

(The information requested is as follows:)

Area breakdown of average Hill-Burton nursing home (400 square feet per patient)

Area	Percent of total gross area	Square foot area per patient
Patient's room including toilet and locker facilities	31.2	125
Treatment facilities	7.2	29
Dining, recreation, and occupational activities	12.1	48
Administration	3.0	12
Circulation (corridors, waiting vestibule, and stairs)	22.6	91
Service (kitchen, lockers, soiled linen, and janitor's facilities)	6.3	25
Storage	5.6	22
Boilerroom and mechanical space	2.0	8
Total net	90.0	360
Exterior walls and partitions	10.0	40
Total gross	100.0	400

Senator Moss. If you could furnish it. And do you have an estimate as to what would be the percentage of non-bed space?

Dr. GRANING. We can get at this indirectly. If I may refer to something which I have here, we undertook a study in 1962 of 40 nursing homes. We picked 20 proprietary homes that had been suggested by the American Nursing Home Association and 20 in the nonprofit category and surveyed them as to size, ownership, geographic location, beds, and patients.

In this study we found that there was not a great difference between the cost of construction per square foot between facilities built with Federal assistance as against those built without Federal assistance, but when we related it to cost per bed we found that because the amount of area provided per bed in the nonfederally aided situation was much smaller, our cost per bed for federally aided facilities was higher and this is interpreted, of course, to mean that we are providing for more space.

Specifically, the median cost per bed in 20 nonfederally aided homes is $3,070 and the median area of 236 square feet per bed, whereas in Hill-Burton aided facilities our median area was 400 square feet per bed and median cost was approximately $6,500.

So, we are providing more space in the facilities that we are helping to build.

Senator Moss. On that basis you would have nearly twice as much space per bed overall within the nursing home; is that correct?

Dr. GRANING. We, of course, insist on having rehabilitation and recreational facilities within the nursing homes which we help build.

Senator Moss. Thank you, Dr. Graning.

Mr. Burleigh, do you have anything to add?

Mr. BURLEIGH. Not a thing, sir. I am quite happy.

Senator Moss. We appreciate your coming to be here with us. We do appreciate your testimony for this record. It will help us a great deal.

The committee will now stand in recess until tomorrow morning at 9:30.

(Whereupon, at 12:15 p.m., the joint subcommittee recessed, to reconvene at 9:30 a.m., Wednesday, December 18, 1963.)

LONG-TERM INSTITUTIONAL CARE FOR THE AGED

WEDNESDAY, DECEMBER 18, 1963

U.S. SENATE,
JOINT SUBCOMMITTEE ON LONG-TERM CARE
OF THE SENATE SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The joint subcommittee met at 9:30 a.m., pursuant to call, in room 4230, New Senate Office Building, Senator Frank E. Moss (chairman) presiding.

Present: Senator Moss.

Present also: Frank C. Frantz and Jay B. Constantine, professional staff members, and Gerald P. Nye, professional staff member (minority).

Senator Moss. The subcommittee will come to order.

We are starting a little early because we have a lot of ground to cover this morning.

I am very pleased to have Mr. Spector, Mrs. Holt, and Mr. Anthony Grezzo, of the FHA, here with us this morning to represent the Housing and Home Finance Agency in this hearing.

This is the second day of hearings of the Special Committee on Aging's Joint Subcommittee on Long-Term Care. In these hearings we are attempting to get a complete picture of all of the Federal activities that involve nursing home facilities and services, and of the policies that the various Federal agencies follow in these activities.

We will begin this morning by hearing from the Housing and Home Finance Agency concerning the FHA program of mortgage insurance for nursing home construction.

We are pleased to have you, Mr. Spector, and your associates, with us this morning, you may proceed.

STATEMENT OF SIDNEY SPECTOR, ASSISTANT ADMINISTRATOR, HOUSING AND HOME FINANCE AGENCY, OFFICE OF HOUSING FOR SENIOR CITIZENS; MRS. HELEN HOLT, SPECIAL ASSISTANT FOR NURSING HOMES, FEDERAL HOUSING ADMINISTRATION; AND ANTHONY GREZZO, SPECIAL PROGRAM ADVISER, FEDERAL HOUSING ADMINISTRATION

Mr. SPECTOR. Thank you, Mr. Chairman. I do have a short statement here which, if it is your wish, I will read through quickly and be available for questioning.

It is a privilege for me to represent the Housing and Home Finance Agency before this subcommittee, whose studies and recommendations on the long-term care of the elderly have been so important in this field.

The Housing Act of 1959 (Public Law 86–372, 86th Cong., approved Sept. 23, 1959) added section 232 to the National Housing Act,

authorizing the Federal Housing Administration—a constituent agency of the Housing and Home Finance Agency—to insure mortgages on qualified, proprietary nursing homes.

The purpose of the section, as stated in the law, is—

> to assist the provision of urgently needed nursing homes for the care and treatment of convalescents and other persons who are not acutely ill and do not need hospital care, but who require skilled nursing care and related medical services.

The Housing Act of 1961 liberalized the financing provisions of section 232 so as to widen the opportunity for its use in meeting the need for nursing beds in the Nation.

Under the law, the FHA may insure mortgages to finance either a new facility or to rehabilitate an existing structure. Not less than 20 beds must be provided in a project. The mortage amount for any one project cannot exceed $12.5 million and 90 percent of estimated value of the project. The maximum rate of interest for these loans is 5¼ percent, plus one-half of 1 percent mortgage insurance premium. The maturity of the loan cannot exceed 20 years.

The nursing homes developed under this program are financed with loans from FHA-approved private lenders, who in turn are insured by the FHA against losses on these loans.

To be eligible for FHA insurance a nursing home must meet the following three conditions:

1. It is licensed or regulated by the State (or authorized State subdivision) in which the facility is located.
2. It is intended for the accommodation of convalescents and other persons who are not acutely ill, or in need of hospital care, but who do need skilled nursing care and related medical service.
3. The skilled nursing care and related medical services are prescribed by, or performed under, the general direction of persons licensed to provide them in accordance with the laws of the State in which the facility is located.

Projects used specifically for hospitals, clinics, diagnostic or treatment centers are not considered nursing homes and are not acceptable for FHA mortgage insurance. Before insuring any nursing home mortgage the FHA also must have from the appropriate State agency of the State in which the nursing home is to be located:

1. Certification that there is need for the home.
2. Certification that there are in force in the State (or its political subdivision) reasonable minimum standards for licensing and operating nursing homes.
3. Satisfactory assurance that such standards will be applied and enforced with respect to any nursing home in the State on which FHA provides mortgage insurance.

The FHA relies on the various States for enforcement of their requirements for continuing licensure.

In processing a mortgage insurance application, the FHA determines its economic feasibility through a mortgage credit analysis. This involves essentially calculation that anticipated net income is sufficient to meet debt service under the mortgage and any other obligations—including operating expenses, taxes, necessary reservations, and reasonable return on capital and invested equity in real estate, equipment, and furnishings.

The FHA mortgage credit review also includes analysis of the sponsoring group with regard to its character and reputation; and their

ability and experience to develop, build, and operate a nursing home of the size and type proposed. It also covers the financial capacity of the group to complete, equip, and furnish the proposed home in accordance with FHA standards and with the needs related to the intended occupants.

The cost of built-in fixtures and equipment which becomes part of the real estate—such as wardrobes, kitchens, snack bars, pantries, nursing stations (including such equipment in work or utility rooms)—may be included in the mortgage. The cost of special medical and therapy equipment may not be included. The FHA must make the commitment for insurance before the date of execution of the mortgage.

The FHA has developed minimum property standards for nursing homes, setting forth the minimum qualities considered necessary in the planning, construction, and development of a home. These standards apply to all new construction and, with specific variations, to all rehabilitation projects. They include standards relating to building height, elevators, fire protection, room sizes, number of beds, door and corridor widths, and closet space.

Prior to January 1, 1961, the FHA had received only 30 applications, representing 2,468 beds, with $13.1 million in mortgage amount. Only 10 commitments had been issued and 2 projects were under construction.

As of November 30, 1963, the FHA had received applications (cumulative) for 500 projects, amounting to 45,676 beds, for a proposed mortgage amount of $296.5 million.

Of these applications, the FHA had issued commitments for 314 projects, amounting to 28,598 beds and $176.4 million in mortgage insurance.

Of these commitments, 85 projects had been completed and 123 other projects were under construction by November 30, 1963. These amount to a total of 18,607 beds for a mortgage insurance amount of $111.2 million.

Nursing homes financed by FHA-insured mortgages through fiscal year 1963 ranged in size from 24 to 453 patient capacity and had an average of 88 beds. One-story structures in calendar year 1962 accounted for 79 percent of the projects committee and for 68 percent of the bed accommodations. Structures with elevators accounted for the remaining 21 percent of the projects and for 32 percent of the bed accommodations. FHA regulations require elevators in all structures of more than one story.

The median mortgage amount per bed was $6,029 for projects for which commitments were made in calendar year 1962. However, the great majority of projects (94.6 percent) were in the cost range of $3,000 to $7,999 per bed. Only 4 percent were in the range of $8,000 to $10,999, and the other 1.4 percent were in the range between $2,000 and $2,999.

Monthly charges per patient in these homes varied from $140 to more than $500 per month, depending generally on the number of beds per room and services provided. The median figure of monthly charges per patient was approximately $300 per month or $10 per patient per day. The median monthly charge for private rooms, comprising 9 percent of all bed accommodations, was $362. Semi-private rooms (two beds) accounted for more than 78 percent of all

beds and had a median charge of $304 per bed. The median charge in three-bed wards, about 4 percent of all bed accommodations, was $267.

At the present time more than two-thirds of the States have developed one or more projects. The FHA has maintained close and cooperative working relations with the Department of Health, Education, and Welfare, with the State health agencies and professional groups in the administration of this program.

As mentioned earlier, under the law, the FHA presently can insure nursing home mortgages only where the mortgagor is a proprietary organization. On October 2, 1963, in testimony before the Subcommittee on Housing of the Senate Committee on Banking and Currency, the Housing Agency indicated that it favored the extension of the nursing home program to include nonprofit groups. Under the present arrangement, nonprofit groups are precluded from this effective method of financing the construction of skilled nursing homes.

In addition to its specific nursing home program, the Housing Agency, through the Public Housing Administration, is giving greater emphasis to the construction of group residential facilities for those older persons who, while mobile and quite independent, may need some assistance in their living arrangements. These group residential facilities can include dining rooms, activity areas, and, with the cooperation of the Department of Health, Education, and Welfare, will offer ready access to a full range of health and social services in the community. In this environment the older person who may no longer wish or be able to live in a fully self-contained unit can be offered a dwelling place in housing of his own choice. This will not be a facility for long-term care, as is a nursing home, but it will provide a more independent living environment for many older persons who might otherwise be placed unnecessarily in a nursing home or other institution.

The Housing and Home Finance Agency is a member of the Subcommittee on Nursing Homes of the President's Council on Aging. This Subcommittee is conducting a study of the costs of nursing homes and is cooperating with the Council of State Governments in the development of a model code for licensing in the nursing home field.

Through these programs we begin to evaluate the role and the need for nursing homes in the Nation. The FHA program of mortgage insurance can play an effective role in meeting the national needs in this important field.

Senator Moss. Thank you, Mr. Spector, for a very fine statement.

In your statement you set forth the median cost per bed and per project for which commitments were made in 1962. Are these based on the total costs or the amount of the mortgage you insure?

Mr. SPECTOR. That is the total cost, the total replacement cost, including the land and construction, and the other costs involved in the construction.

Senator Moss. Of course your mortgage would be something less.

Mr. SPECTOR. The mortgage amount would be less.

Senator Moss. You point out that before any commitment is made for loan insurance on any of these homes you have a clearance from the State.

Is this a certificate that the State gives as to the need for the project?

Mr. SPECTOR. Yes, the mortgagor, the applicant, has to go to the State agency, usually it is the State Hill-Burton agency, and secure a certificate of the need for nursing homes in the particular area in which he would like to build one. We will not process an application until that need has been established.

Senator MOSS. So this clears right through the same channel as the Hill-Burton funds would have to be cleared.

Mr. SPECTOR. Exactly, Mr. Chairman.

Senator MOSS. So far as you know, then, the same criteria would be applied as in the case of a Hill-Burton grant of money?

Mr. SPECTOR. I assume in measuring need they would apply the same criteria with respect to the number or beds needed in a given location.

Senator MOSS. It is your experience, then, that these are all coordinated in the same office.

Mr. SPECTOR. The mortgagor goes to the same agency and I assume in that State they would coordinate the applications they have from Hill-Burton or other agencies in order to make a determination with respect to the need for nursing home beds in that area.

Senator MOSS. Does FHA make a market analysis of the need independent from this certificate of the State?

Mr. SPECTOR. Yes. In addition to the fact of need, which State agency might certify, the FHA of course is concerned with the economic feasibility of a particular proposal. The director in the field office and his staff will make an analysis to determine whether there is a market at the charges which have to be made based on the cost of construction and so forth. So, each project has to be measured for its economic feasibility.

Senator MOSS. We heard reports that in some States the certification to the FHA is based simply on a population formula and does not take into account the existing pattern of health services in the community involved and the actual need or market at the rates that would be charged. Would you comment on that?

Mr. SPECTOR. I would say that the major FHA concern would be, first of all, the certification of need from the State and secondly, but very importantly, its economic feasibility. If a project is not going to be feasible in terms of a specific market for a particular project in a particular location, the FHA will not make a commitment for it.

Senator MOSS. Your testimony would be that you don't rely simply on a population formula, that you do examine such things as the pattern of need in the community, and so on?

Mr. SPECTOR. I think that any FHA director who examines an application would have to be concerned with the available resources in the community because this will help to determine the economic responsibility of a particular proposal.

Senator MOSS. Does the FHA have personnel to review these applications who are skilled in this field of nursing homes and are able to pass on the merits of an application like this?

Mr. SPECTOR. I would say that the FHA has great competence in determining the marketability, the economic marketability of any proposal in the housing field. The main consideration here, as far as the FHA is concerned, is the kind of construction that is going to be used, the facility that is going to be provided, and whether there is a market at the level of charges that have to be made.

With respect to the kinds of services to be included and the quality of care and so forth, I think it would depend on the competence of the State, the State health department primarily, to determine whether it will license that facility.

The FHA has to be shown evidence that the State agency will license the facility before it will do anything on the application.

Senator Moss. In your testimony about the rates that are charged for care in these homes; these seem to be somewhat above the level of the welfare assistance rates that we have. Would it be fair to say that the FHA program does not reach the need in this welfare area?

Mr. SPECTOR. At the level of charges that are required in relation to the cost of construction, the FHA does not reach the lowest income groups where there is obviously a very great need. It does meet a need, however, among persons who require nursing home care and who, either by themselves or through their families, can pay these charges. There is a need for nursing home care at various levels of income and the FHA is meeting one of these levels of income.

Senator Moss. More in the median group as it were, but not the lowest income group?

Mr. SPECTOR. I think that is correct, Mr. Chairman.

Mrs. HOLT. I just want to add one point. Our nursing homes aren't necessarily built for the level of the welfare patient; however, I don't know of any home which refuses to take a welfare patient if there is a need for a bed for the welfare patient. Nearly all of them have some such patients.

Senator Moss. You think the majority of them have some relationship with the State so that the welfare patients might be cared for?

Mr. SPECTOR. Yes, sir.

Senator Moss. Of course, if the level of welfare payments were to be raised in the States, it would probably help greatly.

Can you tell me the margin of profit that you find by experience the proprietors of these nursing homes realize?

Mr. SPECTOR. Mr. Chairman, we do not have that information as to the level of profit. This is a private venture and a business venture and we don't have records at hand of the profits being made in the nursing home field.

Senator Moss. You are concerned that the loan can be serviced and amortized and you let the proprietor worry about whether he makes a profit?

Mr. SPECTOR. We are very much concerned with the repayment of the loan; yes, sir.

Senator Moss. Mr. Frantz points out that in your statement you indicate that the application is examined so that you may be sure that there is enough income to include operating expense, taxes, necessary reserves, and reasonable return on capital and invested equity in real estate, equipment, and furnishings.

Will you expand on that? What do you have to find for a reasonable return?

Mr. SPECTOR. I think that relates to the marketability aspect. We do get an estimate, or a calculation, with regard to the potential revenue that will be derived from the operation of the nursing home. This relates to the total costs involved and, again, to its economic feasibility. The total operating cost, of course, includes a return. Its relationship to the total expected income will determine for us

whether it is going to be feasible to make a commitment on this particular proposal.

Senator Moss. Do you not make any estimate as to whether this ought to return 2 or 4 percent or some other yield to the proprietor?

Mr. SPECTOR. I think generally it runs, as in most other areas, on the prevailing pattern of return there in the area. We would make a judgment with regard to that aspect. But there is no specific amount of return in the law or in our regulations. Generally this will depend upon a calculation with regard to whether the proposal is feasible or not.

Senator Moss. Other than examination to see that the loan is being properly serviced, you take no other part in examining the operation of these homes after they are in existence, do you?

Mr. SPECTOR. No, sir; we cannot undertake to inspect the homes after they are operating. This is a State function and it is performed by the State licensing and inspecting agency. However, under the law we have to be assured that there is the ability in the State to enforce its licensing standards.

Senator Moss. Do you maintain then liaison with the State to satisfy yourself that the State is carrying on its inspection and keeping up with the level of performance, as it were, of the homes?

Mr. SPECTOR. To every extent possible; yes, sir.

Senator Moss. I realize you do not have have much legal authority to compel the State to do that, but I wondered if you satisfied yourselves, if you had a continuing interest to see that the State was doing this job.

Mr. SPECTOR. We are very much concerned to see that there is an enforcement of the licensing regulations in the States. It relates to the success of our nursing homes and we are very much concerned with their success.

Senator Moss. Do you encounter quite a variance in performance, one State to another, in licensing, inspection, and policing activities?

Mr. SPECTOR. I think there is a variety in the States in the level of their standards and the extent to which they enforce their standards. But this is the nature, I believe, of State government; they all do vary.

Senator Moss. Would it be an improvement of the program if there could be some more general standardization then throughout the State?

Mr. SPECTOR. With regard to licensing?

Senator Moss. Licensing and inspection.

Mr. SPECTOR. I think that would be helpful. As a matter of fact, the Council of State Governments, which is the organization of the States and does research for the States, is in the process now of developing a model State licensing code which it will submit to the States for adoption. It is hoped this will achieve some greater uniformity and perhaps at a higher level in the whole field.

Senator Moss. Have you compared your experience on cost of construction with that of the Hill-Burton construction?

Mr. SPECTOR. No, sir; we have not made any interagency studies of this kind.

Senator Moss. You do not know of any comparison?

Mr. SPECTOR. We have not made any comparisons. It is not the kind of thing that one can make an offhand comparison about because

the validity of any such comparison will depend on the variables used in the analysis. Unless those are taken into account and matched, comparisons, of course, are useless. Costs depend on the type of structure to be built and more particularly on the kinds of services that are being provided.

Senator Moss. Thank you, Mr. Spector.

Do either of you have any statement or comment to make?

Mrs. Holt. If I may I'd like to make one comment in favor of the States. Every State is raising standards each year so that gradually nursing home standards are improving all over the United States.

Senator Moss. Your experience is that they are improving in general?

Mrs. Holt. Yes, sir.

Senator Moss. I have some members of the staff who may have some questions.

A good question has been suggested. In your experience how extensively does the medical profession interest itself in this field of licensing, upgrading the standards of nursing homes, or in sponsorship, too, of projects?

Mrs. Holt. There has been a great deal of participation in the program by the medical field. First, among our sponsors (more than any other one group) are nursing home people who have been in the profession. Second, are doctors who are either members of corporations or connected in some way with the nursing home; usually not the actual running of the home but I think that they have helped to raise standards of services.

Senator Moss. You find considerable involvement of the medical profession?

Mrs. Holt. Yes, sir. Important, too, is a close working relationship with the doctors of the community; patients are put into nursing homes by doctor referral. One thing that we didn't mention in the discussion of administration is the fact that along with the Department of Health, FHA examines the qualifications of the person who is going to be the administrator. If the sponsor is not to be the manager, we suggest that he have his administrator working with him in the planning stages. Then the FHA manual requires that the administrator be hired by the time of initial endorsement.

Senator Moss. In my State of Utah the first loan that was made by the FHA on a nursing home was to a doctor and his wife who constructed the nursing home. This experience is rather general in the medical profession?

Mr. Spector. There are doctors who do go into this business of course, and many of them are quite successful at it.

Senator Moss. This seems to be working out well in my State. His wife actually operates it, she is the administrator. The doctor is there and is able to be involved in it very much, of course.

Mrs. Holt. It is interesting to note that we have several family operations. We have another one in White Plains which is being built by a doctor and his wife. There are several projects where the wife is a nurse. In the case mentioned the wife is a social worker and the doctor, a practicing physician.

Senator Moss. Do you know of any registered nurse other than the one you commented on—the wife might be a registered nurse, but do you know of any registered nurse groups that have sponsored any proprietary nursing homes?

Mrs. HOLT. No. We have a few small homes owned and managed by registered nurses.

Senator MOSS. Thank you very much. We appreciate your testimony and your answers to these questions.

Mr. SPECTOR. Thank you, Mr. Chairman. It is very good to be here.

Senator MOSS. Our next witnesses will be Mr. Suss and Mr. Cowles, of the Small Business Administration.

I should apologize to you gentlemen, you were here and waited yesterday and we did not reach you by noontime. We appreciate your coming back, especially when you had to wear your snowshoes to get here.

STATEMENT OF FREDERIC T. SUSS, GENERAL COUNSEL, AND CLARENCE COWLES, DIRECTOR, OFFICE OF FINANCIAL SERVICES, SMALL BUSINESS ADMINISTRATION

Mr. SUSS. Thank you, Mr. Chairman.

I have Mr. Clarence Cowles, who is our Director, Office of Financial Services. He will assist in answering your questions.

Senator MOSS. Thank you.

Mr. SUSS. Mr. Chairman, I appreciate the opportunity to appear before you today in connection with your study of nursing homes and similar long-term care institutions.

The Small Business Administration has been actively participating in the Government effort to encourage construction and improvement of additional nursing home facilities. The national requirement for more good nursing homes is well recognized, and it is clear that small privately owned establishments will be important in helping to meet this need.

SBA financial assistance to privately owned nursing homes is provided under our general authority to make loans to small businesses. I will therefore outline briefly our regular loan program, as well as the requirements applicable to nursing home loans.

The agency's business loan program is designed to provide needed financing to creditworthy small concerns when loans are not available to them on reasonable terms from private lending sources. Loans may be made for business construction, conversion, or expansion; for purchase of equipment, facilities or supplies; and for working capital. The agency's loans are of two types: participation or guaranteed loans, which are made or guaranteed by SBA in cooperation with banks or other private lending institutions; and direct loans, which are made by SBA alone. We are not authorized to make a direct loan if a private lending institution will participate with us in the loan.

The maximum amount which SBA may lend to any one borrower, either directly or in participations under this program, is $350,000. Business loans generally have a 5½-percent interest rate on direct loans and on SBA's participation share; except that in certain designated labor-surplus areas, determined by the Area Redevelopment Administration and the Labor Department, the interest rate is 4 percent. Loans may be made for a maturity of up to 10 years. However, loans for construction purposes may have a maturity of 10 years plus the estimated time required to complete construction;

and loans for working capital purposes are not usually made for more than 5 years.

A basic requirement for an SBA business loan is that the enterprise be privately owned, and operated for profit. This means that it must be operated as a business, with profits accruing to the benefit of its owners. Another essential requirement is that the concern be "small," within the meaning of the Small Business Act.

SBA regulations define nursing homes as those facilities for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require nursing care and related medical services. As indicated previously, the nursing home must be privately owned and operated for a profit in order to qualify for an SBA loan. A nursing home will be considered to be small if its annual dollar volume of receipts does not exceed $1 million.

Loans to small nursing homes may be made for a wide variety of purposes under the SBA business loan program. These purposes include new construction; cost of land and site improvements; conversion of facilities into nursing homes; expansion of existing homes; alterations, repairs, or renovations; and purchase of new medical and therapy equipment or furnishings and supplies. Loans may also be made for repayment of burdensome mortgages or liens or equipment; and for working capital to meet current expenses and payrolls and to carry accounts receivable from patients. Frequently, loans are made for a combination of the foregoing purposes.

The owners and operators of a nursing home applying for a loan must be sufficiently experienced and qualified. Our regulations generally require the administrator of the home to have 2 years experience as a nursing home administrator or in a related field, to have good credit references, and to have the endorsement of two local physicians. He must agree, by an appropriate management agreement, to maintain and operate the facility in a competent and professional manner. In addition, there must be provision for adequate supervision by a competent professional staff.

Information on the prior activity, character, and qualifications of the management is also obtained by SBA from other responsible sources.

Applicants for financial assistance must show that the needed financing is not available from thier own resources or on reasonable terms from other credit sources; that there will be adequate ability to repay the loan out of earnings; and that the owner's investment is commensurate with the amount of loan required from SBA. Collateral is required and must be of such a nature that, when considered with the integrity and ability of the management and the past and prospective earnings of the business, repayment of the loan will be reasonably assured. Real estate or equipment acquired with loan proceeds must be pledged as collateral for the loan.

When licensing is required for nursing homes by a State, county, or local agency, SBA will not make the loan unless the applicant has such a license or the licensing agency has indicated in writing that a license will be issued upon accomplishment of the purpose of the loan.

Another SBA requirement designed to coordinate SBA assistance with State plans for development of health facilities, is the certificate of need. Applicants desiring loans to construct new nursing homes, must submit a letter from the State Hill-Burton committee certifying

the need for the proposed construction or modernization and its effect, if any, on the Hill-Burton program. The need for the proposed new or improved facility must be established before SBA will make the loan.

Our regulations also provide that an applicant will not be deemed to meet the necessary credit requirements, nor to have demonstrated adequate ability to repay the loan, unless the nursing home, after application of the proceeds of the loan, meets the minimum standards generally accepted for such establishments.

SBA form 4–H (issued May 1963) incorporates such recognized minimum standards applicable to nursing home construction and modernization. With your permission, Mr. Chairman, I would like to submit a copy of this form for the record.

Senator Moss. It will be printed in the record at this point.

(The material referred to follows:)

CONVALESCENT NURSING HOMES

(SBA requirements for loans to construct new, to make additions, or to renovate)

SBA will make loans to construct new convalescent and nursing homes, to make additions or to renovate existing homes. Nursing homes are those facilities which are used to accommodate convalescents. They also may provide for other persons who require nursing care and related medical services. To qualify as a small business such homes must be privately owned and operated for profit. Such profits must inure to the benefit of the owners, stockholders, or members. The annual dollar volume of receipts of such homes shall not exceed $1 million.

FACILITIES STANDARDS REQUIRED

The facilities must meet the minimum SBA standards outlined herein. Repairs and alterations should reflect good workmanship and materials and efforts should be made to comply as nearly as possible to new construction requirements. Plans and specifications should be approved by the State health authorities having jurisdiction over nursing homes, as required; and they shall conform with applicable State and local laws, codes and ordinances, including fire regulations. A description is required, in narrative form, of the present or new facility and function, and of any added facilities and services. Also, applicant shall show need for the new or improved facilities. A letter from the State Hill-Burton committee, usually the State health department or State hospital construction authority (having jurisdiction), shall be submitted. It shall contain comments upon the need for any proposed new construction or modernization, and its effect, if any, on the Hill-Burton program.

LICENSING

When licensing is required by a State, county, or local agency, the facility must have (1) a license in good standing or (2) the licensing agency must indicate, in writing, that a license will be issued when the purpose of the loan has been accomplished.

GENERAL ACCEPTABILITY REQUIREMENTS

A. *Defective conditions.*—Unacceptable construction or evidence of continuing settlement, dampness, leakage, decay, termites or other conditions impairing safety or sanitation shall render existing property undesirable for a loan for expansion or additions.

B. *Site location and conditions.*—The site must be in a location approriate to the class and type of project proposed. It must be conveniently located with respect to any facilities or services likely to be needed or desired by the anticipated occupants. It must be accessible to transportation facilities typical of the area.

The property shall not be subject to hazards such as objectionable smoke, odors, and noise. Nor shall it be subject to the possibility of subsidence or the probability of flood or erosion. The condition of soil, ground water level, drainage, rock formations, and topography shall be such as not to create hazards to the property or the health and safety of occupants.

C. *Open space on the site.*—The area of the site not devoted to building improvements shall be adequate for privacy and desirable outlook, natural light, and ventilation. Attention shall be given to yards, courts, and distances between building walls either on the site or walls on adjacent sites. Space shall be provided for fire department or other rescue equipment which may be essential to evacuate patients or control fire in such emergency.

D. *Patients' rooms.*—Private rooms shall have a minimum of 100 square feet and multiple bedrooms 80 square feet per bed. There shall be one clothes closet or wardrobe for each bed in every patient's room. The closet or wardrobe shall not be less than 22 inches deep and 20 inches wide. One shelf above a clear hanging space, the hanging space to be equipped with device for clothes hangers. Beds per room shall not exceed four.

E. *Toilet facilities.*—Toilet facilities will be segregated by sexes. There must be at least one toilet for each eight patients.

F. *Bathing facilities.*—Unless each bedroom has access to a bathtub or shower without entering the public corridor, provide in each nursing unit:

(1) A general bathing room for each sex.

(2) One tub or shower for each 15 beds or fraction thereof but not less than 1 bathtub and 1 shower in each bathing room.

(3) Each bathing room shall have a water closet compartment, lavatory, space for dressing, wheelchair, and attendant.

(4) Showers shall be not less than 4 feet square, have handrails and curtains designed for wheelchair use.

G. *Patients' dining and recreation.*—Provide space in a room or rooms for patients' dining and recreation. Minimum total area: 20 square feet per bed. One-half of required space shall be for dining.

H. *Nurses' station, toilet, and utility room.*—Provide a nurses' station in each nursing unit. It shall have facilities for (1) nurses' call system, (2) charting and supplies, and (3) medicine storage and preparation. The station shall not be more than 100 feet from the entrance of the remotest room served. Provide a nurses' toilet room. Include a water closet and lavatory convenient to the station. Provide each nursing unit, near the nurses' station, with a utility room.

I. *Services and facilities.*—Utilities and service facilities shall be adequate for each property. The property shall contain provision for each of the following:

(1) A continuing supply of safe and palatable water.

(2) Sanitary facilities and a safe method of sewage disposal.

(3) Home heating adequate for healthful and comfortable living conditions.

(4) Domestic hot water in quantity adequate to serve appropriate fixtures.

(5) Electricity for artificial lighting and to serve appropriate electrical equipment.

(6) Provision for removal of garbage and trash.

(7) Appropriate provisions for deliveries in conformity with local custom and practice.

J. *Doorways, hallways, and windows.*—Doorways shall be at least 3 feet 8 inches by 6 feet 8 inches. Hallways shall be at least 6½ feet wide. Window area shall be at least 10 percent of the floorspace.

K. *Heating, air conditioning, or positive ventilation.*—Central heating system must have a capacity to provide heat to 75° with outside temperatures at zero. There shall be either (1) an air-conditioning system acceptable to American Standard Safety Code for Mechanical Refrigeration or (2) a means of mechanical exhaust ventilation so arranged as to provide an induced circulation of air, supplementing the natural ventilation.

L. *Kitchen.*—The kitchen shall meet local sanitary requirements. It should be situated on an outside wall. It must be well ventilated, with hooded stove and exhaust fan. There should be (1) a three-compartment sink or mechanical dishwasher, (2) a lavatory and room area of 400 square feet, and (3) adequate refrigerator space for daily storage.

M. *Fire resistance.*—The building should meet all fire regulations. Walls and floors should be of masonry and concrete. Partitions and ceilings must not have less than 1 hour of fire resistance.

N. *Parking.*—Offstreet parking must be available to meet local ordinance requirements. Direct vehicular access to the property shall be provided by means of (1) an abutting improved public street or way, (2) improved and permanently maintained private street, or (3) way which is protected by a permanent easement. Sole vehicular access shall not be by an alley. The width and construction of streets or ways shall be suitable for all-weather use and the vehicular traffic requirements of the properties served. Dead-end streets shall include adequate

vehicular turning space. The property must be capable of proper use and maintenance without trespassing upon adjoining properties.

ORGANIZATION AND MANAGEMENT

A. *The organization.*—Give complete history of organization and of the management. Show details as to ownership and professional qualifications. There must be provision for adequate supervision by a competent professional staff.

B. *The administrator.*—The administrator should have 2 years' experience as an administrator of a nursing home or related field. He should have the endorsement of two local physicians. His credit references should be good. He shall agree, by an appropriate management agreement, to maintain and operate the facility in a competent and professional manner.

CREDIT

Applicants must (1) show that the needed financing is not otherwise available from own resources or on reasonable terms from another credit source; (2) demonstrate adequate ability to repay out of earnings; and (3) show that its investment is commensurate with amount of loan requested from SBA.

COLLATERAL

Collateral is required and must be of such a nature that, when considered with the integrity and ability of the management and the applicant's past and prospective earnings, repayment of the loan will be assured. Real estate or chattels acquired with loan proceeds must be pledged as collateral for the loan.

PROCEDURES FOR APPLYING FOR LOAN

When an applicant meets the foregoing criteria, an application may be filed in one of SBA's field offices. In each case, the application filed, on an SBA application form, should be supported with a well-defined proposal. It should include the following:

A. A detailed program, setting forth:
(1) Statement of overall objectives.
(2) Preliminary sketches.
(3) Number and composition of proposed units.
(4) Proposed services and the quantity and purpose of non-income-producing space attributable to dwelling use expected to be included.
(5) Statement supporting and explaining the basis for the expectancy of a continued supply of eligible occupants.
(6) Assurance that there will be no additional occupancy beyond that set forth in paragraph D under "General acceptability requirements" to increase income or reduce operating expense.
(7) Complete, detailed information as to the financial requirements of the project and the anticipated sources of income and methods of financing.

B. Evidence that proper State and local authorities have reviewed and approved the proposal; an attorney's opinion that the proposal meets all applicable State and local statutes or ordinances.

C. A detailed operating budget.

D. Evidence that a license has been or will be obtained as required under "Licensing."

Mr. Suss. Applicants desiring assistance to make additions or alterations to an existing nursing home, or to construct a new one, must provide the facilities and comply with the standards specified in the form. The standards are designed to assure an acceptable level of safety and comfort for patients. They are comparable to the minimum standards of the Federal Housing Administration for mortgage insurance for nursing homes, though somewhat less detailed and extensive than the FHA standards.

As of June 30, 1963, the Small Business Administration had made 363 nursing home loans for a dollar amount of $25,347,000. Of these, 171 loans totaling $14,058,525 were made for new construction, expansion or modernization, and 192 loans totaling $11,288,475

were made for other purposes. Average size of loan was approximately $70,000.

We have analyzed these construction loans to determine average nursing home construction costs per square foot and per bed, and average square footage of the homes per bed. The average cost per square foot was $9.75, and the average cost per bed for these new facilities was $2,364. The average square footage per bed was 242. This varies by region of the country as follows:

Area	Average construction cost per square foot	Average construction cost per bed	Average [1] square foot per bed
Northeastern	$9.26	$2,188	236
Middle Atlantic	11.17	2,140	192
Southeastern	8.70	2,165	249
Central States	5.15	2,060	400
Midwestern	14.60	3,017	207
Southwestern	8.69	1,992	229
Northwestern	10.15	2,587	255
Overall average	9.75	2,364	242

[1] Computed by dividing entire nursing home area by number of beds.

SBA nursing home loans for construction, expansion, and modernization have developed a total of more than 5,500 new beds. The number of beds developed by individual loans ranges from about 10 to 165, with an average of 32.

A representative sampling of our loan files indicates that the basic nursing home service includes room and board and limited nursing care. The charge for this basic service varied in the cases sampled within a range from $131 to $238 per patient per month. Additional charges are made for 24-hour nursing care, special therapy, and physicians' care. The majority of homes do not have a physician in residence or affiliated with the home and use the services of local medical people as needed.

In conclusion, I would like to note that, in addition to SBA loans, nursing homes qualifying as small businesses also are eligible for Agency management assistance and for financial assistance from small business investment companies licensed by SBA under the Small Business Investment Act of 1958. SBA management assistance aids small concerns to apply sound financial and operating practices to their enterprise. Small business investment companies, of which there are presently almost 700, supply long-term credit and equity capital to small concerns.

I hope that this statement summarizing SBA policies and procedures for loans to nursing homes, and presenting data on recipients of such loans, will be useful to the committee.

If any further information is desired, I would be glad to supply it.

Senator Moss. Thank you very much, Mr. Suss.

It appears to me that the SBA is involved as deeply, or even deeper in this, than the FHA in the amount of money that you have committed, according to your statement here, for nursing home construction or renovation or expansion.

Mr. Suss. I think the reason for that, Mr. Chairman, is that we have been in this program longer than FHA.

Mr. COWLES. We actually started in 1956 in this program so I think that may account for it.

Senator MOSS. The construction costs per bed, I notice are a little bit lower than that of FHA. Might that be a factor in this difference?

Mr. SUSS. I don't know that I can answer that, Mr. Chairman. I don't know how to account for the difference except that perhaps our applicants are much smaller operators and operate on a smaller budget than those who go to FHA.

Mr. COWLES. I think there is quite a bit of renovation involved in here, too, and additions to nursing homes already established. So I don't think they are quite as large or have all of the facilities perhaps that some of the FHA nursing homes do have at the present time.

Senator MOSS. Do you think that would be a sizable contributing factor to this difference?

Mr. COWLES. Yes, I believe so.

Senator MOSS. Is there a difference in your construction standards from those of FHA?

Mr. COWLES. I think that would be part of it. I don't think ours is quite as rigid as FHA standards. In view of the fact that we do have so many cases which are renovations rather than new, I think practically all theirs are new construction, ours are renovations, additions, and so forth, I think also that would make some of the difference here.

Senator MOSS. You testified that you get a certificate from the State Hill-Burton agency before any small business loan would be granted. To what extent is there followup inspection and determination of whether there is compliance with the State requirements?

Mr. SUSS. We have our loan servicing people go out 30 days after the loan has been disbursed and they make regular visits to the place of business thereafter, I think on an annual basis.

Mr. COWLES. That is right, or more often if the situation develops where it is necessary to go more often. At least it is an annual visit in addition to the visit at least 30 days after the loan has been disbursed.

Senator MOSS. Is there less supervision and followup than FHA makes which might account for some of the difference in the cost figures?

Mr. COWLES. I don't quite get the questions, Senator.

Senator MOSS. I am wondering if there might be a degree of laxity in compelling compliance that might enable borrowers under SBA to keep this cost-per-bed figure down?

Mr. COWLES. I don't believe so. As you probably know, we have engineers in our program also and in all construction cases our engineers do go out and check construction to see that it complies with what was intended and that the funds are used of course for exactly that particular purpose. So I don't believe that that is a factor.

Senator MOSS. Mr. Suss, in your statement you stated that the management for the prospective borrower had to have experience in the nursing home administration or in a related field. Can you tell me what a related field would cover?

Mr. COWLES. I think a hospital field, an area of a hospital field or area caring for people who are ill, areas in that particular line would be areas I would indicate.

Senator Moss. Would it cover, for instance, a registered nurse?

Mr. COWLES. Yes, I would say so. Would require nurse care, of course, in all these cases, a registered nurse. As was indicated by Mr. Spector, we do have a number of cases where nurses have established homes or where doctors have established homes, also.

Senator Moss. Could it also include an experienced businessman, a property operator, provided he could show that he had available nursing assistance that he would use as part of his operation?

Mr. COWLES. I think we generally require a little bit more than that, that he would have to have some experience along this particular line of caring for people. At least that is our intention.

Senator Moss. The position of the SBA is that the nursing home operation is a specialized field that would not fit in just the general operation of the property for business purposes?

Mr. COWLES. That is correct.

Senator Moss. Since SBA must be convinced that the borrower has an opportunity to realize a profit as part of his operation, what do you consider a reasonable profit to make it financially sound?

Mr. COWLES. I don't think we would look at it exactly from that standpoint. Our standpoint is, are there adequate funds generated from the plant to be able to pay off SBA and at least have adequate in addition to take care of the living expense and so forth of the operator so that the funds that they needed for operation weren't going to them and not going to us? It is strictly a case of their being able to repay a loan in every instance.

Senator Moss. Do you have figures that would indicate the profits that have been realized by borrowers in this area who have borrowed from SBA?

Mr. COWLES. We could probably answer it this way: We do not maintain figures of that type. However, we get financial statements from all of our borrowers, sometimes on a quarterly, sometimes 6 months, sometimes yearly basis. So through that particular facility we of course would know what their profits are as they are going along. We do not actually have any figures generally on that subject.

Senator Moss. Mr. Suss, you mentioned, in your statement, an agreement to operate the facility in a competent and professional manner. Now is this an agreement between the borrower-operator and the SBA?

Mr. SUSS. Yes. It is part of the loan agreement.

Senator Moss. Is there a particular form for this part of the agreement?

Mr. SUSS. There is no particular form but we include it in the authorization for the loan, listing the conditions he must comply with before the loan is disbursed.

Senator Moss. That would be part of his loan agreement before he receives any money?

Mr. SUSS. Yes.

Senator Moss. Has the entry of the FHA in this field slowed down your applications for loans from SBA?

Mr. SUSS. No, I don't think it has because usually if the applicant can go to FHA and get financing that way, get an insured loan, then he is required to do so.

Senator Moss. Is the SBA involved also in a number of cases where FHA is involved with the same borrower, for instance, acquiring equipment or anything of that sort?

Mr. COWLES. I don't believe we have had situations of that kind up to the present time. The question has been raised several times but I don't think we have an applicant of that type.

Senator MOSS. You do not have a policy against that?

Mr. COWLES. No.

Mr. SUSS. It is quite possible that an applicant could go to the FHA for a real estate loan and come to us for an equipment loan to buy equipment, or even for working capital.

Senator MOSS. If he satisfied all the conditions you would grant such a loan?

Mr. SUSS. Yes, if he has enough collateral left after going to the bank.

Senator MOSS. Have there been any foreclosures on SBA loans for nursing homes?

Mr. COWLES. I can't answer that. I don't know. We can supply that for the record.

Senator MOSS. Will you please supply that for the record.

(The information referred to follows:)

CURRENT STATUS OF SBA LOANS TO NURSING HOMES

To date, no loans to nursing homes have been liquidated by foreclosure or legal action. Only one loan is presently being liquidated through foreclosure with an estimated loss to SBA of $5,000. Only four loans are in "Problem" category, and of these only one is expected to show a loss if liquidation should take place. The amount of such loss is estimated to be $25,000 or less.

Senator MOSS. Do you have a fixed policy on disposition of a nursing home in the event of foreclosure?

Mr. SUSS. No, I don't think it would be any different than with our regular loan. We turn them over to the U.S. attorney, as you know, for collection. After we do that we surrender jurisdiction of the case to the Department of Justice and they do what they please with it.

Senator MOSS. In your statement on page 3 you say that there must be provision for adequate supervision by a competent professional staff. Now I suppose this indicates you go beyond simply the State certification, you satisfy yourself additionally that this staff is available and will be in operation of the nursing home.

Mr. SUSS. Yes, we require proof of that and with the names and the experience of the staff supplied to us.

Senator MOSS. You do that with your own personnel; those who are investigating the application?

Mr. SUSS. Yes. Our loan processors in the field.

Senator MOSS. Do you have a particular standard that is applied by the loan investigator? How does he satisfy himself?

Mr. COWLES. He of course would make the necessary investigation to check out the administrator, for one thing. The question would be with respect to the registered nurse and nursing care. We would try to check out the nurse also in a similar manner. We would check with the various people in the areas. In most cases of course we do a lot of checking with the banks, and any other areas where we think we should do it. We might talk to doctors and so forth along that line.

Senator MOSS. I still wondered if there was not some particular recognized standard that could be applied. You speak also of

recognized minimum standards being maintained in nursing homes. Rather than just have the loan investigator more or less free to check and dip around wherever in his judgment he could check, I wonder whether there is some particular place where he has to go to see if the recognized minimum standards will be met.

Mr. COWLES. He would check with the State, of course, the Hill-Burton agency. You have your State licensing operation or your local licensing. Of course those would all be checked out also on this particular situation.

Your license would not be issued unless these things would be particularly met. We certainly would not make any loan where a license would not be issued or would be issued after certain situations develop.

Senator MOSS. This comes back again pretty much to a local standard set by the State, it would not be any general Federal standard?

Mr. COWLES. That is correct.

Senator MOSS. In your experience with these loans have you found a considerable variation as to the standards between the different States?

Mr. COWLES. Yes, I think there is quite a difference in these standards.

Senator MOSS. So that in one area a loan might be a good one but might be rejected in another area?

Mr. COWLES. That is always a possibility. Some of the factors we are very strict about are some of the fire standards and health standards which we would make sure about before we would grant a loan in that particular area.

Senator MOSS. Of course, we are all conscious of the two very tragic events that have occurred recently as a result of fires in nursing homes. That would indicate perhaps there might not be as strict supervision on the part of the States as is needed.

Now do you satisfy yourselves beyond State requirements, for instance in this field of fire hazard?

Mr. COWLES. Yes, we certainly would, and we would certainly have our own people, our construction engineers investigate to determine that they had carried out these fire requirements, what we thought was necessary.

Senator MOSS. Mr. Frantz has an additional question.

Mr. FRANTZ. On the question of standards, you submitted a form which you said set forth the generally recognized standards. By whom are these standards generally recognized?

Mr. SUSS. They are patterned after FHA standards. They actually are copied from FHA standards, largely.

Mr. FRANTZ. The Public Health service is usually thought of as the Government's experts in this kind of subject. Have they endorsed these standards as minimum standards?

Mr. COWLES. They have not been submitted to them, no.

Senator MOSS. Thank you very much, Mr. Suss and Mr. Cowles. We appreciate your coming and testifying. You have been very helpful.

Mr. SUSS. Thank you, Mr. Chairman.

Senator MOSS. We now will hear from the Area Redevelopment Administration, Mr. Williams and Mr. Parrette, the Deputy Administrator and the Office of Chief Counsel.

We are happy to have you gentlemen with us this morning to counsel with us and give us information in this field that we are discussing. You may proceed, either one, one at a time or however you wish to go ahead.

STATEMENT OF HAROLD W. WILLIAMS, DEPUTY ADMINISTRATOR, AND BERNARD V. PARRETTE, OFFICE OF CHIEF COUNSEL, AREA REDEVELOPMENT ADMINISTRATION

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

I have a very brief statement which, with your permission, I will read and then we will be available for questions.

Mr. Chairman, I regret that my official purpose here today as Deputy Administrator of the Area Redevelopment Administration is more to explain what ARA cannot do in providing nursing homes and nursing home care, than what it can do. For in no sense can we be said to "have a program" to finance the construction of nursing homes.

The purpose of the Area Redevelopment Act, as you know, is to provide a varied program of Federal assistance, financial and otherwise, for the creation of new, permanent, industrial, and commercial employment in areas eligible for such assistance by reason of previous substantial and persistent unemployment and underemployment. In other words, unlike those programs of assistance which have primarily social objectives, such as the Hill-Burton program and the FHA program, ours is primarily economic: The ultimate criterion of all assistance provided by ARA within redevelopment areas is whether and to what extent a specific project will actually result in the creation of new jobs.

The first questions we ask in considering any application for financial assistance, aside from the economic feasibility of the project, concern the number and kinds of jobs which will result and the amount of Federal investment per job. Under such criteria, a nursing home applicant is at a disadvantage, since the greatest justification for such facilities is social rather than economic, and the personnel they tend to employ are either technical or professional personnel (who are always in short supply), or else relatively unskilled personnel, usually women, whose wages are low. In short, our ultimate criterion must be the economic impact of the facility as a whole, rather than the cost per bed or the cost of construction per square foot of facility. As to the latter questions, we simply require compliance with the minimum property standards for nursing homes as defined by the Federal Housing Administration.

Moreover, our act limits ARA's assistance to facilities for "industrial or commercial usage." We are therefore able to consider applications only for profitmaking enterprises, or else for public facilities necessary for such enterprises. Since it is doubtful if any entrepreneurs refrain from starting new enterprises in a community because the community lacks a nursing home, we have thus far not considered any applications for nonprofit nursing homes under our public facility program.

Finally, as we stated in the pamphlet "Federal Aid for Nursing Homes," published in August by the President's Council on Aging, since ARA by statute can assist proprietary nursing homes "only

when financing is not available from any other source, public or private," the number of profitmaking nursing home applicants who can qualify for ARA assistance is further reduced. It should also be noted that ARA by statute cannot provide funds for working capital.

As a consequence of these limitations, ARA published about a year after it began operations a policy guideline (PGL No. 15, dated Oct. 15, 1962), setting forth its criteria for assistance to nursing homes. A copy of this policy guideline is attached at the conclusion of this statement. You will note that our policy—

is aimed at assisting—homes which are structurally adequate for the safety and proper care of occupants, which are economically sound as business enterprises, and which will provide employment commensurate with the amount of financial assistance requested from ARA.

In spite of these limitations, ARA has thus far approved four loans for proprietary nursing homes, one in California, one in Massachusetts, and two in Ohio. It has also approved a combined loan and grant for water and sewage facilities which will partly serve two nursing homes in Oklahoma. A list of these approved projects is also appended at the end of this testimony, together with the specific information requested by the committee in its letter to the ARA. All of these loans were approved subsequent to the issuance of Policy Guideline No. 15.

In addition to the loans approved, ARA has also declined applications for four nursing homes, and two other applications have been withdrawn. Two of these were denied prior to the issuance of Policy Guideline No. 15, and two were denied subsequently. The two which were withdrawn, were withdrawn within the last few months, after the House Banking and Currency Committee considering possible amendments to our act added an amendment to S. 1163 which would prohibit financial assistance for the construction or expansion of any hotel, motel, or nursing home. This amendment, included in the committee's August 3 report, has not yet been voted on by the Congress.

We have at the present time three applications pending for the construction of proprietary nursing homes, and two applications for public facilities in connection with other nursing homes. All three of the nursing home construction applications were received prior to the Banking and Currency Committee's hearings at which the prohibitory amendment was proposed. Although these applications are still being processed, there is no assurance that they will finally be approved, particularly if the Congress acts on our amendments in the meantime. The two public facility applications are inactive, since both require grant funds, and ARA's grant authority expired on June 30, 1963.

From the foregoing, it will be apparent that the area redevelopment program, as presently constituted, is neither intended nor equipped to carry on an extensive nursing home program. In fact, it may be that we will soon be out of the nursing home business altogether, either by congressional action or by an administrative determination that the limited economic impact of a proprietary nursing home does not justify its inclusion in our efforts to aid the unemployed.

It is not that we do not favor nursing homes—on the contrary, we believe the Nation has a pressing need for more of them, particularly those able to operate at a lower cost per patient than is now the rule—

but the area redevelopment program has been set up in such a way that nursing home applications must necessarily receive a low priority.

Senator Moss. Thank you very much, Mr. Williams.

I see that you have furnished here a breakdown of costs on four of the projects on which you have made loans. These will be included immediately following your statement, along with the listing which you have made of the approved projects and also the policy guideline dated October 15, 1962.

(The documents referred to follow:)

Beaconcrest Nursing Home, Inc. (Massachusetts)

Beds	108
Construction cost per square foot (unequipped)	$13.92
Construction cost per square foot (equipped)	$17.76
Construction cost per bed	$4,470.00
Square feet per bed	269

Nursing and convalescent care, registered nurses on duty 24 hours per day, administration of drugs and medications. Base charge—welfare patients, $6.85 per day; private room, $18.00 per day; semiprivate, in between, extras additional.

Ukiah Convalescent Home, Inc. (California)

Beds	51
Construction cost per square foot	$11.71
Construction cost per bed	$3,824.00
Square feet per bed (private)	144
Square feet per bed (semiprivate)	154

General nursing and convalescent care offered. Charge to patient $275 (semiprivate) and $300 (private).

Summit Acres (Ohio)

Beds	33
Construction cost per square feet	$12.78
Construction cost per bed	$3,756.00
Square feet per bed overall (private)	135
Square feet per bed overall (semiprivate)	141

General nursing care to aged and/or convalescents, charge to patient estimated to be $250 (average).

Arcadia Rest Home (Ohio)

Beds	60
Construction cost per square foot	$12.19
Construction cost per bed	$2,216.00
Square feet per bed overall	181
Square foot per bed each room (private)	240
Square foot per bed each room (semiprivate)	107

General nursing care to convalescents only, flat rate per month (extras additional) $255.

AREA REDEVELOPMENT ADMINISTRATION APPROVED NURSING HOME PROJECTS TO DATE

1. Ukiah Convalescent Home, Inc., Ukiah, Calif.: $125,522 loan for 20 years to construct a 50-bed convalescent home for the long-term care of chronic and rehabilitative patients, with open medical staff and registered nurses. Total project cost $216,418. Frederick C. Pritchard, president and administrator. Approved May 30, 1963.

2. Arcadia Rest Home, Inc., Coolville, Athens County, Ohio: $128,050 loan for 25 years to purchase, enlarge, and convert an existing motel into a 60-bed nursing home. Total project cost $199,817. Charles Levering, executive vice president. Approved December 21, 1962.

3. Beaconcrest Nursing Home, Inc., Lowell, Mass.: $334,849 loan for 20 years to establish a 110-bed nursing home for the convalescent and aged. Total project cost $515,169. Mary C. O'Meare, president. Approved November 9, 1963.

4. Summit Acres, Inc., Caldwell, Ohio: $93,600 loan for 20 years to establish a 33-bed nursing home for the aged. Total project cost $148,000. Paul C. Deitz, president. Approved June 25, 1963.

5. Jay Utilities Authority, Town of Jay, Delaware County, Okla.: $204,000 loan for 40 years and $61,000 grant to establish water and sewerage facilities to serve an expanding poultry processing plant, a new hospital, and two new nursing homes, the Webster Nursing Home (50 beds) and the Betty Ann Nursing Home (50 beds). Approved June 25, 1963.

U.S. DEPARTMENT OF COMMERCE, AREA REDEVELOPMENT ADMINISTRATION

POLICY GUIDELINE—NO. 15

OCTOBER 15, 1962.

To: ARA Staff, Field Coordinators,
Delegate Agencies,
State Designated Agencies.
Subject: Private nursing homes.
From: William L. Batt, Jr., Administrator,
Area Redevelopment Administration.

ARA policy on private nursing homes is aimed at assisting such homes which are structurally adequate for the safety and proper care of occupants, which are economically sound as business enterprises, and which will provide employment commensurate with the amount of financial assistance requested from ARA.

ARA will process applications for private nursing homes only when:

1. The appropriate State agency has:
   a. Certified that there is a need for the home and that facilities of suitable adequacy are not now available within the service area;
   b. Certified that there are in force in the State (or its political subdivision) reasonable minimum standards for licensing and operating nursing homes;
   c. Given satisfactory assurance that such standards will be applied and enforced with respect to any nursing home in the State for which ARA provides financial assistance.
2. Reasonable assurance has been given that financing for the project is not available under the Federal Housing Administration's nursing home program.
3. A prefiling conference has been held with the Small Business Administration and it has been indicated that the project is not eligible for SBA assistance under that agency's statutory requirements.
4. The nursing home will be constructed in accordance with Minimum Property Standards for Nursing Homes as defined by the Federal Housing Administration.
5. The nursing home will provide employment commensurate with the amount of financial assistance requested from ARA. This will require that a detailed breakdown of the employment that will be provided by this facility be submitted with the ARA–1 application. This breakdown should include types of direct jobs, number of each, skills required for each, provision for training, if required, rate of pay and where and how these employees will be recruited.

Senator MOSS. Now in the few that you have approved have you gone through the procedures that we heard from the FHA and from others about first of all getting clearance of need from the Hill-Burton agency of the State, and a certificate that it will be operated as a licensed nursing home under the supervision of the State?

Mr. WILLIAMS. Yes, sir. If I may, I would like to call attention to some of the significant features in our policy guideline. We process applications only when the appropriate State agency, which would be the Hill-Burton agency, has certified that there is a need for the home and that facilities of suitable adequacy are not now available within the service area. It must also certify that reasonable minimum standards for licensed nursing homes are enforced, and give satisfactory assurance to us that such standards will be applied and enforced with respect to any nursing homes in the State for which ARA provides financial assistance.

Senator Moss. The standards you apply, I see from this same guideline, are those defined by the Federal Housing Administration.

Mr. WILLIAMS. That is correct, sir.

If I may add, we adapt the best features of both the Federal Housing Administration program and the Small Business Administration program, because SBA processes our loans in the field and makes the investigator use the safeguards that they use in their own loan investigations when they process applications on our behalf.

Senator Moss. Has ARA consulted with the Public Health Service on setting standards? Have you had any conference with them?

Mr. WILLIAMS. Before we issued the policy guideline we consulted with them and discussed with all of the Federal agencies concerned whether we ought to be in the nursing home financing business at all, and under what conditions. This guideline was issued after consultation with the other agencies in Washington, including the Public Health Service.

Senator Moss. The amendment that was proposed in the Banking and Currency Committee pretty nearly put you out of business altogether on nursing home loans? In fact, if adopted they would have precluded any ARA loans at all?

Mr. WILLIAMS. Yes, sir.

Senator Moss. Thank you very much, gentlemen. We appreciate your coming to testify and helping us to make this record this morning.

We will now hear from the Veterans' Administration, Dr. Engle, Dr. Henke, Mr. Anderson, and Mr. Rosen.

Are all those gentlemen here?

If so, will they come to the witness table?

Thank you; we shall be very interested in your testimony. You may proceed.

STATEMENT OF DR. H. MARTIN ENGLE, DEPUTY CHIEF MEDICAL DIRECTOR; DR. C. P. HENKE, DEPUTY FOR PROFESSIONAL SERVICES; D. M. ANDERSON, ASSISTANT DIRECTOR, SOCIAL WORK SERVICE, AND D. I. ROSEN, DIRECTOR, REPORTS AND STATISTICS SERVICE, VETERANS' ADMINISTRATION

Dr. ENGLE. Mr. Chairman, members of the committee, in 1959, the then Subcommittee on Problems of the Aged and Aging afforded the Veterans' Administration the opportunity to discuss some of the problems which it faced as the result of the aging of the veteran population.

In 1961, a subcommittee of the present committee again heard testimony from our representatives. At those hearings we described certain of the characteristics of the veteran population, particularly of those veterans who are patients of the Veterans' Administration. We also described various long-range estimates of hospital bed requirements, and discussed some of the elements of our philosophy for caring for long-term patients.

I shall briefly update certain key statistical data which are available in more detail from the earlier hearings. But first, I would like to report to you the emergence of a substantive addition to our programs.

On August 12, 1963, President Kennedy authorized the Administrator to activate and operate beds for some 2,000 nursing type patients.

The circumstances which led to this action, and the goals laid out for us, are succinctly described in President Kennedy's memorandum to Mr. Gleason. The President said that the retention of older patients in hospital after they had attained maximum hospital benefit—because outplacement was unsuccessful due to lack of facilities, limited financial resources, and other reasons—was not only costly but placed a strain on the use of hospital beds within the present 125,000-bed limitation. He further indicated that the operation of a nursing home program would not only afford some relief, but would also enable the Veterans' Administration to gain firsthand knowledge and experience in the operation of beds specifically designated for patients requiring attendant type service. By this action, the Veterans' Administration was given the opportunity to evaluate the continuum of institutional care. This we shall be doing against the following background, some of which I will illustrate by the use of charts.

VETERAN POPULATION

At this time, there are 22,032,000 living war veterans. This includes: 2,343,000 World War I veterans; 14,004,000 World War II veterans, excluding 1,096,000 who also served during the Korean episode; 5,663,000 Korean veterans, including those with service in World War II; and 22,000 Spanish-American War veterans.

Included among these are 2,279,000 veterans or 10 percent of the total, who are 65 years of age or older. The median age of these older living veterans is 69.2 years, and almost all of them are veterans of World War I and the Spanish-American War.

The significance of aging on our programs is not truly depicted by these numbers—although they are large, and although we have a substantial number of aged patients now. It is in the future, particularly after 1970, that the aging effects will be extremely massive.

In chart 1, the projection of the number of living veterans is shown to the year 2000. In addition, the number expected in each of three age groups is shown: The "young"—under 55; the "middle"—55 to 64; the "old"—65 and older.

First, consider the estimates for the next 10 to 12 years, we expect that the current peak of older veterans will be reached June 30, 1964, when it is expected that there will be 2,318,000 living war veterans aged 65 or more. These will constitute 10.5 percent of all living war veterans at that time. After 1964 the number of veterans in this age group will decline slightly through 1970. On June 30 of that year only 1,960,000 constituting 9.5 percent of all 20,701,000 war veterans, are expected in the 65 years of age and over group.

Thereafter the number of older veterans will rise continuously, reaching a peak of 8,792,000 in 1995. At that time 78 percent of all living war veterans will be 65 years of age or older.

The major reason for the decrease in the number of older veterans for the next few years will be evident from the next chart (chart 2).

Here the veteran population is shown according to the number alive in each year of age. The Korean and World War I groups are shown separately. You see the wavelike pattern of peaks—representing the separation of the three major wars. As the World War I group ages further, and declines in numbers, the number of older veterans will decrease faster than the World War II veterans mature into the older

CHART 1

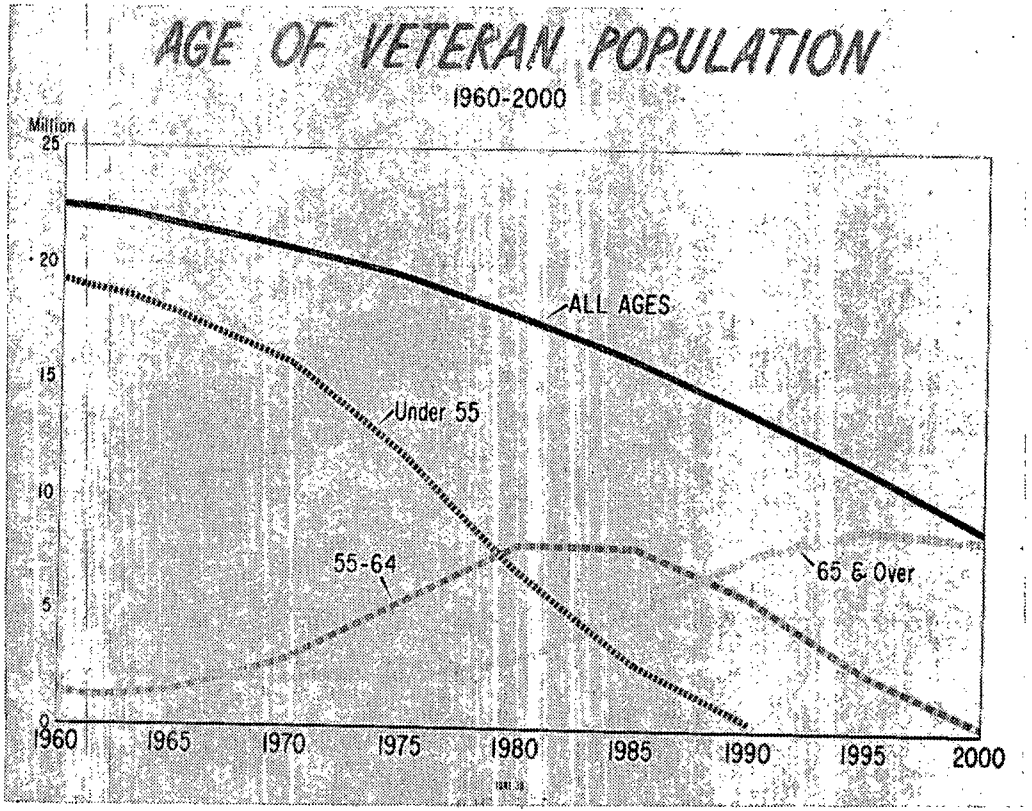
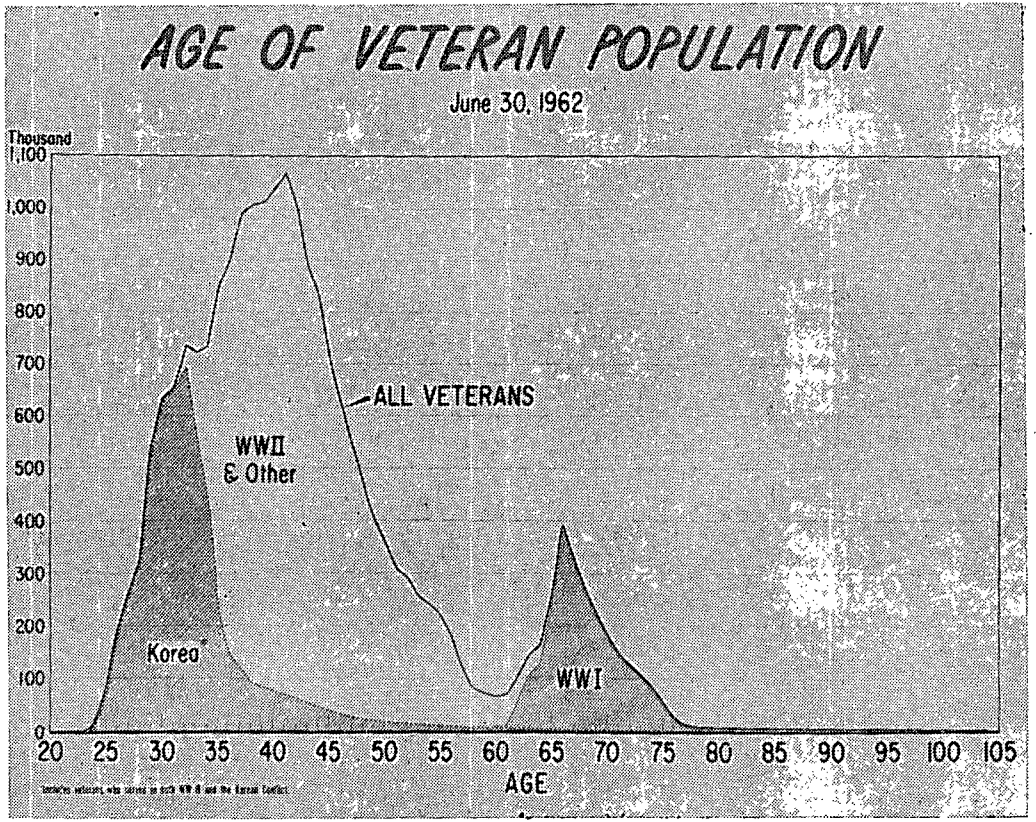

AGE OF VETERAN POPULATION
1960-2000
Million
25
20
15
10
5
0
ALL AGES
Under 55
55-64
65 & Over
1960
1965
1970
1975
1980
1985
1990
1995
2000

CHART 2


AGE OF VETERAN POPULATION
June 30, 1962
Thousand
1,100
1,000
900
800
700
600
500
400
300
200
100
0
ALL VETERANS
WWII
& Other
Korea
WWI
20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100 105
AGE

group. The changing numbers of veterans, and their age composition has had its effects on our patient programs. Some of these are described next.

During fiscal year 1963 there was an average daily VA patient load of 112,593 in VA and non-VA hospitals, and 738,000 patients were treated. The next charts cover certain aspects of this load and past trends. Included are place of care, type of patient, and age.

At this point I would like to call your attention to a distinction between VA hospitalization, and the hospitalization of veterans. All veterans who are hospitalized are not given care by the Veterans' Administration. Those who apply to the Veterans' Administration and are legally entitled and in need of care are admitted to VA hospitals or to non-VA hospitals under Veterans' Administration auspices. I will describe the nature of this load, and in a few moments describe the extent to which veterans receive hospital care without reference to Veterans' Administration.

Chart 3 indicates the extent to which veteran patients are given care by Veterans' Administration in its hospitals and in non-VA hospitals.

1. VA patients in VA and non-VA hospitals: In this chart, the trend in the total census of VA patients is shown since 1920, by the top line. Only a very small part of the VA patient load is not in VA hospitals. At this time less than 3 percent of the average daily census of VA patients is in non-VA hospitals, as indicated by the bottom line.

2. Patients by type (chart 4): About one-half of all VA patients under care on 1 day are under care for psychiatric conditions; the number of patients in hospital for tuberculosis has decreased steadily, and now constitutes only about 6 percent of the total.

3. Patients by age (chart 5): The next chart breaks down the same total patient census shown in the two prior charts. This time, to indicate the changing age composition of our patient load. The trend here, however, is shown only since 1940.

Since hospital utilization is relatively higher as age increases, those veterans in hospital under Veterans' Administration auspices include a disproportion of older veterans. In fact, on October 31, 1962, there were 36,300 veterans in hospital who were over 65 years of age, or 32 percent of the total number in hospital. Only about 10 percent of all living veterans are in this age group.

Since 1940 the total patient load has increased by less than a factor of two. That part aged 65 or older has increased almost sixteenfold.

4. Separate age groups (chart 6): Next in view of the committee's interest, we have prepared additional data—specific to the age of our hospital patients. There are three charts—each prepared the same way, but each for patients of a different age group. Let us consider the patients aged 65 or more first. The panel (in each) to the left shows the trend in the number of beds occupied and the proportion of this total occupied by the patients in three major disease groups (tuberculosis, psychiatric, medical and surgical). However, there is a misleading aspect when we describe the VA paitent load only in terms of the census of patients. We treat, during a year, many more than are under care on any given day. The right-hand panel shows the percent distribution of principal condition among the patients treated—which in this case is a combination of discharges during 1962 and those in hospital on 1 day in that year.

CHART 3

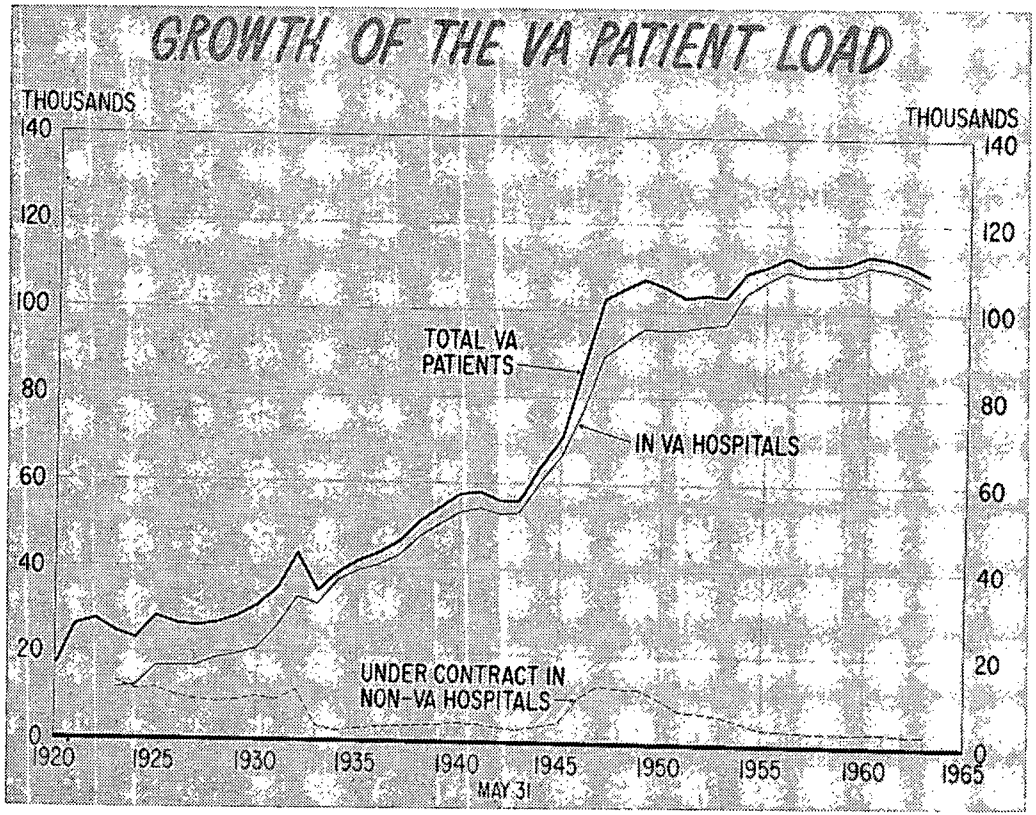

GROWTH OF THE VA PATIENT LOAD
THOUSANDS
140
120
100
80
60
40
20
0
TOTAL VA PATIENTS
IN VA HOSPITALS
UNDER CONTRACT IN NON-VA HOSPITALS
1920
1925
1930
1935
1940
1945
1950
1955
1960
1965
MAY 31

CHART 4

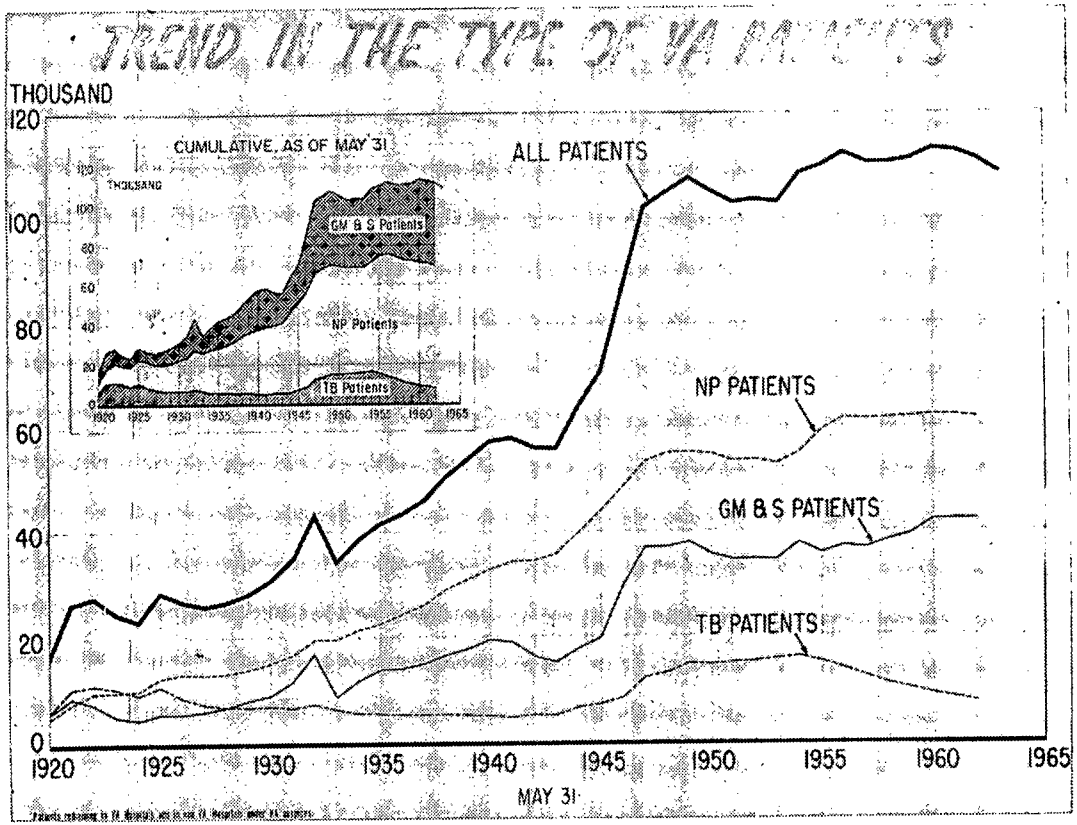

TREND IN THE TYPE OF PATIENTS
THOUSAND
120
100
80
60
40
20
0
CUMULATIVE, AS OF MAY 31
ALL PATIENTS
NP PATIENTS
GM & S PATIENTS
TB PATIENTS
GM & S Patients
NP Patients
TB Patients
1920
1925
1930
1935
1940
1945
1950
1955
1960
1965
MAY 31

CHART 5

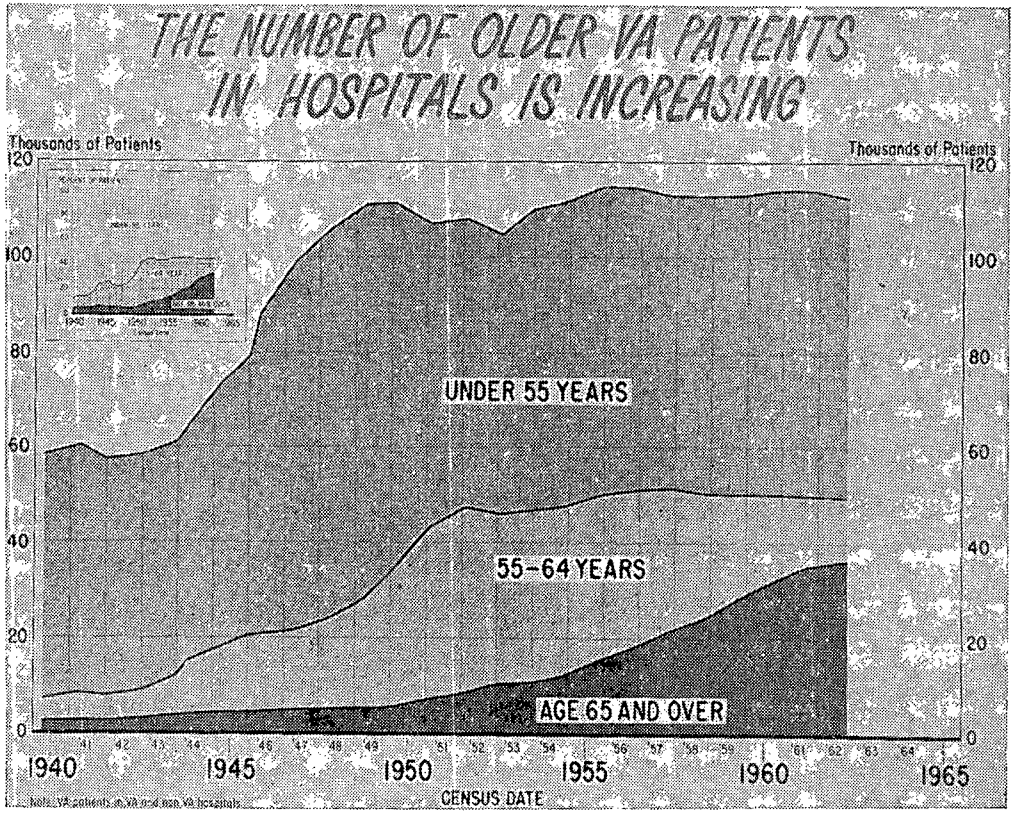
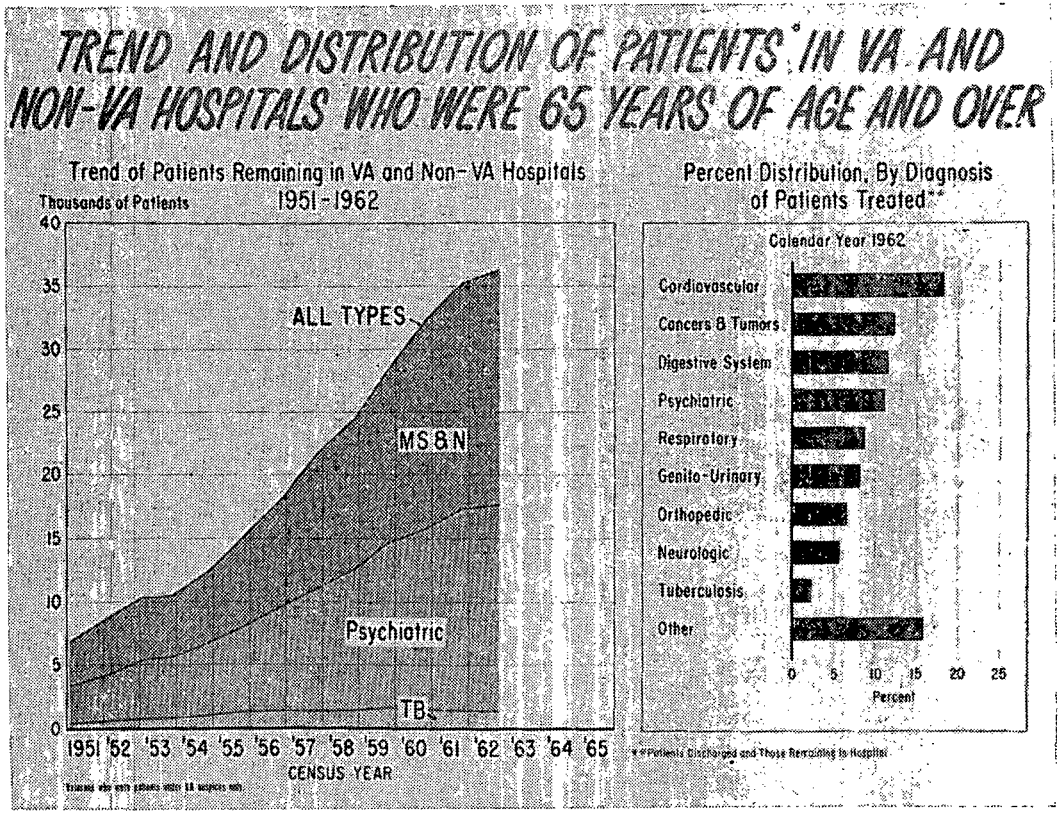

THE NUMBER OF OLDER VA PATIENTS IN HOSPITALS IS INCREASING
Thousands of Patients
Thousands of Patients
120
100
80
60
40
20
0
UNDER 55 YEARS
55-64 YEARS
AGE 65 AND OVER
1940
1945
1950
1955
1960
1965
CENSUS DATE

CHART 6


TREND AND DISTRIBUTION OF PATIENTS IN VA AND NON-VA HOSPITALS WHO WERE 65 YEARS OF AGE AND OVER
Trend of Patients Remaining in VA and Non-VA Hospitals 1951-1962
Thousands of Patients
40
35
30
25
20
15
10
5
0
ALL TYPES
MS&N
Psychiatric
TB
1951 '52 '53 '54 '55 '56 '57 '58 '59 '60 '61 '62 '63 '64 '65
CENSUS YEAR
Percent Distribution, By Diagnosis of Patients Treated**
Calendar Year 1962
Cardiovascular
Cancers & Tumors
Digestive System
Psychiatric
Respiratory
Genito-Urinary
Orthopedic
Neurologic
Tuberculosis
Other
0 5 10 15 20 25
Percent
**Patients Discharged and Those Remaining in Hospital

The bars are arranged in the order of importance which these groups exhibit among the patients aged 65 or more.

5. Age 65 or more (chart 6): Since 1950, as you see on the left, the number of older hospital patients has increased from about 7,000 to 36,000. Diagnostically, cardiovascular disease, neoplasms, and diseases of the digestive system head the list. These accounted for 42 percent of the patients we treated in 1962. In this age group we have more than 36,000 patients in hospital on 1 day, but treat about 200,000 in 1 year.

6. Age 55 to 64 (chart 7): The number of patients in the 55 to 64 age range have decreased. The World War I veterans have aged over 65, and the World War II and Korean veterans have not yet aged over 55 in any significant numbers. This latter element of our patient load has decreased from 38,800 in 1952 to 13,000 last year. It too includes cardiovascular disease as its leading element. The three groups which led in the aged category account for 39 percent of the patients in this age range, but do not include the second highest category—psychiatric disease. In this age group the census on a survey date was 13,100, but we treated more than 65,000 in one year.

7. Age under 55 (chart 8): For the youngest age group, the census of patients has been quite stable—at about 64,000. The three principal diagnostic groups of the 65-year and above category account for only 28 percent of the patients treated here. In this group the psychiatric component is largest. It alone accounts for 25 percent of the patients treated. In this age group there were 63,000 patients under VA care on October 31, 1962, and we treated 323,000 during that year.

OTHER INPATIENT PROGRAMS

In the VA domiciliaries, in our restoration center, and among members in State homes the veterans are drawn from the older age groups. In the next chart (chart 9), the veterans in VA domiciliaries and State homes are shown according to the percent who are older than the age indicated on the horizontal scale. The State homes patient load is the oldest, including 54 percent who are 65 or older. In VA domiciliaries the similar percent is 40. For VA hospital patients the similar percent is 32, while only 10 percent of the entire veteran population is similarly aged.

LONG-TERM PATIENTS

During the past decade it has become increasingly apparent that additional responsibilities and factors have been emerging in the area of medical care for veterans. The operation of the "ability to pay" provision of entitling legislation brings to Veterans Administration, in the non-service-connected patient category, mainly persons with marginal resources to care for short-term illness, and marginal or no resources for the care of long-term conditions. In addition, as persons age, not only does their income decrease but increasingly they have illnesses which do not require the intensive acute treatment of the hospital; yet they are too ill or disabled to meet the standards for independent self-care in the domiciliaries. These are "in-between" veterans whose numbers and categories, and specific needs are as yet ill-defined for the overall veteran population in the Nation,

CHART 7

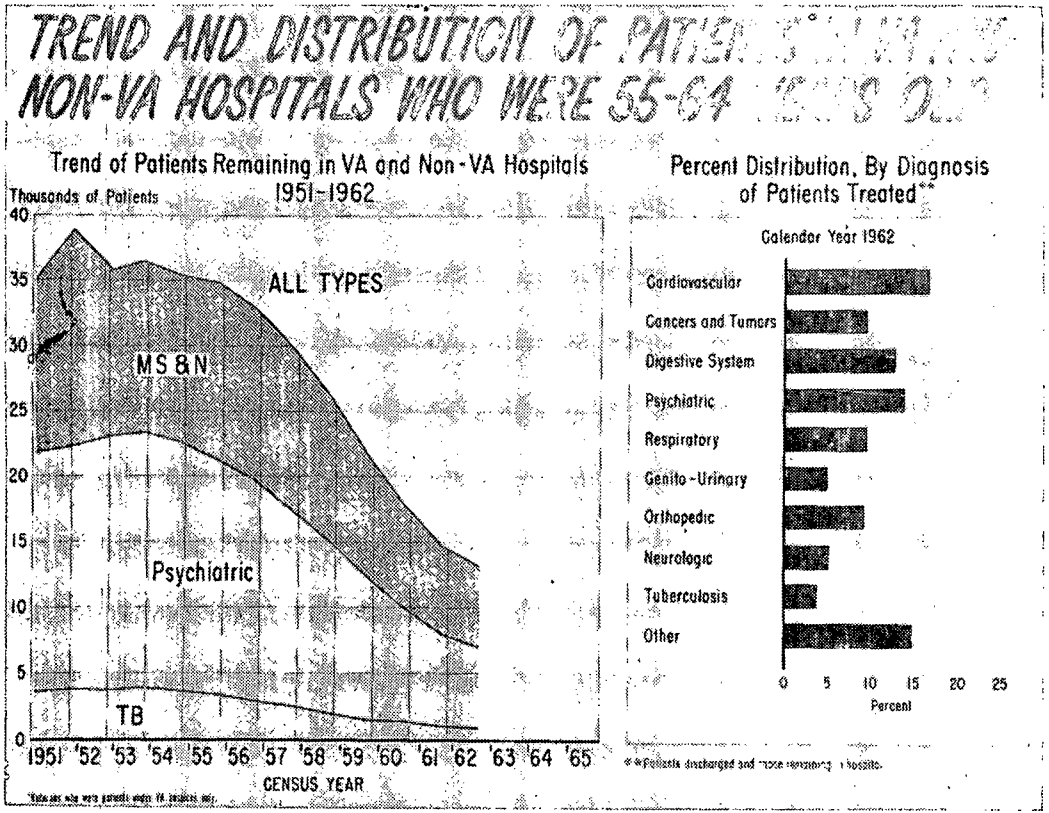

TREND AND DISTRIBUTION OF PATIENTS
NON-VA HOSPITALS WHO WERE 55-64
Trend of Patients Remaining in VA and Non-VA Hospitals
1951-1962
Thousands of Patients
40
35
30
25
20
15
10
5
0
ALL TYPES
MS&N
Psychiatric
TB
1951 '52 '53 '54 '55 '56 '57 '58 '59 '60 '61 '62 '63 '64 '65
CENSUS YEAR
Percent Distribution, By Diagnosis
of Patients Treated**
Calendar Year 1962
Cardiovascular
Cancers and Tumors
Digestive System
Psychiatric
Respiratory
Genito-Urinary
Orthopedic
Neurologic
Tuberculosis
Other
0 5 10 15 20 25
Percent

CHART 8

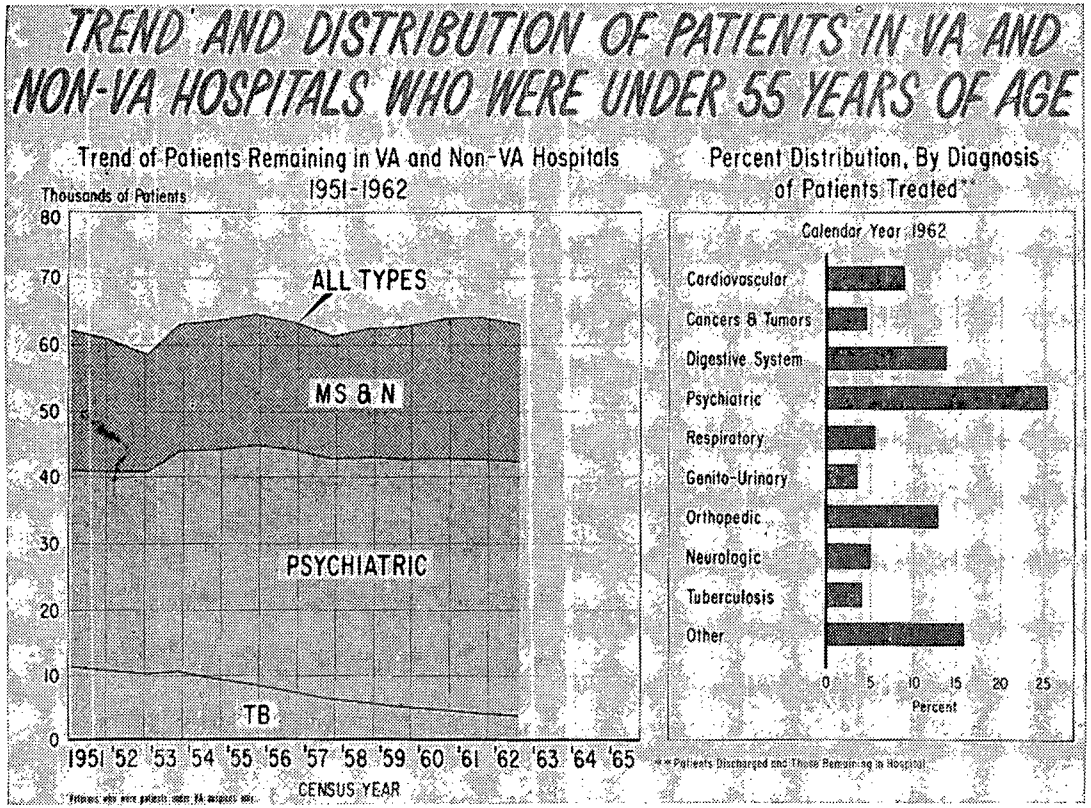
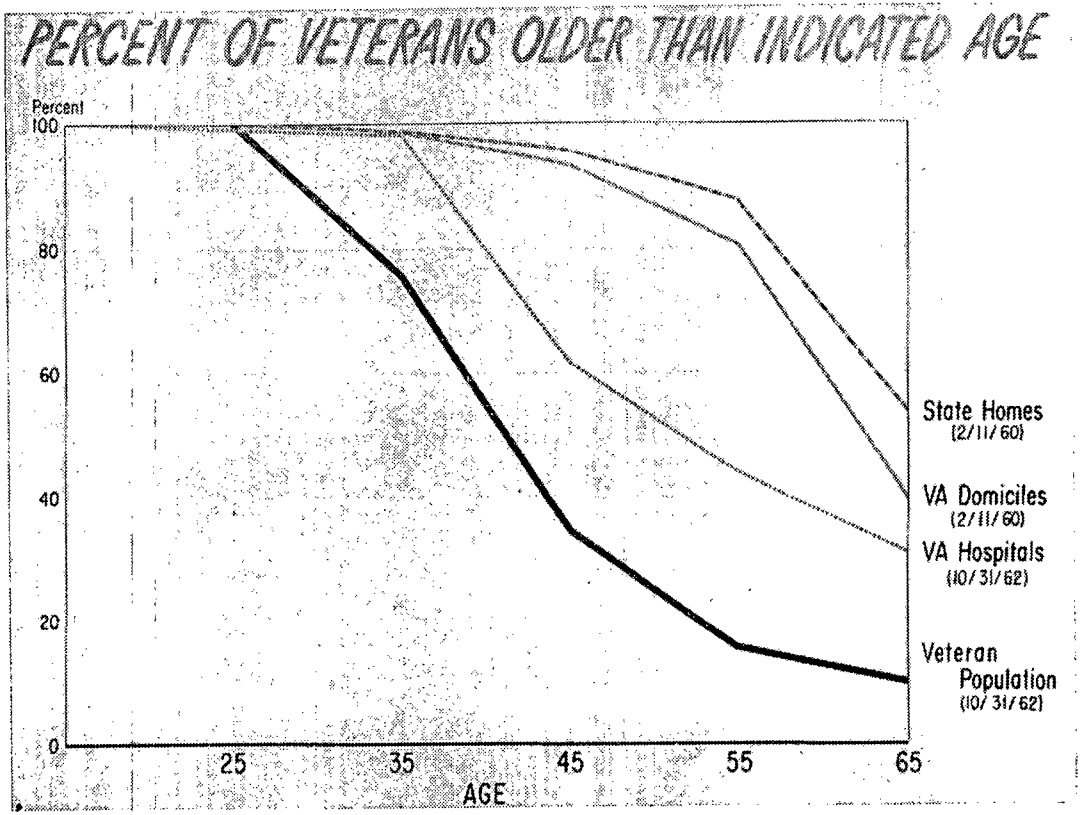

TREND AND DISTRIBUTION OF PATIENTS IN VA AND NON-VA HOSPITALS WHO WERE UNDER 55 YEARS OF AGE
Trend of Patients Remaining in VA and Non-VA Hospitals 1951-1962
Thousands of Patients
80
70
60
50
40
30
20
10
0
ALL TYPES
MS & N
PSYCHIATRIC
TB
1951 '52 '53 '54 '55 '56 '57 '58 '59 '60 '61 '62 '63 64 '65
CENSUS YEAR
Percent Distribution, By Diagnosis of Patients Treated**
Calendar Year 1962
Cardiovascular
Cancers & Tumors
Digestive System
Psychiatric
Respiratory
Genito-Urinary
Orthopedic
Neurologic
Tuberculosis
Other
0 5 10 15 20 25
Percent
** Patients Discharged and Those Remaining in Hospital

CHART 9


PERCENT OF VETERANS OLDER THAN INDICATED AGE
Percent
100
80
60
40
20
0
25
35
45
55
65
AGE
State Homes
(2/11/60)
VA Domiciles
(2/11/60)
VA Hospitals
(10/31/62)
Veteran
Population
(10/31/62)

However, we do have a reasonable fix on those veterans who have entered the VA medical system and then become "chronic" or "long-term" patients in the hospitals, or have regressed in their ability to care for themselves as domiciliary members.

On October 31, 1962, there were more than 10,000 such patients for some of whom outplacement is possible in the medical and surgical beds in the VA general hospitals and more than 2,000 in the domiciliaries. This number has been increasing regularly. Our first surveys, some 6 years ago, placed the level then at about 7,500.

Of these 10,000 in hospital on October 31, 1962, about 46 percent were 65 years of age or more.

In the long range, as we reported to the Senate Committee on Aging in 1961, it is expected that the hospital bed requirements of the entire veteran population will increase—from the level of 187,800 occupied beds in 1957 to 328,100 by 1985 and to 382,000 by the turn of the century. Here we refer to the total need of the veteran population, only part of which is provided by Veterans' Administration.

The VA building and modernization program contemplates about 125,000 beds in its hospitals. In the last several years the rate of VA patient movement has increased, and there have been small but meaningful decreases in duration of stay. Public Law 86–639 which authorized both prehospital and posthospital care for non-service-connected patients has played a role in this achievement. Increased outplacements, and the impending availability of nursing home beds which will free hospital beds for the more acutely ill will also ease the pressures for additional beds. Lastly, the age characteristics, described earlier, of the veteran population during the remainder of this decade, will allow for the further development of programs for optimizing the usage of the 125,000 hospital beds.

In domiciliaries, at this time, the capacity is adequate. Continued adequacy will depend on a continuation of general economic trends and the maintenance of programs designed to make useful alternates to domiciliary care available to prospective members.

There have been various programs developed for the long-term patients depending on professional judgment of needs at particular hospitals, the availability of staff, and relationships with community services. Within the hospital system at this time, many long-term patients are cared for by generalized acute nursing units, such as those of the medical, surgical, and their subspecialty services. Several hospitals have established intermediate care services as separate entities, for those patients who require the long-term use of hospital services and facilities. These patients are characterized by a special emphasis on nursing and rehabilitative measures.

At the VA center, Kecoughtan, Va., a new building has been erected specifically for the care of intermediate patients. This unit is functionally an integral part of the hospital organization and enables patients, whose improvement make it possible, to be outplaced in the community.

The nursing home care units, which we have been authorized to operate, would have a patient composition of veterans not requiring the high intensity of medical skills of the intermediate group but would include those still in need of medical supervision and who require the personal assistance that must be furnished primarily by the registered or practical nurse.

The VA domiciliary facilities provide services for that group of veterans who have disabilities precluding their gaining a livelihood in community living but who are essentially able to care for their own personal needs. The domiciliaries house many veterans who have deteriorated during their stay and who would progressively become candidates for the two previously discussed areas of service or for frequent episodes of acute hospital treatment. During last fiscal year there were 8,800 admissions to our hospitals out of the average daily census of 15,600 members in the domiciliaries.

The restoration center program has been established on a pilot basis with restorative and rehabilitative emphasis for patients with difficult outplacement or adjustment problems. One temporary facility is in operation at Hines, Ill., and another is under construction at East Orange, N.J. The program is intended to assist the family as well as the patient in planning for community living and to guide the restored in the use of community services.

In addition, there are programs that bridge the gap for the veteran between the hospital and the community. Many of these have been devised for the psychiatric patient but also serve the geriatric group of veterans.

You can see the steady increase in community placements of improved psychiatric patients effected by our social service staff in this next chart. (Chart 10.) The number in such placement has increased steadily to 5,095 in 1962. Of this number, 64 percent were placed in foster homes; 29 percent were in special placements such as homes providing employment to patients as part or full payment for their care, boarding homes, personal care homes and group placements, other than halfway houses; and 7 percent were in halfway houses. For the nonpsychiatric patients, our first formal data are available for 1962, but even in that one year there was a substantial effort, with about 5,400 placements in nursing homes and other placements.

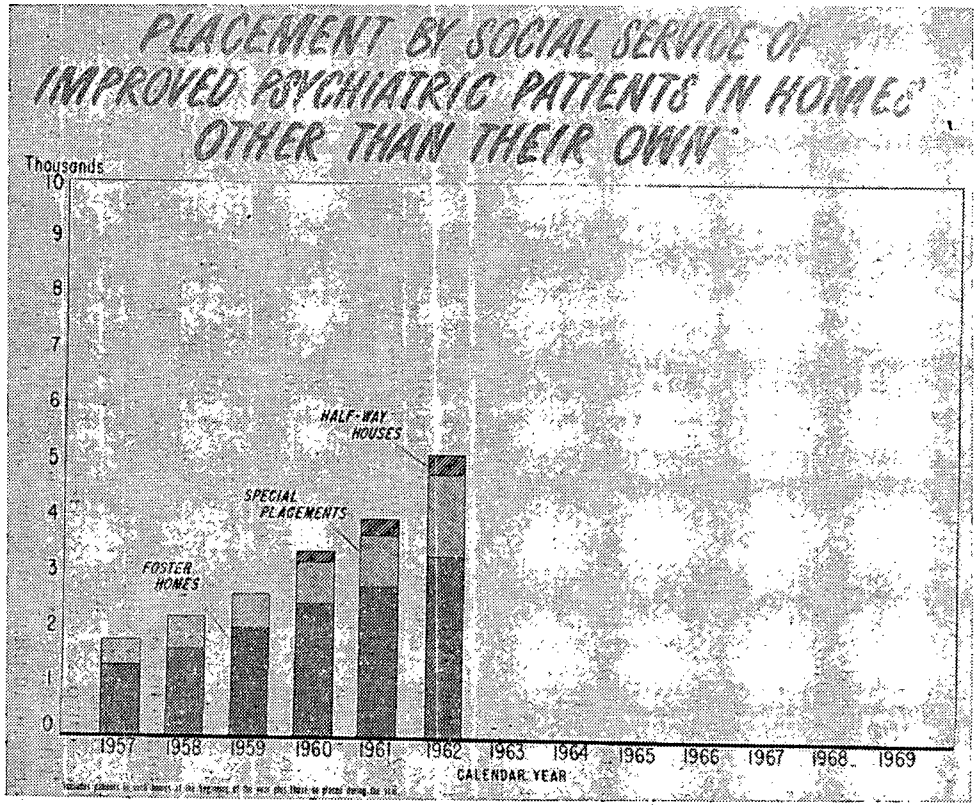
The foster home care program originally was intended for the psychiatric patient, but efforts are now underway to extend this activity to the general medical and surgical geriatric veteran as well.

We have recently conducted a survey among our social service departments to determine the extent to which they were keeping abreast of the community institutional type facilities which might be used to refer or place veteran patients. They have developed a resource list of almost 10,000 of these across the country, and are in possession of substantial information concerning programs offered, staff available, and fees charged, which is needed to guide them in their outplacement activities.

The mental hygiene clinics and day care centers provide supportive care and in many instances prevent continuing hospital care or institutional dependence. There are 67 mental hygiene clinics and 19 day care centers in operation at this time. At the end of fiscal year 1963 the clinics carried a caseload of 60,000, of which 19,000 were under care in the hometown medical care program. There were 443,000 patient visits to the VA mental hygiene clinics, and 113,000 patient visits to the day care centers.

These activities are supplemented in some areas and in varying degrees by the State soldiers' home program. There are 33 of these homes in 28 States which are supported in part by Federal funds (one-half of the per diem cost up to $2.50). The average daily member

CHART 10


PLACEMENT BY SOCIAL SERVICE OF IMPROVED PSYCHIATRIC PATIENTS IN HOMES OTHER THAN THEIR OWN
Thousands
10
9
8
7
6
5
4
3
2
1
0
HALF-WAY HOUSES
SPECIAL PLACEMENTS
FOSTER HOMES
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
CALENDAR YEAR

load, supported as indicated by Veterans' Administration has been about 9,100.

We are proceeding as rapidly as possible with plans to activate the 2,000 beds for nursing home care. These beds will be provided in association and contiguity with VA hospitals. They will be established in existing buildings, as we are not authorized new construction for this purpose. The units will range in size from approximately 24 beds to 120 beds and will be distributed as equitably as possible to provide geographical coverage.

These beds will be utilized for patients in VA hospitals who are no longer in need of hospital care but require nursing service, supportive health services, and consultant services of physicians. Only such patients for whom outplacement attempts have been exhausted will be accepted. The type of care provided will be that which is required to maintain the patient in the best possible mental and physical condition.

We contemplate that the patients admitted to these nursing home care units will require intensive nursing care at the skilled level. Patients who meet the self-care criteria for VA domiciliaries will not be admitted, nor is it anticipated at this time, that patients will be admitted to these beds other than through a VA hospital.

VETERAN HOSPITAL CARE NOT UNDER VA AUSPICES

Most veterans who require hospital care receive it in their community, and most patients who do receive such care from Veterans' Administration return to their own communities.

The 125,000-bed policy was based upon the premise that the care of veterans was a responsibility to be shared by the Federal Government and the local community.

We have examined the extent to which veterans are hospitalized outside of VA auspices. Recently, a survey was made among all hospitals in the United States. It was found that for each non-service-connected patient under VA hospital care on one day, there was one other in hospitals elsewhere. In addition, information from the National Health Survey indicates that for each veteran discharged from VA general hospitals, there were 5.8 discharges from short-term hospitals where Veterans' Administration was not associated in the care.

There are regional variations in the extent to which veterans seek hospital care under non-VA auspices. These are related to the availability of non-VA hospital beds, income levels, and many other socio-economic-medical factors. The percent of veteran residents of each State in hospitals, who are in State, county, municipal, or voluntary hospitals, that is, not in a hospital under VA auspices is shown in these two maps—one for psychiatric, the other for medical, and surgical patients. (Charts 11 and 12.)

I would interpolate that it is extremely interesting to see the tremendous variability nationwide in the number of veterans hospitalized in non-VA hospitals. The States in the darkest shade show the highest percentage. This is for psychiatric patients. High on the list would be New York and Michigan with only 71 percent of the veterans in non-VA psychiatric hospitals.

CHART 11

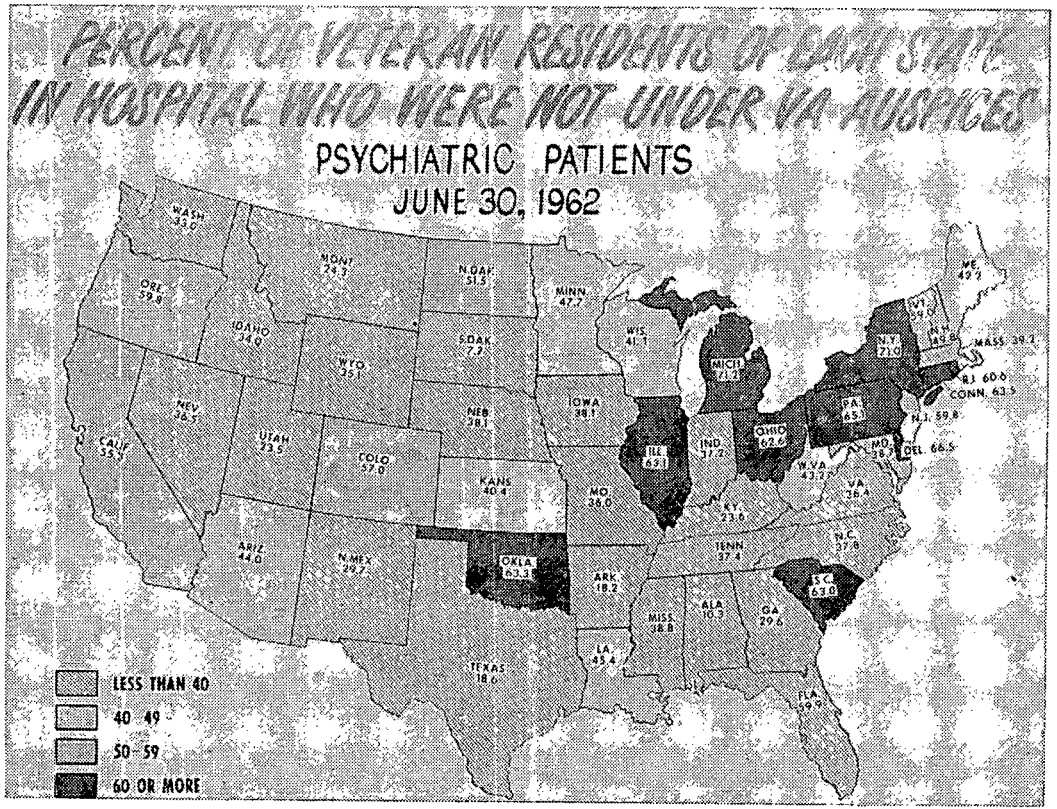
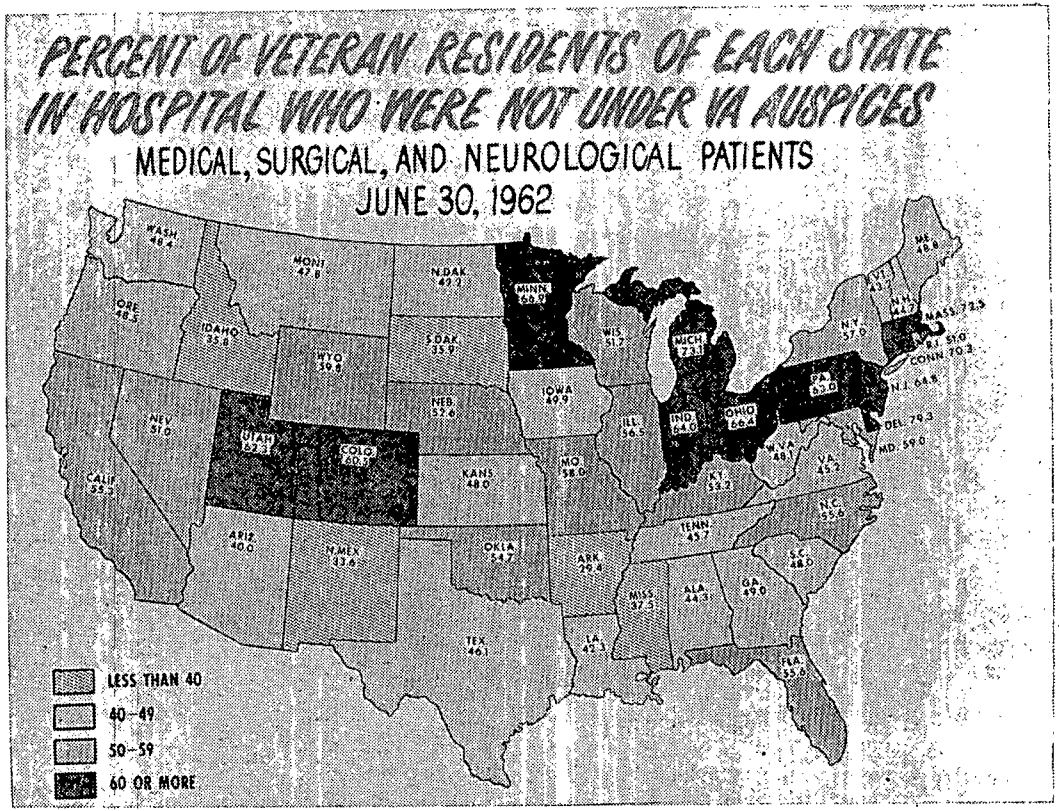

PERCENT OF VETERAN RESIDENTS OF EACH STATE
IN HOSPITAL WHO WERE NOT UNDER VA AUSPICES
PSYCHIATRIC PATIENTS
JUNE 30, 1962
WASH 43.0
ORE 59.6
CALIF 55.9
NEV 36.5
IDAHO 74.6
MONT 74.7
WYO 35.1
UTAH 23.5
ARIZ 44.0
COLO 37.0
N.MEX 29.7
N.DAK 51.5
S.DAK 7.7
NEB 28.1
KANS 40.4
OKLA 63.3
TEXAS 18.0
MINN 47.2
IOWA 38.1
MO 28.0
ARK 18.2
LA 45.4
WIS 41.1
ILL 69.1
MICH 71.1
IND 37.7
KY 23.6
TENN 37.4
MISS 38.8
ALA 10.7
GA 29.6
FLA 59.9
OHIO 62.6
W.VA 43.7
S.C. 63.0
N.C. 37.8
VA 28.4
PA 65.1
N.Y. 71.0
N.J. 59.8
DEL 66.5
MD 58.8
VT 59.0
N.H. 48.8
ME 49.7
MASS 39.1
R.I. 60.6
CONN. 63.5
LESS THAN 40
40 - 49
50 - 59
60 OR MORE

CHART 12


PERCENT OF VETERAN RESIDENTS OF EACH STATE IN HOSPITAL WHO WERE NOT UNDER VA AUSPICES
MEDICAL, SURGICAL, AND NEUROLOGICAL PATIENTS
JUNE 30, 1962
WASH. 40.4
MONT. 47.8
N.DAK. 42.1
MINN. 68.9
ORE. 38.5
IDAHO 35.8
S.DAK. 35.9
WYO. 39.9
WIS. 51.2
MICH. 72.1
N.Y. 57.0
VT. 43.7
N.H. 44.7
MASS. 72.9
R.I. 51.0
CONN. 70.3
N.J. 64.9
PA. 69.8
NEV. 37.0
UTAH 62.1
COLO. 60.7
NEB. 37.4
IOWA 40.9
ILL. 56.5
IND. 64.8
OHIO 66.4
DEL. 74.3
MD. 59.0
W.VA. 48.1
VA. 45.2
CALIF. 55.2
KANS. 48.0
MO. 58.0
KY. 53.1
N.C. 55.6
ARIZ. 40.0
N.MEX. 33.6
OKLA. 47.7
TENN. 45.7
S.C. 48.0
ARK. 39.4
MISS. 37.5
ALA. 44.3
GA. 49.0
TEX. 40.1
LA. 42.3
FLA. 55.0
LESS THAN 40
40–49
50–59
60 OR MORE

It may reflect in large measure the availability of State facilities for this purpose.

In contrast, there are States with almost all of the veterans hospitalized under VA auspices.

Then for medical and surgical patients, similarly the States in the darkest shade are those where 60 percent or more of the patients are hospitalized in non-VA facilities. You will note, Mr. Chairman, that Utah is high up on this list.

Senator Moss. I noticed that, although in the one before Utah was in the lowest group. I wonder about that because we have a very large VA hospital in Salt Lake City, the largest population center there. It is both surgical and psychiatric. I wonder where there would be variance between psychiatric and surgical.

Dr. ENGLE. I don't know. Dr. Henke?

Dr. HENKE. This is the result of the interrelation of the availability of non-VA facilities and the age of the veteran population.

Senator Moss. The new hospital was built, a psychiatric hospital, and draws all that intermountain area. But with the closing of the one up on the avenues they have brought surgical care into that new hospital. I couldn't understand why in one area we would be among the highest and in the other the lowest.

Dr. HENKE. First of all, we are showing the pattern only for the residents of Utah. Veterans from Colorado or Wyoming are shown in their States. Also here is greater accessibility of non-VA hospitals. Many of the acute espisodes that involve the veteran in the GM&S are taken care of in the community. For appendicitis where the doctor sees the patient he goes directly into the community hospital. The GM&S load would be more variable depending on the local factors and the number of acute cases.

Dr. ENGLE. It is very true, Senator, that the demand for hospital care in Salt Lake City at our own installation in both the medical and psychiatric categories has never come up to the expectation. It has always fallen short of what was predicted.

Senator Moss. There is another factor of which I am conscious: Whenever there is a psychiatric problem and it is determined that the person involved is a veteran, it is just routine that they immediately send him off to the veterans hospital there. It is my guess, without having anything to back it up, that the medical or surgical patient who has to go into the hospital and have something done never does get referred or seldom gets referred to the VA but is taken care of in the local hospital of which there are several. There are quite a number of hospitals in the Salt Lake City area.

Dr. ENGLE. We would suggest for the record that the mental health of the people in Utah is above the national average.

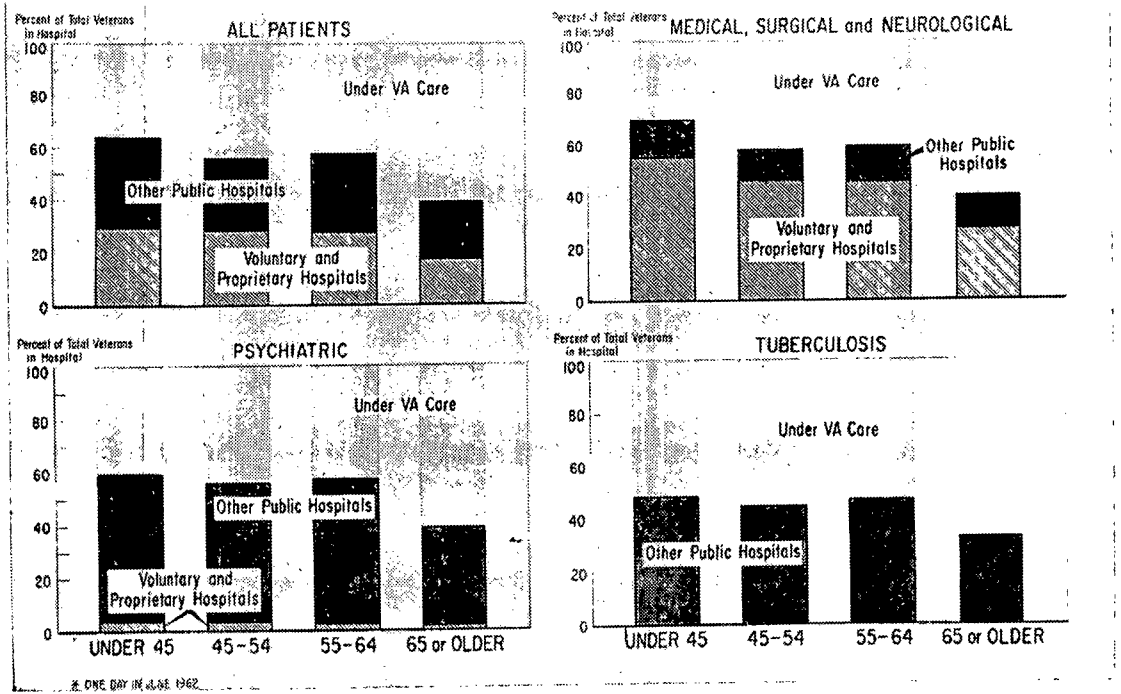
Senator Moss. Thank you. I am glad to have you make the record clear. I was tempted to do that, myself, when I saw the chart. I was going to stand up in protest.

Dr. ENGLE. One variable of some importance is age, and the extent to which care is received outside the Veterans' Administration by veterans, is lower among the older than among the younger veterans.

Chart 13 shows the percent of veterans in hospitals on 1 day, by type of patient and age, who were in non-VA hospitals (Government or voluntary) and in VA hospitals.

CHART 13

THE PROPORTION OF VETERAN PATIENTS IN HOSPITAL FOR NSC CONDITIONS WHO ARE NOT RECEIVING CARE FROM VA DECREASES WITH ADVANCING AGE



In each major medical category as well as in summaries for all patients you note in the older age groups a much higher percentage of the veterans cared for by the VA. Accordingly, a smaller percentage is cared for in other hospitals.

What this pattern of community support may be in the future is difficult to foretell, but the environment for mutual cooperation must be continuously developed.

COORDINATION WITH THE COMMUNITY

Coordination with the community begins when the local VA station establishes working relationships with existing health and welfare agencies. As working understanding develops and cooperative efforts are advanced, the Veterans' Administration and the community are made aware of gaps in essential services to accomplish treatment goals for all patients returning to the community. VA stations recognize their responsibility to become an integral part of their communities and to help develop health and welfare services. The Veterans' Administration does not limit its role to only that of consumer of services for its own patients. VA staff with a background of accumulated experience and knowledge share with all, a concern about problems of basic services, health care, and rehabilitation.

The limited supply of acceptable nursing homes, the inadequacies of public welfare programs, the negative public attitudes toward mental illness and a host of other problems must be faced by communities and the Veterans' Administration as well.

VA stations are involved in a variety of ways with communities. For example, the VA Center, Biloxi, Miss., holds monthly meetings for foster home and nursing home administrators. Programs involve discussion of professional and administrative matters of interest to the administrators of these community facilities. Our VA hospital staff at Chillicothe, Ohio, sparked and promoted community interest in halfway houses and nursing homes. These facilities, later established, were available to all patients, with no more than 20 percent of their occupants veteran-patients.

Urban communities have formally organized agencies and health and welfare councils for planning and coordination. VA staff are active in serving on boards and communities. In this way, the Veterans' Administration demonstrates its interest in the broader concern for services and participates in solving problems between agencies.

Voluntary and service organizations are an important part of the network of services and a prime potential for meeting needs of patients. An example of this type of cooperation comes from VA hospital, Sunmount, N.Y. Social workers expressed their concern for patients in community placements who did not have enough constructive activity to occupy their time. The hospital director presented this need to representatives of voluntary service organizations. The end result, a sheltered workshop and recreation hall for veteran patients who were experiencing difficulty in returning to community living.

Veterans' Administration cooperation is not confined to local communities. Of increasing importance is participation at the State and Federal levels of planning and coordination.

The Veterans' Administration also engages in broad forms of coordination and planning. These include (1) interdepartmental planning at the Federal level; (2) participation through seminars of national voluntary and Federal agencies; and (3) cooperative planning efforts with national voluntary agencies.

An example of the first, is the Administrator's membership on the President's Council on Aging and the participation of members of central office, D.M. & S. staff on working committees.

The second form, participation through nationwide seminars such as the Brandeis University seminar on community planning for the aging and the seminar on protective services under the leadership of the National Council on Aging.

The third form, has involved VA social work services and the Family Service Association of America in the Ford Foundation project on aging which is centered in family service agencies in 40 communities throughout the country.

While the administrative mechanics for this were developed at the national level, the cooperation and implementation is occurring at the local community level.

This completes our formal statement, Mr. Chairman. We shall be glad to answer any questions which the subcommittee may present.

Senator Moss. Thank you, Dr. Engle.

Let me congratulate you on a very comprehensive and well-documented statement. The illustrative charts which you have showed us here and which are appended to the statement make dramatic the points which you have made before us. We are glad to have them for the record.

We are concerned here, of course, primarily with the problems of nursing homes and nursing home care, and provision of this service. The VA has seemed to have exhibited a considerable reluctance toward the idea of expanding its program to include skilled nursing home care. The 2,000-bed conversions you referred to I think was undertaken under Presidential directive and was not initiated by the VA. Not only in the terms of the limited number of beds presently authorized but with regard to the additional thousands of beds that will be obviously needed in the future, what specific plans does the VA have for getting into this nursing home area? Is it going to confine itself solely with cooperation with other agencies or will there be a movement of the VA into nursing homes?

Dr. Engle. I can say first of all, Mr. Chairman, that the Department of Medicine and Surgery at this time is highly receptive to the nursing home program and anxious to gain experience in this field. I think we have acknowledged the fact that this is a very significant problem in our system; that is, the care of patients requiring only nursing home attention.

We are looking forward to the experience that we will get from operating the 2,000 beds and only after that, I think, we will be able to make intelligent projections as to what the demands will be in the future and what our resources will be and what our responsibilities will be in this regard. I think, though even at this time it is very difficult to say, that we can in the future be responsible for all veterans requiring nursing home care because, as you note, there are going to be after 1970 very progressive and tremendous increases in the number of aged veterans. There is a limit to the professional man-

power that we can recruit in the Department for this purpose, and the solution of the problem spreads down through a vast number of communities.

Senator Moss. Do you have any figures or any estimate of how many veterans are presently occupying beds in a veterans hospital who could be adequately cared for in a nursing home?

Dr. ENGLE. There have been a number of surveys on this score and variable statistics but there may be about 10,000 patients in our system that probably could be cared for under some circumstances outside hospital—in nursing homes, their own homes, etc. We are not certain.

Senator Moss. Do you have any plans now for expansion of this 2,000 number?

Dr. ENGLE. We have no present plans; no, sir.

Senator Moss. I understand that in the domiciliary homes these are limited to people who can completely care for themselves there. Is there any plan of changing that or grading that type of care to be able to take care of veterans who do not have full ability to care for themselves but need maybe a minor amount of assistance?

Dr. ENGLE. I would like to refer that question to Dr. Henke, Mr. Chairman.

Dr. HENKE. We have this assistance in some domiciliaries. The domiciliary population is composed of primarily three groups; a group able to take care of themselves, a group that is more or less highly transitory, and lastly a group that has regressed after a period in the domiciliary and are borderline nursing home or chronic hospital care candidates. These three groups are usually supported in a ratio that depends on the number of able bodied who are able to assist those who are more disabled. Almost all of the domicilaries ıdo have a nonduty section or an area where this type of member is taken care of.

Senator Moss. Are there any current plans to expand or increase this kind of care?

Dr. HENKE. Not at this time.

Senator Moss. In your statement you talked about a center that is being erected in Virginia for intermediate type of care. Are there any additional plans for buildings of that sort?

Dr. HENKE. We have no plans for buildings of that sort but in many installations, wards or sections of buildings, have been devoted to this purpose.

Senator Moss. In your statement you referred to a halfway house care. Can you explain that to me?

Dr. ENGLE. Yes, sir; I would like Mr. Anderson of our social service department to explain that.

Mr. ANDERSON. The halfway house is used to describe group living which we use as an inbetween stage from the hospital to the community. It has been used for psychiatric patients who have achieved a status where they can return to the community, but to go directly to the community or to return to their previous environment makes for difficulties. Within the halfway house they do receive supervision, support, and also are given certain guidance and help that they need in this transitory movement to the community. We have not used this type of group living for our general medical and surgical patients. It has been used in our psychiatric group.

Senator Moss. This is a sort of transition care, moving from hospitalization for psychiatric disturbance back into community living?

Dr. ENGLE. That is correct, sir.

Senator Moss. In how many States does the Veterans' Administration operate domiciliary centers; and are veterans in a State without such a center eligible to enter such a center in another State?

Dr. HENKE. The Veterans' Administration has 18 domiciliaries in 16 States. In some States as in California, the VA domicile is connected with the State home in a nonofficial or professional fashion. This relationship and outlet does provide a very good spectrum of care for these individuals.

The domiciliary program has had a decreasing member load. It is now about 15,300 members. Part of this we feel is the availability of social security. In addition with the ability to make better living arrangements on the outside, we are finding that with rehabilitative measures and restorative approaches many of these men in domiciliary are able to go out to the community.

Senator Moss. Is it possible for a veteran from one State to go to a home in another State?

Dr. ENGLE. Yes.

Senator Moss. There is no limitation on that?

Dr. ENGLE. No, sir.

Senator Moss. I wonder if any of you has an opinion as to the effect that the King-Anderson bill might have on the hospital load should it become law?

Dr. ENGLE. I would say without any hesitation that there would be no way that we would have of coming up with a prediction with any degree of validity as to the impact of King-Anderson or similar legislation on the VA. I think it would only be reasonable to say that any program of social legislation similar to King-Anderson should have some effect in lessening demand on VA hospital facilities but the exact degree of this would be most difficult. It would be impossible to say.

Senator Moss. I realized it would have to be an estimate. I was following up the doctor's testimony where he said social security had lessened the number of applicants for domiciliary care. So if we had hospitalization for older people available to them it seems to me it would follow that there would be less pressure on the VA for that sort of hospitalization.

Dr. HENKE. I would like to add that the general economic level is also a factor in the domiciliary picture. We accept in the domiciliary the marginal group, those who are economically marginal as the result of disability. When the job situation becomes acute in an area we do see an increase in number, since they are among the first affected.

Senator Moss. A very high percentage of your patients, VA patients, have non-service-connected disabilities. They also have inadequate resources, which is the major reason for their being admitted. Therefore, if they had available to them hospitalization from another source, it would be reasonable to expect they might use that rather than come to the VA.

Dr. ENGLE. Yes, sir.

Senator Moss. I understand from your statement, Dr. Engle, that you do use some privately operated skilled nursing homes where the

VA assumes some of the financial obligation. Has there been consideration given to expanding that at all?

Dr. ENGLE. No, Mr. Chairman. We are sorry if the statement was confusing in this respect. At the present time we have no authority or no responsibility for nursing home beds outside of the Veterans' Administration. It is true that through the efforts of our social service department and with the sanction of the responsible physician, patients from our hospitals are sent to community nursing homes but the payment for the nursing home is from the patient's own resources. This may in large part be VA compensation or pension but the primary responsibility for the selection of the nursing home is that of the patient and his family, not the Veterans' Administration.

Senator Moss. It comes out of his own resources, then?

Dr. ENGLE. Yes, sir.

Senator Moss. Is there any policy determination yet as to whether the VA might get into this area of assigning patients to a skilled nursing home as part of his medical benefits, assume some or all of the obligation?

Dr. ENGLE. The terms of the Presidential letter authorizing the operation of the nursing home beds, Mr. Chairman, quite specifically said that we were only authorized to operate these beds in existing Veterans' Administration facilities and gave us no authority to go beyond that.

Senator Moss. You consider that your limitation now is within the Veterans' Administration facilities only?

Dr. ENGLE. Yes, sir.

Senator Moss. Do you foresee any difficulties in recruiting medical staffs for your hospital when the greater emphasis goes over to the chronic rather than the acute case?

Dr. ENGLE. Well, as a physician I am somewhat reluctant to answer that because I think that is true. Unfortunately a high percentage of physicians do not find the care of the chronically ill or the long-term patient to be especially stimulating or challenging. We would hope, however, to attract to the VA a group of physicians who do consider this a challenge. It is certainly an area of medicine where much needs to be known. The characteristics of aging veterans are mirrored too in the problems outside the VA because all people, veterans and nonveterans alike, are living longer and the knowledge of disease of older persons and how to cope with them is a challenge to everyone in American medicine. So, in summary we anticipate some difficulty, yes, sir, in attracting sufficient physicians to competently care for this load. We choose to be optimistic about it.

Senator Moss. Because this is a growing area?

Dr. ENGEL. Yes, sir.

Senator Moss. And therefore is a challenge to the medical profession?

Dr. ENGEL. Yes, sir.

Senator Moss. I meant to ask this question earlier: I wondered why the high percentage of veteran patients were in the neuropsychiatric field among the lower age group.

Dr. ENGLE. Because major psychiatric illness starts in the relatively earlier decades of life, from 20 to 30 and 30 to 40. The major psychiatric disease is schizophrenia. This characteristically starts in these age groups, in veterans and nonveterans alike.

Senator Moss. This is not peculiar then to a new breed of veteran which has come on?

Dr. ENGLE. No, sir; the same thing would be true of the population in general. As outside the VA, 50 percent of our beds are devoted to psychiatry.

Senator Moss. Would this also be in part due to better diagnosis and attempts to treat psychiatric disturbances now than we have in times past?

Dr. ENGLE. Partly, but this would be tempered by better treatment modalities available now in contrast to the past, so that a patient admitted for the first time to a psychiatric hospital now has a much, much better chance of being returned to the community and living a useful life than he would have had 20 or 30 years ago.

Senator Moss. With this high number of patients, psychiatric patients in the VA hospitals and in view of the testimony that we had from the Public Health Service people that there is a trend successfully to transfer many of these to skilled nursing homes and then on out, do you see a likelihood that the Veterans' Administration might follow a similar pattern?

Dr. ENGLE. Yes, sir. We would certainly hope that many of our psychiatric patients could be cared for in such community facilities.

Senator Moss. Is this the reason that you in your statement say you have developed this list of about 10,000 of these community facilities across the country?

Dr. ENGLE. Yes. I might add a comment here because it ties in with one of your earlier questions, Mr. Chairman. This current fiscal year money is going to be appropriated as a line item by the Congress which will allow us to intensively study the nursing home question in a sample of communities. This will be done to determine how many patients hospital or domicile members would be in need of nursing home care or other forms of community environment and to study the availability of necessary resources in the community. At the completion of this study we would hope to have much more accurate information. We would then expect to be better able to identify the present number of VA patients requiring nursing home care, the suitability of facilities in the community for this purpose and the future levels of each.

Senator Moss. Do you expect this study to be completed in the next calendar year?

Dr. ENGLE. Depending on when the appropriation is passed, sir, because it is an item in the appropriation. We would get on with it as fast as we could.

Senator Moss. Well, I cannot give you any assurance as to when the appropriation will be passed.

Thank you very much, Dr. Engle, and your associates. We appreciate your coming. This has indeed been an excellent exposition. We are very pleased to have it.

Dr. ENGLE. Thank you, Mr. Chairman.

STATEMENT OF MRS. NELL STEPHENS, GEORGIA REGISTERED LICENSED PRACTICAL NURSE

Mrs. STEPHENS. I would like to say a word to you in connection with this legislation. There is much need of nursing homes in connection with the Veterans' Administration. I happen to have had experience this last October, November, and December, being in Augusta, Ga.

Senator MOSS. Will you sit down here a minute and give your name.

Mrs. STEPHENS. I am Mrs. Nell F. Stephens, a Georgia registered practical nurse. I am registered lobbyist with Congress and have been for over 12 years.

Senator MOSS. Is your home in Georgia?

Mrs. STEPHENS. No; my home is in Washington, D.C., at the moment. We have been here 12 years. But I continue to have my Georgia registration. I have worked on this legislation and many things regarding nursing homes. That is my interest; that is my profession. This particular legislation I have not had an opportunity to go over and read everything that is in it, but I think it is much needed.

Senator MOSS. We do not have any particular legislation before us, Mrs. Stephens.

Mrs. STEPHENS. That is what I thought. I didn't think I had lost out on anything, because I had been on private duty.

Senator MOSS. We have no legislation before this committee at the present time. We are making inquiries into this whole field.

Mrs. STEPHENS. Then I am happy to state to you the need is great for a nursing home in connection with the Veterans' Administration. Dr. Niles down at the Columbia VA Hospital, director of the Department in that area, and Dr. Freedman over at the Veterans' Administration hospital in Augusta, Ga.—I happen to have my brother veteran of World Wars I and II—called me to help them with him. I said of course I will. That is the reason I wasn't available the last few months here. So I learned in doing so for my brother there were many, many veterans who absolutely had no place to go. Yet they do have a domiciliary home down in Thomasville, which Thomasville people do not like. Therefore, I would not say it is a success at all, but I feel that the need is great. As I said to the doctors down there, I wish I could go to Augusta and make a nursing home in connection with the VA, but separate from the VA hospital, itself; however giving them nursing home care, making a home for them. That is my idea of any nursing home. If a patient needs hospitalization, he needs to be hospitalized then put the patient back in the Linwood division or what division of medical need to go to. That would be very helpful because there are so many veterans whose families have rejected them.

Fortunately, my brother is very, very happy about the whole situation. He is at home now with his wife and family in Charleston, S.C., getting along wonderfully well. He was a victim of mustard gas poisoning in World War I. It has continued over a period of years. Every now and then he has to go back. In visiting him I have seen so much need for this type of care and I am happy to be with you and I will help you in any way that I can.

Forgive me for not having this in writing, but I will do my best and submit anything I can that will be helpful. I assure you that the doctors in Augusta with the VA will be happy to know I am here, that I have had these moments to say this to you. Congratulations, Mr. Moss, it is a much-needed project.

Senator Moss. It is indeed, Mrs. Stephens. We appreciate your coming here. We are glad to have your statement in the record. We are convinced there is a great need in this area. That is the reason we are exploring it.

Mrs. STEPHENS. That would employ more licensed practical nurses.

Senator Moss. Yes, it would.

Mrs. STEPHENS. The situation all over the country is not like it is in Washington, D.C. Some day we will have legislation for the licensed practical nurses. We are working toward that.

Thank you, Mr. Moss. God bless you all and merry Christmas to you.

Senator Moss. Thank you very much.

The hearing will now be in adjournment subject to the call of the chairman.

(Whereupon, at 11:50 a.m. the committee was recessed subject to call.)

○